Wellfleet and Cigna Colorado Network Access Plan

Cigna Preferred Provider Organization (PPO) Network

Quality Assurance Standards

Quality Program Scope

The Quality Program provides direction to management for the coordination of both quality improvement and quality management activities across all departments, matrix partners, health services affiliates and delegates. The Program promotes communication across departments, outlines quality-monitoring standards, monitors results to ensure the achievement of established goals, and provides guidance in initiating process improvement initiatives when opportunities are identified. Quality Improvement Projects are designed and documented to objectively and systematically monitor, evaluate and improve the quality, customer safety, and appropriateness of care and service.

Quality Program Goals

- Promote and build quality into the organizational structure and process.
- Maintain an effective quality committee structure that fosters communication across matrix areas, collaboratively works towards achievement of established goals to performance metrics, monitors progress of improvement efforts to established goals, and provides necessary oversight and leadership reporting.
- Enhance consistency in quality program activities.
- Ensure that the Program supports the organization's mission to improve the health, well-being, and sense of security of the customers we serve, including those customers with complex health needs.
- Ensure that the Program is sufficiently organizationally separate from the fiscal and administrative management to ensure that fiscal and administrative management does not influence decision-making.
- Validate quality program results and customer impact through pursuit and maintenance of external accreditation.
- Validate quality program results and customer, health care professional and client satisfaction through the initiation of surveys or analysis of other activities.
- Ensure consumer confidence and safety by meeting applicable accreditation, state and federal regulatory requirements.

Quality Program Measurement Activities

- Reviewing performance against key indicators as specifically identified in the quality work plan or quality committee scorecards.
- Evaluating satisfaction information, including survey data and complaint and appeal analysis.
- Evaluating access to services of its contracted health care professionals.

Annual Evaluation

An annual evaluation is conducted to assess the overall effectiveness of the various organizations' quality improvement processes. The evaluation reviews all aspects of the Quality & Medical Management Programs with emphasis on determining whether the Program has demonstrated improvements in the quality of health care professional care and services that are provided through the organizations. The annual evaluation includes:

- The impact the quality improvement process had on improving the services provided to customers and healthcare professionals.
- An assessment of whether the year's goals and objectives were met.
- A summary of key program performance indicators, comparison to previous year results, and/or an evaluation of whether goals were met.

- Potential and actual barriers to achieving program goals, which may include a review of whether resources were adequate to meet established quality or performance standards.
- Recommendations for program revisions and modifications for the coming year.

The annual evaluation is reviewed and approved by the Medical Management Quality Committee and the Quality Management Governing Body. The results of the annual program evaluation are used to develop, update and prioritize activities for the annual work plan for the upcoming year.

Access Plan Elements

Provider and Facility Availability

Cigna's adheres to a provider and facility availability policy which helps ensure that Cigna maintains an adequate network of health care professionals and facilities and monitors how effectively the network meets the needs and preferences of its clients and meets the Colorado requirements for having and maintaining an adequate network. The provider availability policy also helps ensure that the provider network meets the availability needs of clients by annually assessing three (3) aspects of availability (Assessments are performed against Cigna's book of business.

- Geographic distribution - participating health care professionals are within reasonable proximity to clients.
- Number of health care professional(s) - an adequate number of participating health care professional(s) are available, and
- Cultural, ethnic, racial and linguistic needs and preferences of participating health care professional(s) meet the cultural, ethnic, racial and linguistic needs and preferences of clients.

The Cigna National Network Development Team conducts an annual audit of provider availability by state/market. The audits are conducted utilizing available software such as GEO Access, Quest Analytics or Map Xtreme, using established standards to ensure a sufficient number of participating health care professionals and facilities. The audit is conducted to ensure that Cigna is complying with the CO network adequacy requirements. (Note, assessments are performed against Cigna's book of business only. The measurements used for Colorado are noted below. Wellfleet provides Cigna with a list of our Colorado School Plan members and Cigna uses that enrollment list to complete the CO Enrollment template to assess provider to member ratios.

As required by Colorado regulations, the following availability standards are followed:

Access to Service/Waiting Time Standards

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met > 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care-Routine, non-urgent, non-emergency	Within 7 calendar days	Met> 90% of the time
Prenatal Care	Within 7 calendar days	Met> 90% of the time

Primary Care Access to after-hours care	Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician	Met> 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met> 90% of the time
Specialty Care – non urgent	Within 60 calendar days	Met > 90% of the time

In remote or rural areas, occasionally these geographic availability guidelines are not able to be met due to lack of, or absence of, qualified providers and/or hospital facilities. Cigna may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval.

Cigna Behavioral Health also has facility, clinic and individual practitioner contracting policies in place to help ensure adequate coverage for behavioral health needs.

In the event that Cigna determines that the network does not meet the adequacy requirements, Cigna's medical recruitment team (MRT) is engaged. The MRT makes phone call and/or sends e-mails to viable providers. A minimum of 3 attempts are made to the Provider. Any interested Provider is sent materials to allow the Provider to join the network.

Medical Services Accessibility

Accessibility to medical care is formally assessed against standards at least annually.

Accessibility standards for customers are as follows:

- Emergency: Immediately. 24 hours a day, 7 days a wee
- Urgent: Within 24 hours* (Urgent medical needs are those that are not emergencies but require prompt medical attention, such as symptomatic illness and infections).
- Symptomatic Regular and Routine Care: 7-14 days, or within the timeframe specified by treating physician
- Preventive Screenings and Physical: Within 30 days
- Obstetric Prenatal Care**:**
  - High-risk or urgent: Immediately
  - Non-high risk and non-urgent: 1st trimester, within 14 days; 2nd trimester, within 7 days, 3rd trimester, within 3 days
- Routine and Symptomatic Diagnostic Testing**:** Within the timeframe specified by treating health care professional. Appointments for symptomatic testing are usually provided in shorter timeframes than routine testing
- After hours care: Health Care Professional provides 24-hour coverage, if available.

Referral Policy

Prior Authorization for Inpatient Services

Prior authorization is required for all non-emergency inpatient admissions and certain other admissions. Failure to obtain prior authorization prior to an elective admission to a hospital or certain other facility may result in a penalty or lack of coverage for the services provided. Prior Authorization can be obtained by the customer or provider by calling the number on the back of the customer's ID card. Emergency admissions will be reviewed post admission. Inpatient prior authorization reviews are conducted for both the necessity for the admission and the need for continued stay in the hospital.

Ongoing Monitoring

Health Care Professional Availability and Accessibility monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established standards for reasonable geographical location, number of practitioners, hours of operation, appointment availability, provision for emergency care and after-hours services are measured. (Note, assessments are performed against Cigna's book of business. Monitoring activities may include evaluation of satisfaction surveys, on-site visits, evaluation of complaint and appeal reports, geo-access surveys, evaluation of health care professionals to member ratios, and monitoring of closed primary care physician panels. An assessment of the health care professional network is also performed to ensure that the network meets the cultural, ethnic, racial and linguistic needs and preferences of individuals. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance. Data are presented to the Service Advisory Committee for evaluation and recommendations. (Note, assessments are performed against Cigna's book of business. Wellfleet provides Cigna with a list of our Colorado School Plan members and Cigna uses that enrollment list to complete the CO Enrollment template to assess provider to member ratios.

Needs of Special Populations

Training

- Cultural competency and clear communication training designed to increase the knowledge and skills of staff working with diverse individual populations. Regular meetings with medical management staff and health management employees to discuss cases that involve specific cultural issues.
- Making resources available to staff; e.g. cultural resource center and newsletters

Pilots

- Pilot project teams in partnership with network health care professionals, communities, or other healthcare constituents to identify barriers to testing and treatment within certain at-risk sub-populations and develop actions/initiatives to remove those barriers. If successful, the pilot projects serve as blueprints for future programs.

Data Efforts

- Development of central repository of cultural and linguistic activities to be used as reference point for future activities.
- Tracking and trending language program service utilization.

Communication Efforts

- Implementation of clear health communication and translation policies addressing health literacy and the needs of limited English proficient individuals.
- Development of a central repository providing access to documents translated into non- English languages.
- Language proficiency testing for bilingual staff with direct customer contact.
- Employee Resource Group (ERG) efforts √ training and using employee resource groups to improve the individual's experience, by informing culturally appropriate communications and interventions.
- Words We Use (Spanish and Traditional Chinese) Guidelines - guidelines for staff that offer everyday Spanish or Chinese words for health care jargon commonly used.
- Translation efforts - identifying translation needs from across the company.
- Facilitating cultural reviews and translation reviews of print and electronic customer messaging based on requests from business units across Cigna.
- Cigna HealthCare Directory audit - identifying gaps in reported language for physicians and office staff and reporting back to the HealthCare Directory Book of Records team.

Health Needs Assessment

Healthcare professional satisfaction is assessed through evaluation of survey data and complaint information. Satisfaction surveys are designed to assess satisfaction with the organization's services. Survey data are used for continuous quality improvement in several key areas: 1) to establish benchmarks and monitor national and local performance 2) to assess service performance in comparison to competitors, 3) to assess medical management program health care professional satisfaction levels and 4) to assess the quality and accuracy of benefit information provided on the organization(s) web sites.

Coordination Activities

Specialty Case Management

Case managers with special expertise and training in a therapeutic area deliver specialty case management services. They work collaboratively with specialty physician leads as a team to enhance care coordination, address gaps in care and help individuals be informed, active participants in the health care process. These specialized resources adhere to the same case management process noted above, and focus on high impact conditions that have proven to be at risk for complications and subsequent high health care utilization. The specialized team goals are to facilitate access to appropriate services in order to improve the medical outcomes for these individuals, and, thereby, decrease utilization and cost. Specialty Case Management Services are available depending upon contract terms and may include the following specialties:

- Transplant

Wellfleet

Access Plan

A copy of this Network Access Plan is available to members on the Wellfleet website on this URL https://wellfleetstudent.com/forms/. Members may also contact the Wellfleet Customer Service team at the phone number on their I.D. card to obtain a copy of the access plan.

Out-of-Network Provider Paid at In-Network Level

Wellfleet has an "Out-of-Network Provider Paid at In-Network Level" guideline for our Customer Service Representatives to follow to assist members who contact the Wellfleet Customer Service team using the number on their member I.D. card. This guideline applies when there are no in-network participating providers available to treat a member as outlined in the guide. This provision is also outlined in the member's Explanation of Coverage (EOC).

Continuity of Care

Wellfleet has a "Continuity of Care" guideline for our Customer Service Representatives and Clinical Team to follow to assist members who contact the Wellfleet Customer Service team using the number on their member I.D. card. This guideline applies when a participating provider leaves a network while a plan member is in an active course of treatment. This provision is also outlined in the member's Explanation of Coverage (EOC).