Quality Improvement Program Description 2023

Capital Blue Cross Medicare Advantage

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I. Introduction

A. Summary of the Quality Improvement Program

Capital Blue Cross (Capital) administers a comprehensive Quality Improvement (QI) Program on behalf of its subsidiaries Capital Advantage Assurance Company® (CAAC), Keystone Health Plan® Central (KHPC), and Capital Advantage Insurance Company (CAIC). The QI Program encompasses all aspects of care and services provided to the entire diverse population for Capital. The QI Program is based on the principles of continuous improvement regarding the quality, safety, and health of the members, and improving the member and provider experience in the delivery of care.

Capital's QI Program Description provides detailed quality improvement strategies for Capital's Medicare Advantage products including Capital Blue Cross | WellSpan Health. Capital's corporate strategy, accreditation, governmental, and other regulatory requirements, serve as the foundation for the QI Program's strategic planning. The QI Program aligns with national, regional, and local trends and supports Capital's mission and vision. As the healthcare industry is rapidly evolving, Capital's QI Program is a fluid plan that can be adjusted as needed to respond to the ever-changing environment.

B. Capital Blue Cross' Mission and Vision

Capital's mission is to improve the health and well-being of our members and the communities in which they live.

Capital's vision is to earn the trust of our customers by improving the physical and emotional health of our members, and by delivering on our promise of a premier customer experience.

II. Quality Improvement Program Structure

A. Organizational Structure

Capital's subsidiaries, CAIC, CAAC, and KHPC each have their own Board of Directors. The QI Program is administered using the same structure and processes for all of Capital.

B. Authority and Responsibility

The CAIC, CAAC, and Capital Boards of Directors have delegated to the KHPC Board responsibility for receiving, reviewing, and approving information related to the QI Programs.

The KHPC Board has delegated oversight of the program to the Senior Vice President and Chief Medical Officer of Capital and the Quality Improvement Committee (QIC). This includes an annual review and approval of the Quality Improvement Program Description (QIPD), an annual and periodic review and approval of the QI Work Plan, and an annual review and approval of the Quality Improvement Program Evaluation (QIPE). The KHPC Board reviews and approves the annual QIPE. The Senior Vice President and Chief Medical Officer delegates to the Director of Quality Improvement and Accreditation the responsibility to establish, maintain and support the QIP. Various personnel execute day-to-day operational activities.

C. Quality Improvement Program Committee Structure

The QIP committee structure includes the QIC as well as sub-committees that are responsible for oversight of the QIP at Capital. The QI Committees provide direction and continuous monitoring of quality improvement initiatives in the areas of quality of clinical care, quality of service, the safety of clinical care, and member and provider experience.
Refer to *Attachment A: Quality Improvement Committee Structure*.

1. Quality Improvement Committee (QIC)

The Quality Improvement Committee (QIC) provides direction and continuous monitoring of the Quality Improvement (QI) initiatives in the areas of clinical care, service, patient safety, and member and provider experience. The Committee monitors progress toward meeting all the QI program goals and objectives through an annual review of Capital's program descriptions, program evaluations, and work plans. The QIC continually strives for excellence and quality in healthcare delivery and services to the members, customers, and the community.

The Senior Vice President and Chief Medical Officer, or designee, Chairs the Quality Improvement Committee (QIC), and has the authority to oversee the QI Program. The participating providers are representatives of specialties in Capital's network. Capital's designated behavioral health provider is a psychiatrist who participates in and advises the QIC and the improvements for the QI Programs.

The viewpoint of these providers who practice in the community can assist Capital with continuous quality improvement efforts to identify opportunities and implement programs that will improve member safety as well as the care and service delivered to members. The provider's background, expertise, and knowledge of the local health delivery system and the characteristics of the population make the local provider an important member of the quality improvement team.

Composition:

- Executive Sponsor – Senior Vice President and Chief Medical Officer.
- Chairperson – Senior Medical Director, Member Health and Wellness.
- Vice President, Population Health.
- Senior Director, Network Management.
- Senior Director, Utilization Management.
- Director, Quality Improvement and Accreditation.
- Senior Director, Population Analytics and Quality.
- Associate General Counsel.
- NCQA Quality and Accreditation Team Lead.
- Senior Quality Improvement and Accreditation Consultant.
- At least eight external providers and varying specialties are reflective of Capital's network.

Responsibilities:

- Review and approve the Quality Improvement Program Description (QIPD), Quality Improvement Program Evaluation (QIPE), and QI Work Plan.
- Analyze data related to quality metrics and member access to healthcare.
- Evaluate and approve significant clinical initiatives, and programs to ensure appropriate clinical input from providers.
- Review, monitor, and evaluate Capital's quality improvement activities to determine the effectiveness.

2. Internal Quality Improvement Committee (IQIC)

The Internal Quality Improvement Committee (IQIC) is a multidisciplinary committee of subject matter experts. This committee of cross-functional leaders provides a framework for the planning, organization, and oversight of the strategic activities and interventions that are focused on continuous improvement in the quality and safety of clinical care and services provided to the members. The QIC Chair approves the committee composition of the IQIC. The Committee ensures focus on these key elements in interactions with all healthcare system stakeholders (members, providers, employers, and vendors) and the alignment and

integration of the QI Program with Capital's overall health plan improvement strategy. The IQIC is responsible for the oversight of activities delegated to the vendors that provide healthcare-related services and can function on behalf of Capital.

Composition:

- Executive Sponsor – Senior Vice President and Chief Medical Officer.
- Chairperson – Senior Medical Director, Member Health and Wellness.
- Vice President, Population Health.
- Vice President, Pharmacy Strategy and Services.
- Vice President, Core Operations.
- Vice President, Provider Partnerships.
- Vice President, Brand and Market Strategy.
- Vice President, Analytics and Reporting.
- Managing Medical Director.
- Senior Medical Director, Medical Policy and Coding.
- Senior Director, Vendor Alliances.
- Senior Director, Individual Markets and CHIP.
- Senior Director, Population Analytics and Quality.
- Senior Director, Utilization Management.
- Senior Director, Care Management.
- Director, Behavioral Health.
- Director, Medical Management Compliance.
- · Director, Commercial Appeals and Grievances Resolution.
- Director, Quality Improvement and Accreditation.
- Corporate & ACA Compliance Officer.
- Medicare Compliance Officer.
- NCQA Quality & Accreditation Team Lead.
- Senior Quality & Accreditation Consultant.

Responsibilities:

- Review performance metrics, audit reports, and/or outcomes of QI activities and interventions to monitor and identify cross-functional opportunities for quality improvement.
- Incorporate the Plan, Do, Study, Act (PDSA) cycle in the identification of improvement Opportunities.
- Review performance reports and annual audits of delegated vendors that provide healthcare-related services to Capitals' members.
- Review and approve the Quality Improvement Program Description (QIPD), QI Work Plan, and QI Program Evaluation.
- Review and approve the Population Health Management (PHM) Strategy and analysis of the PHM Strategy impact.

3. HEDIS® STAR CAHPS® Plan Performance Improvement Committee

The mission of the HEDIS® Stars CAHPS® Plan Performance Improvement Committee (HSC PPIC) is to ensure that the organization improves the quality and effectiveness of care to the members improve the overall plan for performance ratings and improve Capital's ability to offer competitive and sustainable products in the market.

The HSC PPIC is a subcommittee of the IQIC. The Committee educates and promotes cross-functional information sharing of all Capital's activities being pursued and/or implemented to

maintain, improve, and report on Capital's performance for Healthcare Effectiveness Data Information Set (HEDIS®), Five-Star Quality Rating System (Stars), and Consumer Assessment of Health Providers and Systems (CAHPS®).

Composition:

- Executive Sponsors – Senior Vice President and Chief Medical Officer, Senior Vice President Government Programs, Senior Vice President, and Chief Informational Officer.
- Chairs: Vice President Data Governance and Clinical Partners Data Integration, Vice President, Population Health.
- Senior Medical Director, Member Health and Wellness.
- Director, Population Analytics.
- Director, Quality Improvement and Accreditation.
- Manager, Member & Customer Experience.
- Director, Network Strategic Implementation.
- Lead Business Consultant for Analytics and Reporting.
- Senior Plan Performance Consultant.
- Director, CHIP.
- Senior Director, Product Innovation.
- Senior Director, Individual Markets & CHIP.

Responsibilities:

- Clarify and socialize plan performance objectives.
- Confirm and help determine ownership of various tasks, decisions, and initiatives tied to Stars, HEDIS®, and Regulatory/Accreditation-related survey performance; and consults, as needed, to help determine initiatives and decisions on plan performance activity.
- Confirm and coordinate timelines with all operational areas that impact plan performance.
- Promote transparent, cross-functional information sharing and reporting regarding plan performance.
- Coordinate and help to ensure alignment of decisions that impact plan performance, including decisions concerning HEDIS® reporting software; data integration and governance; gaps-in-care prioritization and focus areas; supplemental data acquisition; resource requests; and plan performance improvement strategies.

4. Member Safety Program

Capital's Member Safety Program provides a framework to allow swift and appropriate action to be taken when a potential safety event involving one of our members is identified. Additional program components include follow-up on confirmed member safety concerns, interventions and monitoring of provider performance issues, and tracking and trending of data. A cross-functional Member Safety Committee is tasked with oversight of Capital Blue Cross' Member Safety Program and meets minimally on a monthly basis, or ad hoc for urgent/emergent Potential Member Safety Concerns (PMSC). The Member Safety Committee is co-led by A Senior Medical Director and the VP of Provider Partnerships. Committee representation also includes staff from the Appeals and Grievances Resolution Unit (AGRU), Network and Contract Management, General Counsel, and Sales and Marketing. Committee findings are reported as needed to Capital's Internal Quality Improvement Committee (IQIC) and/or Quality Improvement Committee (QIC).

Member Safety Committee responsibilities include:

- Immediate action/investigation of significant urgent/emergent Potential Member Safety Concerns (PMSCs), especially Serious Reportable Events (SREs).
- A comprehensive review of PMSCs with high severity ratings, including a review of providers who have met/exceeded thresholds for trended PMSCs.
- Oversee provider performance issues.
- When member safety issues have been confirmed, recommend additional actions to be taken including but not limited to:
- Development, implementation, monitoring, and resolution of provider corrective action plans or other monitoring activities, including claims review and/or chart audit.
- Limits, suspension, or termination of a provider's contract.
- Reporting to regulatory entities as applicable.

Member Safety Committee goals include:

- Ensuring members receive quality clinical care and service in a safe and effective manner.
- Identifying opportunities for improvement in the clinical care and service provided to our members through the review of trended information on member safety and provider performance issues.

5. Utilization Management Committee

The Utilization Management Committee (UMC) oversees the timely development and implementation of an effective Utilization Management (UM) Program. This is accomplished through a review of utilization management activities and metrics, a review of medical necessity criteria and medical policies for both Capital Blue Cross and delegated UM vendors, and a review and analysis of over and underutilization patterns for practitioners and providers in the contracted networks.

Composition of the UMC includes, but is not limited to:
Four to six practitioners representing various specialties from Capital's practitioner's network, typically two to three primary care practitioners and one to three specialty practitioners.
All UMC practitioners are voting members.

Capital Blue Cross committee members:

- Chair - Senior Medical Director, Member Health and Wellness (votes only in the case of a tie).
- Vice President Population Health (Voting).
- Senior Director, Utilization Management (Voting).
- Senior Director, Care Management (Voting).
- Senior Medical Director, Medical Policy and Coding (Voting).
- Managing Medical Director, Utilization Management (Voting).
- Director, Quality Improvement (Voting).
- Director, Medical Management Compliance (Voting).
- Manager, Utilization Management (Voting).
- Director, Commercial Appeals and Grievances Resolution (Non-voting).
- Clinical Appeals Manager (Non-voting).
- Executive Assistant (Non-voting).
- Other ad hoc staff as appropriate.

Responsibilities of the UMC include, but are not limited to:

- Review and approve the annual Utilization Management Program Description.

- Review UM key performance indicators and program results.
- Analyze results of physician and clinician inter-rater reliability studies.
- Review member and provider satisfaction with UM programs and processes.
- Review and approve UM medical necessity criteria.
- Analyze and trend all organization determinations for compliance with regulatory requirements. This includes the timeliness of UM decisions and timely notification to members/providers/practitioners based on regulations from the Department of Health (DOH), the National Committee for Quality Assurance (NCQA), and CMS, among others.
- Review and approve delegated UM vendors and activities.
- Analyze reports to detect plan-wide or practitioner-specific over or underutilization.
- Review plan-wide utilization trends and recommend strategies to impact utilization.
- Review reports from the Clinical Advisory Committee (CAC) and Medical Specialty Formulary Committee.
- Review reports from the Pharmacy and Therapeutics (P&T) Committee.

6. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee reports activities to the UMC. The P&T Committee is accountable for assessing the drug formulary systems and pharmaceutical management programs based on clinical evidence, including objective clinical perspectives from practicing providers. The Committee ensures there is a regular review and appropriate updates to the formulary to remain responsive to the needs of Capital's members and providers. The Pharmacy and Therapeutics (P&T) Committee membership reflects a diversity of clinical specialties and geographic representation. Formulary issues related to behavioral health medications are addressed by a psychiatrist who serves on the P&T Committee.

Composition:

- Sponsor: Senior Vice President and Chief Medical Officer.
- Co-Chair: Medical Director.
- Co-Chair: Senior Clinical Pharmacist.
- Clinical Pharmacy staff.
- Vice President, Pharmacy Strategy and Services.
- Executive Vice President, Chief Operating Officer, Strategy and Business Operations.
- Eight practicing pharmacists and providers representing diverse specialties.
- Two members from the Children's Health Insurance Program (CHIP).

Responsibilities:

- Establish and maintain a drug formulary system that promotes the use of safe and effective prescription drug therapies.
- Support efforts to deliver high-quality formulary management and drug coverage through evaluation of new and existing drug therapies.
- Review and guide the formulary management and prescription drug-related clinical programs, as well as applicable Pharmacy Benefit Manager (PBM) pharmaceutical management activities.
- Evaluate and recommend appropriate drug utilization programs that encourage compliance with current clinical practice guidelines.
- Assess and recommend changes, when applicable, to policies concerning the pharmaceutical management system.
- Promote educational strategies to support the formulary process.
- Maintain and communicate activities and recommendations of the committee.

- Ensure compliance with accrediting and regulatory agencies such as NCQA, CMS, and DOH, based on required reporting from the PBM.
- Ensure timeliness of decisions based on periodic audits of approval, denial, and exception pharmacy claim.

7. Clinical Advisory Committee

The Clinical Advisory Committee (CAC) oversees the development, revision, adoption, and execution of medical policy based on current clinical practice and community practice standards. CAC includes participation of a senior-level physician actively involved in implementing the organization's utilization management (UM) program, CAC is comprised of a core group of internal physicians as well as consulting network clinicians, representing a variety of clinical specialties. The CAC is responsible for evaluating medical policy, including medical necessity, appropriateness of medical services, and adoption of new technology and new applications of existing technology.

Composition:

Voting Members

- Chairperson- Senior Medical Director.
- Managing Medical Director, UM.
- Lead Medical Director, Clinical Compliance.
- Senior Director, UM.
- Manager, Medical Policy and Coding.

Non-voting Members

- Director, Appeals and Grievances Resolution or designee(s).
- Senior Clinical Pharmacist.
- Other ad-hoc members as appropriate.

Responsibilities and Functions:

The functions of the Clinical Advisory Committee (CAC) include, but are not limited to, the following:

- Review medical policy for consistency with evidence-based medical practices, current technologies, medical necessity, and community practice standards. Reviews may include policies, recommendations, and guidance from:
  - Blue Cross Blue Shield Association
  - Evidence-based guidelines and other peer-reviewed literature
  - Policies adopted by other insurers active in the community
  - DOH, NCQA, CMS, and other regulatory bodies
  - External reviews from physicians or other professionals who have expertise in the technology and/or specialty
- Review strategies to improve efficiency.
- Review and approve specific medical policies utilized on behalf of Capital Blue Cross by vendors.

Specific to behavioral health, a physician, clinical PhD or PsyD is involved in evaluating new technology, evolving technology, and application of existing technology.

8. Medical Specialty Formulary Committee

The Medical Specialty Formulary Committee (Med Spec) oversees the development, revision, adoption, and execution of medical policies related to injectable drugs. These policies

incorporate published evidence, current clinical practice, and community practice standards. Med Spec includes participation of a senior-level physician actively involved in implementing the organization's utilization management (UM) program. Med Spec is responsible for evaluating medical injectable policies, including medical necessity and appropriateness of services, and adoption of new technology and new applications of exiting technology.

Composition:

Clinical Voting Members

- Chairperson- Senior Medical Director, Medical Policy & Coding.
- Chief Medical Officer.
- VP of Pharmacy Strategy & Services.
- Senior Director, Pharmacy and Clinical Services.
- Senior Clinical Pharmacist.
- Managing Medical Director (or designee).
- Director, UM.
- Manager, Medical Policy and Coding.

Non-voting Members

- Senior Director, Network Management.
- Director, Pharmacy Trade and Pricing.
- Pharmaceutical Contract and Administration Manager.
- Associate General Counsel (or designee).
- Director, Appeals and Grievances Resolution (or designee) *.
- Manager, UM.
- Medical Management Program Consultant, UM.
- Medical Policy & Coding Staff.
- Ad-hoc members as appropriate.

Responsibilities and Functions:

The functions of Med Spec are to include, but are not limited to, the following:

- Review medical policy for consistency with evidence-based medical practices, current technologies, medical necessity, and community practice standards. Reviews may include policies, recommendations, and guidance from:
  - Blue Cross Blue Shield Association.
  - Evidence-based guidelines and other peer-reviewed literature.
  - Policies adopted by other insurers active in the community.
  - DOH, NCQA, CMS, and other regulatory bodies.
  - External reviews from physicians or other professionals who have expertise in the technology and/or specialty.
- Review strategies to improve safety, access, efficiency, and cost effectiveness.
- Review and approve specific medical policies utilized on behalf of Capital Blue Cross by vendors.

Specific to behavioral health, a physician, clinical PhD or PsyD is involved in evaluating new technology, evolving technology, and applications of existing technology.

9. Substance Use Task Force

Capital's Substance Use Task Force provides a framework for the planning, organization, and oversight of the strategic activities and interventions focused on addressing the growing concern about the misuse of substances that is sweeping the nation. The Substance Use Task Force directs projects and initiatives, aligning with the Centers for Disease Control and Prevention (CDC), the Blue Cross® Blue Shield® Association (BCBSA), and Pennsylvania state initiatives.

The Substance Use Task Force integrates into its foundation the IHI Triple Aim framework of improving population health, improving the member experience of care, and reducing the per capita cost of care. The Substance Use Task Force collaborates with the Pharmacy Benefit Manager and behavioral health vendor to leverage their expertise to develop the strategy.

Composition:

- Sponsor: Senior Vice President and Chief Medical Officer.
- Chairs: Senior Medical Director, Member Health and Wellness, and Senior Clinical Pharmacist.
- Senior Director, Pharmacy and Clinical Services.
- Director, Behavioral Health.
- Senior Director, Utilization Management.
- Vice President, Population Health.
- Senior Director, Network Management.
- Vice President, Pharmacy Strategy and Services.
- Manager, Medicare Clinical Pharmacy Services.
- Senior Pharmacy Data Analyst.
- Clinical Appeals Manager.
- Manager, Communications Oversight.
- Managing Medical Director.
- Senior Director Government and Regulatory Affairs.
- Medical Directors.
- Clinical Pharmacist.
- Medicare Compliance Officer.
- Corporate & ACA Compliance Officer.
- Program Manager, Behavioral Health.
- Senior Director, Special Investigations and Payment Integrity.
- Behavioral Health Quality Consultant.

Responsibilities:

- Develop and evolve Capital's overarching strategy and approach to addressing substance use, misuse, and abuse.
- Determine and oversee the implementation of programs and services to address the opioid and substance use epidemic.
- Review performance metrics, reports, and outcomes of activities and interventions to monitor and identify the impact and any opportunities for improvement.
- Provide appropriate messaging and education to stakeholders including the members, providers, customers, and community.

10. Credentialing Committee

The Credentialing Committee is responsible for developing, monitoring, and revising Capital's credentialing program. The committee is composed of participating providers and representatives employed by Capital. The committee meets regularly and reviews all program standards at least annually. The Credentialing Committee reviews all credentialing assessments (and reassessments) for in-network providers and facilities. If the Committee decides to deny an initial assessment or terminate an existing contract (denial of reassessment), a written notice is sent to the provider or facility describing the reason for denial and explaining appeal rights.

Composition:

- Chair: Clinical Medical Director and Compliance.
- Nine network providers.
- Manager, Provider Credentialing.
- Senior Director, Provider Data and Credentialing Services.
- Credentialing Coordinator.
- Legal Advisor.

Responsibilities:

- Reviewing all files identified by the Credentialing Manager as files with issues.
  - Malpractice case settlements that result in death or permanent disability.
  - Malpractice cases that settle for a high dollar amount.
  - Patterns of settled lawsuits and disciplinary issues.
- Review and approve the credentialing/re-credentialing policies and procedures for providers and facilities as required by NCQA, Pennsylvania DOH, and CMS.
- Credentialing Chair signs off on all files with no issues.

D. Data Analytical Support

The QI team works closely with the Population Analytics, Analytics and Reporting, and analyst within the business units at Capital to assess the relevant information and data sources to determine opportunities for improvement. These include, but are not limited to:

- Access and availability data.
- Experience of care and service data, both member and provider.
- Members' understanding of written materials.
- Continuity and coordination of care and services data.
- Patient safety data.
- Population health management information.
- UM statistics, including over- and under-utilization trends.
- Clinical and service indicators.
- Member complaints/appeals/quality of care issues/quality of service opportunities.
- Credentialing/re-credentialing activities.
- Delegated and vendor activities.
- Behavioral Health.
- Health Equity.
- Social Determinants of Health.

E. Designated Physicians in the Quality Improvement Program

In addition to providing care and service to the members, contracted providers (as indicated and/or requested by other providers) serve on various committees at Capital to offer input and

recommendations based on clinical and regional practice experiences. The role of the physicians and providers participating on committees includes, but is not limited to:

- Developing and applying credentialing and re-credentialing criteria.
- Providing input and expertise in discussions regarding analysis and results of clinical QI activities and intervention strategies and follow-up on recommended interventions.
- Recommending potential areas of focus for quality improvement initiatives based on the review of performance and outcome trends.
- Providing input on opportunities for improvement in member safety and reviewing and tracking suggested interventions.
- Providing input into prioritization of clinical care, service, and safety issues, and recommendations for needed actions and follow-up.
- Reviewing and providing feedback on proposed health maintenance guidelines, clinical protocols, medical policies, administrative policies and procedures, and formulary management.

The Medical Director for the Managed Behavioral Healthcare Organization (MBHO) vendor is a board-certified psychiatrist who is the designated behavioral healthcare provider collaborating on the behavioral health aspects of Capital's QI Program, who provides input on an ad hoc basis to several committees. These committees include the QIC, P&T Committee, CAC for new technology, and the UMC. The MBHO Medical Director will also participate in medical-behavioral-health joint case rounds.

III. Quality Improvement Program

A. Scope

The QI Program provides a formal structure and process to monitor and evaluate the quality and safety of care and services provided to the members. The scope is organization-wide, encompassing all of Capital's products. Capital's central Pennsylvania service area includes both rural and urban regions. Capital's BlueJourney service area includes 21 counties. Capital Blue Cross | WellSpan Health's service area includes six counties. When appropriate, special considerations for cultural competency needs relating to language, ethnicity, gender, age, the complexity of health needs, and economic status are provided to assist the members in effectively accessing and using covered benefits. Through the formal QI Program inclusive of Triple Aim outcome metrics, key focus areas for Capital's continuous quality improvement efforts include:

- Population Health Management.
- Behavioral Health Management.
- Utilization Management.
- Pharmaceutical Management.
- Quality of Care.
- Member Experience.
- Network Management and Credentialing.
- Oversight of Delegated Vendors and Activities.
- Health Equity.
- Social Determinants of Health.

Business leaders responsible for these activities provide subject matter expertise and data analysis to comprehensively understand the appropriateness, productivity, availability, timeliness, and continuity of care delivered to the members. Longitudinal and trended data allows for the identification of opportunities to improve operational processes, the efficiency

and effectiveness of the health outcomes to the members, and member and provider satisfaction.

Capital implements a continuous quality improvement cycle where designated staff conduct measurement and analysis of key performance indicators; assess and prioritize the indicators; and plan, implement, and subsequently evaluate those interventions to further improve and enhance the quality of care, quality of service, patient safety, and member experience. Qualitative and quantitative data analysis is performed, and outcomes are compared to established goals and/or benchmarks. When available and appropriate, Capital utilizes standardized measurement tools, including HEDIS®, CAHPS®, and Health Plan Ratings (HPR) that allow for consistent performance calculations and comparison to regional and national benchmarks. Results of Capital's QI activities are presented and discussed with the members of the QI committees, including IQIC and QIC. The composition of these committees allows for multidisciplinary collaboration on improvement initiatives and oversight.

B. Goals and Objectives

Capital's quality improvement strategy and framework provide a holistic, integrated, and whole person approach for the QI Program. The program is designed to promote improvement in coordination of the intersecting variables and stakeholders that are involved in improving the quality, safety, and cost-effectiveness of clinical care, services, and member experience. Stakeholders include members, providers, employers, and vendors.

Capital's QI Program promotes objective and systematic monitoring, evaluation, and improvement of healthcare services while taking into consideration health disparities related but not limited to race, ethnicity, gender, social determinants of health, cultural, linguistic needs, and complex health needs of the population. The QI Program focuses on monitoring and evaluating the quality and appropriateness of care provided by Capital's provider networks, and the effectiveness and efficiency of systems and processes that support the healthcare delivery system. Capital focuses on assessing its performance outcomes to identify opportunities for improvement in the provision and delivery of healthcare and health plan services.

Goals of the QI Program include:

- Assess and evaluate the quality and safety of the care and services provided to the Members and identify opportunities for improvement; plan and implement appropriate interventions, and evaluate the effectiveness of the interventions.
- Assess the characteristics and needs of the population and relevant subpopulations and ensure programs and services are addressing those needs.
- Identify and address the needs of the population, including those with complex, chronic, special needs, and Social Determinants of Health (SDoH).
- Ensure the delivery of quality care and services to the members complies with state and Federal requirements, utilizing best practices and benchmarks to drive performance improvements. Ensure all regulatory and reporting requirements are met.
- Achieve goals related to healthcare quality, cost, and satisfaction and optimize performance in standardized performance metrics including but not limited to HEDIS® and CAHPS® results.
- Promote the delivery of high-quality, safe, and effective medical, behavioral health, and preventive care from the providers ensuring that care meets or exceeds accepted standards of quality within the community, regionally, and nationally and aligns with best-practice guidelines.
- Ensure geographic availability of providers and facilities as well as accessibility to healthcare services.

- Identify and address the needs of the population based on demographic information, including evaluation of ethnic and racial healthcare disparities and language barriers.
- Measure, analyze, evaluate, and improve the administrative services and processes within Capital's organization.
- Empower the members to make healthy lifestyle choices through health promotion activities, support for the self-management of chronic conditions, community outreach efforts, and coordination with community resources.
- Educate the members about patient safety issues, healthcare options, and how to navigate the healthcare system such as but not limited to, health promotion activities, member newsletters, and community outreach efforts.
- Provide service that meets or exceeds expectations and benchmarks.

The QI program goals and objectives are detailed in the QI Work Plan.

IV. Quality Improvement Program Description, Evaluation, and Work Plan

A. Quality Improvement Program Description

The purpose of the Quality Improvement Program Description (QIPD) is to provide a formal structure and process to objectively and systematically measure and monitor the quality of care and services provided to the members, member and provider experiences, and oversight of care and services provided by Capital's delegates and vendors. The QIPD contains an overview of Capital's multi-year quality improvement strategies, with further detail captured in the Quality Improvement Work Plan. The QIPD is reviewed, at a minimum, annually and is updated more frequently as needed. The IQIC and QIC are responsible for reviewing and approving all updates to the QIPD.

B. Quality Improvement Work Plan

The annual QI Work Plan is developed to assure the completion of planned activities, which are constructed to meet the objectives of the QI Program. These activities ensure:

- The current needs of the population are being evaluated.
- Changes are tracked and trended.
- Programs are implemented to address identified needs.
- Facilitation of continuous quality improvement.

The QI Work Plan serves as a detailed and fluid document, capturing key programs, initiatives, objectives, and goals of Capital's QI Programs. The QI Work Plan is regularly reviewed, updated, and approved throughout the year through the IQIC, where senior leaders represent all business areas involved in the QI Program. As needed and requested, review and approval by QIC may be performed.

C. Quality Improvement Program Evaluation

The Quality Improvement Program Evaluation (QIPE) highlights the accomplishments of Capital's QI Program and provides details on improvement projects, their outcomes, results, and continued opportunities and strategies for overall quality improvement. Additionally, the QIPE facilitates the development of the subsequent year's Quality Improvement Strategy. This formal and comprehensive evaluation is completed annually, but as goals and objectives of the QI Programs and initiatives are recognized throughout the year, results are presented and reviewed through the IQIC and QIC.

The QIPE is reviewed and approved through the IQIC and QIC, with a final review and approval completed by the KHPC Board in the spring. Once approved, the QIPE is also used

by Capital to meet several regulatory filing requirements, including but not limited to those for DOH and PID.

V. Medicare Advantage

A. Population Health Management

1. QualityFirst Gaps in Care Program

Capital's Gaps in Care program helps Primary Care Providers (PCPs) identify and address specified HEDIS® and Star quality measure care gaps. A gap in care is a discrepancy between recommended best practices and care provided. It represents possible missed opportunities including, but not limited to preventive services, missing age-based or seasonal vaccines, and chronic condition management services. The Gaps in Care program will ensure the members receive important healthcare services. The program's goal is to have a statistically significant difference per member per month, pre- versus post- for those who have become compliant for a HEDIS® measure compared to the non-compliant population.

2. Leapfrog Value-Based Purchasing Program

Capital Blue Cross employs the Leapfrog Value-Based Purchasing Program (LVBPP) to evaluate and reward hospitals for quality, resource use and patient safety as measured by the Leapfrog Hospital Survey. Using a transparent and effective payment model, the health plan identifies high-value hospitals, providing both educational support and financial incentive. Biannual educational events focus on regional Leapfrog Hospital Survey performance, with opportunities to network and share best practices.

The LVBPP strives for all hospitals to submit the Leapfrog Hospital Survey and to demonstrate excellence as measured by these quality and safety standards. Increased participation in the survey improves the amount of publicly available data for consumers to make informed choices about hospital care. Supporting hospital quality initiatives improves patient outcomes and enriches care for all in Central Pennsylvania.

Capital's goals are to have all eligible network hospitals submit an annual Leapfrog Hospital Survey and be contracted with Capital to participate in the LVBPP. Additionally, hospitals are incentivized to improve the annual value score or maintain a top value score year over year.

3. HEDIS®

(applies to Capital Blue Cross Medicare HMO and PPO and Capital Blue Cross | WellSpan HMO and PPO)

Capital collects Healthcare Effectiveness Data and Information Set (HEDIS®) data to evaluate the performance and effectiveness of the quality programs. Capital's Medicare Advantage lines of business are benchmarked using CMS Stars cut points. Capital will meet or exceed the four Stars cut points.

4. Transition of Care (TOC)

(applies to Capital Blue Cross Medicare HMO and PPO and Capital Blue Cross | WellSpan HMO and PPO)

Capital's overall TOC program consists of a collaboration between internal departments, the facility, post-discharge providers, and community resources. The program supports members through transitions, identifying risks, and enhancing coordination to prevent readmission. The Transition of Care (TOC) program is designed to reduce readmissions and improve the coordination of care for the members as they move through the continuum of care. The QI program goals and objectives are detailed in the QI Work Plan.

5. Mandated Quality Improvement Projects Chronic Care Improvement Project (CCIP) (Comprehensive Diabetes Care-CDC HEDIS)

The Chronic Care Improvement Program (CCIP) is a CMS-mandated project designed to improve healthcare outcomes for Medicare Advantage PPO and Medicare Advantage HMO members who are diagnosed with diabetes. The CCIP will promote effective diabetes management, HEDIS® comprehensive diabetes care (CDC) and Stars measure performance in the measures at a rate of five percent. Diabetes management can be achieved through an array of available interventions including care management, medication therapy management, and member incentives for screening services. Capital will monitor the progress quarterly, by reviewing quality measure compliance rates and intervention engagement.

6. Landmark Program

(applies to Capital Blue Cross Medicare HMO and PPO and Capital Blue Cross | WellSpan HMO and PPO)

Members identified with multiple chronic conditions are referred to an in-home provider (Landmark) to coordinate needs holistically. The Landmark program is a medical provider group that specializes in caring for patients with complex, chronic conditions in their home environment. A multi-disciplinary team collaborates with Capital to care for the whole patient, bringing medical care, behavioral health, palliative care, and social support services to patients in the comfort of their homes, wherever and whenever they need it. Landmark does not replace a patient's PCP, instead, they help patients follow care plans in the home. PCPs are a part of the care team, are consulted on recommended medication adjustments, and are updated following each home visit.

The program is designed to help patients stay well and avoid emergency department visits and inpatient hospital stays. Landmark's goals are the following:

- Member Satisfaction: ≥ 85% of responses are good or excellent on the Landmark administered survey for members attributed and engaged in the Landmark program.
- Depression Screening (PHQ – 9): ≥ 85% PHQ - 9 completed by Landmark clinical staff for members attributed and engaged in the Landmark program.
- Blood Pressure Control: ≥ 75% of attributed Landmark members will achieve blood pressure control.
- HbA1C control < 9.0: ≥ 72% goal of attributed Landmark members will achieve HbA1C control.
- Nephropathy Screening (in-home urine microalbumin testing) ≥ 95% of attributed Landmark members will complete nephropathy screening.
- Retinal Eye Exam ≥ 73% of attributed Landmark members will complete a retinal eye exam.

7. SurgeonCheck

Capital Blue Cross developed a data-driven surgical quality program to evaluate the performance of surgeons and their associated health systems. In collaboration with SurgeonCheck, an independent third-party vendor, Capital provides another level of quality data specific to surgical performance and outcomes. SurgeonCheck's cloud-based analytics platform extrapolates data from longitudinal health plan claims, clinical registries, and hospital sources. This enables the health plan to objectively assess individual provider performance on elective inpatient and outpatient procedures on the basis of quality and cost, and by facility and procedure. The quality metrics are outcome-focused, literature-based, and peer-reviewed by a team of board certified, fellowship trained surgical subspecialists. A weighted score for provider/procedure/facility combinations is derived from a partnership between Capital and SurgeonCheck analytics.

B. Capital Blue Cross | WellSpan Health HMO and PPO

This section only applies to Capital Blue Cross | WellSpan Health products.
The defined scope of the delegated care management model includes the management of Catastrophic and Unstable Multi-Chronic stratification levels for all joint Medicare Advantage (MA) product members, including those attributed and not attributed to Capital Blue Cross | WellSpan Health providers. Members within these tiers will be identified and stratified by Capital Blue Cross and provided to Capital Blue Cross | WellSpan Health for the execution of care management. Capital delegates to WellSpan the following case management functions:

- Case Management for the unstable chronic and catastrophic populations ("top 2 tiers") of Capital's population health pyramid.
- Transition of Care – 30-day program with weekly engagement following:
  - Inpatient Admission.
  - Inpatient Discharge to Home.

The Catastrophic stratification level is defined as members with a critical and/or acute healthcare need. The Unstable Multi-Chronic stratification level is defined as members with multiple unmanaged chronic conditions.

Objectives of the Capital Blue Cross | WellSpan Health delegated Care Management (CM) program include:

- Bring provision of care closer to the member through provider-led CM.
- Enable better collaboration and integration between payer and provider.
- More efficiently and effectively manage quality, health outcomes, and Medical Loss Ratio.

The QI program goals and objectives are detailed in the QI Work Plan.

C. Network Management and Credentialing

Capital's credentialing and re-credentialing program ensures that the providers within the network are qualified to provide quality healthcare to the members. The providers are initially credentialed before admission to Capital's network and then re-credentialed every three years. This process includes, but is not limited to, a review of the quality of care, service data, as well as member complaints and adverse events data. The applications for initial credentialing and continued participation in Capital's network are received, processed, and, if needed in alignment with credentialing policies, reviewed by the Credentialing Committee. The Credentialing Committee assesses the initial credentialing within 180 days of the date of the signed application. Additionally, all professional providers are re-credentialed a minimum of every 36 months, using primary sources to verify sanction information and credentialing information that is subject to change.

VI. Resources Support

The Board of Directors, senior management staff, and Capital employees are committed to quality, safety, and service. Capital's employees are accountable for the implementation and support of the QI Program. The key staff is charged with working to align efforts with established goals and communicating the QI Program interdepartmentally. For a reporting structure of the key staff involved in the QI program, please refer to Attachment B.

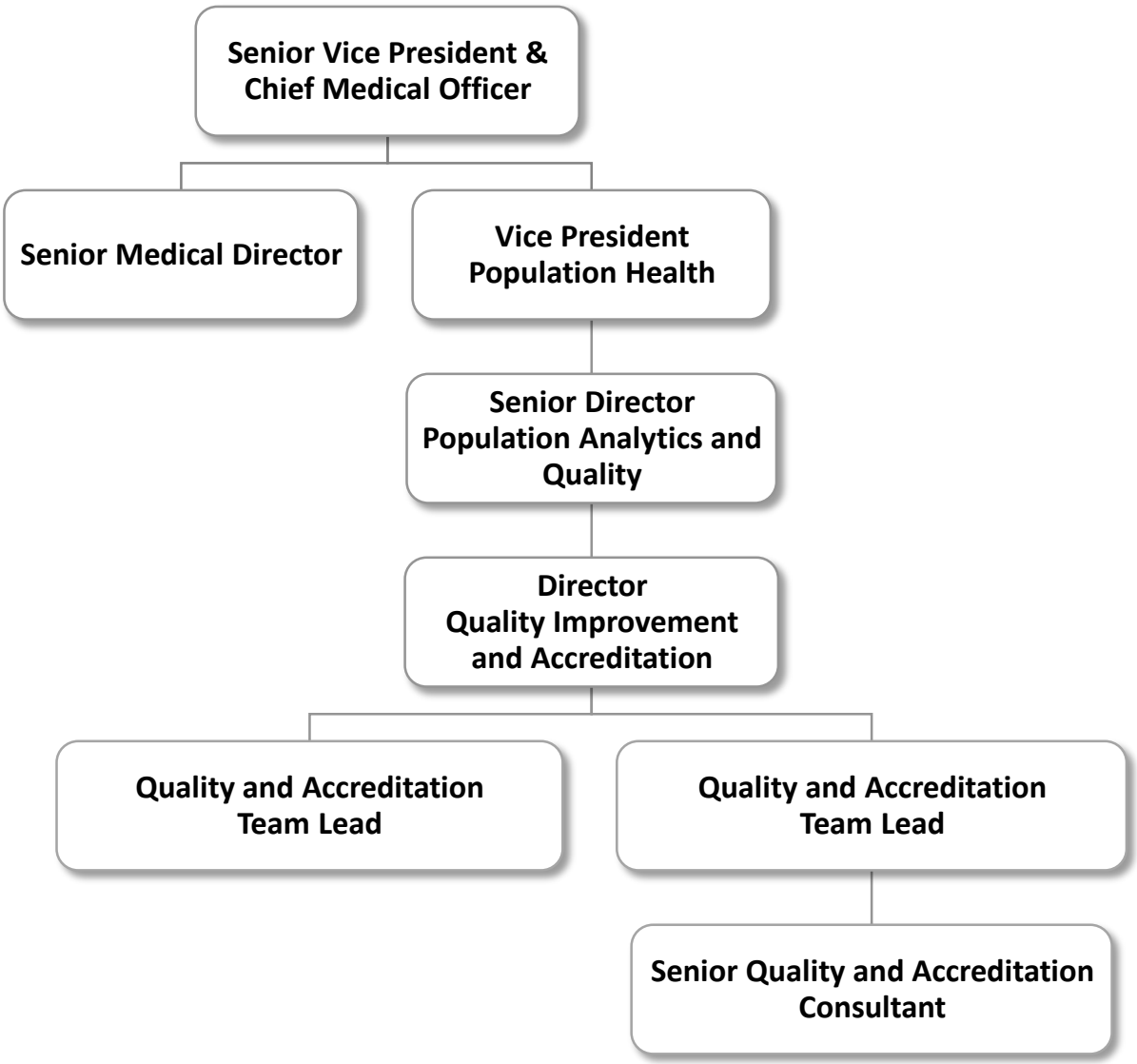
Specific staffing resources include, but are not limited to:

- The Senior Vice President and Chief Medical Officer or designee is the QIC Chair and oversees the QI Program activities.
- Director Medical Management Compliance is responsible for operations of the compliance and audit activities within Capital's Utilization Management and Care Management programs.
- Manager Population Health Integration is responsible for the integration of population health programs and processes within our clinical systems/applications. This position is able to incorporate the strategic vision into operational clinical processes to support population analysis and program evaluation of our clinical programs to ensure cost containment effectiveness for our employer groups and health and wellbeing of our members.
- Senior Director, Care Management is responsible for the strategic integration of care management as part of Capital's overarching population health strategy to drive towards the goal of population health programs and positive outcomes through collaboration with network providers, integration and collaboration of value-based relationships, and strategic alignment with various vendor relationships. The Senior Director, Care Management has clinical oversight for all care management leadership and staff and is responsible for the oversight of day-to-day operational management of the Care Management unit to include Care Management, Disease Management, Social Work, and specialty programs.
- Senior Director Utilization Management is responsible for strategic and operational oversight of Capitals Utilization Management (UM) Program, including providing leadership to Prior Authorization, Concurrent Review, and Medical Claims' Review teams, so as to maintain a compliant, efficient, and cost-effective UM program that prioritizes the customer experience and quality of patient care.
- Senior Medical Director Member Health and Wellness broadly supports the strategy set by Capital's Senior Vice President and Chief Medical Officer, with a specific focus on utilization management, quality improvement, care coordination, and behavioral health.
- Director of Quality Improvement and Accreditation oversees the day-to-day quality improvement activities, delegation oversight, and collaboration with appropriate business units to ensure NCQA.
- Director of Behavioral Health is responsible for Capital's behavioral health strategy, including oversight of the behavioral health vendor relationship.
- Vice President of Population Health is responsible for supporting the ongoing development and implementation of Capital's Population Health Strategy. The Vice President of Population Health has direct responsibility for Health Promotion and Wellness, Care Management, Value-based Provider Quality Programs, and Quality and Accreditation. This individual is accountable to ensure that all population health management interventions are measured and coordinated to drive the expected outcomes. Member experience and satisfaction, clinical and quality outcomes, and cost of care for all programs will be monitored and reported regularly to key stakeholder groups in Capital.
- Senior Director of Health Promotion and Wellness is responsible for strategic oversight and direction for the department's wellness and clinical programs, inclusive of but not limited to, our Health Promotion and Wellness programs and clinical vendor point solutions.
- The Senior Director, Population Analytics and Quality provides strategic direction and oversight for the department's population analytics, health plan performance, as measured through HEDIS, CAHPS, and STARS, and quality and accreditation activities. The Senior Director provides leadership for a comprehensive and evolving set of population analytics includes Capital's value-based quality programs – including specialty projects for surgical provider and skilled nursing home quality, disease prevalence, internal and vendor program effectiveness, and financial evaluations working directly with actuary.

- Vice President, Provider Partnerships is responsible for strategic oversight and development of Capital's provider network. The Vice President, Provider Partnership leads and manages the fee-for-service and value-based contracting strategies.
- The Manager, Member and Customer Experience is responsible for the deployment, data collection, and communication of survey findings to various parts of the organization and collaborates cross-functionally, as needed, on survey content and implications of results (most often related to member experience and initiatives) and impacts to established goals.
- Director of Member and Provider Services collaborates cross-functionally with Corporate Performance and the Quality Assurance Team to work on new end-to-end process improvements to enhance quality scores in addition to overall member touch metrics via huddles, newsletters, and updated desktop enhancements.
- Appeals and Grievances Resolution (AGR) Director is the owner of the NCQA internal compliance process. The Director consults with the Senior Operations Business Consultant on the completion of the operations work plan. The Director and Senior Operations Business Consultant certify all work is completed.
- Director of Quality and Operations Improvement leads Capital's operational quality effort to ensure the members, groups, and providers have an outstanding experience with Capital. He/She will collaborate inter-departmentally to ensure processes produce quality results and that appropriate controls are in place to validate outcomes.
- Senior Director of Pharmacy and Clinical Services collaborates cross-functionally on the development and implementation of clinical pharmacy and benefit-related management activities, such as adherence programs, drug waste minimization programs, and embedded pharmacists with local health systems.
- The Government Programs Quality and Stars Director is responsible for leading strategic initiatives that influence our Stars operations to support outcomes that impact member's overall health and wellness.

A. Attachment A: Quality Improvement Committee Structure

B. Attachment B: Reporting Structure



C. Acronyms

- AGR - Appeals & Grievances Resolution
- BCBSA – Blue Cross® Blue Shield® Association
- BH - Behavioral Healthcare
- CAAC - Capital Advantage Assurance Company®
- CAC - Clinical Advisory Committee
- CAHPS® - Consumer Assessment of Health Providers and Systems
- CAIC - Capital Advantage Insurance Company®
- CBC - Capital Blue Cross
- CCIP - Chronic Care Improvement Program
- CDC - Centers for Disease Control & Prevention
- CHIP - Children's Health Insurance Program
- CMS - Centers for Medicare & Medicaid Services
- DOH - Department of Health
- FEP - Federal Employee Health Benefit Program
- HCIF - Healthcare Improvement Foundation
- HEDIS® - Healthcare Effectiveness Data and Information Set
- HMO - Health Maintenance Organization
- HOS - Health Outcome Survey
- HSC PPIC - HEDIS® STAR CAHPS® Plan Performance Improvement Committee
- IHI - Institute for HealthCare Improvement
- IQIC - Internal Quality Improvement Committee
- KHPC - Keystone Health Plan Central®
- LVBPP - Leapfrog Value-Based Purchasing Program
- MA - Medicare Advantage
- MAP - Member Advocates Program
- MBHO - Managed Behavioral Healthcare Organization
- NCQA- National Committee for Quality Assurance
- OON - Out-Of-Network
- P&T - Pharmacy and Therapeutics
- PBM - Pharmacy Benefit Manager
- PCP - Primary Care Provider
- PHM - Population Health Management
- POS - Point of Service
- PPO - Preferred Provider Organization
- PQI - Potential Quality Issue
- QHP - Qualified Health Plan
- QI - Quality Improvement
- QIC - Quality Improvement Committee

- QIPD - Quality Improvement Program Description
- QIPE - Quality Improvement Program Evaluation
- QOC - Quality of Care
- SNF - Skilled Nursing Facility
- UMC - Utilization Management Committee
- UM - Utilization Management