QUALITY IMPROVEMENT

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QUALITY IMPROVEMENT

This chapter summarizes our quality improvement programs established to improve the medical and behavioral health care outcomes of our members.

OVERVIEW

EmblemHealth's Corporate Mission is to create healthier futures for our customers and communities by championing access to high-quality, affordable care and building innovative partnerships in the communities EmblemHealth serves because we believe that everyone deserves to be taken care of. This will be done by providing members with a broad range of benefits and services; striving to simplify the provider experience; offering our purchasers high value; and partnering with the communities in which we live and work to improve their overall health.

GOALS AND OBJECTIVES

In line with EmblemHealth's Corporate Mission, as a quality-driven organization, EmblemHealth has adopted Continuous Quality Improvement in medical (including pharmaceutical and dental) and behavioral health care and service provided to a complex, culturally and language diverse membership as a core business strategy. Our Executive and Management teams use data-driven, decision-making methodologies in the strategic planning process. EmblemHealth has adopted the Institute for Healthcare Improvement (IHI) and the Centers for Medicare & Medicaid Services (CMS) Triple-Aim for Healthcare Improvement. We strive to simultaneously improve the health status of our members, improve each member's experience of care, and reduce the per capita cost of health care. As a result of this ongoing improvement and monitoring process, EmblemHealth will better serve the needs of members, including all demographic groups and those with special needs, as well as employers, employees, participating practitioners, providers, accounts, service partners, brokers, consultants, and regulatory and accreditation bodies. Toward this end, the goals and objectives of the Quality Improvement Program are to:

- Improve the health status of our members.
- Improve the member/provider experience of health care and services.
- Reduce the per capita cost of health care.
- Address members' complex needs (medical and behavioral health) through quality of care, coordination of care, disease management, and case management initiatives.
- Address specific monitoring requirements related to special populations, such as Medically Fragile Children, to ensure benefits and services are appropriately delivered.

All goals and objectives are in alignment with applicable regulatory and accreditation requirements.

SCOPE OF ACTIVITIES

The scope of activities within the Quality Improvement Program provides a framework to monitor and evaluate significant aspects of care and service provided to health plan members and their service delivery systems. EmblemHealth takes an active position in helping its members stay healthy, get better quickly, and live effectively with illness. Measures for monitoring important aspects of medical care, behavioral health care, and quality of service, including patient safety, have been developed and implemented. These activities include:

- Quality of Care
- Quality of Service
- Patient Safety
- Utilization Management
- Member and Physician Satisfaction
- Accessibility
- Availability
- Delegation
- Member Complaints, Grievances and Appeals
- Member Decision Support Tools
- Cultural Diversity
- Care for the Family Caregiver

AUTHORITY AND RESPONSIBILITIES

The Quality Improvement Committee (QIC) is responsible for policy decisions, planning, designing, implementing, coordinating, analyzing, and evaluating QI activities, instituting needed actions and ensuring follow up as appropriate. The QIC also ensures practitioner participation in the QIP through planning, design, implementation, committee participation, and review. Various committees and subcommittees support the functions of the QIP and report their activities to the QIC at least quarterly. Network practitioners, including behavioral health care practitioners and consumers, participate in the following committees that advise the QIC:

- Quality Improvement Committee
- Behavioral Health QualityManagement Subcommittee
- Care Management Committee
  - Medical Policy Committee
  - Behavioral Health Utulization Management Subsommittee
- Credentialing/Re-credentialing Committee
- Delegation Oversight Committee
- Pharmacy & Therapeutics Committee
- HARP Medicaid BH Advisory Subcommittee
- Children's Medicaid Health and Behavioral Health Advisory Committee
  - Committee Structure

A main aspect of the Children's Health and Behavioral Health Benefit is the expansion of existing Quality Management committees and Behavioral Health Quality Management sub-committee functions to ensure they meet the quality requirements and standards for the populations, benefits, and services for children under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster care agencies. This includes expanding the membership of the Behavioral Health Quality Management sub-committee to include in an advisory capacity: members, family members, youth and family peer support specialists, and child-serving providers. The Behavioral Health Quality Management sub-committee is responsible for carrying out the planned quality activities for the children's membership with behavioral health conditions, including those in the following subgroups: seriously emotionally disturbed children and children with diagnoses across multiple HCBS categories who

access behavioral health benefits and/or HCBS services.

A detailed chart of the QIC Structure can be found at the end of this chapter.

ACTIVITIES AND PERFORMANCE INDICATORS

EmblemHealth uses appropriate processes and methodology for conducting and evaluating quality improvement activities through appropriate study design that includes baseline measurement, root cause analysis, development and implementation of appropriate interventions, and re-measurement to determine the impact of the interventions, utilizing appropriate statistical analyses. Sampling methodology is developed and the frequency of data collection is determined based on the nature of the quality indicators and/or committee recommendations. Studying aspects of care and service includes setting goals, comparing indicators to benchmarks, establishing thresholds for the outcomes of required actions, and tracking measures over time. Performance indicators are established and measured periodically to monitor multiple dimensions of performance. These indicators correlate directly to the scope of the program and are developed based on scientific evidence or are adopted from authoritative sources.

The responsibility for monitoring and managing the improvement of these rates has been assigned to the Quality Management Department.

DATA SOURCES AND RESOURCES

The data sources used for quality improvement measurement, analysis of barriers, and determining appropriate interventions include, but are not limited to, encounters, claims, utilization review, pharmacy, laboratory, enrollment, behavioral health, medical records, and appeals data. Additionally, provider and member complaints, applicable case management and disease management databases, and telephone response data are also utilized. Other sources of data include HEDIS®/QARR data, Quality Compass®, national and regional epidemiological, demographic, and census data about EmblemHealth's membership, and practitioner, provider and member surveys. Provider surveys include, but are not limited to, provider satisfaction surveys, GeoAccess studies, and Access and Availability surveys. Member surveys include, but are not limited to, the following: CAHPS®, EES, Health Outcomes Survey (HOS), new member surveys, member satisfaction with and assessment regarding the network, member loyalty surveys, disease management surveys, and case management surveys.

Integrated data systems collect member, practitioner and provider information, utilization, population-based and/or specific member information, and practitioner/provider specific information. Software includes, but is not limited to, claims systems, NCQA-approved HEDIS® software, credentialing and re-credentialing software, Microsoft products, and other systems to support both clinical and service interventions.

CMS Stars Ratings Data Sources: EmblemHealth complies with the annual Medicare HEDIS®, HOS, and CAHPS® reporting requirements, and other administrative measures required by CMS. This information forms the basis of the CMS Star Ratings used to assess the quality of Medicare Advantage plans.

HEDISÂ® Reporting Requirements

EmblemHealth submits audited summary-level HEDIS® data to NCQA and to the Centers for Medicare & Medicaid Services-designated contractor. The data collection methodologies are either administrative or hybrid types. The administrative method is from transactional data for the eligible populations, and the hybrid method is from medical record or electronic medical record and transactional data for the sample.

Because of the critical importance of ensuring accurate data, EmblemHealth is required to participate in an external audit of the HEDIS® measures before public reporting. EmblemHealth contracts with an NCQA-licensed organization for the Compliance Audit. Following receipt of the Final Audit Report, EmblemHealth makes available a copy of the complete final report to CMS.

Medicare HOS Survey Process Requirements

EmblemHealth is required to report results for a baseline HOS and a follow-up survey. EmblemHealth contracts with an NCQA-certified vendor for administration of both the baseline and follow-up surveys. Each year, baseline cohorts are drawn and the CMS identifies a number of randomly selected members per contract to be surveyed. Additionally, each year the cohort measured two years previously at baseline is resurveyed. The results of this re-measurement are used to calculate a change score for the physical health and emotional well-being of each respondent.

Individual member level data is not provided to EmblemHealth until approximately a year after the entire baseline/followup cohort study is completed. CMS provides EmblemHealth with a HOS Baseline Report and HOS Performance Measurement Report and Data containing the results of the follow-up survey. The survey vendor provides EmblemHealth with details of the survey administration.

Medicare CAHPSÂ® Requirements

EmblemHealth is required to report results of the CAHPS® Survey. EmblemHealth contracts with an approved MA & PDP CAHPS® vendor for survey administration. This vendor adheres to CMS requirements for fielding, collecting, and reporting CAHPS® data, thereby ensuring valid and reliable results.

Childrenâ€™s Health and Behavioral Health Medicaid Benefit

The Plan's Children's Health and Behavioral Health Medicaid Benefit integrates physical health and behavioral health for children under 21 years of age to create better quality of care and lay the groundwork for better health outcomes for adults. This includes addressing the needs of Medically Fragile Children, children with behavioral health diagnosis(es), and children in Foster Care (FC) with developmental disabilities. This benefit also includes Home and Community Based Services to address the membership's complex needs.

Reporting Requirements for Children's Health and Behavioral Health Medicaid Benefit:

- Children's Consumer Perception Survey

  The Plan will participate in a consumer perception survey for the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es), and children in voluntary foster agencies in adherence to New York State guidance. The Plan will also report results according to New York State guidance.

- Home and Community Based Services (HCBS)

  The Plan will comply with the federal HCBS quality assurance performance measure reporting requirements for children under 21 years of age receiving HCBS as defined by New York State.

- Outcome Measures

  The Plan will report on required outcome measures for the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster agencies, as specified by New York State.

- Performance Improvement Project

  The Plan will participate in an internal performance improvement project as defined by New York State on a topic affecting the children's population under 21 years of age, including those in the following subpopulations: Medically Fragile Children with physical, emotional, or developmental disabilities diagnosis; behavioral health diagnosis(es); and children in voluntary foster agencies.

- Quality Assurance Reporting Requirements (QARR)

  The Plan will continue to submit reports to New York State as specified in the Quality Assurance Reporting Requirements (QARR) within the time frames provided by the Medicaid Managed Care Model Contract.

MONITORING AND EVALUATION

Quality Improvement Program Description

The Quality Improvement Program Description is reviewed annually and amended as necessary. The review process incorporates input from the Quality Improvement Committee and final approval by the Quality Improvement Committee and the Quality Improvement Committee of the Boards and Quality Assurance Committee of the Board—the governing bodies. The timeline for completing the review process is set forth in the annual Quality Improvement Work Plan. Information about the Quality Improvement Program is published on EmblemHealth's website

The Annual Quality Improvement Program Work Plan (QIPWP)

The Quality Improvement Work Plan encompasses quality and performance improvement activities that EmblemHealth will initiate, continue, complete, or terminate for all lines of business. The development of this review requires the cooperation of multiple departments, including, but not limited to: QualityManagement, Accreditation, Care Management, Utilization Management, Delegation, Behavioral Health, Customer Service, Claims, Enrollment, Marketing and Communications and Grievances and Appeals. This dynamic work plan reflects and integrates planned quality improvement activities throughout the year for all lines of business from all areas of the organization (clinical and administrative), and includes requirements for external reporting. The Quality Improvement Program Work Plan includes the following elements:

- Yearly planned quality improvement activities and objectives for improving:
  - Quality of clinical and behavioral health care
  - Safety of clinical and behavioral health care
  - Quality of service
  - Members' experience
- Time frame for each quality improvement activity's completion.
- Staff member(s) responsible for implementation and management, initiation of the time frame, and the targeted completion date for each activity.
- Planned monitoring and follow-up activities of previously identified issues.
- Calendar of :
  - QI Committee Meeting Schedule
  - Presentation schedule for Quality Improvement Program documents
  - Presentation schedule for Utilization Management Program documents
  - Delegated activities reporting
  - Reports and documents to the Quality Improvement Committee and the Board of Directors.

The status of the work plan items are updated quarterly and reviewed by the Quality Improvement Committee. The Quality Improvement Work Plan and its activities are subject to ongoing revisions and updates throughout the year as needed to meet changing priorities, regulatory requirements, and identified areas for improvement. Subsequent revisions and updates will be reviewed and approved by the Quality Improvement Committee.

The Annual Quality Improvement Program Evaluation

The Quality Management Assistant Vice President, Quality Improvement manager, and other applicable staff as identified, in collaboration with all relevant departments, prepare the annual Quality Improvement Program Evaluation, which:

- Acknowledges the Quality Committee of the Boards' oversight and evaluation of the Quality Improvement Committee, the effectiveness of the Quality Improvement Committee structure and organizational structures that support implementation.
- Describes and evaluates completed and ongoing quality improvement activities that address quality and safety of clinical care, quality of service, and members' experience.
- Tracks the trending of measures such as HEDIS®, CAHPS®, and organization-specific key performance indicators, to assess performance in the quality and safety of clinical care and quality of service.
- Analyzes and evaluates the impact, results, and effectiveness of quality improvement activities described within the program and work plan and of its progress toward influencing network-wide safe clinical practices. Focus includes, but is not limited to, delegated functions, SNP quality improvement projects, and the Chronic Care Improvement programs implemented during the year.
- Identifies the limitations and barriers to improvement; analyses of barriers include staff who had direct experience with the processes and have presented barriers to improvement.
- Identifies opportunities for improvement, including adequacy of resources, committee structure, practitioner participation, and leadership involvement in the Quality Improvement Program.
- Recommends upcoming year's activities, including those that will carry over into the next year.

The Quality Improvement Program Evaluation is presented to the Quality Improvement Committee and the Quality Improvement Committee of the Boards for feedback and final approval, in accordance with the Quality Improvement Program Work Plan. Members, practitioners, providers, and employees are annually informed of EmblemHealth's Quality Improvement Program results through EmblemHealth's website.

CONFIDENTIALITY

EmblemHealth requires that each employee and committee member sign a Confidentiality Agreement to ensure that information regarding its members and practitioners/providers is held to confidentiality standards. Confidentiality standards are governed by written policies and procedures and are applicable to oral and written confidential information, including member, practitioner/provider, and company proprietary information. In addition, key departments have internal privacy and confidentiality policies and procedures specific to their function. It is the responsibility of department management to review these policies and procedures annually with each of their employees. The Corporate Compliance Committee has oversight responsibility for development and implementation of privacy and confidentiality policies.

All quality assessment and improvement data, committee minutes, reports, recommendations, and actions are kept strictly confidential and under the auspices of the Quality Improvement Committee. Information pertaining to a member and his/her family will not be released to any third party without the expressed written authorization of the member or his/her legal guardian except as required or permitted by law or with a bona fide legal demand. All medical information utilized to study the general quality and effectiveness of medical services provided to members shall be presented in de-identified form, excluding all individual patient information.

Provider, and practitioner-specific quality assessment and improvement information is maintained in each provider and practitioner's file with restricted access. Documents and information obtained through the Quality Improvement Program are regarded as confidential and protected under Quality Assurance and Peer Review processes.

EmblemHealth is responsible for developing, compiling, evaluating, and reporting certain measures and other information to CMS, its enrollees, and the general public. EmblemHealth safeguards the confidentiality of the doctor-patient relationship, and reports to CMS in the manner required for cost of operations, patterns of utilization of services, and availability, accessibility, and acceptability of Medicare-approved and covered services. All documentation required by regulatory and accrediting bodies, including CMS, is made available in the format required by the regulatory and accrediting bodies, upon request. This includes, but is not limited to, the Quality Improvement Program Description, Work Plan, Evaluation, Policies, Operational Processes, Quality Improvement Activities, etc.

DELEGATION OVERSIGHT

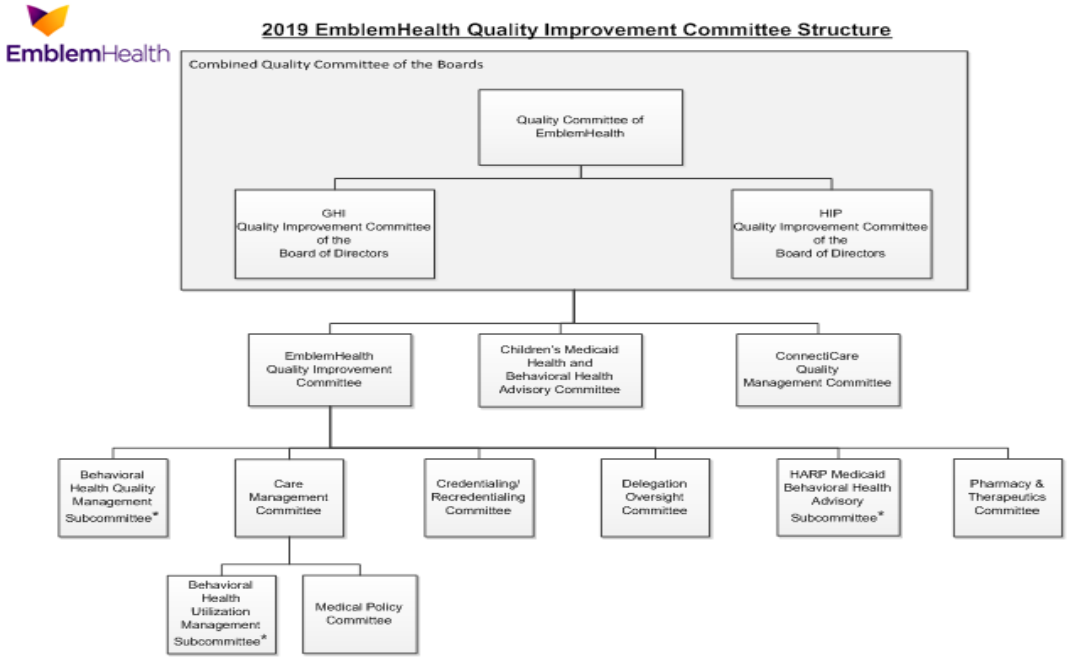
Delegation Oversight Committee

Purpose: The Delegation Oversight Committee assesses and oversees all delegated activities performed by contracted delegates. The Delegation Oversight Committee monitors the delegates' compliance with EmblemHealth's policies and procedures, accreditation standards, and applicable laws, rules, regulations and stipulations, thereby ensuring that all members receive equitable access to care and services.

Responsibilities: The responsibilities of the Delegation Oversight Committee include but are not limited to:

- Responding to and addressing the concerns of the EmblemHealth operational departments in a process-oriented manner as it relates to the performance/non-performance of delegated entities.
- Using objective criteria/metrics to evaluate the measures/processes of performance of the delegated entities against EmblemHealth's and the health care industry's standards and benchmarks to identify areas of success and areas in need of improvement. Metrics help to ensure that the Delegation Oversight Committee's decisions concerning delegated activities and processes are based on objectively measured outcomes and results. It is the Delegation Oversight Committee's responsibility to provide oversight of the audit tools and metrics used to measure delegate performance in the context of frequently changing regulatory and accreditation requirements and changes in industry practice. Audit tools are reviewed and, if applicable, revised on a periodic basis to assure the tools remain sensitive and specific to assess delegate compliance.
- Reviewing all applicable pre-delegation materials and annual audit materials against established protocols.
- Making recommendations to the Quality Improvement Committee regarding delegation activities including, but not limited to, a potential delegate being approved as a delegate, adding functions and/or lines of business to an established delegate, rescinding the delegate status of delegate to that of a vendor, rescinding the contract of a delegate and/or pursuing recommendations that impact the delegate.
- Establishing time frames and protocols for auditing and reporting the functionality of delegated entities to the Delegation Oversight Committee. Delegation audits are completed as frequently as necessary to evaluate compliance, but no less than annually, started and completed within 10 months to 14 months of the prior year's audit.
- Recommending the decisions regarding the delegates to the Quality Improvement Committee in a manner that allows the Quality Improvement Committee to act within timely and appropriate time frames. The Delegation Oversight Committee communicates with all affected and concerned customers in a confidential manner.
- Overseeing statements of deficiencies and improvement action plans to ensure completion of recognized deficiencies and compliance with CMS, NYS, the NYC Department of Health, and other state and federal regulatory and accreditation bodies. If serious problems cannot be corrected, the Relationship Manager and Subject Matter Experts present the unresolved issues to the Delegation Oversight Committee. The Delegation Oversight Committee may recommend to the Quality Improvement Committee partial or full revocation of delegated activities.

2019 EMBLEMHEALTH QUALITY IMPROVEMENT COMMITTEE STRUCTURE



* Behavioral Health specific subcommittees. All other committees are integrated and are responsible for addressing medical and behavioral health (effective 07/01/15).