EmblemHealth®

Quality Improvement Program

EmblemHealth's mission is to create healthier futures for our customers and communities. We do this through: Care — valuing and respecting EmblemHealth's customers, partners, and employees; Diversity — committing to building a culture of inclusion; Agility — being nimble and proactively seeking out opportunities to improve and innovate; and Partnership — working together and taking a leadership role.

EmblemHealth has a comprehensive Quality Improvement Program that encompasses all operational areas. It establishes a framework and processes that continuously work to improve the health care and services our members receive, including the quality and safety of clinical care and services it provides.

We routinely monitor and review the following areas to ensure that our members in all health plans, including specialty programs such as Health and Recovery Plans (HARPs), have access to the highest quality medical and mental health care and services:

- Quality of care, including continuity and coordination of care.
- Quality of service.
- Patient safety.
- Utilization management program.
- Member and physician satisfaction.
- Accessibility.
- Availability.
- Delegation and vendor oversight.
- Member complaints, grievances, and appeals.
- Member decision support tools.
- Cultural diversity.

EmblemHealth uses various data sources and software to measure quality improvement processes and outcomes, determine barriers to improvement, and identify ways to improve quality and overcome obstacles. Data sources include:

- Appeals data.
- Applicable Care Management programs/initiatives databases.
- Behavioral health data.
- CAHPS®[1] (Consumer Assessment of Healthcare Providers and Systems).
- Children's Consumer Perception Survey data.
- Claims data.
- Complaints from doctors and members.
- Encounter data (data showing use of provider services by health plan enrollees).
- Enrollment data.
- Health Outcomes Survey (HOS) data.
- HEDIS®[2] (Healthcare Effectiveness Data and Information Set).
- Home and community-based services data.
- Integrated data collection systems that collect member and provider information.
- Laboratory data.
- Medical records.
- National and regional epidemiological demographic, and census data. Epidemiology is the study of the distribution and causes/risk factors of health-related states and events in specified populations.
- Utilization review data.
- Pharmacy data.
- Population-based member information.
- Evidenced-based practice guidelines that comply with recommendations of professional specialty groups or the guidelines of programs such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American Psychiatric Association, the U.S. Task Force on Preventive Care , the New York State Child/ Teen Health Program (C/THP), the American Medical Association, the U.S. Department of Health and Human Services, the New York State Office of Addiction Services and Supports (OASAS), American Society of Addiction Medicine (ASAM), U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the American

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). [2]HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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College of Obstetricians and Gynecologists, the American Diabetes Association, the National Standards for Culturally and Linguistically Appropriate Services (CLAS), and more.
- QARR (Quality Assurance Reporting Requirements).
- Quality Compass®[3].
- Quality improvement projects/studies.
- Telephone response data.
- Utilization review data.
- Various provider and member surveys.

Highlights of the Quality Improvement Program include, but are not limited to, the following:

QUALITY OF CARE

Clinical and health promotion activities are selected and prioritized. Interventions are based on accepted, evidence-based clinical guidelines and member-specific identified needs. Due to COVID-19, the way we conducted some of our Quality of Care activities, which focused on optimizing the health and well-being of EmblemHealth's members, moved to virtual delivery for at least part of the year. Activities include:

- Mailings of preventive health reminders, preventive health guidelines, member newsletters, and health and wellness information to help members maintain and improve their health status.
- Calls to members to confirm certain diagnoses, as well as to encourage them to use appropriate medications and get needed tests completed.
- Medication adherence activities, including contacting providers whose members did not refill medications.
- Our Peace of Mind initiative, through which members received calls letting them know about telehealth options, how to get same-day prescription delivery and 90-day prescription fills without leaving the house, and other services available to help them stay safe during the COVID-19 outbreak. Medicaid members who delayed routine care due to the virus were also contacted by telephone and reminded to complete childhood well- and dental visits, and colon cancer, breast cancer and diabetes screenings.
- Maintaining collaborative relationships with the quality teams and leadership of provider-practitioner groups in our network. Monthly gaps in care reports, provider report cards, and HEDIS measure dashboards are distributed to provider groups highlighting performance and opportunities for improvement.
- Calls to members recently discharged from the hospital, including those discharged from the emergency room, to ensure they follow up with appropriate providers.
- Collaboration to promote HEDIS, QARR, and Stars measures identified by the Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (NYSDOH) within internal departments including Care Management and Pharmacy.
- Partnerships with vendors who conduct at-home tests, such as bone mineral density and diabetic testing.
- Providing accessible colon cancer screening to members starting with an initial targeted "opt-in" offer for a FOBT (fecal occult blood test) kit followed by a FOBT kit direct mailing campaign.
- Providing tailor-made health outreach programs both in-person and virtually in response to COVID-19 concerns, such as those offered at EmblemHealth Neighborhood Care locations, as well as our Care for the Family Caregiver program and the National Diabetes Prevention Program (National DPP).
- Developing and maintain regulatory-required reports and projects, including applicable interventions.
- Addressing continuity and coordination of care through multiple means, such as data exchange with primary care providers and specialists, to alert them to members who have not received certain services and tests, based on claims. Additionally, EmblemHealth addresses continuity and coordination of care through studies such as Comprehensive Diabetes Care: Diabetic Retinal Eye Exams; Reduction of Avoidable 30-day Readmission Rates; Primary Care Practitioners (PCPs) 7-30-day Visits after an Emergency Department Visit; and Postpartum Depression.
- Collaboration with physicians, pharmacists, and behavioral health practitioners within the Quality Improvement Committee and subcommittees.
- Engaging with community agencies to address specific needs of children, HARP members, Special Needs Plan (SNP) members, and special populations.

CARE MANAGEMENT

EmblemHealth has adopted a Population Health Management model. The model identifies high-risk members who would most benefit from Care Management programs and/or Population Health Management interventions. Relevant criteria for each Care Management intervention is reviewed and incorporated into the stratification process to identify the most critical members for whom we can make an impact.

EmblemHealth's strategy focuses on keeping members healthy and includes, but is not limited to, various wellness programs, managing members with emerging risk, assessing social determinants of health, patient safety initiatives, and supporting members with multiple complex health conditions.

The model also ensures the programs are fully integrated with one another so members with multiple conditions are supported holistically. Our programs work with members to reduce barriers to care, ensure adherence to any treatment plans, and help with navigation to appropriate resources. They include:

Healthy Futures Program

This newly designed member program aims to empower and educate members throughout their pregnancy and beyond, to keep themselves — and their baby — healthy. The program provides weekly pregnancy tips and resources starting from 6 weeks of pregnancy all the way through delivery and postpartum care. New moms also receive messaging throughout their child's first 12 months, educating them on immunizations, well-visits, nutrition, lead testing, developmental

[3]Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

screenings, and other helpful topics. Members have free access to question-and-answer sessions with our medical experts and telephonic access to a nurse who can answer questions about pregnancy, child care, family planning, and more. Members complete two health assessments with care management staff throughout their pregnancy and one after delivery to help identify and navigate a high-risk pregnancy or other chronic conditions.

NICU Program
Our NICU program provides resources and caregiver support for members and their newborns while confined to the NICU and for up to a year after discharge, as appropriate. After discharge, babies who were in the NICU with continuing needs such as long-term care, home care, durable medical equipment, and/or chronic or disabling conditions are followed by the Care Management team until health goals are met or they reach one year of age.

Asthma Program
The goal of the program is to empower members to manage their asthma at home and avoid unnecessary emergency department visits and hospitalizations. Care Managers provide disease-specific education and tools that members and their caregivers need to manage their condition.

Diabetes Management Program
Our Diabetes program, accredited by the American Association of Diabetes Educators (AADE), aims to provide our members with the tools they need to improve self-management of their condition and prevent their illness from progressing. The program includes delivery of onsite and virtual diabetes education courses by Certified Diabetes Educators (CDEs), integration with CDE Pharmacists and Registered Dieticians, and Care Management services.

HIV Program
The goal of the program is to empower members to take charge of their care and avoid hospitalizations and emergency care. Case Managers partner with members to ensure access to appropriate providers and resources and educate members on ways to reduce high-risk behavior.

Transplant Program
The goal of the program is to provide members care coordination and care management services before and after a transplant. In addition to these services, Case Managers will work with members and their caregivers to facilitate advanced care planning as needed.

Long-Term Services & Supports Program
The goal of the program is to drive member empowerment and assist with navigation to appropriate resources for Medicaid members identified as having chronic illnesses or those who are disabled and need long-term services and supports.

Special Needs Program
The goal of the program is to assist members with special needs, including older or disabled members, at-risk populations, low-income individuals, those with multiple medical-psychosocial issues or multiple chronic conditions, and behavioral health issues. Holistic, dynamic, and integrated Care Management services and support are provided.

Transition of Care Program
The goal of the program is to help members avoid preventable hospital readmissions and other acute care through education and planning. We do this by ensuring discharge planning needs have been met and by offering members appropriate transitional resources for 30 days after discharge from the acute care setting. Interventions provided to members by the Transition of Care team include education on condition management, emergency room avoidance, signs and symptoms to report, keeping medications up to date, coordination of follow-up appointments, and navigation to other appropriate resources, as needed. Members can be referred to Complex Care Management if additional needs are identified beyond the 30-day transition period.

Emergency Room (ER) Avoidance Program
The goal of the program is to reduce avoidable Emergency Room (ER) visits by contacting members to assess reasons for visiting the ER, educate members about alternatives to ER care (i.e., Urgent Care Centers), and help members find appropriate resources for which they may be eligible such as primary care, care management programs, or Health Homes.

Advanced Illness Program
The goal of the program is to improve quality of care and reduce unnecessary tests and services for members who are diagnosed with serious and/or terminal conditions. Members will receive Care Coordination services and psychosocial support to address their complex care needs, including end-of-life care and navigation to palliative care, when appropriate.

Chronic Kidney Disease (CKD)/End-Stage Renal Disease (ESRD) Program
The goal of the program is to offer support, care management, and education to members diagnosed with Chronic Kidney Disease (CKD) Stages 1-5 and End-Stage Renal Disease (ESRD) to improve condition management and help them throughout their health care journey. Care Managers work with members and their caregivers to provide disease-specific education and tools to manage their condition, as well as other care management services.

Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD) Programs
The goal of this program is to empower members to manage their Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) at home and avoid unnecessary use of hospitals and other acute care settings. Care Managers provide disease-specific education and tools that members and their caregivers need to manage their condition, as well as other care management services.

EmblemHealth's Care Management programs were developed to create an alliance among EmblemHealth's network practitioners, clinicians, hospitals, facilities, and ancillary services to meet our members' health care needs. The programs utilize a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options, services, and resources.

The programs provide interventions based on the assessment of members' needs. They are deployed using a multi-disciplinary team made up of network practitioners, nurses, registered dieticians, certified diabetic educators, social workers, mental health care specialists, and non-clinical care specialists. Services include, but are not limited to:

- Regularly scheduled telephonic or face-to-face contacts to help members who have complex medical needs reach health care goals. This is done by assessing health status and developing care plans that include long-term and short-term goals that address barriers or gaps in care.
- Educational mailings sent to promote members' self-management of their conditions.
- Assistance in care coordination, including home care and guidance to appropriate resources, including durable medical equipment (DME).
- Ensuring post-discharge primary care provider (PCP) and/or specialist appointments are made.
- Comprehensive discharge planning and post-discharge plan of care reinforcement.

HEALTH AND WELLNESS PROGRAMS

Health and Wellness programs are offered to EmblemHealth members with conditions that benefit from monitoring and clinical support.

These include:

- The Tobacco-Free Quit-Smoking program offers a telephonic-based behavior modification program to members 18 years and older who want to stop smoking. Members who engage in the program receive a comprehensive educational kit and support calls from a smoking cessation specialist.
- The Healthy Living Program offers a toll-free line available to members 24 hours a day, seven days a week. It is staffed by registered nurses trained in telephone triage. This line gives eligible members access to immediate clinical support for everyday health issues and questions that may have otherwise led to unnecessary doctor or emergency room visits. Nurses guide callers in making informed decisions about many health conditions and how best to handle medical concerns.
- Health and Wellness programs are offered through WellSpark. This encompasses chronic disease self-management, diabetes prevention, and lifestyle coaching.

PATIENT SAFETY

EmblemHealth continues to address patient safety through a variety of activities and initiatives including the following:

- Targeted provider and member communications addressing patient safety topics such as the use of high-risk medications.
- Encouraging members to complete a Personal Health Record (PHR).
- Articles in member and provider newsletters about patient safety topics and medical safety issues.
- Alerts for members and practitioners through EmblemHealth's website. Alerts have been posted on topics including FDA or voluntary drug recalls, communicable disease outbreaks, and new immunizations.
- Concurrent drug utilization review at the time prescriptions are dispensed that alert the pharmacist to potential safety concerns such as drug-drug interactions, drug-disease interactions, high doses, pregnancy, age and/or gender restrictions, and therapy duplication.
- Documenting medication errors or potential medication errors as part of the Medication Errors Reporting Program.
- Credentialing and recredentialing process that ensures access to qualified practitioners and facilities.
- The Quality Risk department reviews, addresses, tracks, and trends clinical complaints and grievances.

Patient Safety — Pharmacy Management

EmblemHealth monitors the utilization and appropriate use of prescription drugs. Pharmacy Services addresses opportunities for improvement by encouraging the prescribing of appropriate medications by providers, educating members about medications that may have been prescribed to them, and promoting the safe use of medications — including following the medication schedule. Pharmacy Services monitors members to ensure they take their medications as prescribed and consult with their health care providers to optimize therapeutic outcomes. Pharmacy Services also coordinates with our case and disease management programs to ensure appropriate prescription utilization by targeted members through one-on-one support and intervention. EmblemHealth's Medication Therapy Management (MTM) program targets members with a high-prescription drug spend, multiple chronic conditions, and multiple covered medications.

Monitoring and Evaluation

EmblemHealth collects and analyzes data to continually monitor its performance and identify areas for improvement, using HEDIS® scores to determine if members are getting needed preventive screenings and treatments and to identify areas of improvement in members' care and service. EmblemHealth compares the plan's HEDIS scores to relevant industry benchmarks, such as National Committee for Quality Assurance (NCQA) Quality Compass®, CMS Medicare Star Ratings Program, and New York State averages, to measure its performance compared to other health plans. Improved scores year over year indicate that EmblemHealth is continuing to reduce gaps

in the health care its members receive, as needed interventions are developed and implemented to address member quality and safety of clinical care and services and satisfaction with the care and services.

EmblemHealth also uses Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Enrollee Experience survey to survey its members about the interpersonal aspects of their health care as well as the members' relationship with their doctor and experiences with their health plan. CAHPS results are publicly reported on various forums and used by consumers to guide their selection of health plans. CAHPS is required by CMS for Medicare, and the Qualified Health Plan Enrollee Experience Survey for Qualified Health Plans. They are also required by the NYSDOH, Federal Employee Health Benefits (FEHB) Program, Medicaid (including HARP), and NCQA. Additionally, CAHPS results impact the Medicare Stars Quality Bonus Program and the NYSDOH Medicaid Quality Incentive Program, and the potential revenue associated with both programs. The NYSDOH also assesses member satisfaction. These results are shared with the Quality Improvement Committee (QIC) to address member satisfaction.

EmblemHealth also addresses compliance and reports from regulatory and other agencies such as, but not limited to, the NYSDOH, New York State Department of Financial Services, OASAS, New York State Office of Mental Health (OMH), and CMS.

ACCREDITATION

EmblemHealth remains an NCQA-health plan accredited for HIP Commercial HMO/POS, HIP Medicare HMO, HIP Exchange HMO, and EmblemHealth Plan, Inc. formerly known as GHI PPO Commercial lines of business. The NCQA accreditation status remain in effect through September 10, 2022. Collection, review, and analysis of documents as part of the ongoing quality oversight and in preparation for the next NCQA submission continues. Submission for the next review is June 2022; file review is scheduled for August 2022.

Additional highlights of EmblemHealth's combined HEDIS, CAHPS, and NCQA accreditation status can be viewed at **NCQA Health Insurance Plan Ratings**.

QUALITY OF SERVICE

Translating EmblemHealth's mission and core values into every customer's experience is critical to the delivery of quality services. At every point of contact, EmblemHealth aims to improve the customer experience. We do this by:

- Using simple language and appropriate reading levels to make our communications easy to understand.
- Providing online tools to help members manage their health care.
- Providing information about services available to members, brokers, providers, and administrators.
- Processing claims fast and accurately.
- Answering phone calls promptly, courteously, and effectively.

Service encompasses both operations (claims and enrollment) and customer service. The experience that members, providers, practitioners, and customers have during these routine interactions influences their perspective and impacts their satisfaction with us. Striving to improve this experience, as measured and monitored by CAHPS®, Enrollee Experience Survey (EES), and other internal and external satisfaction survey tools and key performance indicators, through innovative activities resulting from root cause analysis, helps guide EmblemHealth in developing a more satisfying customer experience.

Customer Service

EmblemHealth monitors member and provider telephone service standards, including specific service levels. The results are tracked and trended. After-call survey data is reviewed to ensure the member's questions were addressed, procedures were followed, accurate information was provided, the response met quality requirements and was legally compliant, and there was resolution accountability (for example, if a member's existing referral is ending, the representative reminded the member to get a new referral from their PCP).

Claims Operations

EmblemHealth continually monitors claims processing standards to ensure specific service levels are met.

Cultural Diversity

EmblemHealth is committed to clinical and non-clinical services being available and accessible to members in a culturally competent manner to accommodate members' needs.

When they enroll, and any time after that, members can select from a provider network and plan services that meet the member's cultural, ethnic, racial, gender, age, and language needs. Member requests for providers who speak a specific language are directed to Customer Service. Customer Service matches the request based upon need and provider availability. Members can also use our web directories to find providers based on gender and languages spoken.

Providers also have available to them services to assist them in addressing their patients' individual cultural, racial, and ethnic language needs and preferences. Examples of services available to providers include:

- Translation services, including translation of materials that EmblemHealth provides.
- Cultural competency continuing education and resources on EmblemHealth's website.

EmblemHealth identifies, reviews, and analyzes metrics; develops, prioritizes, and implements activities; and evaluates outcomes to address gaps in member receipt of services and member satisfaction based upon cultural, ethnic, racial, language, and gender needs. Some of the ways EmblemHealth determines that services are received, and needs are met are through:

- CAHPS® survey analysis.
- Language Translation Line utilization.
- Customer service.

- Provider directories that include information collected during the credentialing/recredentialing process such as wheelchair accessibility, languages spoken, gender, practice hours, and locations.
- Practitioner availability such as the number and/or percent of PCPs, obstetricians, and mental health providers by county, gender, language and, as available, by race/ethnicity, to determine network adequacy.
- Member materials, which can be provided in large print, non-English translation, or braille.
- Complaints, grievances, and appeals.
- HEDIS® Effectiveness of Care measures are analyzed to determine health care disparities in member use of services.
- Data collection through health risk assessments, regulatory agencies, disease and case management teams, and surveys including the annual Cultural Diversity Survey.
- Employee and practitioner training in cultural competency, disparities in health care, health literacy, and other relevant topics.

EmblemHealth Neighborhood Care is a community-based service provided to members. Neighborhood Care centers are located within culturally diverse geographic areas. These community-integrated walk-in centers provide members with access to information and services and are offered by culturally diverse EmblemHealth employees.

EmblemHealth has partnered with Cityblock Health, a company that uses technology-enabled services to address the unmet health and social needs of urban populations, to bring a new model of care to its members in Crown Heights, New York. The comprehensive approach addresses social determinants and behavioral health as fundamental pillars of delivering services to those who are traditionally underserved. Cityblock provides a place for engagement between members, Cityblock caregivers, and community-based organizations to address complex health needs and social factors at the neighborhood level. The care management model leverages community health partners and an integrated, personalized care team who can assist beneficiaries with many aspects of their health. Members can access their care teams where and when they are most comfortable — at Cityblock, in their homes, or in the community.

The Quality Improvement Committee is dedicated to promoting cultural competency practices within EmblemHealth and establishing platforms across the organization to address health care disparities.