2025 Quality Program Executive Summary

The Quality Program provides a formal process to measure and improve the Health Plan's excellent quality ratings across all lines of business systematically and objectively.

The Quality Program's mission is to lead a dynamic and cross-functional quality program that demonstrates and drives excellence in quality and customer experience. In strategic alignment with the Enterprise 7 Block Strategy, the Quality Program has a specific focus on "improving member and community health." In addition to its quality focus, the program strives to achieve affordability and growth in all membership populations.

The Key elements of the Quality Program are aligned with regulatory requirements from the Center for Medicare and Medicaid Services (CMS), New York State Department of Health (NYSDOH), National Committee for Quality Assurance (NCQA), and the National Quality Strategy visions. The quality program's foundation is driven by an organization-wide improvement strategy, Quality Improvement Program Description, an annual quality improvement evaluation of performance, and an annual Quality Improvement Program Action Plan. To support improvement efforts, monthly measurement and reporting also exist to trend and forecast performance.

Continued review of quality improvement activities requires ongoing:

- Execution of member engagement tactics to close gaps in care and improve experience.
- Advancement of the collection of clinical data through partnerships with health information exchanges.
- Continual monitoring of strategic action plans for all lines of business including the expansion of the Dual Eligible Special Needs population and a strong focus on Medicare Stars.
- Implementation of additional Predictive Analytics with integration into Quality Stratification for multiple-gap outreach and outcomes.
- Evaluate potential for additional Medicare Value Based Payment (VBP) arrangements and/or new incentive programs to improve core quality metrics performance.
- Aligned Health Equity regulations and strategies into Quality Program initiatives and outcome reporting.

2025 Quality Improvement Program Description

The Program Description is a comprehensive document that describes the Health Plan's quality governance structure, program scope, goals and objectives, and additional regulatory components, all which are inclusive of physical and behavioral health for all lines of business. The connection to external providers and community partnerships and a demonstration of a heightened focus on Health Equity is described within the program description. The Program Description incorporates all lines of business as well as NCQA Accreditation and addresses health outcome inequities by integrating the health equity corporate strategy.

In alignment with the Quality Program vision, the program description demonstrates the organization-wide efforts in place to achieve and maintain nationally recognized excellence in health care quality for all member populations that drives mission and strategy aligned quality, affordability, and growth. The Quality Improvement (QI) Program provides a formal process to monitor, improve, and evaluate the quality, efficiency, affordability, safety, and effectiveness of care and service utilizing a cross-functional, integrated, and collaborative approach.

2024 Quality Improvement Program Evaluation

The program evaluation reflects organizational outcomes from the 2024 Action Plan. As part of the quality program, this document highlights accomplishments, measurement outcomes, barriers, and next steps for each initiative. The information contained in the program evaluation is modeled after the Plan-Do-Study-Act methodology to demonstrate the process from strategic planning to tracking milestones, barriers, lessons learned and future planning. All initiatives are regularly monitored with key stakeholders throughout the year 2024 Program Evaluation Highlights:

Domain	Highlights:

Corporate Scorecard Metrics	• Corporate Scorecard Quality Rating Program results were achieved:
	  o The CMS Medicare Star quality rating results met board goals. The Health Plan achieved 4-star rating in Medicare HMO (Health Management Organization); 4-star rating in Medicare PPO (Preferred Provider Organization) and 4.5 stars in Medicare PDP (Prescription Drug Plan).
	  o Targets were also met for SafetyNet Quality Percentage which ranked Top 50% of NYS plans (5 out of 12) and a Commercial NCQA Rating of 4 Stars.
	  o Performance in these programs and other core quality programs generated aligned revenue of $175 Million.

Quality Program Performance Assessment	• Overall, 80% of Healthcare Effectiveness Data and Information Set (HEDIS) measures either improved or maintained benchmark position. • Focused quality measure initiatives show 7% performance over those measures with no known targeted interventions. Medicare and Essential Plan had the largest differences. • Quality program performance remains steady year over year, up 5% between 2023 and 2024. • Excellus Health Plan was 1 of 7 FEP plans to receive the "Blue Vase" plan excellence award from FEP. FEP Performance allocation brought in $1.7M in revenue. Success was driven in part by quality improvement campaigns aimed at closing gaps through outbound calls, HEDIS Medical Record Review, Gap Indexing, the CAHPS dental campaign, and provider education outreach.
Advancing NCQA Accreditation	• Once again Excellus Health Plan has achieved Health Plan Accreditation for all lines of business. The accreditation cycle lasts for three years, and our next review will be in late 2026. We have recrafted our documentation tools to create robust tracking for milestones and risks. • Excellus Health Plan was one of three plans in New York to earn NCQA Health Equity (HE) Accreditation and was also the first and only health plan in the state to receive accreditation for all products including Commercial plans, Medicare, Medicaid, and plans on the Exchange. This accreditation was awarded in Quarter 3 of 2024 for a 3-year cycle. • The team is working toward HE Plus Accreditation in the future. This program is for organizations that have implemented core HE Accreditation activities and are ready to leverage new processes and cross-sector partnerships to ensure that care is high quality, equitable and continuously improving.
Health Equity	• Within the community, health equity innovation awards represented more than $700,000. This money is awarded to 144 community-based organizations working to address disparities across the upstate New York area. • The Health Equity strategic roadmap was socialized in Quarter 1 of 2024. This roadmap will guide the health plan through the next 5 years of health equity strategic advancement and focuses on education, infrastructure identification, health disparities and social risk factors, solutions and interventions and performance/outcome tracking. • The inaugural Health Equity Ambassador was launched in Quarter 2 2024. Topics discussed included the history of racism and bias in healthcare, maternal health equity, the importance of data collection and more. • Advancing health equity is a critical requirement for demonstrating quality in care and services.
Duals Special Needs Program (D-SNP) Readiness	• Medicaid Advantage Plan (MAP) approval remains pending, and the team continues to respond to questions and provide documentation to New York state for review. • 99.6% compliance was achieved for Health Risk Assessment (HRA) completion and 100% of Individualized Care Plans were completed within 90 days of effective enrollment dates. • Case Management and the High Value Outreach teams continue to connect with members to close gaps in care. • While D-SNP is currently too low in membership volume to receive a Star rating, plans have been executed for successful quality ratings in the future. This includes Implementation of the D-SNP Model of Care Quality Improvement Program and launch of cross-departmental monthly D-SNP Quality Outcomes committee to monitor quality metrics.
Member Experience	• Continued collaboration occurred between Quality Programs, Customer Care, Clinical Operations, Marketing and Customer Experience to prioritize and drive organization-wide

	member engagement campaigns aimed at improving improve quality program performance across all lines of business. • Consumer Assessment of Healthcare Provider and Systems (CAHPS) is a critical component to all health plan quality rating programs, across all lines of business. By continuing to maximize on CAHPS survey performance, in 2024, this contributed to $171M in revenue across all lines of business. • According to member loyalty survey results, conducted by the Research Insights team, Medicare Advantage members have become more comfortable using their benefits which is, in part, due to the ongoing CAHPS risk-based engagement strategies implemented in 2024. • Results from member loyalty surveys and CAHPS were used as insight to develop member education and benefit messaging throughout 2024. • To better understand the member rating scores, in-depth interviews were conducted and the feedback from these interviews helped to prepare messaging for member outreach. • A paid digital media plan targeted existing Medicare members and touched on retention/CAHPS improvement topics such as wellness visits, how to save money on medical prescriptions, getting most of plan/extras, etc. o Detailed metrics from the paid digital campaign showed higher than average overall engagement rates for the paid content (14%- 22% vs. 8% typical average).
Provider Experience	• Annual provider and office manager satisfaction surveys were sent using electronic vs. paper delivery. The overall satisfaction rate was 76%. Although slightly below the 80% target, relationships with providers remain strong. Provider perceptions of the Health Plan versus our competitors improved in every category in 2024. • Cultural Competency training was made available to providers for Continuing Medical Education credits (CME) in partnership with Rochester Academy of Medicine. • Value Based Payment incentives were offered to Accountable and Quality Cost Agreement (ACQA) providers as part of a new Total Cost of Care program. The agreement focused on Health Equity, Consumer Assessment of Health Providers and Systems (CAHPS) and Quality Improvement projects.
Quality Data Strategy	• Enhancements to several Power BI system dashboards were implemented which helped to demonstrate refreshed performance views of Medicare Stars and Consumer Assessment of Healthcare Providers and Systems (CAHPS), provider performance, Customer Care Gap Tool weekly utilization and Health Outcome Survey (HOS) measurement ratings. • Created connections with 3 regional Health Information Exchanges (HIEs) (HealtheLink, Rochester Regional Health Information Organization (RHIO), and HealtheConnections). These connections allow the plan to obtain additional member data and more efficiently identify and close gaps in care. • Social Needs Screening data was submitted in the annual Healthcare Effectiveness Data and Information Set (HEDIS) submission for the first time. • Completion of a disparities analysis HEDIS and CAHPS measures by Race, Ethnicity, Gender, and Language for Health Equity Accreditation.

Gap Closure Strategy	• Predictive analytics methodology continued throughout 2024 and identified over 326k gaps in care including colorectal cancer screening, breast cancer screening, cervical cancer screening and eye/kidney screenings for members with diabetes.
	• Predictive analytics campaign collateral was refreshed to be more member-centric and inclusive. Messages were sent to members with gaps in care via email or postcard.
	• Population Health Engagement outreach by Care Management and High Value Outreach (HVO) teams included:
	  o Targeted Outreach Calls: 350,000+ calls projected
	  o Engaged Members: 17,200+
	  o Gaps Addressed: 60,000+
	  o Healthcare Effectiveness Data and Information Set (HEDIS) Measures Covered: 20
	• Increased the utilization of the Customer Care (CC) Gap-in-Care tool by 23% from 2023 to 2024. This tool prompts CC reps to inform members if they have open HEDIS gaps. Members who received a reminder when calling CC were twice as likely to get their screening and close their gap in care.

	• A cross-functional campaign focused on Medicare members getting their Annual Care Visits (ACVs) and included messaging in social media, member and provider newsletters, Medicare Calendars, Radio and TV spots, and member Town Halls. A year-over-year comparison of compliance showed an increase in ACVs by ~7%. • Two clinical quality improvement programs were recognized for their innovation and impact on community health as part of Rochester Business Journal's "Healthcare Heroes" 2024 awards: These programs included (1) our Customer Care Gap in Care Tool (formerly known as "Whisper") that equips Customer Care advocates to have conversations with members about preventive services that may be due; and (2) our mammography High Value Outreach team project with Rochester Regional Health and Anthony Jordan Health Center that supports women who may be experiencing transportation barriers to care.
Quality Program Enhancements	• A new enhanced consent process was implemented for the Quality Program Oversight Committee (QPOC) based on committee member feedback and in alignment with the Corporate Governing Board. • All functional areas presented their progress towards their 2024 Quality Improvement Action Plan milestones during QPOC. Topics were themed to demonstrate alignment and collaboration across the organization when it comes to quality. • To reflect the team's enterprise-wide impact, the Health Care Improvement team underwent a name change to Quality Programs. This change was socialized across the organization. • Promoted Quality Programs topics through 12 blog posts and updated learning content made available on the SharePoint page and employee learning platform.

2025 Quality Improvement Action Plan

The Quality Improvement Action Plan is an organization-wide document to assure ongoing evaluation of quality improvement initiatives across collaborating departments. Regular review with initiative stakeholders assures continued momentum, clarity in shared goals and accountabilities, and that barriers are being addressed as part of the Quality Program, the 2025 Action Plan is focused on goal alignment and coordination across the enterprise. Connections between corporate priorities such as Health Equity, member and provider experience and advanced data strategy are incorporated into the document. The plan is structured based on the Plan-Do-Study-Act improvement framework and includes detailed milestones/deliverables, timing, and related ownership/accountability for each initiative. The goal of each improvement effort is to positively impact quality ratings across all lines of business.

The results of the 2025 Action Plan are assessed and documented in the 2025 program evaluation.