oscar

Quality Improvement

Program Description

2024

TABLE OF CONTENTS

VISION AND MISSION 4
OBJECTIVES 4
ANNUAL WORK PLAN 5
ANNUAL EVALUATION 5
AUTHORITY, ACCOUNTABILITY AND RESOURCES 6
- A. Governing Body 6
- B. Quality Committees 6
- Delegation Oversight Committee 6
- C. Key Roles 7
  - a. Clinical Leadership 7
    - b. Quality Improvement Operations 7
    - c. Network Practitioners 8
    - d. Health Information System, Technology and Data resources 8

PROGRAM SCOPE 9
1. SIMPLE AND ENGAGING MEMBER EXPERIENCE 9
- Concierge Teams 9
- Reducing Health and Health Care Disparities 9
- Language Services 10
- Complaints, Grievances and/or Appeals 10
- Member Engagement and Technology 10
- Member Feedback 11

2. EASY ACCESS TO BETTER CARE 11
- Network Construction and Care Routing 11
- Credentialing and Recredentialing 12
- Quality Network Agreements 12

3. BETTER HEALTH OUTCOMES AT A LOWER COST 12
- Healthcare Effectiveness Data and Information Set (HEDIS) 12
- Quality of Care Issues and Peer Review 13
- Clinical Practice Guidelines and Standards of Care 13
- Standards for Medical Record Documentation 13
- Population Health Strategy and Programs 13
- Behavioral Health 14
- Continuity and Coordination Between Medical Care and Behavioral Healthcare 14
- Utilization Management 15
- Pharmacy Management 16

QUALITY IMPROVEMENT PROCESSES UTILIZED 17
PERFORMANCE STANDARDS - ACCREDITATION 19

CONFIDENTIALITY AND RECORD MAINTENANCE 19
2024 QUALITY WORK PLAN 21
EXHIBIT A: 57
 2024 Quality Committee Structure and Descriptions 57
EXHIBIT B: 58
 2024 Quality Improvement Department 58
Addendum: Oscar Health Plan of Georgia NCQA Health Equity Accreditation Requirements 59
 Overview 59
 Policy 60

VISION AND MISSION

The Plan was developed and structured to make a healthier life accessible and affordable for all. In conjunction with our provider partners, we are the entry point and guide for our members through the healthcare system — we facilitate their access to care so that providers can focus on keeping members healthy. Our unique vision drives our mission to refactor healthcare to build richer connections and take the best care of our members. There is a growing body of evidence to support the rationale that when members are highly engaged and can easily access the medical and behavioral healthcare they need, they can make informed decisions with their providers that lead to better health outcomes.

OBJECTIVES

In order to continuously improve the care and services our members receive, promote safety and use of evidence-based guidelines, and provide a satisfying experience for both the member and provider, the Plan takes an enterprise-wide approach to the methodology and structure of the Quality Improvement Program (QI Program). QI Program projects, objectives and goals are focused on three aims:

1. Simple and Engaging Member Experience
    a. Create a simple and engaging member experience through activities and analysis of continuous quality monitoring and member feedback data.
2. Easy Access to Better Care
    a. Improve easy access to care through analysis and improvement activities based on access and availability monitoring that influence seamless care routing.
    b. Provide access to better care through a high quality network of providers and facilities through the Credentialing, PQI monitoring, value-based partnership, and clinical outcome monitoring activities.
3. Better Health Outcomes at a Lower Cost
    a. Improve patient safety through potential quality issue identification, utilization and pharmacy management review, and trending. Take action when appropriate and follow up on corrective actions or performance improvement plans.
    b. Improve the health of our members through population health activities that understand the impacts of the social determinants of health.
    c. Understand the unique cultural and linguistic needs of our member populations and incorporate the feedback in the Language Assistance Program

ANNUAL WORK PLAN

The Plan monitors the QI Program through the Annual Work Plan. The Annual Work Plan[3] identifies all yearly planned activities, quality improvement projects (QIPs) and objectives which address quality of clinical care, safety of clinical care, quality of service, and member experience. The Annual Work Plan outlines the timeframe for each activity's completion, the staff member responsible, the ongoing monitoring required, and the final evaluation of the activity. See page 20 for the 2023 Annual Work Plan.

ANNUAL EVALUATION

On an annual basis, the entire QI Program is reviewed and evaluated. The evaluation consists of a review of all goals and their status, along with a comprehensive analysis of barriers for those goals not achieved. The evaluation assesses the overall effectiveness in improving the quality of care and service to members as well as progress towards improving patient safety and influencing network clinical practices. Barriers to achieving goals are identified, and corrective action recommendations, including corrections to the Plan's policies and procedures, will be made to address those barriers. As a result of this analysis, activities that need to be carried over into the next year are identified as well as new areas of measurement or improvement focus. The analysis will lead to the creation of quality improvement projects to be completed during the following year, in partnership with internal stakeholders for input from their respective areas. The annual evaluation may also lead to identification of educational and/or training needs, the establishment and/or revision of policies and procedures, or the alteration of operations to minimize risks in the delivery of care and service.

The completion of the annual evaluation contributes to the development of the following year's QI Work Plan. An executive summary will be created and made available to Oscar members.

The Annual Evaluation will include:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service.
- Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices.

3 NCQA HPA Standards QI.1B

AUTHORITY, ACCOUNTABILITY AND RESOURCES[4]

A. Governing Body

The Plan's Board of Directors (Board) is ultimately responsible for the oversight of the QI Program. The Board fully delegates responsibility to the Quality Improvement Committee (QI Committee) which is responsible for the review, implementation, and enforcement of administrative, operational, personnel and patient care policies, procedures and related documents for the operation of the health plan. The Board supports the QI Program through its oversight and by providing the financial resources and staff within all operational areas to carry out performance improvement initiatives and activities.

B. Quality Committees[5]

The Plan has an organizational structure that includes a Quality Improvement Committee of the Board (QI Committee) and QI subcommittees that will oversee all aspects of quality performance and are responsible for implementation of the QI Program (Exhibit A). A record of the committee and subcommittee meetings will be kept including: minutes, reports, corrective actions and/or follow up actions.

The Joint Operations Committees (JOCs) are active subcommittees of the Compliance Committee. The primary function of each JOC is to provide guidance to, and oversight of the operations specific to the scope of delegated activities to each delegated organization. Included in the JOC is the review of periodic activity reports from delegated entities, support of compliance with all regulatory standards and regulations related to the delegation relationship, and recommend actions to address any identified opportunities for improvement in delegated services, as well as organization or individual report cards. The purpose of the JOC is to provide oversight, monitoring, and assessment of the appropriateness and quality of services and care provided on behalf of the Plan to the members. The JOCs will include representation from the Plan's functional area/s as appropriate for each agenda, as well as the delegated entity representation.

Delegation Oversight Committee

The primary functions of the Delegation Oversight Workgroup (DOC) is to provide guidance to, and oversight of, the operations affecting the scope of functions of Delegated and Downstream Entities, review periodic activity reports from Delegated Entities, promote and document compliance with applicable federal, state, regulatory, and accreditation standards, and recommend actions to address

4 NCQA HPA Standards QI.1A.1

5 NCQA HPA Standards QI.1A.5

any identified opportunities for improvement in delegated activities. This workgroup reports to the Corporate Compliance Committee.

C. Key Roles

a. Clinical Leadership[6]

i. The Chief Medical Officer (CMO) is the designated senior leader responsible for QI program oversight. The CMO is responsible for submitting executive summaries of subcommittees to the Board. The CMO provides feedback from the Board to the QI Subcommittees. The CMO, along with appointed clinical leadership participates in the development and monitoring of key indicators, outcomes studies, and provider quality monitoring, profiling, and best practices. The CMO has designated a lead Medical Director for the Plan. The Plan's lead physician holds a current, valid, and unrestricted license to practice medicine in the United States and where applicable in the state they are designated to oversee. The designated lead physician is responsible for medical direction and oversight of the Utilization Management and Quality Improvement programs for the Plan. The CMO has direct oversight of the Quality Performance Improvement team, including the Quality Improvement team responsible for Accreditation (Exhibit B: Organizational Chart). The CMO may also designate a physician with responsibility for the direction of the Credentialing program.

ii. The Plan delegates members' behavioral healthcare to an NCQA accredited Managed Behavioral Healthcare Organization (MBHO). The Plan works closely with the delegate to coordinate care, monitor delegated activities and oversight, and to determine that there is communication between providers. Physician oversight, direction, and involvement play an essential role in the QI process for behavioral health, and ensure that clinical activities are planned and developed within that framework. The delegate designates a behavioral health physician who has responsibility for the delegate's QI Program. A behavioral healthcare practitioner will attend and advise in The Plan's internal quality subcommittees and Quality Improvement Committee of the Board[7]

b. Quality Improvement Operations[8]

i. The Quality Performance Improvement team is responsible for the quality management and accreditation functions including: managing programs, projects and reporting necessary to achieve quality improvement. Quality nurses and physicians are responsible

6 NCQA HPA Standards QI.1A.3

7 NCQA HPA Standards QI.1A.2

8 NCQA HPA Standards QI.1A.1

for the development and implementation of the quality of care elements, including quality of care identification, investigation and resolution.

ii. The Clinical Analytics, Data Science provide the analytics necessary to conduct population health assessments. The Quality Improvement team monitors and identifies the need for new population health programs and strategies. The Plan's Population Health Management Subcommittee meets on a quarterly basis and is responsible for monitoring annual population health reports, reviews updates, trends and areas of improvement for Population health and Continuity of Care programs. The Population Health subcommittee reports into the Quality Improvement Committee of the Board which directs all QI efforts for the Plan (see Exhibit A).

iii. The Quality Performance Improvement department leads the strategy development and collaborative implementation of efforts aimed at improving the quality of care and services for beneficiaries as measured through HEDIS, CAHPS and QHP Enrollee Survey.

iv. Appointed staff from the Network, Complaints, Grievances and Appeals, Concierge, Claims, Clinical Review, Product and Compliance departments work directly on QI activities and report directly to QI subcommittees.

c. Network Practitioners[9]

i. Network providers are required to cooperate with the Plan's QI program process. The Plan recruits network participating practitioners and they are voting members in our Clinical Advisory and Pharmacy and Therapeutics Committee and involved in the development of clinical guidelines development, Peer Review, and credentialing decisions. The Plan's Quality Improvement (QI) program information is outlined in the provider manual that is distributed to all network providers and gives direction on how to participate in quality committees or any elements of the program.

d. Health Information System[10], Technology and Data resources[11]

i. The Plan provides a consolidated clinical profile of each member in order for the Plan nurses to provide better care management and for members to have transparency into their insurance statistics. ROSCO is the Plan's internal tool for storing all member and provider information. Each member has a searchable profile that includes

9 NCQA HPA QI.1A.5

10 (42 CFR §422.152(f)(1))

11 NCQA HPA QI.1A.1

their demographic information, previous and current policy information, relevant documents, claims data, and more.

ii. The care management systems are housed in Aerial Care Management, a Medecision documentation platform. Aerial is a care management platform that drives meaningful member engagement through data-based insights. The Clinical Care Team uses Aerial to support members in achieving positive health outcomes across the continuum of care.

iii. Optum is utilized to collect claims, supplement and chart abstraction data that contribute to the measurement of Healthcare Effectiveness Data and Information Set (HEDIS).

iv. Analytic reports are generated using Periscope and Google software to unify data and enable transformative analysis.

PROGRAM SCOPE[12]

The program scope applies to all membership served by the Plan including direct services provided by the Plan through our concierge teams and by the Plan's network of providers. A summary of the program and annual results are posted on the Plan webpage and is also available upon request.

1. SIMPLE AND ENGAGING MEMBER EXPERIENCE

Concierge Teams

The Plan's Concierge Teams aim to be an entry-point to the healthcare system for Plan members. Quality of the service provided is regularly monitored through member feedback, internal quality oversight mechanisms, and comprehensive monitoring dashboards. All pieces of member feedback, including complaints and grievances are used to identify member pain points, frustrations and opportunities for improvement in the Plan's concierge services.

Reducing Health and Health Care Disparities[13]

The Plan fully recognizes the growing impact that lack of access and health care disparities can have on the well-being of members. The reduction of these disparities and the promotion of good health requires an in-depth relationship between patient and caregiver—the kind of relationship that is at the core of the Plan's approach to health care.

12 NCQA HPA QI.1A.1

13 NCQA HPA Standards QI.1A.6

The Plan trains concierge guides on encouraging practitioners to provide culturally competent services. The Plan attempts to obtain self reported data from members on language and cultural preferences to further identify and understand the needs of membership and make adjustments to the network and services as appropriate.

Language Services[14]

The Plan has a culturally and linguistically diverse membership which means that services are provided to people of all cultures, races, color, national origin, creed, ancestry, language, age, gender, marital status, sexual orientation, sexual identification, and health status or disability, in a manner that recognizes, values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each.

To support our Spanish-speaking members, the Plan provides a dedicated concierge team with qualified bilingual representatives who have undergone proficiency assessments in Spanish. For members requiring assistance in other languages, the Plan offers interpreter services through a professional supplier capable of supporting over 170+ languages. The Plan informs members and practitioners they can access language assistance services at all points of contact, at no charge, including but not limited to Plan documents, outbound letters and concierge guides.

The Plan conducts quality assessments on both English and Spanish calls and continuously monitors the quality of interpreter services provided by the vendor to ensure they meet our standards for effective and respectful communication.

Complaints, Grievances and/or Appeals

The QI program uses the collection, tracking and trending of member complaints, grievances and/or appeals to identify member paint points and opportunities for improvement with our direct services and products, network adequacy and quality, cultural competency, marketing, and the overall member experience. These issues are collected and responded to using strict timeliness and quality standards. The Plan interfaces with the Plan's partners and delegated entities to resolve complaints and grievances and to issue a formal response letter detailing the resolution.

Member Engagement and Technology

The Plan's system is enabled by a technology platform that brings multiple vendor programs and resource information together. The Plan's database includes (but is not limited to) the following information: member Health Survey (Risk assessment); member care plans; authorizations; preventive service needs; claims history; medication history; member telemedicine and customer service inquiries; and all other interactions the member has had with the Plan. The Plan employs the technology to offer a single point-of-contact to members through a dedicated member portal.

14 NCQA HPA Standards QI.1A.6

The Plan provides individuals with simple options, more control and more convenience to create an integrated approach to wellness. The goal is to help members achieve their optimal health status by proactively engaging members to adopt healthy lifestyles. The consumer-centric approach provides members with tools, easy-to-understand plan materials, and customer support that encourage them to engage the Plan in managing their care. This program includes: early identification and intervention in the event of health issues; referral to care management programs as needed; guidance to maximize utility of care episodes and eliminate gaps; advocacy to help navigate the healthcare system; support to identify and reinforce adherence to the appropriate mix of wellness programs; and tools and educational materials to foster and support self-management of a member's health and wellness.

The Plan encourages members to stay active with the Plan's Step Tracking Program. This program incentivizes members to remain active by allowing them to track steps with compatible smartphones. The rewards can be cashed out at any time in the form of an Amazon.com gift certificate.

Member Feedback

Many steps are taken to evaluate the member's experience during their time with the Plan. These include but are not limited to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Qualified Health Plan (QHP) Survey, Net Promoter Scores, and internal assessments for the concierge teams and network providers. At least annually, the Plan compiles and monitors this feedback in a cohesive analysis meant to find opportunities for improvement in the products and services provided.

2. EASY ACCESS TO BETTER CARE

Network Construction and Care Routing

By working closely with network partners, the Plan can work to create a better experience for members through the effective use of health information exchanges. The partners who are chosen are committed to the same vision of better end-to-end healthcare and are willing to work closely with the Plan to create it.

The Plan specifically requires that contracted practitioners and specialists cooperate with QI activities and that practitioners may freely communicate with patients about all treatment options, regardless of benefit coverage limitations. This information is outlined in the Provider Manual, which is presented to all participating practitioners and updated when appropriate.

To maintain an adequate network, at least annually, the Plan conducts a quantitative and qualitative analysis of the populations' linguistic and cultural needs, network access standards, and practitioner availability for primary care providers and high-impact specialists, and provider directory accuracy. The Plan analyzes member complaints, grievances, and appeals related to the network access and availability. QI

activities are identified through this analysis and added to the Work Plan or regular monitoring as appropriate.

Credentialing and Recredentialing

The Plan strives to ensure members have access to a wide range of high quality providers who can meet each of their individual care needs, which is supported by: credentialing providers in a timely manner, site visits when required, monitoring applicable sanction lists, and monitoring complaints/grievances and quality of care issues for trends in provider performance. The Credentialing Program maintains and adheres to criteria established for selection, retention, and removal of practitioners and organizational providers. The Plan monitors credentialed practitioners and maintains oversight of credentialing delegation through regular reporting. Quality issues that impact member care are reviewed by peers during ongoing monitoring and recredentialing meetings and as outlined in the Potential Quality Issue policy.

Quality Network Agreements

With the pursuit of deeper integration with systems that foster routing and data sharing, the Plan intends to implement value-based payment (VBP) agreements where appropriate with network partners. These arrangements include financial and quality components to ensure that practitioners are incentivized to continuously improve the care they provide members. The Plan will monitor VBP arrangements to identify the most effective method for rewarding quality care.

Agreements include stipulations that appropriate care, consistent with professionally recognized standards, is not withheld or delayed to the Plan's members for any reason, including financial gain and/or incentive to providers and/or others. They also make clear that the Plan does not exert economic pressure to cause institutions to grant privileges to health care providers that would not otherwise be granted, nor does the Plan exert pressure on health care providers to render care beyond the scope of their training or expertise or to make decisions for their own or the Plan’s financial gain.

3. BETTER HEALTH OUTCOMES AT A LOWER COST

Healthcare Effectiveness Data and Information Set (HEDIS)

The Plan submits and reviews HEDIS data every year. The data is used to monitor the quality of care delivered to members in a standardized way. This data helps us identify shortfalls in prevention and care and areas for improvement, and informs quality objectives with network partners in some cases. At least annually, as appropriate based on the population size, the Plan will monitor and evaluate the results of the HEDIS measure set including the appropriate “Effectiveness of Care” measure set. Based on this analysis, the Plan will identify ways to improve performance on select measures.

Quality of Care Issues and Peer Review

The Plan has a Potential Quality Issue (PQI) policy to provide a systematic method for the identification, reporting, and processing of quality of care issues and other patient safety events to determine opportunities for improvement in the provision of care and services to Plan members and to direct actions for improvement based upon the frequency and severity of the PQI.

All PQIs which are identified are reviewed by clinical staff to determine if a quality of care or quality of service issue exists. PQIs are regularly tracked and trended over a period of time to identify any potential trends or significant sentinel events.

PQIs are reviewed at relevant QI subcommittee meetings and monitored for trends by the Peer Review and Credentialing Subcommittee. Details of state specific reporting and requirements are outlined in the Potential Quality Issue Policy.

Clinical Practice Guidelines and Standards of Care

The Plan, along Managed Behavioral Health Organization (MBHO) utilizes network participating practitioners and other specialists in quality committees to approve, adopt, and distribute evidence-based clinical practice guidelines for medical and behavioral health conditions to practitioners to improve healthcare quality and reduce unnecessary variation in care when such issues are identified through monitoring practice patterns and quality of care concerns. These standards are distributed to network practitioners through the Provider Manual. Guidelines are to be monitored through review of HEDIS measure data, medical record audits, and PQI medical record review. The MBHO conducts regular oversight of behavioral health standards of care.

Standards for Medical Record Documentation

In order to encourage consistency across primary care provider service and care, the Plan has created medical records documentation standards which are outlined in the Provider Manual. The Plan requires that primary care physicians (PCP) maintain and make readily available medical records. If Quality of Care issues arise and the Medical Director or Peer Review and Credentialing subcommittee determines it necessary, the Plan will perform a random medical record audit of any provider within the Plan. When required by the applicable state governing body, annual chart audits will be conducted on a random sample of primary care providers.

Population Health Strategy and Programs

The Plan maintains a Population Health Strategy with the goal of designing, implementing and evaluating interventions to improve members' health and their receipt of evidence-based care, as well as enhance the performance of the Plan's Case Management teams. The programs include activities for keeping members healthy, managing members with emerging risk, patient outcomes across settings and managing multiple chronic illnesses.

At least annually, the Plan conducts an assessment of the population to understand the members' health and utilization profile. As further described in the Population Health Management Strategy, the Plan will monitor effectiveness of all activities and monitor member satisfaction and engagement.

Continuity and Coordination of Care

The Plan recognizes the importance of strong member-provider relationships, particularly for members with serious health issues. To ensure that provider relationships are maintained in clinical situations where a provider transition could disrupt a member's recovery or put the member at risk, the Plan has a process to provide coverage for ongoing services with a member's existing providers when deemed appropriate for a member's circumstances, as outlined by the Continuity of Care and Transition of Care Policies. The Plan proactively monitors members who will be affected by network changes and conducts outreach to assist with the transition. Annually, in the Population Health Strategy, the Plan identifies opportunities to improve coordination of medical care by collecting data on member movement between practitioners and member movement across settings. The Plan selects opportunities to be acted upon and monitored for effectiveness.

Behavioral Health[15]

The Plan fully recognizes the significant impact that mental health and substance abuse related conditions have on the well-being of members. These types of conditions often require a highly personalized treatment plan and an in-depth relationship between patient and caregiver—the kind of relationship that is at the core of the Plan's approach to health care. To ensure that the Plan's members have convenient and confidential access to personalized mental health services when needed, the Plan partners with an NCQA accredited Managed Behavioral Healthcare Organization (MBHO). The MBHO works closely with the Plan to ensure that behavioral health services are adequate and appropriate and of high quality. The MBHO's Case Management for behavioral health will identify the highest risk members with indicators among diagnosis/comorbidity, clinical condition, complexity of care, and cost of care significance. Behavioral health services and utilization is monitored regularly through a JOC and the case management and QI programs are evaluated annually for effectiveness.

Continuity and Coordination Between Medical Care and Behavioral Healthcare[16]

For behavioral health coordination, the Plan has a Case Manager specifically assigned to liaise between the Plan's Concierge teams and MBHO case managers to ensure care goals and messaging are coordinated for members with integrated care needs. Case Managers provide a variety of services to Plan members based on clinical

15 NCQA HPA Standards QI.1A.2

16 NCQA HPA QI.1A.1

segment and individual needs, with the understanding that the integration of medical and behavioral care must occur to benefit members with comorbid conditions.

The Plan collaborates with the MBHO to annually evaluate the data on opportunities for collaboration between medical care and behavioral health care to identify improvement activities to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network.

Utilization Management

To help improve patient safety, minimize errors, and promote adherence to best clinical practices, The Plan's Utilization Management (UM) Program applies clinical guidelines to support the delivery of appropriate care in the right setting at the right time. By requiring pre-service authorization, this program is designed to ensure the appropriate use of tests, studies, and treatments including but not limited to: outpatient procedures, inpatient stays, rehabilitation services, behavioral health services, outpatient medical services (such as oncology, cardiology, radiology, and musculoskeletal services), specialty drugs and prescription medications. To that end, the Plan offers a variety of programs designed to evaluate provider performance and utilization patterns against established best clinical practices, to encourage adherence to evidence-based standards of care, and to employ the latest health information technology – all with the goals of the quality, efficacy, safety, and ultimately, the success of all types of treatment members receive.

Oscar's Utilization Management (UM) Program affirms the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage
- Oscar does not specifically reward practitioners or other individuals for issuing denials of coverage
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization
- No UM reviewer shall conduct a utilization review of health care provided by any facility or entity in which that person or any member of his or her family has, directly or indirectly, a financial interest. That reviewer shall recuse himself or herself from such review.

The Plan standardizes the utilization management process and audits it to ensure that the process is followed consistently and with the same result by implementing inter-rater reliability monitoring, and acting on opportunities for improvement. The process includes the use of evidence-based and nationally accepted clinical guidelines as outlined in the UM Program document which is evaluated and updated annually. Satisfaction with the UM process is analyzed through surveys and member complaint review. Appeals related to medical necessity determinations are tracked and monitored to identify opportunities for improvement.

Pharmacy Management

The pharmacy management program is designed to enforce appropriate prescribing patterns and benefits utilization, consequently helping reduce errors and ensuring patient safety and best health outcomes. The Plan partners with a Pharmacy Benefits Manager (PBM) to monitor safety and act on identified opportunities. The PBM manages the following programs:

- Safety and monitoring solution: This program evaluates pharmacy claims for patterns of potential overuse or misuse. On a quarterly basis, our PBM evaluates controlled substances and other select drug claims (along with supporting medical data, if available) to identify potential medication abuse and fraudulent claims for appropriate intervention.
- Prior Authorization*: The Prior Authorization program offers the following benefits: it promotes appropriate drug prescription by ensuring adherence to approved treatment protocols and promotes member safety.
- Step Therapy*: The Step Therapy program ensures that the Plan members choose the most therapeutically appropriate drugs first. Step therapy protocols optimize appropriate drug therapy and support patient safety by defining how and when a particular drug or drug class should be used, based on a member's drug history. Post-step prior authorization is also available to allow coverage for clinically appropriate situations that do not meet the initial step therapy protocol.
- Quantity Limits: Quantity Limits will be implemented as an alternative or a supplement to the Prior Authorization program, affording control over drugs with the potential for abuse, misuse, or safety concerns, without eliminating coverage.

- Point of Service Safety Review: Point of Service (POS) Safety Review is the baseline safety solution. Whether a prescription is presented through the mail service pharmacies or the retail network, the pharmacy system automatically evaluates the prescription in the context of the member's complete drug history. When appropriate, real-time alerts are issued to the dispensing pharmacist regarding possible issues.

*Prior authorization and step therapy programs are subject to state law restrictions and may not apply in all areas or for all plans.

All prescriptions are first checked for member eligibility and plan design features and then compared against histories of prescriptions filled by the same pharmacy, by other participating retail network pharmacies, by the mail service pharmacies, and submitted paper claims. All drug conflicts are detected online when the prescription is entered into the computer system. If a conflict is identified, the pharmacist reviews the member's history and may contact the prescriber to make any adjustments prior to filling the prescription. To ensure that there is no delay in members receiving necessary prescriptions, the pharmacist may override an edit when they have reviewed the data with the member or prescriber and have determined that the prescription is safe to dispense. The Concurrent DUR program includes key edits such as drug interactions, drug allergy interactions, drug age alerts, and therapeutic duplication.

The Plan will not limit or exclude coverage for a drug it previously approved for an enrollee for a medical condition.

QUALITY IMPROVEMENT PROCESSES UTILIZED

1. Comprehensive Data Analysis and systematic monitoring through QI subcommittees
    1. Subcommittees are used to improve changes in organizational processes and impact quality. They are composed of interdisciplinary staff that work together to process data, determine the root cause of suboptimal quality efficiency and effectiveness and then formulate the action plans to improve clinical and/or administrative processes.
    2. The Plan uses the following data for monitoring of quantifiable metrics to identify issues and opportunities for improvement in care and services by establishing baselines to analyze trends or to re-measure against quality goals at least annually:

Data sources
HEDIS
CAHPS/QHP Enrollee Survey
Member claims
Complaints, grievances and appeals
Concierge team performance metrics
Member and provider satisfaction surveys
Provider Education Tickets
Provider disputes
Credentialing, recredentialing and sanctions monitoring reports
Single case agreements
Data accuracy assessments
Member utilization of Plan products and services

Clinical Review operational performance
Clinical Review interrater reliability and quality audits
Population Health Strategy effectiveness metrics
Over/under utilization trends
Quality of Care issues and Potential Quality Issue trends
Complex Case Management operation metrics

If problems or opportunities are identified through regular monitoring or other internal surveillance the Plan will track the action items in the appropriate QI committee or subcommittee to define the issues, identify the root causes or barriers and to clearly outline the steps and timeline to correct the problem. This tool will be presented to the QI Committee for oversight.

1. Quality Improvement Methodologies used:
    a. PDSA (Plan, Do, Study, Act): A method for action oriented learning.
    b. Root Cause Analysis (RCA): A method to analyze and develop action plans for risk issues and is structured to address systems rather than individuals.
    c. Barrier Analysis: A method for identifying and assessing outcomes and determinants of those outcomes.
    d. Failure Mode and Effects Analysis (FMEA): A method used for analysis of potential risk and provides a systematic way to prospectively examine a process for ways a failure may occur. The technique involves an analysis to identify potential mistakes before they happen and determine whether or not the consequences of those mistakes would be tolerable or intolerable. Potential failures are reported as "failure modes" as opposed to causes. Actions must then be taken to improve the process and prevent the potential "failure modes."
2. Corrective Action Plans (CAPs) and Performance Improvement Plans (PIPs)
    a. Based on comprehensive data analysis and other systematic monitoring mechanisms the QI program may issue a CAP or PIP depending on the nature of the issue identified.
    b. These plans will include specific and measurable objectives that are achievable, relevant and time-bound.
    c. CAPs or PIPs specific to network participating providers will be monitored by the Peer Review and Credentialing subcommittee.

DELEGATED QI ACTIVITIES[17]

[17] NCQA HPA QI.1A.1

The Plan does not delegate its QI program structure. The Plan can delegate certain QI activities. If Plan activities are delegated to an external provider, the Plan will:

1. Inform each provider of the scope of that provider's responsibilities, and how it will be monitored by the Plan.
2. Ensure that each provider can fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources.
3. Have ongoing oversight procedures in place to ensure providers are fulfilling all delegated responsibilities.
4. Require that standards for evaluating that enrollees receive health care consistent with professionally recognized standards of practice are included in the provider's program, and be assured of the entity's continued adherence to these standards.
5. Ensure that the quality assurance/utilization review mechanism will encompass provider referral and specialist care, including timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.
6. Ensure that services include appropriate preventive healthcare measures, consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

PERFORMANCE STANDARDS - ACCREDITATION

The Plan will maintain adherence to all applicable NCQA Accreditation standards for both Health Plan and other Accreditation programs (i.e. Utilization Management, Network, Credentialing, Health Equity). NCQA Accreditation not only involves a rigorous review of a health plan's consumer protection and quality improvement systems, but also requires health plans to submit audited data on key clinical and service measures in order to achieve the highest levels of accreditation.

CONFIDENTIALITY AND RECORD MAINTENANCE

Performance Improvement (PI) is the umbrella under which all QI activities occur. Performance Improvement is a broader category than Quality Assurance and any and all concerns about specific material should be reviewed with the Compliance Department or Privacy Officer/s.

Any process within the organization that has as its purpose the improvement of quality of care should be included under the category of Performance Improvement to be

afforded the confidentiality protections of the law. Conversely, any process within the organization that seeks to gain the protections of the law must have as a primary purpose the improvement of patient care. Performance Improvement subcommittees are integrated into the structure to have a reporting relationship with the QI Committee. This integration ensures the protection of the Peer Review and Credentialing subcommittee and the laws governing confidentiality.

All PI material will be considered Confidential Performance Improvement Material. Employees who maintain PI materials should keep them in confidential files (i.e. locked drawer or file or secure google drive folder). Minutes will be succinct, factual and include the factual basis for demonstrating that the purpose of the meeting was to improve patient care and member services.

All employees will attend annual Compliance training within 90 days of hire and annually thereafter. All employees are required to comply with the terms outlined in the following privacy policies and procedures and those mandated by the Compliance Department:

1. HI-001-All: Accounting of Disclosures
2. HI-004-All: Member Access to Protected Health Information
3. HI-005-All: Member Amendment of Protected Health Information
4. HI-006-All: Use and Disclosure of Protected Health Information
5. HI-009-All: Breach Notification Policy
6. HI-010-All: Minimum Necessary Policy