Quality Improvement Program Description 2023

Commercial, Exchange, and Federal Employee Program (FEP)

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I. Introduction

A. Summary of the Quality Improvement Program

Capital Blue Cross (Capital) and its subsidiaries, Capital Advantage Assurance Company® (CAAC), Keystone Health Plan® Central (KHPC), and Capital Advantage Insurance Company (CAIC) have a comprehensive Quality Improvement (QI) Program. 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 Commercial, Exchange, and Federal Employee Program (FEP) product lines. 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 VP 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 QI Program committee structure includes the QIC as well as sub-committees that are responsible for oversight of the QI Program. 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

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 Descriptions (QIPD), Quality Improvement Program Evaluations (QIPE), and QI Work Plans.
- 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

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 Capital's members.
- Review and approve the Quality Improvement Programs Descriptions (QIPD), QI work plans, and QI Program Evaluations.
- Review and approve the Population Health Management (PHM) Strategy and analysis of the PHM Strategy impact.

3. HEDIS® Stars 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, improves the overall plan performance ratings, and improves 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 Information 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 the 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 and DOH based on required reporting from the PBM.
- Ensure timeliness of decisions based on periodic audits of approval, denial, and exception pharmacy claims.

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. 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, among others.
- Credentialing Chair signs off on all files with no issues.

10. 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.

D. Data Analytical Support

The QI team works closely with Population Analytics, Analytics and Reporting, and analyst(s) 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 of 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 service area includes 21 counties of central Pennsylvania, including both rural and urban areas. 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, 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, federal, and NCQA requirements, utilizing best practices and benchmarks to drive performance improvement.
- 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 NCQA Health Plan Ratings which includes 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 and the National Committee for Quality Assurance (NCQA). 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 NCQA, DOH, and PID.

V. Commercial, Exchange, and Federal Employee Program (FEP)

A. Population Health Management

1. Population Health Management Programs

Capital's Population Health Management (PHM) Strategy is designed to improve the physical and psychosocial well-being of individuals and promote health equity through whole person care, cost-effective, PHM programs and services. Capital's PHM Strategy also includes activities that are not direct member interventions such as value-based program (VBP) arrangements. PHM programs and services address the needs of Capital's member population and subpopulations across the continuum of care in each of the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

Annually, Capital develops a comprehensive PHM Strategy based on the needs of Capital's member population and subpopulations identified in the semi-annual population assessment. The needs assessment includes the evaluation of clinical markers (medical and behavioral health) and Social Determinants of Health (SDoH), race, gender, and ethnicity. The evaluation of the

effectiveness of Capital's PHM strategy from the previous year informs the development of the subsequent year's annual PHM Strategy and associated programs and services.

The effectiveness of Capital's PHM Strategy impact is evaluated annually and includes a quantitative/qualitative analysis of Capital's PHM programs and services. Refer to QI work plan for specific clinical, cost/utilization, and member experience metrics and goals.

2. Value-Based Programs

QualityFirst value-based programs are designed to recognize providers who are delivering high-quality, patient-centered, affordable care to the members. Aligned with the Triple Aim; enhancing the patient experience, improving population health, and reducing health care costs, these programs provide a framework that encourages multidisciplinary communication and collaboration. The QualityFirst Accountable Care Arrangements, Medical Neighborhood Program, and Primary Care Recognition Program meet nationally consistent criteria for the patient-, value-based care and are recognized as Total Care programs, a Blue Cross® Blue Shield® Association designation.

Quality programs are evaluated annually to drive improvement in health outcomes with value-based provider partnerships. Success is measured through performance evaluation utilizing HEDIS® and CMS preventive quality measures. Statistically significant improvements in quality metrics are evident when comparing the members attributed to value-based programs compared to members not attributed to value-based health systems.

Value-based programs' cost-effectiveness is provided through volume-based incentives, risk adjustment, reimbursement, and attribution. Attribution is where practices receive a list of prospectively attributed members at least monthly. Volume-based incentives include partial or full primary care capitation with more than 50% of revenue reimbursed through capitated or non-visit-based payments. Risk Adjustment provides an alternative to Fee-For-Services payment wherein a member's risk adjustment is taken into account for factors including, but not limited to health status and/or member demographics. Lastly, Practice reimbursement is influenced by outcomes, not process where performance-based payments are tied to Clinical Quality, Health Improvement, Total-Cost-of-Care, and/or Utilization Measures such as HEDIS® and CMS Preventative Quality Measures.

3. 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.

4. 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 publically 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.

5. HEDIS®

Capital collects Healthcare Effectiveness Data and Information Set (HEDIS®) data which is evaluated for the performance and effectiveness of the quality programs. HEDIS® audited rates are reported separately by product lines of business. Capital's Commercial HMO/POS and PPO lines of business are benchmarked using the Quality Compass Mid-Atlantic Region percentiles and the target is to meet or exceed the 75th percentile. Capital's Marketplace product goals are based on the Quality Rating System's star ratings. Capital's goal is to meet or exceed the four-star rating by measure. The Office of Personnel Management establishes Federal Employee Program (FEP) performance measures, to meet or exceed the 90th percentile based on National benchmark percentiles for the identified measure set. FEP targets are identified at the 75th percentile for partial credit towards the identified measure set.

6. Marketplace Quality Improvement Projects

The Marketplace Quality Improvement Strategy focuses on improving health outcomes for members enrolled in an individual plan on the state-based exchange who have been diagnosed with diabetes. Capital utilizes value-based payment arrangements to promote high-value care amongst provider organizations. Members who are diagnosed with diabetes are incentivized to receive screening and monitoring services to aid with disease management.

The Marketplace Quality Improvement Projects will expand the value-based provider program by increasing the attribution of the exchange population to provider organizations in an alternative payment model based on quality and value. This program is to improve the overall health of the enrolled exchange population diagnosed with diabetes through increased member engagement in the disease management program. The goal of the program is to increase quality measure performance at a rate of five percent. Progress is monitored every quarter, by reviewing attribution rates to value-based providers, performance in clinical quality metrics, engagement rates in the disease management program, and by measuring the acuity of moderate and high-risk stratified members with diabetes.

7. Transition of Care (TOC)

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.

8. 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.

9. Ovia

Ovia Health is a digital women's and maternal health platform designed to provide comprehensive services to help women make decisions around their preconception, fertility, prenatal, postpartum, and overall health. With a focus on maternity management, the Ovia Pregnancy app supports members during the journey of starting a family by engaging the member to track their health, receive critical health alerts, and access trusted resources. Ovia provides customized clinical programs, offers one-on-one coaching, and connects members with Capital Blue Cross Maternity Care Management, when needed for high-risk pregnancies. This program is designed to help engage members earlier in their pregnancy, provide personalized support, identify wellness risk and alert members when to seek care.

Ovia's programs leverage:

- Health assessments to identify and intervene sooner.
- Self-monitoring programs help members to understand their body and risk better.
- Programs to help have a healthier pregnancy, childbirth, and family.
- Preventive outreach to help members with everyday advocacy and support to enhance the relationship with doctor and care team.

Capital's program goals are the following:

- Increase early identification of pregnancies.
- Reduction in preterm delivery and NICU stays.
- Reduction in c-sections.

B. Behavioral Health

In 2023, Capital will prioritize the development and implementation of the ideal member-centric management for the members' behavioral healthcare needs. Capital Blue Cross has transitioned to a new behavioral health vendor, Beacon Health Options on April 1, 2021. Capital's behavioral healthcare strategy is continuously evolving to create a strong and meaningful partnership with Beacon Health. Capital will continue to develop and improve a collaborative, holistic approach to address the needs of the members, including behavioral health services and the coordination of medical and behavioral healthcare. The behavioral health vendor will continue to support the pursuit of the mutual goals of high-quality service, access to care, and the continued development of the Capital's network of high-quality, appropriately licensed behavioral health providers.

In 2023, the collaboration between Capital and Beacon, the new MBHO, will continue as Capital moves from completing the post-implementation phase and into the ongoing business as usual (BAU) phase. The behavioral health vendor will remain focused on improving Triple Aim outcomes for the members. Capital will ensure an appropriate frequency and processes for vendor oversight to comply with all regulatory and accreditation requirements. Based on the contractual performance guarantees, Beacon will demonstrate either improvement over the current baseline or meet or exceed the NCQA mid-Atlantic 75th regional benchmark for Capital's members.

1. Continuity and Coordination between Medical and Behavioral Health

The Behavioral Health Team will collaborate with Beacon Health Options to improve communication between behavioral and medical providers. The focus will encompass educating high-volume behavioral health providers, distributing quarterly newsletters, and providing training opportunities. This initiative will focus on improving the frequency and quality of information via two-way communication between PCP and OP BH providers, including visit notes, referral information, and all related sharing of PHI. This aligns with Capital Blue Cross's whole person care model.

The initiative to educate and train providers on the importance of sharing information concerning mutual patients for continuity of care between medical and behavioral health will focus on PCPs and psychiatrists at a lower level of care (outpatient). A focus on enhanced education relative to communication between providers can lead to lower inpatient psychiatric admissions, and earlier interventions, and provide better long-term outcomes for the member and stakeholders involved in their care.

The goal for 2023 is to improve these HEDIS® measures by five percentage points:

1. Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD).
2. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
3. HEDIS® Antidepressant Medication Management (AMM) Measure.

To report on progress or issues and support Capital's quality improvement initiatives, Beacon Health Options holds bi-weekly meetings with the Capital Blue Cross behavioral health team. Quarterly joint operating committee meetings also occur, where Beacon reports and updates Capital Blue Cross on all activities included in our delegated partnership, including quality improvement. A representative from Capital's Behavioral Health team who works in conjunction with Beacon, reports on progress to the Quality Improvement Committee on an annual basis.

2. Provider Quality Management (PQM)

In collaboration with Beacon Health Options (Beacon) the Provider Quality Management (PQM) Program was developed and implemented, a data-informed approach in partnership with behavioral health providers. The behavioral health delivery system is constantly evolving to keep pace with industry changes including, but not limited to, growing demand for services, changing regulations, growing demand to manage the cost of care while ensuring access to high-quality services, and new developments in the best practices. This Provider Quality Management strategy bridges a key gap in current managed care approaches specific to behavioral health. Capital's ability to work with providers toward shared outcomes and goals is enhanced by the PQM program. Goals and activities to meet the desired outcomes are informed by provider-facing reports and the use of aligned data definitions.

Capital providers are selected for participation based on factors including the volume of members served and how integral the selected providers are to the care delivery system. Provider Quality Managers (PQMs) are licensed clinicians selected and employed by Beacon, who will work in close alignment with Capital's Provider Engagement team. The PQMs are selected based on their clinical expertise, knowledge of their local delivery system of care, their skills in collaborating with providers, and their ability to analyze and assess patterns and trends in aggregated data.

Beacon's PQM program incorporates advanced clinical and systemic improvements that will address opportunities to improve care and operational practices. Leveraging managed care expertise and sharing comprehensive utilization and quality data, the partnership between Beacon and Capital will drive improvements in services at the patient, provider, and systems levels.

Beacon reports on PQM activities in both monthly and quarterly meetings in order to share the progress they have made with engaging Capital Blue Cross behavioral health providers in the program, to report on provider performance in the specific metrics of focus for this program, and to discuss any issues that surround specific providers. A summary for the previous quarter's activity is generally delivered in a PowerPoint presentation. The meetings also provide an opportunity to discuss updates to the program, as well as allow for collaborative conversations between Capital Blue Cross and Beacon Health Options. Capital's Director of Behavioral Health presents an update at least annually to the Quality Improvement Committee

3. Substance Use Task Force

Capital's Substance Use Disorder Task Force provides a framework for the planning, organization, and oversight of the strategic activities and interventions that are focused on addressing the growing concern about the misuse of substances of abuse sweeping across the nation. The Substance Use Disorder Task Force integrates the foundation from the Institute for Healthcare Improvement's (IHI) Triple Aim framework for improving population health, member experience of care, and reducing the per capita cost of care.

Substance Use Disorder Task Force Committee develops strategies around combating the opioid crisis through expansion of prevention, treatment, and recovery support services and remains in alignment with Substance Abuse and Mental Health Services Administration (SAMHSA) initiatives. The key component of the Substance Use Disorder Task Force Committee is to review performance metrics, reports, and outcomes of activities and measurable interventions to monitor and identify the impact and any opportunities for improvement. The Committee will assess potentially high-risk opioid analgesic prescribing practices. The prescribing members who are 18 years and older and are receiving prescription opioids for >15 days during the measurement year from multiple providers.

The three rates are:

- **Multiple Prescribers:** The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
- **Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
- **Multiple Prescribers and Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different prescribers *and* four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

C. Utilization Management (UM)

1. Utilization Management Program

The purpose of the Utilization Management (UM) program is to ensure that medically appropriate services are provided to the members through a comprehensive framework that assures the provision of high-quality cost-effective, medically appropriate healthcare services in compliance with the member's benefits and in accordance with regulatory and accreditation requirements.

Through the application of UM standards, including those from the NCQA, Capital assures the delivery of medically necessary, quality patient care through the consistent provision and management of health care services in a coordinated, comprehensive, fair, consistent, and culturally competent manner without discrimination based on the health status of members. Additionally, Capital's UM program includes focus on interventions designed to improve the overall health of the members with chronic conditions and those at high risk for adverse health events.

Key objectives of the UM program include:

- Development and maintenance of a comprehensive UM program with processes, policies, and procedures that maximize operational efficiency and improve the quality of interventions.
- Providing members and providers with a process by which utilization decisions affecting the health care of members (including behavioral health care) are timely, appropriate, medically necessary, impartial, and consistent.
- Development, review, and adoption of clinically sound protocols and criteria for determining medical necessity and appropriateness of health care services.
- Annual evaluation of utilization trends to promote improved UM program interventions and performance.

- Using data and implementing technology enhancements that support the UM process.

In order to achieve these objectives, the UM department performs inter-rater reliability assessments and case audit reviews. Additionally, there is regular monitoring of the timeliness of UM decision-making and notification and routine analysis and monitoring of utilization patterns and associated costs.

2023 Goals for the UM program include:

- Inter-rater reliability (IRR) assessments conducted on all staff involved in UM decision-making with performance threshold ≥ 90%.
- Case audit reviews, including workflow and call monitoring audits, performed on all staff involved in UM activities with performance thresholds of ≥ 90% for any single case reviewed and ≥ 90% overall for all cases reviewed.
- Timeliness of UM decision-making and notification meeting or exceeding applicable regulatory and/or accreditation requirements applicable to the member's benefit and product.
- Regular analysis and monitoring of utilization patterns, including inpatient admission and readmission rates, average length of stay, emergency department utilization rates, observation and outpatient service utilization, and top diagnostic categories for these various levels of care to identify variation in practice patterns, including over-and under-utilization, with development of strategies and implementation of interventions to impact unwarranted variation.

D. Pharmaceutical Management

1. Pharmacy Management Program

The Pharmacy Management program is the framework that objectively appraises, evaluates, and administers clinical programs and Pharmacy Utilization Management (UM) criteria as well as reviews and updates the appropriateness of the formulary system. Capital's Pharmacy and Therapeutics (P&T) Committee reviews and updates the formulary and associated clinical and UM programs regularly but no less than quarterly. The Pharmacy Financial Workgroup (PFW) determines the formulary placement of P&T-approved drugs based on financial impact.

The Pharmacy Management Program continuously monitors and implements appropriate clinical programs to address topics including, but not limited to, medication adherence, generic drug utilization, and therapeutic substitution, point of sale management, infused or injected drugs and biologicals, and Pharmacy Benefit Manager (PBM) activities that address underuse, overuse, and drug safety.

The P&T Committee will make a reasonable effort to review a new chemical entity within 90 days and make a decision on each new chemical entity within 180 days of its release onto the market. The Formulary design will support an Ingredient Cost trend of less than seven percent year-over-year.

2. Federal Employee Program (FEP) Medication Therapy Management

Capital's pharmacy department will outreach to the Federal Employee Program (FEP) members to provide Medication Therapy Management services and educate the members. The Pharmacy department will increase the outreach by 10% to the FEP members. The eligible members are identified through the data that is provided by the FEP Director's Office and the referrals from case management.

The interventions of the pharmacy department may include but are not limited to adherence education in diabetes, hypertension, Statin medication therapy, blood pressure device, and referrals from case management.

3. High-Value Pharmacist (HVP) Program

The High-Value Pharmacist (HVP) is a liaison between the Pharmacy Benefit Manager (PBM) and Capital for specific clinical pharmacy programs. The HVP collaborates with a multidisciplinary team including members from Pharmacy, Utilization Management, Population Health, and Case Management to review cases and align on strategy and next steps to have an opportunity for acceptance.

The HVP will utilize prescription and/or medical claims data to conduct comprehensive medication reviews and generate clinical recommendations. High-Value Pharmacist will identify and implement care management, cost management, and process improvement opportunities. The HVP will identify high-cost members for potential medication therapy optimization and provide feedback on the upstream formulary or utilization management processes.

E. Quality of Care

1. Quality of Care and Quality of Service

Capital maintains a process to address members' expressions of dissatisfaction and respond appropriately to the member's quality of care and quality of service needs. Members can file a quality of care and/or quality of service complaint by way of the Member Services phone line or by submitting a written complaint to Capital. Potential Quality Issues (PQI) are submitted concerning the medical care or services a member has received. Case Management and Utilization Management nurses along with Appeals and Grievances Resolution Unit's (AGRU) PQI submission portal file PQIs on behalf of members, to ensure a proper investigation is conducted on the potential quality issue. All complaints are reviewed by the AGRU's Clinical Nurse. Additionally, all member-submitted complaints are coded into one of the five NCQA classifications: Access, Billing/Financial, Quality of Care, Attitude/Service, or Quality of Practitioner Office Site.

Capital promotes optimal care and services to the members, by building a collaborative relationship with Provider Engagement, Member Experience, and the Credentialing Departments. AGRU's Clinical Manager, Quality Nurse, and appeals analyst review the quality of care data complaints on a monthly and quarterly basis to assess the trends. Root cause analysis is performed and appropriate outreaches are made to providers and/or facilities for records to ensure proper investigation. Capital's goal is to ensure all complaints are thoroughly reviewed and responded to within 30 days so that the member has full awareness of their submitted complaint and the departmental review process. Capital maintains a <1\1,000 per member threshold for complaints; this measure is a calculation of the count for complaints divided into the enrollment figure (for all in-scope product lines), which is then multiplied by 1000. Capital's Quality department conducts letter audits to ensure readability, accuracy, and timeliness; there is an established 98% goal for letter quality audits.

2. Continuity and Coordination of Medical Care

Capital is committed to improving the quality of care delivered to members. This commitment is demonstrated in Capital's facilitation of continuity and coordination of medical care functions across the healthcare network. Coordinated care is a critical element that supports positive health outcomes for members. Capital collects and analyzes data to assess coordination of care during care transitions. Capital collaborates with network providers to impact communication and information sharing while reducing inefficiencies with the aim of responding to members' unique care needs.

Capital monitors the continuity and coordination of care by assessing the facilitation of medical services across transitions of care settings and between clinical providers. The analysis of the continuity and coordination data identifies four areas or measures for improvement to support positive health comes for members. The objective of this program is to collect and analyze data,

identify areas requiring improvement in continuity and coordination of medical care, and implement interventions to improve coordination of care during care transitions.

The table below shows the four areas and measures identified for improvement with goals related to the continuity and coordination of care.

Measure	Goal
Avoidable ED Visits	Decrease utilization by five percent annually
Plan All-Cause Readmissions	Decrease Plan All-Cause Readmissions by five percent annually
Comprehensive Diabetic Care – Eye Exams	Improve diabetic eye exams by five percent annually
Use of Opioids - Multiple Prescribers and Multiple Pharmacies	Three percent reduction in proportion (rate) year over year

F. Member Experience

1. Member Surveys

Capital's member experience and/or satisfaction is assessed, in part, through the evaluation of member surveys. Capital administers the CAHPS® survey annually to evaluate member satisfaction. CAHPS® results are reported separately by-product lines of business, for example, Commercial PPO, Commercial HMO/POS, and FEP PPO. The Exchange PPO information is collected through the QHP Enrollee Experience Survey. Performance rates are compared to the state, regional, and national benchmarks for all reporting product lines of business. Supplemental member surveys are conducted to further assess CAHPS® and QHP Enrollee Survey results.

Capital also evaluates data from other member satisfaction research, e-community participation, website comment cards, focus groups, ad-hoc research, outcomes data, the complaint and appeal and grievance processes, and other operational data, to further the understanding of the survey results and members' perceptions. The data analysis provides a comprehensive understanding of whether Capital is meeting the expectation of the members. Member satisfaction results are considered met if at least 85% of members are satisfied with Capital, and/or the survey measures meet at least the 75th percentile, using Quality Compass data.

2. Member Complaints

Capital systematically monitors and assesses the management of member complaints. Member complaints are handled by Member Services and Appeals and Grievance Resolution Unit. This unit is comprised of Member Service Representatives and Appeals and Grievance Resolution Specialists (nurses). Capital performs annual trended quantitative and qualitative analysis that includes evaluation of Consumer Assessment of Healthcare Provider and Systems (CAHPS®), Qualified Health Plan (QHP) Enrollee Experience Survey, and Internal Member Satisfaction Survey to appreciate the members' feedback or complaints regarding access to the provider network, benefit materials, and Capital's operations. Member Experience and Satisfaction are essential to Capital's operation. Capital delivers the best-in-class member experience through operational excellence and innovation which aligns with Capital's vision.

Capital utilizes valid methodology to analyze non-behavioral and behavioral complaints about each of the five required categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site. The threshold for each category within each product line is less than one complaint per 1,000 members. The Mid-Atlantic Regional Benchmark set by Capital is the 75th percentile for CAHPS® survey results. Capital's corporate goal for Member Satisfaction is 85%

for the following years (2021, 2022, & 2023). The complaint data is audited quarterly and reported annually out of the OnBase appeals solutions platform.

3. Member and Provider Appeals and Grievances

Capital demonstrates its commitment to quality healthcare and services, by facilitating thorough and unbiased processing of member and provider appeals, with timely and appropriate resolution. The members submit their appeals to either seek resolution of a benefits dispute or denial of service due to not meeting medical necessity criteria. Additionally, member-submitted appeals are coded into one of the five NCQA classifications: Access, Billing/Financial, Quality of Care, Attitude/Service, or Quality of Practitioner Office Site. Appeals are reviewed and decided upon by an AGRU specialist, AGRU nurse, and Medical Director.

AGRU's management team maintains an enhanced control of oversight and monitoring of appeals and/or outcomes, allowing for a robust program with the capabilities to track, trend, and respond to appeals. AGRU's management team and Capital's legal and compliance teams review policies and procedural documentation to ensure compliance with detailed state, federal, and NCQA regulations.

Capital's goal is to ensure timely processing of appeals, by maintaining an internal timeliness measure of 97%, which aligns with the Blue Cross® BlueShield® Association (BCBSA) member touchpoint measure (MTM) measure. Capital's Operations department reviews timeliness measures monthly. Capital maintains a <1\1,000 per member threshold goal for appeals; this measure is a calculation of the count of appeals divided into the enrollment figure (for all in-scope product lines), which is then multiplied by 1000. Capital's Quality department conducts appeal determination letter audits to ensure readability, accuracy, and timeliness; there is an established 98% goal for letter quality audits.

4. Quality and Accuracy of Telephone and Web Information (Pharmacy and Medical)

Capital has a documented process to evaluate the quality and accuracy of information provided to the members. The quality and accuracy of information provided to the members are determined by collecting, evaluating, and analyzing data through telephone calls received through the Call Center. Capital utilizes the data collected to measure performance against standards, determine causes of deficiencies, and improve the deficiencies. Capital completes a quantitative analysis of the data collected to measure performance against the standards. Qualitative analysis is performed to identify improvement opportunities. Regular quality improvement meetings are held with a multidisciplinary group of stakeholders who have oversight of the analysis of the identified barriers and opportunities to prioritize, develop, and implement a process improvement plan.

Capital collects, evaluates, and analyzes data on the quality and accuracy of the information on its website communications to ensure the members have the information they need to easily understand and use their health plan benefits. The quality and accuracy of telephone and web will meet the target of 95%.

5. Cultural and Linguistic Needs

Capital is aware that cultural and linguistic barriers can have an impact on the members. Capital utilizes Language Line Services Inc., to ensure systems are in place to address objectives for serving a culturally and linguistically diverse membership. In collaboration with this vendor, Capital provides free aids and services to people with disabilities or whose primary language is not English, such as qualified sign language interpreters; written information in various formats (large print, audio, or accessible electronic format); and qualified interpreters and information written in other languages. The Language Line Services Inc. is available through Capital's hotline telephone number (800) 962-2242 (TTY: 711). Members can directly provide feedback regarding the

interpreter, language line, or translation services to Capital's Member Service hotline telephone number which is located on the back of the membership card.

The vendor management, information technology and delivery (IT&D), and Operation departments collaboratively work to identify the linguistic, racial, ethnic, and cultural needs of the members. Those departments evaluate the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Internal Member Satisfaction Survey, Qualified Health Plan Enrollee Experience Survey, Capital Interpreter Language Line Report, 2020 U.S. Census Bureau Demographics, and Provider Language Index to determine the unmet needs of Capital's membership in all four aspects related to network and communication platforms. Capital can evaluate and adjust the availability of providers as well as implement action plans to establish goals that will ensure Capital is meeting its membership's preferred language and communication methods. Capital will continue to make accommodations whether via marketing materials, telephone, and/or web access for the member.

G. Network Management and Credentialing

Capital manages the provider network for Commercial and Exchange lines of business except for FEP. For the FEP population, the provider network is managed by Highmark®, an NCQA-Accredited Health Plan, as part of the co-management of this population.

1. Availability of Practitioners

Capital maintains a network of primary care physicians (PCPs), high volume and high impact specialists, and behavioral healthcare specialists. The Network department annually measures and evaluates the number of providers (provider-to-member ratio), provider availability, and geographic distribution (acceptable distance or time to a provider's office). On a quarterly basis, an analysis is performed to monitor the adequate availability of the provider network. The Quest software generates the availability of care report, which utilizes the member and provider data, specific to the number of providers and geographic distribution.

Capital has established measurable standard primary care services through the adoption of the Pennsylvania Department of Health (DOH) code chapter 9 §9.679. Capital complies with the Pennsylvania Department of Health regulations for the geographic distance standards for access to care for its managed care networks.

These are the counties designated as Metropolitan Statistical Area (METRO): Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Lehigh, Northampton, Northumberland, Schuylkill, and York. Capital has continuously met the standard for 90% of the members having access to covered services within 20 miles or 30 minutes travel from the member's residence or work.

These are the counties designated as Micropolitan Statistical Areas (MICRO): Fulton, Juniata, Mifflin, Montour, Perry, Snyder, and Union. Capital has continuously met the standard for 90% of the members having access to covered services within 45 miles or 60 minutes travel from a member's residence or work.

Capital annually monitors its member population for cultural, racial, ethnic, and linguistic needs. This is to ascertain the Cultural and Linguistically Appropriate Services (CLAS) characteristics of network practitioners are sufficiently meeting the members' language preferences. Processes are in place to assist members in identifying practitioners to meet their (CLAS) preferences, as well as; adjustments to the network if necessary. A variety of sources are used to analyze whether the practitioner network is adequate in relationship with members' cultural needs and preferences. Data collection consists of the Internal Member Satisfaction Survey, CAHPS®, QHP Enrollee Experience Survey, Capital Interpreter Language Line, 2020 U.S. Census Bureau, Association of Religious Archives, and Capital Practitioner Foreign Language Report.

2. Accessibility of Services

Capital establishes mechanisms to monitor and ensure network accessibility for Primary Care Physician (PCP), Behavioral Healthcare (BH), and Specialty Care Services. Capital completes a quantitative analysis to measure performance against accessibility timeliness standards. Qualitative analysis is conducted on the performance results to identify improvement opportunities as it relates to routine, urgent care, and after-hours appointments for primary care and behavioral health services. Specialty care analysis is completed on the first and follow-up appointments. Data is compiled from a member satisfaction survey focusing on provider accessibility complaints and a supplemental provider access survey is administered to Capital's network of providers annually. If a decrease is reported from prior years on a member satisfaction survey, excluding the Clinical and Group-Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®) survey. Capital monitors the network's accessibility of services, via the supplemental practitioner access survey, against the goal of 90% for the first available appointment each practice will meet the timeliness standard established by Capital's Accessibility of Care procedure.

3. Assessment of Network Adequacy

Capital provides members with adequate accessibility to network providers for needed healthcare services by evaluating the Out-of-Network (OON) requests and utilization reports. The practitioner access survey will be administered to monitor network adequacy and implement action plans through data collection and analysis to identify gaps specific to geographic areas or types of providers, including non-BH and BH providers. With the collaboration between Network and Quality and Accreditation departments, the use of Out-Of-Network (OON) requests and utilization reports are analyzed to monitor the volume of OON requests and utilization, including the percent of total requests approved and denied. The data from these reports are designated by geographic location at the county level, product line, and provider specialty type (primary care, specialist, behavioral health). The execution of a practitioner access survey is administered if the internal member survey resulted in less than 90% of the members responding within the access timeliness standards. In addition to the OON reports and provider access survey, member complaints and appeals are analyzed to measure the member's experience within the network. Capital maintains two goals for Out-of-Network (OON) requests and utilization reports which are specific to primary care physicians, specialists, and behavioral health providers. The first is the percent of total requests per thousand members and the number of total requests approved and denied. Lastly, the Practitioner Access Survey's goal is 90% for the first available appointments at each practice that will meet the timeliness standard established by Capital.

4. Physician Directory Accuracy

Capital utilizes MyCareFinder, a web-based provider and hospital directory to assess the accuracy of the information. The information on MyCareFinder is the latest provided by the doctor's office. Capital validates with the provider during the survey call if the information is accurate or if the information should be updated. In 2022, Network implemented a Provider Attestation 90-day program. A requirement by the Consolidated Appropriations Act, 2021 (CAA), when a provider is non-compliant with the attestation program it will result in their removal from the directory to ensure accuracy. Capital has partnered with Quest Analytics to perform this outreach and manage the attestation program. The Credentialing Department is to provide the members with the most up-to-date directory information on a quarterly basis and to be in full compliance with CAA guidelines.

5. Credentialing and Re-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.

6. Organizational Provider Assessment and Reassessment

The facility and/or ancillary providers are assessed via credentialing before contracting and reassessed at a minimum every three years. To meet accreditation and regulatory requirements, the following are included in the review: Acute Care Hospitals, Home Health Agencies, Hospice, Skilled Nursing Facilities, Ambulatory Surgical Centers, and Behavioral Health Facilities (inpatient, residential, and ambulatory). Evaluation of the Skilled Nursing Facility (SNF) network currently under contract with Capital is occurring to determine adequate coverage for members while employing a quality perspective to the analysis. The goals are to complete the assessment of all new organization providers during the application process and to assess organizational providers biannually through the development of an SNF Quality program. The SNF Quality program includes the assessment of the current SNF network in relation to the Center for Medicare and Medicaid Services Star ratings. Reassessment of the existing SNF network is under a program consisting of a series of quality and utilization measures.

The Skilled Nursing Home Network Quality Initiative is designed to ensure members have access to a SNF network focused on quality care at a cost-effective price point. A biannual quality scorecard, based on internal and external sources, will be utilized to identify high and low-performing facilities. During the initial pilot, outreach was made to three high and five low-scoring providers. High performers are encouraged to share best practices, while low performers are placed on an individualized performance improvement plan aimed at improving their overall score. As biannual scorecards are refreshed, an additional set of six providers will be included in the process with each new refreshment of the scorecards.

H. Oversight of Delegated Vendors

1. Delegation

Capital engages with multiple entities/delegates to complete business needs across several areas of the organization, including Quality Improvement, Population Health Management, Network Management, Credentialing, Utilization Management, and Member Experience. Delegation oversight is completed to ensure the satisfaction of all delegation requirements, regulatory requirements, accreditation standards, and contractual obligations. This includes, but is not limited to, pre-delegation assessments, mutually agreed upon contracts, business associate agreement (if applicable), reporting analysis, sharing of data with delegates, ongoing monitoring of Quality Improvement initiatives, and an annual review of all program documents, policies, and procedures.

Delegated oversight activity is conducted by individual business units with guidance from the Quality Improvement and Accreditation team. The QI&A team guides the business units to allow for a thorough review of all delegated activity and promote both member and provider satisfaction. Capital and all delegates work as strategic partners to improve the health and well-being of the members. The scope of this activity includes but is not limited to, non-behavioral healthcare, behavioral healthcare, and pharmacy services.

Every delegate will undergo Committee review of required reports at least semi-annually. Additionally, every delegate will undergo an annual Committee review consisting of, but not limited to, analysis of program documents, review of policies and procedures, as well as adherence to delegated NCQA standards, file review, system controls monitoring, and review of required reports. Semi-annual and annual reviews will clearly document all opportunities for improvement and interventions implemented to ensure quality and satisfaction of contractual obligations.

VI. Resources Support

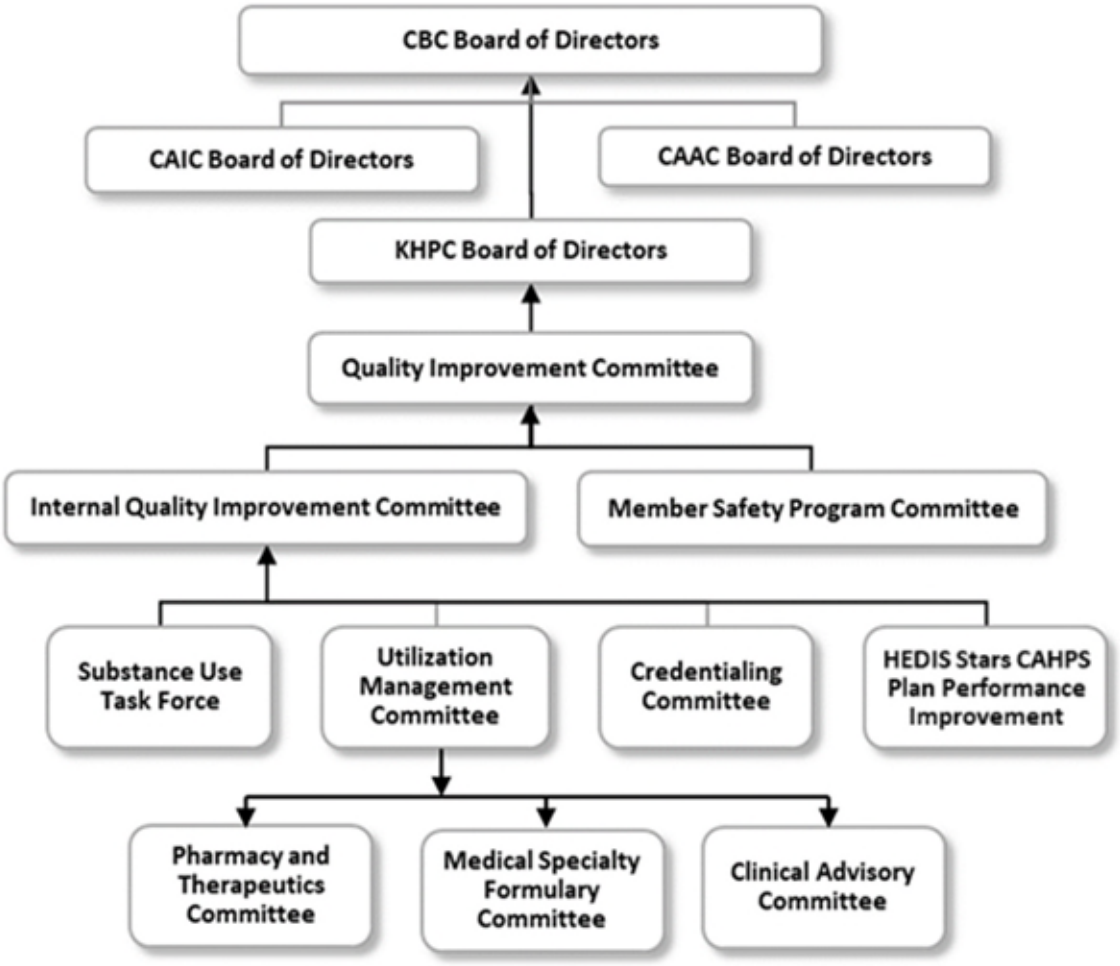
The Board of Directors, senior management staff, and Capital employees are committed to quality, safety, and service. Capital's employees are accountable for the implementation and support of the QI Program. The key staff are charged with working to align efforts with established goals and communicating 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:

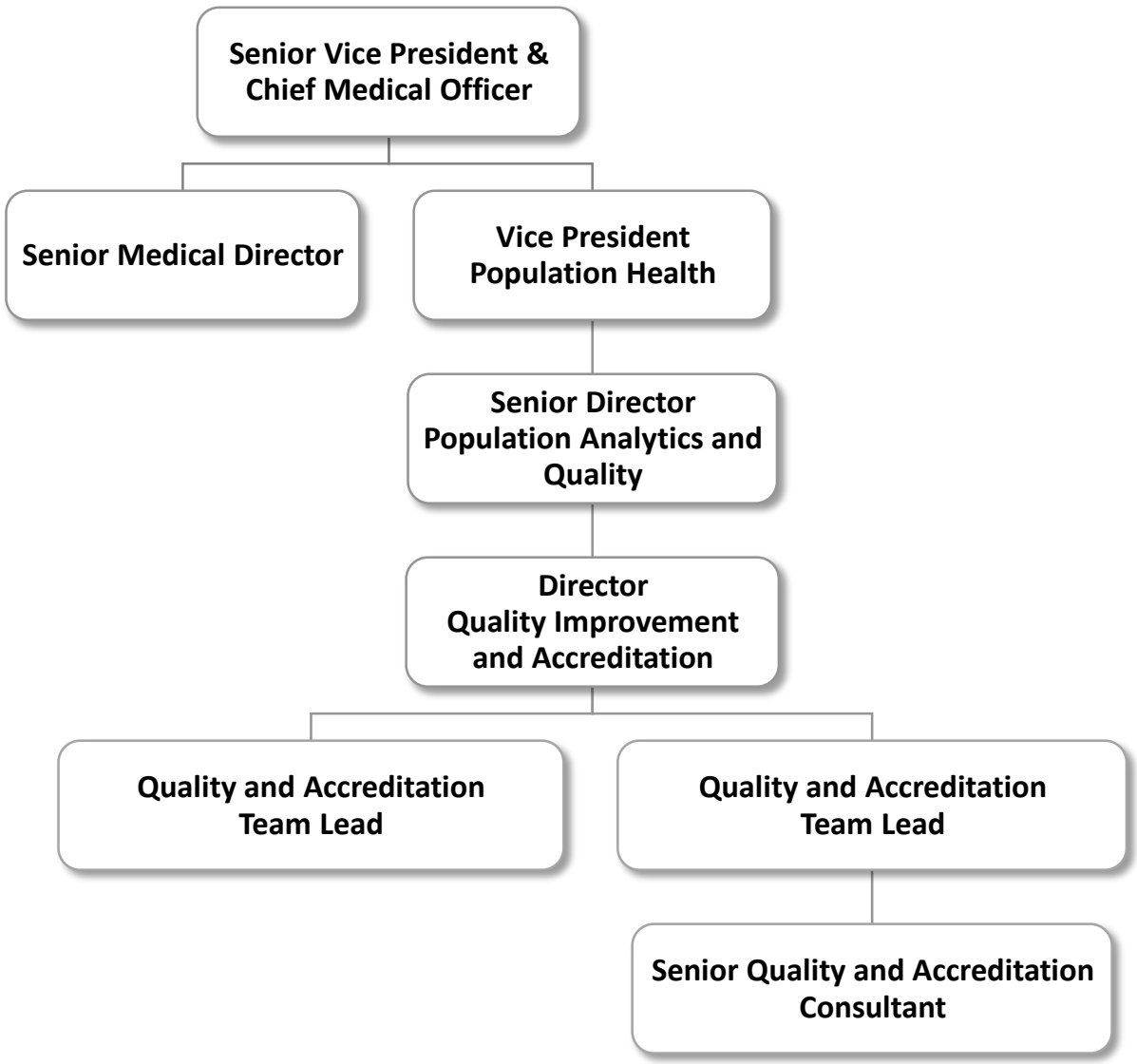
- The Senior Vice President and Chief Medical Officer or designee is the QIC Chair and oversees the QI Program activities.
- Director Medical Management Compliance is responsible for operations of the compliance and audit activities within Capital's Utilization Management and Care Management programs.
- 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.

Attachment A: Quality Improvement Committee Structure



B. Attachment B: Reporting Structure



C. Definitions

Commercial – Unless otherwise noted, Commercial refers to the following products:

- Commercial HMO
- Commercial POS
- Commercial PPO
- Comprehensive
- Exchange PPO
- FEP PPO
- Medicaid CHIP HMO
- Traditional

- **Delegation** - An organization gives an entity the authority to perform certain functions on its behalf. Although the organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.
- **Facility** - An institution or organization that provides services, such as a hospital, residential treatment center, home health agency, or rehabilitation facility.
- **My Care Finder** - Capital's provider and facilities directory.
- **Provider** – A licensed or certified professional who provides medical care or behavioral healthcare services.

D. 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
- CLAS- Culturally and Linguistic Appropriate Services
- 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