JANUARY 2025

*CDPHP Medicare HMO and PPO health plans are among the highest-rated, both in New York State and around the country, by NCQA.**

**NCQA Health Plan Ratings 2024*

CDPHP® Medicare Advantage

4.5 Stars

Out of 5 Stars Overall from Medicare 2025

Every year, Medicare evaluates plans based on a 5-star rating system.

Capital District Physicians' Health Plan, Inc.

Quality Management Program Evaluation 2024

25-29671

I. EXECUTIVE SUMMARY

A. Mission Statement

"We provide quality health care at a reasonable cost for our subscribers and operate CDPHP as a model for the delivery, financing, and administration of health care services."

B. Company Background

Capital District Physicians' Health Plan, Inc. (CDPHP®) is a not-for-profit, community-based health plan serving nearly 400,000 members in 29 counties across upstate New York. Since its founding in 1984, the physician-founded health plan has been providing top-quality health coverage across all product lines to individuals, families, and businesses throughout New York, and is known regionally and nationally for its commitment to high-quality care and superior customer service.

The CDPHP national network includes more than one million providers across the country, providing patients with access to superior health care coverage virtually anywhere in the United States.

CDPHP also partners with the nation's top-rated telemedicine provider, Doctor On Demand, to offer members access to live, video-based doctor appointments 24/7 for a variety of medical conditions, including coughs, fevers, migraines, pink eye, rashes, sprains, and mental health concerns, such as depression and anxiety.

CDPHP is also proud to partner with two behavioral health care providers to expand access to needed mental health care services. Valera Health and aptihealth provide virtual mental health care services to CDPHP members 12 years and older.

The affiliated companies collectively known as CDPHP include Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits,® Inc., and Capital District Physicians' Healthcare Network, Inc.

The CDPHP family of products includes three business lines:

- **Capital District Physicians' Health Plan, Inc. (CDPHP®) -** Health maintenance organization (HMO), high deductible HMO (HDHMO), Healthy New York, Medicare Choices (HMO), Medicare CSNP, Medicaid, HARP, Child Health Plus, Marketplace HMO, and Essential Plan.

- **CDPHP Universal Benefits,® Inc. (CDPHP UBI) -** Preferred provider organization (PPO) and high deductible PPO (HDPPO) plans, exclusive provider organization (EPO) and high deductible EPO (HDEPO) plans, transitional plans (EPO and PPO), CDPHP Shared Health plans (EPO and PPO), CDPHP Embrace Health plans (EPO and PPO), Medicare Choices (PPO), and Medicare Choices Medicare Supplemental insurance.

- **Capital District Physicians' Healthcare Network, Inc. (CDPHN) -** Administrative services only (ASO), Health funding accounts, Healthy Direction, Practice Support Services, Strategic Solutions, Real estate ventures, Tech investments, Pharmacy – retail and wholesale, and Healthy Direction

2024 Awards and Recognition

CDPHP prides itself on being rated among the top health plans in the state, as well as the nation. Below are just some of the plan's recent recognitions:

- **NCQA's Private Health Insurance Plan Ratings 2024**
  - Capital District Physicians' Health Plan, Inc. Commercial (HMO): **4.5 out of 5**
  - Capital District Physicians' Healthcare Network, Inc. Commercial (HMO/POS) **4.5 out of 5**
  - Capital District Physicians' Healthcare Network, Inc. Commercial (PPO): **4.5 out of 5**
  - CDPHP Universal Benefits, Inc. (PPO): **4.5 out of 5**
  - Capital District Physicians' Health Plan, Inc. Medicaid (HMO): **4.5 out of 5**

- **NCQA's Medicare Health Insurance Plan Ratings 2024**
  - Capital District Physicians' Health Plan, Inc. (HMO): **4.5 out of 5**
  - CDPHP Universal Benefits, Inc. (PPO): **4.5 out of 5**

- **Centers for Medicare & Medicaid Services (CMS) - Medicare Overall Stars Ratings *2025***
  - CDPHP Medicare PPO earned quality rating of **4.5 out of 5** Stars
  - CDPHP Medicare HMO earned quality rating of **4.5 out of 5** Stars

CDPHP was named a Best Company to Work for in New York State for the 16th consecutive year!

CDPHP successfully achieved accreditations for all lines of business brought forward during the NCQA triennial survey. This was the first year Medicare PPO was brought forth for accreditation.

C. Commitment to Health Equity

CDPHP is committed to improving health equity. The following statement is published on the company website, cdphp.com*; At CDPHP, we believe that everyone should have the opportunity to achieve their highest level of health and recognize the important role we play in addressing health disparities within the communities we serve. We understand that a commitment to health equity is a continuous process, and are committed to developing solutions that benefit all, and to providing the tools and knowledge our employees and providers need to deliver the most inclusive, high-quality care for our members.*

Effective July 1, 2022, NCQA offers Health Equity Accreditation. In response to this offering, the Quality Department continues ongoing Health Equity Accreditation readiness assessment.

Activities to strengthen health equity, cultural competency, diversity, and inclusion concepts included:

- Completed Health Equity gap analysis
- Completed first iteration of Health Equity roadmap, refinement will be ongoing
- Conducted biweekly meetings of internal stakeholders to assess the level of potential bias as it relates to eligibility for PHM programs
- Preparation for the NY Health Equity Reform 1115 waiver rollout on 01/01/2025 included internal team coordination, resource allocation and external collaboration with the state designated regional Social Care Network, Healthy Alliance
- Compliance with Health Equity standards and guidelines was presented to the enterprise risk management team with identified risks discussed.
- An overview of the 1115 waiver services relevant to children was presented to the Children's Advisory committee which is comprised of internal and external stakeholders.
- Members from the CDPHP Human Resources and the Diversity Matters workgroup participated in an external workshop titled *Resilient Leadership: Advancing DEI in a Complex Landscape*. Practical strategies were shared to advance efforts of fostering an inclusive environment.

- Ongoing review of our extensive Diversity, Inclusion and Belonging Policy and Staffing Policy which includes details around diverse recruitment.
- The Diversity Matters workgroup celebrates its 8th year at CDPHP. Diversity Matters is a volunteer workgroup comprised of CDPHP employees from a diverse cross section of the organization. The goal of the Diversity Matters workgroup is to enhance cultural and linguistic competency and promote health literacy both internally and externally. The workgroup is also focused on awareness for health disparities facing our membership and plays a key role in fostering a work culture of inclusion.
- CDPHP partnered with the Pride Center of the Capital Region to offer a Trans Health Care presentation for the community.
- The CDPHP Equity Challenge was updated. The CDPHP Equity Challenge is an opportunity to develop a deeper understanding of how inequity and racism affect our lives and our community.
- Renewed focus on health literacy for staff, members, and providers.
- Expanded Diversity Matters communications and resources to the CDPHP Family of Companies.
- Diversity and Inclusion Training remains part of New Employee Orientation and is updated throughout the year based on feedback and current events.
- Employee access to an inclusion calendar of cultural events which is updated continuously based on employee feedback is listed on Connections.
- The Health Equity Spotlight–a recurring internal communication raising awareness for health disparities—covered topics like heart health, neurodiversity, maternal mental health, and caregiving.
- The Pulse offered a presentation coordinated by Diversity Matters and the Health Disparities subgroup highlighting information and resources related to maternal mental health.
- The CDPHP Career page includes a focus on diversity, inclusion and belonging.
- The CDPHP Employee Exit Interview includes a discussion around inclusion and belonging.
- 1,336 CDPHP employees completed the annual mandatory cultural competency training launched in July.
- 42 newly promoted managers completed mandatory implicit bias training.
- As mandated by the New York State (NYS) Department of Health, CDPHP required all Medicaid providers in our network to attest annually to completion of cultural competency training for all staff who have regular and substantial contact with CDPHP members. The U.S. Department of Health & Human Services offers free e-learning programs for various provider areas that can be accessed below to meet this requirement. Certain provider training programs have multiple courses. If there are multiple courses the provider is only required to take one of the courses and can alternate year-to-year between the various courses within the training program. The training follows National Culturally, and Linguistically Appropriate Services (CLAS) standards intended to advance health equity, improve quality, and help eliminate heath care disparities.

D. Corporate Population Health Management (PHM) Priorities

It is commonly understood that over eighty percent of population health outcomes are determined by factors impacting individuals outside of health care settings and disparities across the communities within which people eat, sleep, work, and play significantly impact the opportunity of individuals to achieve optimal health.

It is from this lens of common understanding, that CDPHP aligned PHM priorities for continued commitment to health equity, maintenance and expansion of community partnerships to support disease prevention and management, continued partnership with our providers to meet the unique needs of the populations we serve, and ongoing expansion of our population health management (PHM) analytics to support data-driven PHM program design and evaluation, with an ever-present focus on identification and elimination of social inequities, longer-term.

Continuation of the CDPHP rich history of partnerships with community-based organizations to drive health promotion through preventive services within the communities we serve remained a critical priority for our PHM program across 2024.

Highlights of 2024 included continued collaboration with the Catholic Charities Care Coordination Services and Trinity Alliance to close gaps in care and address social determinants of Health (SDoH).

As a member of the Alliance for Community Health Plans (ACHP), 2024 presented the opportunity for CDPHP to demonstrate our continued commitment to ACHP's 2030 Chronic Disease Pledge initiative, under which we made a commitment to measuring and addressing specific drivers of diabetes and heart disease in the communities we serve. In alignment with the CDPHP commitment to reducing the burden of cardiometabolic disease (diabetes, obesity, hypertension) among members, CDPHP established two pledges:

1. CDPHP will reduce the prevalence of obesity among CDPHP Medicaid and CHP members aged 18 and under at greatest risk for social vulnerability by 2030.
2. CDPHP will reduce the prevalence of A1c > 9 among CDPHP members with Diabetes identified as having a BH comorbidity by 2030.

To support this pledge, and in recognition of the need for a systems-based approach to tackle the lifestyle diseases of childhood obesity and diabetes, in 2024, CDPHP continued its collaboration with Healthy Capital District, Troy School 2, and the Troy City School District, to better understand the prevalence of correlates of childhood obesity among the CDPHP socially vulnerable members and to begin the process of identifying key components of a child-focused initiative aimed at supporting healthy weight in this population. This work will provide the foundation and framework for the design of community-level intervention(s) in support of the CDPHP chronic disease pledges in 2025 and beyond.

Following on a series of meetings in 2023 with our Enhanced Primary Care (EPC) Providers to solicit their feedback regarding how CDPHP can continue to support their teams in meeting the needs of their sickest and most vulnerable patients, 2024 marked the introduction of a new PHM-centered component to the EPC value-based payment model designed to improve primary care provider awareness of, and member engagement in, the CDPHP portfolio of PHM program offerings. Across 2024, this new PHM Engagement component of the EPC model resulted in bidirectional communication between CDPHP and the EPC provider network regarding imputed patients (CDPHP members) identified as at higher risk, and for whom additional clinical review to assess for unmet needs might be valuable. Based on the adoption and outcomes of this initiative in 2024, this PHM engagement component of the EPC model will continue into 2025.

Finally, 2024 marked continued commitment to the expansion of the CDPHP PHM analytics data assets, vis-à-vis the CDPHP Corporate Analytics Member 360 initiative, which supports all PHM analytics within the organization, including ongoing member segmentation and cohort profiling which provides the foundation for understanding patterns in population demographics, chronic conditions, risk scores, cost of care, access to care, as well as program eligibility and enrollment. This data serves as the basis for identification of potential disparities in care and racial bias and directly informs new program design in alignment with identified population needs. Across 2024, exploration and expansion of efforts to expand clinical data capture of social needs screening data to inform the new HEDIS SNS-E measure remained a priority, as did introduction of new member-centric analytic concepts including the Quality Index Score (QIS), which fostered the ability of teams to profile members based on the volume and nature of their current quality gaps.

E. CDPHP Specialty Transformation

Building on the success of the well-established Enhance Primary Care (EPC) Patient-Centered Medical Home model, CDPHP is committed to fostering and advancing innovative partnerships with the specialty provider community in pursuit of a Patient-Centered Neighborhood, a system encouraging shared responsibility and heightened communication between Primary Care Providers (PCPs) and Specialists to improve overall patient care, clinical quality outcomes and impact cost reduction.

Since July 2021, CDPHP offers an innovative, comprehensive Specialty Value-Based Program (SVBP) payment model to incent and support participating Specialty practices to increase access to care for CDPHP members, improve clinical quality outcomes and reduce utilization of inappropriate and costly emergency department (ED) visits, hospital admissions and readmissions.

The CDPHP SVBP model allows specialty practices to earn Fee For Service (FFS) consistent with the traditional model as well as enhanced earning opportunities based on attributed members including a Quality Performance Bonus Incentive (quality metrics largely specialty specific). Quality serves as the foundation and gateway of the program. Meeting quality thresholds is required for any additional bonus opportunities.

Participating providers have an opportunity to share in any medical cost ratio (MCR) reduction upon achieving quality thresholds. Innovative Quality Aligned Provider Incentives, by design, offer additional financial opportunities incenting providers to pursue specific efforts addressing costly chronic condition management and drive SVBP performance.

CDPHP Specialty Value-Based programs include Cardiology, Renal and Network Behavioral Health prescriber practices. To date, over thirteen (13) Specialty TINS participate in the CDPHP SVBPs caring for over 47,000 members across all product lines.

Innovative clinical management solutions to support specialty providers include but is not limited to Same Day/Walk In Clinic for cardiology and renal, remote dielectric sensing, and cardiac rehabilitation. Renal SVBP Clinical Management Solutions include incenting early dialysis in a non-emergent outpatient setting and home dialysis and implementation of an evidence-based, data driven, GDMT Chronic Kidney Disease (CKD) Management Program.

The CDPHP clinical Specialty Transformation team continues to develop comprehensive, innovative solutions to model the principle of the Quadruple AIM.

F. The Hospital to Home Program and Care Transitions

In 2019-2020, CDPHP launched the Hospital to Home (H2H) Program. This program is in partnership with Albany Medical Center Hospital, St. Peter's Hospital, Samaritan Hospital, Ellis Hospital, and Saratoga Hospital, which together, covers 75 percent of our hospital admissions. The other 25 percent of members are followed remotely by the Utilization Review team.

When a care management need is identified in a member outside of a H2H facility, the Utilization Review team will refer the member for care management follow-up through the general/complex care management team. The intent behind the H2H program was to redesign how our members progress through the continuum of care while both in the hospital and after discharge.

To that end, CDPHP created a care team approach. The team consists of RN care managers, medical and behavioral health social workers, medical directors, pharmacists, transition coordinators, certified recovery peer advocates (CRPA) and health care advocates. The key measure of success to our H2H and care transitions program is lower readmission rates and an increase in follow up visits, particularly Transition Care Management (TCM) visits. Within the H2H program, CDPHP has integrated with the hospital staff to assure that all our members' needs are met by emphasizing the concept of "discharge planning on admission".

Upon admission, members are telephonically engaged by the virtual H2H care team or met at the bedside by the embedded H2H care team. Regardless of whether the member is engaged virtually or in-person the care manager performs a clinical assessment, social determinant of health/safety needs assessment, and assesses for any barriers to discharge.

Within this assessment, the team is identifying who is a part of the member's care team (i.e., spouse, family member, provider, community based organization, etc.) that will assist in keeping the member out of the hospital, assessing for any home care/DME needs, recommending closure of any actionable Healthcare Effective Data and Information Set (HEDIS) gaps (i.e., lab work, vaccinations, etc.) and setting appointments to close those HEDIS gaps that are not actionable during the hospital stay (i.e., mammogram, colonoscopy, etc.), attempting to set appointments prior to discharge or assisting to set the appointments after the member has been discharged in cases it cannot be accomplished while the member is in the hospital, obtaining any releases of information to discuss Protected Health Information (PHI), and performing a medication needs assessment (educating on adherence, identifying prior authorizations, etc.).

With the new integrated H2H approach, a member handoff no longer occurs between an inpatient and outpatient team as the same care manager (whether virtual or embedded) will follow that member for up to 30 days post discharge. The intensity of outreach will be determined based on the need of the member. The duration will be determined by the clinical presentation of the member and the clinical judgment of the care manager. At minimum, if the care manager is not following the member post discharge, they will ensure the member has appointments set, resolve any access barriers, confirm that no urgent safety issues exist, that the member has been educated on any open HEDIS care gaps, and there are no concerns around the member's health literacy.

Bi-weekly, the H2H team, general/complex care management team, and the medical directors meet to review cases as a group related to patients with complex medical needs and those who have been readmitted. These case reviews also include Community Care Physicians as they are one of the largest volume primary care practices in the CDPHP network and allows for tighter collaboration between the groups. For each case presented, the team will discuss different interventions, document the discussion, and apply any recommendations made accordingly.

The full H2H program build in sales force went live in June 2023. The second half of 2023 was being used to collect data to analyze trends to establish specific process metrics to measure the success of the program. These metrics will be in addition to the already measured readmission rates and follow up visits. CDPHP will also explore engaging in a virtual hospital to home program where members in facilities outside the five hospitals are managed virtually in a comparable manner.

Population health and wellness focused on member-centric quality initiatives, while our performance measurement and physician engagement teams focused on practitioner/provider-centric quality initiatives.

CDPHP continues to participate in the NCQA (National Committee for Quality Assurance) recognized Partner in Quality Program. This distinction recognizes organizations that provide financial incentives or support services to practices seeking recognition through NCQA Patient Centered Medical Home (PCMH) programs.

PCMH is a health care setting that facilitates partnerships between patients and their personal physicians and, when appropriate, the patient's family. Care is facilitated by registries, information technology, the exchange of health information, and by other means to ensure that patients get the care necessary, when and where they need and want it, in a culturally and linguistically appropriate manner.

NCQA Partner in Quality participation allows CDPHP to pass financial savings on to those Enhanced Primary Care (EPC) practices seeking PCMH recognition. Specifically, participating practices will receive a 20 percent initial application discount.

G. The Future of CDPHP: *Building Our Health Value Strategy*

CDPHP continued to work with employers, members, providers, as well as CDPHP employees, to ensure the provision of quality health care at reasonable costs and operate CDPHP as a model for the delivery, financing, and administration of health care services.

I. EXECUTIVE SUMMARY

CDPHP is an innovator in health care transformation and payment reform and remains committed to offering more choice and flexibility to employer groups, ultimately providing health care solutions and value through all stages of our members' lives. CDPHP continued to introduce and promote innovations in care and population management, leading the move to value-based payment as the true partner with our physician network and providing expertise and resources to aid in their move to new payment methodologies.

CDPHP has emerged as a leader for practice transformation and training care management resources by offering unique approaches to population health.

CDPHP seeks to continue to form partnerships with organizations that can bring value in the shared goals of the Quadruple Aim. CDPHP is committed to driving a strategy focused on population health to deliver better care and improved outcomes to our diverse membership across a wide variety of disease states and health conditions.

Health Value

CDPHP continues to be one of the leading not-for-profit health plans in the country known for a commitment to quality, payment and care innovation, and customer service. This corporate strategy reflects a commitment to working with members, practitioners, providers, regulators, and the larger community to enhance the value of the services that members receive and to move to payment methodologies that encourage and reward value.

Basic tenets of health value are:

- Goals are aligned with the Quadruple Aim of improved health, improved member experience, provider satisfaction, and control of cost increases.
- Quality must be maintained or enhanced and cannot be compromised for cost.
- Quality includes the six areas defined by the Institute of Medicine: safe, effective, patient-centered, timely, efficient, and equitable.
- Overall, the value of the services will be enhanced through better continuity and coordination of care and increased compliance with evidence-based guidelines to provide better outcomes.
- Identification of populations with similar health care needs and organizing resources to address those needs effectively and efficiently.
- Payment reform is focused on value over volume, with comprehensive payment for comprehensive care.
- Population Health Management (PHM) is centered on improving the quality of care and outcomes of our diverse membership across many different disease states and health conditions.

The key strategies employed toward the goal of being one of the leading not-for-profit health plans in the country that's known for our commitment to quality, payment and care innovation, and customer service are:

- Develop a deep understanding of our customers and ensure culturally competent communications.
- Be valued partners with our physicians.
- Maintain our market-leading position in the Capital Region across all product lines.
- Improve the health and economic well-being of our community while addressing health care disparities.
- Be profitable by controlling medical and pharmacy costs.
- Utilize data to segment member population and drive data insights.
- Build morale internally and trust externally.

In this document, the CDPHP 2024 quality management (QM) program activities are summarized and evaluated, including the program's major accomplishments and trending of data and results over time. The evaluation includes information regarding: program structure; QM, performance measurement, and related committees and their accomplishments; resources dedicated to the program; clinical guideline development; practitioner/specialist and provider credentialing/recredentialing; network adequacy; utilization management/resource coordination; member complaints and appeals; medical record review; Healthcare Effectiveness Data and Information Set (HEDIS) reporting; clinical and service quality initiatives; patient safety; member education; health promotion; and population health management program goals and initiatives.

Also included is a description of completed and ongoing quality management activities, including trending of results to assess performance, quantitative and qualitative analysis of results (including identification of barriers and mitigation plans), and overall evaluation/analysis of the effectiveness of the quality management program.

This process leads naturally to the development of recommendations for the upcoming year, which are then incorporated into the *2025 QM program description and 2025 QM work plan*.

Through the annual QM program evaluation, CDPHP is able to assess the strengths of the program and also to identify opportunities for improvement, enhancing our ability to improve care and service to members by incorporating the lessons learned from ongoing activities.

After reviewing and evaluating overall performance and program effectiveness in all aspects of the 2024 QM program, including its progress toward influencing network-wide safe clinical practices, adequacy of QI program resources, QI committee structure, and practitioner participation and leadership involvement in the QI program, it has been determined by the quality management committee (QMC) and board of directors that all planned activities in 2024 were completed and yearly objectives were met. Thus, the QM program was effective and does not require any restructure in 2025.

H. Quality Management (QM) Program

CDPHP maintains a comprehensive, proactive quality management (QM) program that provides the structure, process, resources, and expertise necessary to systematically define, evaluate, monitor, and ensure that high-quality, cost-effective care and service are provided to CDPHP members. The program is a commitment to continuous quality improvement principles and requires participation of the CDPHP board of directors, CDPHP practitioners and providers, and CDPHP staff members.

The CDPHP QM program includes a continuous, objective, and systematic process for monitoring and evaluating key indicators of care and service; identification of opportunities for improvement; development and implementation of interventions to address the identified opportunities; and re-measurement to demonstrate effectiveness of program interventions. All QM program activities are evaluated and reported here in the *CDPHP annual QM program evaluation for 2024.*

The QM program monitored PHM activities and progress towards goal in 2024 to the quality management committee (QMC). QMC reviews PHM strategy effectiveness and the impact on our members. Recommendations are made accordingly.

As new lines of business are offered, the enrolled population is integrated into quality programs and process improvement initiatives.

CDPHP is committed to excellence, the community, achieving better health, personalized care, and member experience and enhanced relationships among patients/members, CDPHP, and pharmacies.

I. EXECUTIVE SUMMARY

CDPHP has embarked on a strategic endeavor to become a National Committee for Quality Assurance (NCQA) 5 Star rated health plan for Commercial, Medicare and Medicaid lines of business, as well as a Medicare 5 Star health plan according to the Center for Medicaid & Medicare Services (CMS).

NCQA ratings are a culmination of clinical treatment, access and prevention as measured through Health Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Satisfaction (CAHPS) and health plan accreditation scoring. Standards scores will be calculated and reported separately for each product line that is brought forward for accreditation.

Medicare Stars is a measure of quality from CMS which is comprised of 42 measures from both Medicare Part C (medical) 30 measures and Part D (pharmacy) 12 measures. These measures include results from HEDIS, CAHPS, Health Outcomes Survey (HOS), Appeals, Prescription Drug Events (PDE) and CMS administrative measures.

Healthcare Effectiveness Data and Information Set (HEDIS) is the standard approach to evaluating managed health care plans and the most widely used set of performance measures in the health care industry, covering quality, access, utilization, service, and satisfaction for prevention, disease management and resource use.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) refers to a set of surveys that ask patients to report on their health care experiences. The surveys are available in the public domain and focus on health care quality aspects that patients find important and are well equipped to assess.

Health Outcome Survey (HOS) is a longitudinal survey measuring beneficiary health outcomes related to activities of daily living, physical and emotional health, bladder control and fall risk concerns.

Quality improvement (QI) is considered a critical component of health care delivery, and a health plan's success is tied more and more to its quality measures. Factors influencing our desire to become a 5 Star health plan include competition within the industry, the impact of mergers, the rising cost of health care, regulatory compliance, social and moral obligations, reputation, and financial performance incentives.

Strategies to become a 5 Star health plan require CDPHP to be resilient, agile, data and information rich, willing to invest in and promote health information exchange, as well as transform health care delivery to drive quality and improve health.

Work teams had been formed in response to data segmentation and analysis and have been tasked with improving performance outcomes through coordinated outreach to our members and health care providers. The initiative is named "Drive to 5."

In 2024, the CDPHP Drive to 5 (DT5) strategy transitioned from a measure-centric to member-centric strategy under the theme "Get In High Gear." The CDPHP member-centric strategy was founded upon segmentation of the CDPHP entire member population into a series of mutually exclusive sub-segments defined by member PHM segment (Healthy, Emerging, Multiple Chronic, and Complex Chronic) and line of business (LOB). Corresponding DT5 workgroups, and assigned team leads, were given responsibility for specific sub-segment(s) and tasked with developing a comprehensive 2024 quality strategy for the sub-segment, including identification of segment-specific 1) priority quality measures based on past performance and current PHM priorities and 2) pathways to drive engagement.

Quality Program Accomplishments

Quality and Service Indicators monitored in 2024:

Indicator	2024 Goal	2024 Performance
Enhanced Primary Care (EPC); patient-centered medical home (PCMH) metrics of Healthcare Effectiveness Data and Information Set (HEDIS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) results.	Meet or exceed goal for each select measure as listed on QM program work plan	Overall sustained HEDIS measures and member satisfaction performance noted.
Member services abandonment rate: Percentage of members who hang up before reaching a phone representative.	≤ 5%	5.2%
Member services average speed of answer: Length of time caller waits before call is answered	< 30 seconds	1.37 seconds
Member services call answer timeliness percent: Percent of member calls answered ≤ 30 seconds.	≥ 80%	59.7%
Member services quality score	93–98%	93.8%
Member services correspondence turnaround time.	≤ 21 days	2.66 days
Secure email response meets (1) business TAT.	95%	96.3%
PCP website change quality and accuracy	95% for quality and accuracy	96.7%
Utilization management (UM) determination TAT	96% or greater	96%
Behavioral health (BH) access center abandonment rate	≤ 5%	2%
BH access center call answer timeliness percent	75% in 30 seconds or less	88%
BH determination TAT	≥ 96%	97%
Member Satisfaction Survey	Maintain/improve previous levels of satisfaction.	Refer to **Member Experience Analysis: Nonbehavioral and Behavioral Healthcare** of this document.
Member satisfaction with primary care provider (PCP)	Maintain/improve previous levels of satisfaction.	Refer to **Member Experience Analysis: Nonbehavioral and Behavioral Healthcare** of this document.

I. EXECUTIVE SUMMARY

Indicator	2024 Goal	2024 Performance
Member satisfaction with BH services	Maintain/improve previous levels of satisfaction.	Refer to page **Member Experience/Satisfaction-Behavioral Health Member ECHO Survey** of this document
Hospital to Home Program survey	Maintain/improve previous levels of satisfaction.	Refer to **Population Health Management Impact – Program Effectiveness Report** of this document.
New Member Survey	Maintain/improve previous levels of satisfaction.	Refer to **Member Experience/Satisfaction-Assessing New Member Understanding Survey** of this document.
Health outcomes survey (HOS) Centers for Medicare & Medicaid Services (CMS) HOS is administered to our Medicare members to provide information on Medicare members' state of health	Maintain/improve previous levels of satisfaction.	Refer to **Member Experience/ Satisfaction- Health outcomes survey (HOS)** of this document.
Marketplace Member Survey	Maintain/improve previous levels of satisfaction.	Refer to **Practitioner and Provider Accessibility Analysis** of this document.
Network management GeoAccess study	85% combined average to meet access standards	Refer to **Practitioner Availability Analysis** of this document. Goal Met for all lines of business with no barriers to access identified.
Credentialing: After-hours Accessibility	85%	Refer to **Practitioner and Provider Accessibility Analysis** of this document.
Credentialing: After-hours Accessibility- To ensure the practitioner responds within one hour	100%	Refer to **Practitioner and Provider Accessibility Analysis** of this document.
Credentialing: Appointment Availability	95%	Refer to **Practitioner and Provider Accessibility Analysis** of this document.

Indicator	2024 Goal	2024 Performance
Medication Therapy Management Program (MTMP) – Capital District Physicians' Health Plan, Inc. (CDPHP®) enhanced MTM The MTMP program is designed to ensure that medications prescribed to targeted enrollees are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse drug events, including adverse drug interactions.	Increased adherence of chronic medication in MTM enrollees as measured by the medication adherence STAR measures. The CMR rate will be monitored weekly to assess progress towards the plan's goal of 5 stars.	The CDPHP MTM program ensured that medications prescribed to targeted enrollees were appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse drug events, including adverse drug interactions.
Continuity and Coordination of Care	As noted in the Continuity and Coordination of Care; Non-Behavioral and Behavioral Health Studies.	Refer to the **Continuity and Coordination of Care, Non-Behavioral and Behavioral Health Studies** of this document.
Complaint and appeal analysis	As noted in the Member Experience Analysis.	Refer to **Member Experience Analysis: Nonbehavioral and Behavioral Healthcare** of this document.
Member appeal/ complaint resolution TAT	As noted in the Complaints and Appeals Resolution Report.	Refer to **Member Experience/Satisfaction-Complaints and Appeals Resolution** of this document.
Safety Plan		
All network practitioners/providers at initial credentialing and during recredentialing: • Verify good standing with state and federal regulatory agencies. • Verify that provider has been reviewed and approved by an accrediting body. • Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints.	Monitor potential quality of clinical care review (CQR) concerns related to patient safety as identified throughout the delivery care system	Refer to QMC meeting minutes. No quality concerns noted.
Skilled nursing facilities: • Monitor publicly available data (e.g., www.medicare.gov) to detect existing patterns of poor quality or safety. • Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints.	Inpatient care specialists and discharge planners to assist in identifying potential safety concerns regarding a skilled nursing facility.	Refer to QMC meeting minutes. No quality concerns noted.

Indicator	2024 Goal	2024 Performance
Hospitals: Include contract language requiring hospitals to submit national quality of care standards relating to patient safety.	Links on CDPHP.com website to publicly report comparisons of safety and quality [Centers for Medicare & Medicaid Services (CMS) Hospital Compare, New York State Department of Health (NYSDOH).	Hospital quality data, published by CMS Hospital Compare, is publicly reported via online physician and hospital directories, Find-A-Doc (FAD).
At initial credentialing and during recredentialing:	Progress report toward goal to be submitted quarterly to QMC. • Verify licensure, education and training, board certification status, history of malpractice, or actions on license. • Receive signed attestation to lack of present illegal drug use, history of loss of license and felony convictions, and history of loss or limitation of privileges or disciplinary activity. • Conduct site visit during any study conducted during calendar year. • Assess handicapped accessibility, proper containment, and storage of prescription drugs, appropriate maintenance of refrigerators used to store biologicals, storage of sharps and biohazards, and confidentiality of medical records.	Refer to Credentialing Committee meeting minutes. No quality concerns noted.
	• Conduct additional site visit in response to any complaints received by the plan. • Monitor all sanctions and limitations on licensure, any complaints, adverse events, or instances of poor quality through clinical quality review (CQR) process. • Perform pharmacy reviews, including systematic checks for potential drug interactions, drug utilization reviews, and poly-pharmacy reports. • Performance is monitored for measurements of quality, efficiency, safety, and member satisfaction. • Identify physicians meeting National Committee for Quality Assurance (NCQA) physician recognition standards in provider directory, including FAD.	

Indicator	2024 Goal	2024 Performance
	• Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints. • Monitor to ensure members receive persistent medications; high-risk medications in elderly; or known contraindicated medications, or medications that could interact with their data collection and augmented particular disease state are being tested appropriately to prevent adverse outcomes and referred, when applicable to medication MTMP enhanced MTM *MedCheck* for comprehensive medication review (CMR) or targeted medication review (TMR). • Monitor use of high-tech imaging studies to reduce unnecessary radiation risks to members.	
Primary Care Practitioners:	• Enhanced primary care (EPC) patient-centered medical home (PCMH) payment model and bonus potential is based on measurements of quality, efficiency, safety, and member satisfaction. • Monitor compliance with CDPHP preventive health and clinical guidelines through targeted medical record studies to meet regulatory requirements. • Practitioners' clinical practice guidelines based on evidence-based medicine via the secure practitioner portal on www.cdphp.com. • Measure continuity of care between primary care practitioners (PCPs) and specialty care practitioners.	CDPHP distributed physician reports that include quality, safety, efficiency, and member satisfaction via Consumer Assessment of Healthcare Providers and Systems Clinical and Group Survey (CG-CAHPS) results from monthly surveys to imputed EPC members. Refer to **Quality Review Process-Documentation Studies** of this document
OB/GYN practitioners	Monitor compliance with CDPHP clinical practice guidelines, measured annually to ensure continuity of care with PCPs.	Refer to **Quality Review Process-Documentation Studies** of this document
OB/GYN practitioners and Oncologists are high-volume and high-impact specialists. Member access to care to these network specialists will be monitored.	Member access to care monitored for the following: • Appointment access and availability • Ratio analysis specialist to member 1:2,400 • Geocache's monitoring	Refer to the Network Provider and Practitioner Availability Analysis of this document.

I. Quality Management Program Resources

The following resources were dedicated to the quality management program in 2024:

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Executive vice president, chief medical officer, MD	1	0.30	25
Vice president, specialty transformation, MD	1	0.30	43
Vice president, member health, senior medical director	1	0.30	27
Medical directors	5	2.00	135
Medical director, behavioral health integration, MD	1	0.35	18
Executive vice president, chief pharmacy officer, RPh, MBA	1	0.60	44
Senior vice president, chief quality officer, MS, RN, NE-BC	1	1.00	38
Medical director, clinical analytics integration, and quality	1	0.60	14
Vice president, physician contracting	1	0.10	21
Director, population health management	1	1.00	12
Vice president, healthcare economics and analytics operations	1	0.25	19
Manager, quality analytics operations	1	.75	9
Senior statistician, healthcare economics and operations	1	1.00	15
Senior HEDIS reporting analyst	1	0.75	34
Senior Statistician Quality Analytics	1	0.75	17
Manager, accreditation, and quality program, BSN	1	1.00	45
Vice president, healthcare quality, RPh	1	1.00	49
Director, healthcare quality	1	1.00	29
Quality improvement nurse specialists, RN	4	4.00	103
Temporary HEDIS nurses, RN	19	15	422
Medicare Stars administrator	1	1.00	4
Quality member specialist	1	1.00	4
Delegation oversight program manager	1	0.50	7
Healthcare quality project manager	2	2.00	28
Director, credentialing	1	0.50	24
Project oversight and technical manager, credentialing	1	0.50	29
Expansion oversight lead, credentialing	1	0.25	12
Credentialing specialists	7	1.50	144
Credentialing coordinator	1	0.25	13
Credentialing team lead	1	0.25	10
Project oversight manager, appeals	1	1.00	30
Manager, member appeals and ambulatory review	1	1.00	11
QCC and delegated vendor analyst	1	1.00	13

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Clinical appeals specialists, RN	6	6.00	163
Team lead Medicare quality and appeals	1	1.00	33
Medicare appeals analyst	1	1.00	30
Director, utilization review, RN	1	0.40	41
SVP, member health operations	1	0.35	10
Director, care management	1	0.75	23
Director, Hospital To Home	1	0.75	17
Senior vice president, pharmaceutical care program, RPh	1	0.25	33
VP clinical pharmacy program and residency program	1	0.50	26
Managed care pharmacists, RPh	9	4.00	237
Director, clinical pharmacy operations	1	0.30	33
Director, Medicare Part D pharmacy programs	1	0.75	33
Senior vice president, strategic physician engagement	1	0.25	24
Director, physician engagement	1	0.75	12
Physician engagement specialist	3	3.00	45
Performance management admin coordinator	1	0.75	43
Director, specialty transformation	1	0.25	16
Practice transformation manager	1	0.50	13
Vice president, ancillary contracting	1	0.20	27
Network operations coordinator	1	0.20	5
Vice president, service operations	1	0.10	30
Manager, provider relations and provider services	1	0.10	30
Manager, provider registry configuration	1	0.50	19
Manager, member services communication contact center	1	0.25	11
Director, member services government programs	1	0.25	8
Marketing manager(s)	2	0.25	30
Communications specialist	1	0.10	3

In addition to staff resources, data resources include claims, encounters data, enrollment, health reimbursement arrangements (HRAs), complaints, grievances and appeals, utilization management (UM) and pharmacy data, Medication Therapy Management Program (MTMP), utilization of services, medical record data elements, Healthcare Effectiveness Data and Information Set (HEDIS), Quality Assurance Reporting Requirements (QARR), Enhanced Primary Care (EPC) performance metrics, member satisfaction data, including Medicare and Medicaid, practitioner surveys, Health Outcome Survey (HOS), Experience of Care & Health Outcomes (ECHO), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Qualified Health Plan (QHP), and Clinical and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) surveys.

Under corporate analytics, the quality informatics staff enhanced the HEDIS data processing and reporting and gap lists data corrections process to positively impact HEDIS rates and national ratings. In addition, they continue to improve interim HEDIS reports (MY 2024) to run an actionable gap list to help

move low-performing practitioners on high impact HEDIS measures, particularly our EPC practices, within the measurement year. The analytical data warehouse (ADW) continues to improve the efficiency of data analysis. Corporate analytics staff expertise in statistical analysis and utilization of other advance statistical tools continues to improve the QM program accuracy, reliability, and validity testing regarding data collection, sampling, and analysis for our HEDIS, QARR, and EPC performance metrics; Network GeoAccess reporting, Practitioner to Member Ratio Analysis reporting, practitioner gap lists, and practitioner quality performance profiling.

All departments participate in the ongoing quality improvement process through active involvement in the internal team structure, which forms the mechanism to link quality management activities with other management functions.

Internal team structure supports ad hoc end-to-end quality improvement efforts through the continuous quality improvement model of W. Edwards Deming's Plan-Do-Study-Act (PDSA) and monitors clinical and service quality through established quality indicators, which are reported quarterly to QMC and the board of directors.

Salesforce continues to improve care management workflows and personalized member communications (e.g., targeted campaign member mailings, telephone outreaches) in support of care management and population identification.

The pharmacy team supports our members through the MTMP, through the Enhanced MTM service, known *as MedCheck*, and the pharmacy analytics team facilitated data analysis to improve quality and impact cost and utilization for all lines of business. The Medicare Stars team actively engaged Medicare members in managing their health care to achieve the best possible outcomes.

Embedded behavioral health social workers and care managers in select hospitals and Enhanced Primary Care (EPC) practices, MTMP pharmacists, performance management coordinators, and staff working directly with community health partners and population health and wellness specialist have been effective in improving health services and positively impacting health outcomes as evidenced by improvements in resource utilization, HEDIS, and QARR scores and member experience as measured by satisfaction surveys for our members.

J. Committee Structure: Roles, Responsibilities, and Accomplishments

1. Board of Directors

The CDPHP board of directors, as the governing body, maintains overall accountability and responsibility for the quality management program. The board delegates the responsibility and accountability for the day-to-day operation and administration of the program to the quality management committee (QMC) and to the executive vice president (EVP)/chief medical officer (CMO).

The EVP/CMO, who reports to the president and chief executive officer, is responsible for the implementation and operation of the program and for ensuring responsible reporting and communication of plan progress and evaluation from the QMC to the board of directors, and back to the QMC.

The senior vice president, chief quality officer coordinates the overall development, review, and revisions of the program description and the review of the effectiveness of the quality management program evaluation in collaboration with the EVP/CMO and the QMC.

A 15-member board of directors, including eight community physicians, governs CDPHP, along with community directors who play a vital role in policy setting and administration. In addition, community physicians share in the management of the plan through participation in the nominating committee, physician compensation committee, member grievance committee,

credentials committee, quality management and peer review committee (QMC), utilization management committee (UMC), behavioral health committee (BHC), pharmacy and therapeutics committee (P&T), joint health services committee (JHSC), clinical quality teams (ad hoc), and the physician grievance committee.

2. Quality Management Committee (QMC)

The board of directors has designated the quality management committee (QMC) as the responsible entity for the oversight and management of all quality-related activities, including developing, implementing, and overseeing the quality improvement program.

The QMC, chaired by the medical director, is comprised of fully credentialed physicians representing primary care and high-volume specialties, including OB/GYN and behavioral health, as well as representatives from CDPHP, behavioral health committee, community leaders, board members, and adjunct providers.

The committee members are appointed by the EVP/chief medical director, subject to board approval, for a three-year term and may be reappointed.

The senior vice president, chief quality officer, the accreditation and quality program manager, the vice president of health care quality, and the principal informatics analyst are also on the committee. Additional plan staff serve as ad hoc staff to the committee as needed.

The QMC met six times in 2024. Contemporaneous minutes are recorded for all committee activities. The QMC reports regularly to the board of directors, which has ultimate responsibility for the quality management program. The QMC is accountable to and receives regular recommendations from the board.

Responsibilities of the quality management committee include:

- Review, approve, and make recommendations for the QM program, including all pertinent quality-related activities, the annual work plan, and annual program evaluation.
- Review, approve, evaluate results, make recommendations and policy decisions, institute needed actions, and ensure appropriate follow-up regarding pertinent quality activities, including all clinical and service initiatives. Quality activities include, but are not limited, to the following:
    - Member and physician satisfaction, including complaints/grievances/appeals monitoring and satisfaction surveys.
    - Practitioner network availability monitoring through GeoAccess and ratio analysis, including high impact and high-volume specialist.
    - Appointment accessibility.
    - Enhanced Primary Care (EPC) and specialist incentive programs.
    - Member accessibility to the plan.
    - Clinical quality safety measures.
    - Service quality measures.
    - Clinical quality review (CQR) of practitioners (peer review).
    - Healthcare Effectiveness Data and Information Set (HEDIS) monitoring.
    - Regulatory compliance, federal and state.
    - Utilization and resource coordination monitoring.
    - Pharmacy and therapeutics/formulary management.
    - Credentialing/recredentialing.
    - Cultural, ethnic, language, diverse and linguistic objectives for network and members.
    - Oversight of delegated activities, including first-tier, downstream and related entities (FDRs).
    - Practitioner medical record and practitioner office site complaint reviews.

    - Preventive health and population health management program initiatives, including clinical practice guideline development and review.
- Establish clinical quality indicators and quality teams or subcommittees to address specific clinical or service issues.
- Recommend and monitor continuity and coordination of medical care across the care continuum and behavioral health care initiatives, including coordination between behavioral and medical.
- Provides oversight of the PHM strategy implementation, monitors PHM goal performance and makes recommendations accordingly.
- Submit regular reports of QM activities to the board of directors.

2024 Quality Management Committee Accomplishments

- Reviewed and approved the 2023 *QM evaluation* and the 2024 *QM program description* and *work plan.*
- Regularly evaluated organization's progress toward meeting goals as outlined in the *program description* and *work plan.*
- Reviewed and approved the 2024 Population Health Management (PHM) strategy.
- Monitored PHM goal performance.
- Reviewed and approved all submitted meeting minutes and policy reviews from reporting committees.
- Reviewed and approved all quality management and appeals policies and procedures.
- Approved objectives to address overall health equity of language, cultural, and linguistic needs of members, staff, and network.
- Established clinical quality indicators, quality teams, and physician work groups to address specific clinical issues.
- Reviewed and approved all clinical, safety, and service quality management initiatives, programs, and activities.
- Reviewed and approved service indicator quarterly reports.
- Reviewed and approved quarterly potential clinical quality concerns via clinical quality reviews (CQR) – peer review and complaint monitoring.
- Reviewed and approved final grading of all CQR quality of care cases initially graded as level 4 or level 5; no case fell into level 4 and zero level 5 grading in 2024.
- Reviewed and approved pre-delegation assessment audits, delegation agreements, onsite reviews, and ongoing delegation oversight activities for all delegated entities, including first tier downstream and related entities (FDRs).
- Reviewed and approved evidence-based medical and behavioral health clinical practice and preventive health guidelines for distribution and monitoring.
- Reviewed and monitored practitioner/provider sanctions as a result of quality monitoring activities through committee minutes and reports.
- Reviewed and approved continuity and coordination of care initiatives.
- Reviewed and approved patient safety initiatives.
- Reviewed annual physician and member satisfaction survey results and evaluated member complaints and appeals quarterly.
- Quality management committee (QMC) members recommended changes to quality management studies, including studies involving the coordination and continuity of medical care across the health continuum to improve data validity and demonstrate improvement.
- Reviewed progress of CDPHP Enhanced Primary Care (EPC).
- Monitored and made recommendations for improving Healthcare Effectiveness Data and Information Set (HEDIS) results.
- Monitored progress on interim HEDIS Measurement Year 2024.
- Reviewed results of all health plan national ratings.
- Reviewed results of health plan Medicare Star ratings.

- Discussed, approved, and monitored any plans of correction with the New York State Department of Health (NYSDOH) as per the annual Quality Performance Matrix and Performance Improvement Plan.
- Provided oversight to the behavioral health management program.
- Reviewed and approved the Medicaid Health and Recovery Program (HARP) for eligible Medicaid members.
- Reviewed and monitored the Centers Medicare & Medicaid Services (CMS) 2022-2024 Chronic Conditions Improvement Project (CCIP), promoting Improvement in Statin Use.
- Provided oversight in sunsetting the cervical cancer screening (CCS) Quality Improvement Strategy (QIS) for NYSDOH Marketplace HMO and EPO members.
- Monitored and made recommendations for implementation of the Quality Improvement Strategy (QIS) of the NYSDOH Marketplace regarding improving performance of Eye Exam for Patients with Diabetes (EED) for our HMO and EPO marketplace members in 2024.
- Provided oversight of the NYSDOH Quality Performance Improvement Project (PIP) focused on Improving rates of cancer screenings and prevention.
- Monitored continued compliance with National Committee for Quality Assurance (NCQA) 2024 health plan accreditation standards and requirements.
- Monitored the progress of NYS Performance Improvement Project (PIP) on Perinatal Care Study.
- Provided oversight of the 2024-2025 HARP NYS Performance Improvement Project (PIP): Continuing Engagement in Care and Treatment
- Monitored implementation of the 2024-2025 HARP NYS Performance Improvement Project (PIP)
- Monitored and made recommendations for the 2024 Performance Improvement Quality Matrix (QARR MY 2022) corrective action plan to improve performance for Chlamydia Screening in Women (CHL) and Follow-up After Emergency Department Visit for Mental Illness (FUM) for Medicaid and HARP members.
- Made recommendations to support and participation in the Alliance of Community Health Plans (ACHP) *New* Chronic Conditions Pledge (2023-2030)- Pledge 1: Reduce percentage of adults with diabetes with an A1c>9 and Pledge 2: Reduce the proportion of children with obesity.

Overall quality and safety of clinical care and quality of service goals and objectives were met in 2024. Performance was supported through quality, population health management, member experience and network adequacy initiatives. Although not all PHM goals were met, CDPHP maintains its commitment to improving performance. Member and provider satisfaction will continue to be a strong focus.

3. Credentials Committee

The credentials committee has the responsibility for the review and revision of the credentialing and recredentialing criteria, standards, policies, and procedures. The committee reviews, approves, denies, or terminates participation of physicians, mid-level practitioners, adjunct practitioners, ancillary, and facility providers. This committee also monitors practitioner and provider access and availability standards.

The credentials committee is chaired by a medical director, as designated by the EVP/Chief Medical Officer (CMO), or their designee. The committee membership meets at least six times per year and is appointed by the EVP/CMO, or their designee, with approval from the board of directors, and includes both primary care and specialty physicians.

Minutes from the committee are reported to the quality management committee (QMC) and to the board of directors.

The credentialing director serves on the committee and additional plan staff such as team lead, tier II, and III specialists, and/or credentialing specialists participate as needed.

The credentials committee reports to the QMC.

2024 Credentials Committee Accomplishments

- Reviewed and approved all current credentialing program policies and procedures.
- Made recommendations for 2,853 initial credentialing applications.
- Made recommendations for 5,201 recredentialing applications.
- Reviewed and approved all delegated credentialing activities.
- Continued to support ongoing network development and recruitment of practitioners and providers into the CDPHP network.

The credentials committee met six times between January and December 2024. Contemporaneous minutes were recorded for all committee activities.

4. Utilization Management Committee

The utilization management committee (UMC) is responsible for the development, review and implementation of resource coordination policies and recommendation of enhancements to the utilization management program; new technology evaluation, including new uses of existing technology; recommending revisions to the member benefit package; monitoring of institutional, professional, and ancillary practitioner utilization trends; development or selection of industry-standard medical necessity/medical appropriateness screening criteria used for utilization management (UM) decision-making; monitoring of timely resolution of UM determinations and service indicators, including the inter-rater evaluation process for physician and non-physician reviewers; and evaluation for potential over- and underutilization on a plan-wide, product-specific, and practitioner-site level, with recommendation of corrective action as appropriate. The UMC also serves as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.

The UMC meets on a bi-monthly basis and is chaired by a medical director who has a primary focus in UM, as designated by the EVP/CMO and consists of participating primary care and specialist physicians. Additional Plan employees serve as ad hoc staff to the committee as needed. The committee reports through the QMC to the board of directors.

2024 Utilization Management Committee Accomplishments

- Reviewed and approved the 2024 *UM Program Description.*
  - A review of the UM Program Description is conducted on an annual basis to include a comprehensive review of sections such as, roles and reporting, program scope, program components, medical necessity denials, etc. It was determined there is no need to change the overall structure of this document. The document will continue to be reviewed on an annual basis and will include input from applicable areas. While resources dedicated to the UM Program Description are currently adequate, CDPHP continually monitors those resources to ensure they remain adequate and may make changes as needed.
- Review and approval of resource coordination external policies as forwarded by the policy committee:

Resource Coordination External Policies Year-End Total = 143

- There were 7 new external policies.
- Reviewed 41 existing external policies without change.

- Revised 92* existing external policies.
- Retired 3 existing policies.

***This number represents the number of times policies were revised. Multiple policies were revised more than once during the calendar year.*

- Reviewed the Utilization Management Program Description, outlining the organization and structure, roles and responsibilities and components of the UM Program.
- Discussed the collaboration with CDPHP and Community Care Physicians (CCP), including the launch of the CCP hospitalist program at Albany Medical Center to assist with transitions of care and reducing readmissions.
- Monitored the utilization trend of inpatient and ambulatory care, as well as behavioral health utilization.
- Monitored utilization metrics on a year-to-date basis for both medical, behavioral health and pharmacy.
- Monitored member health service indicators in relation to established goals.
- Provided an overview of the clinical criteria used to make UM determinations.
- Monitored inter-rater reliability education/testing for all staff making UM determinations.
- Reviewed member and physician satisfaction with the UM process.
- Monitored delegation oversight activities for all delegates associated with UM, care management (CM), or disease management, including Avalon, Delta Dental, and Landmark.
- Provided updates on the CDPHP Care Management program, including the services and supports this program offers.
- Overview of the Hospital to Home program. This program is an innovative program and provides exclusive benefits to members during and after a hospital stay. The program has been successful with engagement and in decreasing readmissions.
- Reported results of Experience of Care and Health Outcomes (ECHO) survey. The rating of counseling and treatment in 2024 is stable and significantly higher than the PG Average (Press Ganey).
- Review of the Chronic Special Needs Plan (C-SNP), which is a plan for Medicare members with chronic conditions, including chronic heart failure, COPD and End Stage Renal Disease (ESRD). This plan is being terminated as of 12/31/2024 due to historically low membership.
- Pharmacy provided an update on the current pharmacy trend and broke down average costs of medications. The cost of prescription drugs over the first 8 months of 2024 is the highest it has ever been.
- Reviewed legislative and regulatory updates, including NYS budget and the Medicare Wage Index.
- Provided an overview of the Specialty Value-Based Program (SVBP). The program has been successful with reducing hospital admissions and readmissions. The program is patient and provider centric and focuses on improving access to care.
- CDPHP has grown its Medicare Advantage program by ten thousand members this year, making us the third fastest growing Medicare Advantage plan in the country.

The utilization management committee met six times in 2024. Contemporaneous minutes were recorded for all committee activities. The utilization management committee reports directly to the QMC.

5. Behavioral Health Utilization Management Committee

The behavioral health utilization management committee (BH UMC) makes recommendations concerning utilization management related to behavioral health and provides expert opinions on behavioral health issues.

Discussions include the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit package; monitoring utilization trends; development/selection of industry-standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

The committee members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to effect better outcomes with specific populations. Their scope includes all CDPHP lines of business except Medicaid HARP.

The primary goal is to impact the behavioral health community by moving them toward the fulfillment of the CDPHP health value strategy. The committee meets four times a year, is chaired by the CDPHP behavioral health medical director, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance use treatment. Committee minutes are reported to the UMC, QMC, and then to the board of directors.

2024 Behavioral Health Utilization Management Committee Accomplishments:

- Inpatient and outpatient utilization was reviewed including membership trends, inpatient and outpatient utilization rates, cost drivers, readmissions, MLR, and Medicaid programs.

- BH Access Center, Contact Lifeline, and BH Authorizations performance was reviewed.
- CDPHP offered substance use disorder (SUD) webinar series which is focused for primary care providers. Focus is to reduce stigma, increase awareness around diagnosing within a primary care setting, and increase linkage to SUD care/services.
- HEDIS 2024 changes were presented to the committee.
- Education provided on new mental health resources, like the Ellis Family Room.
- Updated provided on a Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications
- Presentation on Mental Health Parity.
- CDPHP collaborated with a program call YST which focuses on prevention of youth suicide and this was presented to our care management team.
- BH medical director was interviewed by local news regarding awareness of SUD issues and importance of Narcan. Committee members shared available resources related to this topic.
- Updated provided on CDPHP and Lifetime affiliation.
- BH Medical Director informed the committee that CDPHP has contracted with RISE housing & support services for part 820 residential services, added children's crisis residence to the BH Services North agreement at 17 Wells Street, Plattsburgh NY 12901, and contracted with Save the Michaels of the World which is a new part 820 residential provider in Buffalo, NY. There are an additional BCBA providers join the CDPHP network. Currently we are in discussion to contract with Better Life Partners which is a SUD telehealth provider.
- Overview provided of recent NCQA audit. There was only 1 issue identified from the BH universe but more importantly, feedback from the auditors showed that authorization documentation was clear and easy to follow, the clinical conversations between reviewing staff and MDs was thorough, and they appreciated the high level of clinical documentation that was provided by the clinical offices.

6. Health and Recovery Program (HARP) Utilization Management Committee

The HARP UM committee consists of participating providers, representing behavioral health specialties, and provides advice and recommendations concerning utilization management related to behavioral health for the members of the CDPHP Medicaid HARP product and expert opinions on behavioral health issues. Discussions include the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies, medical

interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit package; monitoring utilization trends; development/selection of industry-standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

The committee meets four times a year, is chaired by the CDPHP behavioral health medical director, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment.

The committee submits results of its activities to the UMC, which reports through the QMC to the board of directors.

2024 HARP Utilization Management Committee Accomplishments

- Presented case vignettes on real member stories and successes from the HARP care management team. These presentations focused on the coordination with community providers regarding social determinant of health barriers, coordination with medical and behavioral health providers on member needs, collaboration with hospital staff and internal teams on discharge and treatment plans. Each case demonstrated that through linkage to services, communication among providers, and follow through from the member, overall utilization of inpatient/ED services decreased.
- Provided an overview of UM including:
  - Relationship between CDPHP membership for HARP and inpatient and outpatient utilization rates; readmission rates, MLR data, AOT enrollment and engagement
- Discussed how to increase utilization referral strategies, how to increase collaboration from inpatient facilities, how to increase impact of Medicaid infrastructure funds to improve referrals to CORE services.
- Reviewed the final results of the 2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus, including a discussion of barriers with implementing interventions, and the success or challenges with those interventions.
- Reviewed 2023-2024 HARP PIP: Continues Engagement in Care and Treatment, including a discussion of barriers with implementing interventions, what the plan is doing to address identified barriers, and relevant next steps.

7. HARP Quality Stakeholder Advisory Group

The HARP quality stakeholder advisory group (QSAG) is chaired by the behavioral health medical director and led by the behavioral health quality management administrator; meets quarterly; reports to the HARP UM committee; and maintains records documenting attendance, findings, recommendations, and actions.

It is responsible for carrying out the planned activities of the HARP behavioral health quality management program and is accountable to and reports regularly to the HARP behavioral health UM committee concerning BH QM activities for the Medicaid HARP line of business only.

The HARP QSAG members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and care management activities.

They provide expert opinions on behavioral health issues, encourage, and promote communication between CDPHP and the BH provider network, review and provide input for satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations for effecting better outcomes with specific populations.

The committee's mission is to exchange ideas on how to effect better treatment outcomes and review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

State requirements for the CDPHP HARP product include the involvement of stakeholders in an advisory capacity, and members, family members, peer specialists, providers, plan subcontractors, NYS Regional Planning Consortium (RPC), and/or other member-serving agencies. Satisfaction of this requirement is met by the creation of the HARP QSAG, which reports to the HARP UM committee.

2024 HARP Quality Stakeholder Advisory Group Accomplishments

- Presented case vignettes on real member stories and successes from the HARP care management team. These presentations focused on the coordination with community providers regarding social determinant of health barriers, coordination with medical and behavioral health providers on member needs, collaboration with hospital staff and internal teams on discharge and treatment plans. Each case demonstrated that through linkage to services, communication among providers, and follow through from the member, overall utilization of inpatient/ED services decreased.

- Discussed how to increase utilization referral strategies, how to increase collaboration from inpatient facilities, how to increase impact of Medicaid infrastructure funds to improve referrals to CORE services.
- Reviewed the final results of the 2022-2023 HARP PIP: Improving Cardiometabolic Monitoring and Outcomes for HARP Members with Diabetes Mellitus, including a discussion of barriers with implementing interventions, and the success or challenges with those interventions.
- Reviewed 2023-2024 HARP PIP: Continues Engagement in Care and Treatment, including a discussion of barriers with implementing interventions, what the plan is doing to address identified barriers, and relevant next steps.
- Presentation from St. Peter's Health Home Director on Health Home budget cuts and proposals.
- Reviewed an overview of the quality performance of CDPHP based on NYS matrices, how CDPHP performed, and which measures have been selected for the plan of correction

8. Behavioral Health Quality Stakeholder Advisory Group

The Behavioral Health Quality Stakeholder Advisory Group (QSAG) is chaired by the behavioral health medical director and led by the behavioral health quality management administrator; meets quarterly; reports regularly to the behavioral health UM committee; and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the behavioral health quality management program and be accountable to and report regularly to the behavioral health UM committee concerning BH QM activities for all lines of business except HARP.

The QSAG members are responsible for sharing information relative to trends in the behavioral health industry and exchanging ideas on how to affect better outcomes with specific populations. The QSAG reviews the findings of BH specific quality improvement initiatives (QIAs), performance improvement projects and focused studies.

2024 Behavioral Health Quality Stakeholder Advisory Group Accomplishments

- Behavioral health monthly teaching rounds.
- Discussion around OMH Transition of Care & Communication

- Reviewed HEDIS changes for 2024 as they relate to Behavioral Health measures. In addition, reviewed MY2023 HEDIS results. Discussed current HEDIS structure and strategic interventions for measures related to post hospital and ED follow up, cardiovascular and diabetes measures associated with Behavioral Health measures.
- CDPHP offered substance use disorder (SUD) webinar series which is focused for primary care providers. Focus is to reduce stigma, increase awareness around diagnosing within a primary care setting, and increase linkage to SUD care/services.
- Updated provided on a Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications
- BH Medical Director participated in the maternal health forum as well as an event hosted by Albany Medical Center encouraging medical students to come into the field of psychiatry.
- BH Medical Director created a short web video on MDD coding with the intent to assist providers with accurate clinical diagnosing and coding.
- Hospital to Home Director discussed the hospital to home program and opportunities in the SUD readmission population.
- Hospital to Home program is partnering with CCP to put together a hospitalist program over at Albany Medical Center. The hospitalist will be employed by CCP, and this program is set to launch in June 2024.
- Hospital to Home data: advised there were roughly 7k face to face visits within the 5 Hospital to Home facilities (June-Sept), 80% off member cases were closed successfully, 99.5% of members opted into the program which reflects the success of engagement efforts. Of those opting in, only 1.5% declined after opting in and 17% lost due to being unable to contact.
- Clinical practice guideline review and approval.
- Group discussion about OMH transition of care and communication.
- Review of CDPHP priorities around perinatal and maternal mental health services.
- Grant opportunities reviewed for committee members and providers.
- Mental Health Parity review and discussion.
- Presentation on Innovative Approaches to Address Mental Health in Adolescence
- CDPHP sponsored, Rensselaer County Chamber of Commerce: Mental Health Empowerment Event.
- Behavioral Health CM onsite at Confider Park SUD treatment center to support with CM needs and post discharge planning.
- Provider updates: 11 new individual BCBA (Board Certified Behavioral Analyst) providers join the network.
- Policy updated provided: Transcranial Magnetic Stimulation (TMS) and Applied Behavior Analysis for Autism Spectrum Disorders (ABA).

9. Children's Advisory Committee

The CDPHP Board of Directors has approved the formation of a Children's Advisory Committee (CAC). The CDPHP CAC is co-chaired by the CDPHP behavioral health medical director for children and the CDPHP pediatric medical director; meets quarterly; reports regularly to the utilization management committee; and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for advising and assisting CDPHP in identifying and resolving issues related to the management of children's health and behavioral health benefits.

The CAC responsibilities are to provide expert opinions on children's health issues. This includes, but is not limited to, the review, detailed discussion and provision of input regarding:

- Service or quality monitors, including HCBS, for medically fragile children and children with serious emotional disturbance (SED).
- Preventative and clinical practice guidelines.
- Medical/behavioral health integration and care management activities.

- Suggestions for medical policies and procedures.
- Member and provider satisfaction surveys.

The CDPHP Children's Advisory Committee (CAC) is co-chaired by the CDPHP behavioral health medical director for children and the CDPHP pediatric medical director; meets quarterly; reports regularly to the utilization management committee; and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for advising and assisting CDPHP in identifying and resolving issues related to the management of children's health and behavioral health benefits.

The CAC responsibilities are to provide expert opinions on children's health issues. This includes, but is not limited to, the review, detailed discussion and provision of input regarding:

- Service or quality monitors, including HCBS, for medically fragile children and children with serious emotional disturbance (SED).
- Preventative and clinical practice guidelines.
- Medical/behavioral health integration and care management activities.
- Suggestions for medical policies and procedures.
- Member and provider satisfaction surveys.

The CAC members are responsible for sharing information relative to trends in the delivery of health care for children, and exchanging ideas on how to affect better outcomes for the various subpopulations of children, including medically fragile children and children with SED.

The scope of responsibility of the CAC is not the oversight of daily operations, claims payments, provider reimbursements, contracting, or other functions which are the primary responsibilities of other committees or departments within CDPHP.

The CAC submits results of its activities to the UMC, which reports through the QMC, up to the board of directors.

2024 Children's Advisory Committee Accomplishments

- Provided updates on the CDPHP enhanced Health Equity program, including introduction of Health Equity Program Manager and background on the 1115 Social Care Network Waiver benefits.
- Discussed ongoing trends in vaping amongst children and adolescence and discussed treatment availability and options in the community.
- Discussed ongoing opioid epidemic, and the impact on younger populations, and provided overview of Narcan to community members.
- Solicited feedback from committee on challenges and opportunities for communication and collaboration among providers, hospitals, community organizations, and MMCP's, and discussed best practices.
- Provide ongoing updates to CDPHP network contracting, especially facilities that specialize in children and adolescents.
- Provide ongoing updates to CDPHP HEDIS and NCQA quality performance and solicit meaningful feedback from committee members to guide quality strategy.
- Discuss, strategize, and develop plans for youth who do not have imputed pediatricians
- Provide ongoing updates to Youth specific programs, including challenges and successes (Waiver, Foster Care, Medically Fragile youth, Youth ACT, etc.).
- Present on CDPHP's success with quality measures for Foster Care members, identifying top performances in NYS.
- Present on utilization trends for Children HCBS and CFTSS, and discuss CDPHP's process of oversight to ensure appropriate utilization, and address both under- and over-utilization
- Thoroughly review the NYS budget proposals to determine impact to youth and families and strategize around this impact.

- Present on the Healthy Steps model, used in pediatric primary care settings that serves to mitigate early childhood stress. Discuss ways to expand this model.
- Review the CDPHP ACHP pledge related to Childhood Obesity and solicit important feedback and strategies from the committee.
- Solicit feedback and share successful develop of video produced on the HPV vaccine, in collaboration with a network pediatrician. Encouraged distribution of this video to assist with uptake of HPV vaccine.
- Discuss and distribute resources for youth experiencing substance use disorders and overdose.
- Provided information on specialized programs to support youth experiencing suicidality, including the Youth Nominated Support Team (YST).
- Provide ongoing updates related to CDPHP's Polypharmacy workgroup, dedicated to reviewing children on potentially clinically inappropriate psychotropic regimens. Discussed the successes and accomplishments CDPHP's has seen through this program (improvements in children receiving necessary labs, reduction in polypharmacy, improvement in medication consolidation and dose optimization).
- Presented on CDPHP's new program focused on members living with sickle cell disease.
- Discuss and solicit helpful input on the challenges related to flu vaccines and the decreasing rates of vaccinations among young people.
- Generally, provide the committee ongoing updates related to NYS implementations and changes, to solicit feedback in best supporting youth members in managing these changes in programs and systems.

10. Pharmacy and Therapeutics Committee

The role and function of the pharmacy and therapeutic (P&T) committee is to ensure that the most clinically appropriate and cost-effective drugs will be available for the plan's members. The committee recommends the adoption of policies regarding evaluation, selection, and therapeutic use of drugs; recommends or assists in the formulation of programs to meet the pharmaceutical needs of practitioners; and recommends and maintains the plan's formularies in accordance with resource coordination policies and procedures. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) or Federal Parity law requires that coverage for mental health or substance use disorder (MH/SUD) benefits be no more stringent or restrictive than coverage for medical/surgical benefits. This applies to any limitation including prior authorization status, application of quantity limits or step therapy, and drug formulary design. CDPHP and the P&T committee will make recommendations for the application of any limitations, without regard to type of drug, when a defined factor triggers the application of said limitation.

The P&T committee consists of practicing physicians, advanced practice practitioners (APP's) and pharmacists appointed by the health plan's board of directors, who represent a cross-section of primary care physicians and specialties from the plan's practitioner panel. The members of the P&T committee are bound by a confidentiality and conflict of interest agreement and are renewed annually and as necessary. A staff medical director from the plan chairs the committee.

Up to five pharmacists from participating pharmacies, as well as other plan partners, may be invited to attend meetings as consultants to the committee. The plan's member health representatives, the senior vice president/chief pharmacy officer, vice president of pharmaceutical care programs, managed care pharmacists, and representatives from the plan's pharmacy benefits management company serve as presenters and consultants to the committee. The P&T committee meets five times per year. Committee minutes are forwarded through the QMC to the board of directors.

<u>2024 Pharmacy and Therapeutics Committee Accomplishments</u>

- Reviewed new drug entities and new unique drug delivery systems to market for the calendar year 2024.
- Reviewed new to market injectable agents and HCPCS codes for coverage determination and assignment as either a pharmacy or medical benefit.
- Reviewed and approved the plan's 2024 Medicare Part D prescription drug formulary updates and the 2025 Medicare Part D formulary and utilization management tools.
- Reviewed and approved the plan's commercial formulary updates.
- Reviewed NCQA Pharmacy Turnaround Time Report for Pharmacy Utilization Management/Formulary Exception Decisions and Summary of Audit Findings of Pharmacy Utilization Management Denial Systems Controls quarterly and the annual review of the Report of Timeliness of Notification of Pharmacy Medical Necessity Denial Determinations from 2023.
- Reviewed and approved pharmacy department policies as forwarded by the policy and decision workgroup for the Commercial and Medicaid lines of business, including the review of 54 policies and the revision of 71 policies. Twenty-one policies were made obsolete in 2024, and 30 new policies were created. Reviewed and approved pharmacy department policies as forwarded by the policy and decision workgroup for the Medicare line of business, including 10 new policies, 3 obsolete policies, 34 reviewed policies, and 38 revised policies for 2024.
- Reviewed and approved the annual CDPHP clinical formulary booklets for 2024 for the commercial line of business with pharmacy benefits and the plan's medical benefit drug formulary/prior authorization list, which are available on the public website for plan enrollees and practitioners and printed as requested.
- Reviewed and approved the P&T committee charter document.
- Reviewed the new Wegovy indication to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight and its Medicare Implications.

The pharmacy and therapeutics committee met five times in 2024. Contemporaneous minutes were recorded for all committee activities. The P&T committee reports directly to the QMC.

11. Joint Health Services Committee

Delegation Oversight:

The CDPHP board of directors and QMC have delineated responsibility to the joint health services committee (JHSC) to monitor delegation oversight and coordination of delegated activities. CDPHP entrusts first-tier, downstream, and related entities (FDRs), also known as vendors and delegated entities, to deliver specified services to its members and thus has entered into mutual service and delegation agreements to perform precise activities.

Separate documents clearly delineate the plan's oversight and responsibility for individual delegated activities. These include the functions and methodology used to evaluate and assess delegated activities on a regular basis in accordance with CDPHP policies and procedures.

The JHSC consists of all FDRs and delegates, including our pharmacy benefit manager (PBM), disease management, in-home complex care management, online physician/provider/hospital directories, Medicaid and Medicare dental services, credentialing and recredentialing delegates at specific sites, virtual self-management tools, community engagement partners and select vendors.

The accreditation and quality program manager chairs the JHSC meeting and other members include representatives from the delegated entities and the CDPHP delegation team, including a medical director, quality, pharmacy, appeals/grievances, resource coordination, behavioral health, care management, credentialing, customer service, government programs, corporate compliance, information technology security, sourcing/contracting, vendor management, corporate analytics and member services staff. CDPHP FDRs and delegates develop agendas in consultation with and approval by the CDPHP delegation team.

Through approval of a delegate's activities, quarterly reporting, and annual oversight evaluation, CDPHP will identify any deficiencies in the delegate's processes, clinical care, and services provided to the health plan's members. The health plan will work with the delegated entity in correcting deficiencies identified, through corrective action plans (CAP) and if the deficiencies are not corrected as agreed, the health plan may revoke the delegation arrangement according to the terms outlined in the executed agreement. The committee meets quarterly and submits results of its activities to the QMC and the board of directors.

Joint Health Services Committee responsibilities include but are not limited to:

- Approve pre-delegation assessment evaluation audit, including on-site visit.
- Approve mutually executed delegation agreements, quality management evaluations, programs, and work plans.
- Monitors delegate requests for member experience and clinical performance data.
- Review quarterly reports containing results of delegated activities with corrective actions plans (CAP), if applicable.
- Pursue plan of correction for areas not meeting standards and consider delegate termination where applicable. When a CAP is enacted, CDPHP requests that the delegate responds directly to the correction item for each piece identified and include a timetable for completion, identify the person, by position, who is responsible for implementation and monitoring for continued compliance.
- Ensure delegates' adherence to delegation responsibilities/functions, CDPHP policies, procedures, compliance, privacy, fraud-special investigation unit (SIU) and information security and quality improvement (QI) goals on a quarterly and annual basis and assess delegate's performance as: delegate fully compliant, approved CAP, or revocation of delegation agreement.
- Review annual oversight reports of delegated activities, including disaster plans, Health Insurance Portability and Accountability Act (HIPAA) HITECH breaches, Statement on Standards for Attestation Engagements (SSAE) 16 Systems and Organization Controls (SOC) 1 and SOC2, corporate compliance program, fraud, waste, and abuse (FWA), and privacy programs.

As part of delegation oversight and coordination of delegated activities, in 2024, the JHSC required the following delegates to report to the committee: pharmacy vendor (Capital Rx), dental vendor (Delta Dental for Essential Plan, State Programs), care management (Landmark), utilization management for genetic testing (Avalon), Population Health Management delegates, (Trinity Alliance Catholic Charities, Ovia Health, and Virgin Pulse Transform), vision vendor (Davis Vision), hearing care vendor (Hearing Care Solutions), claims management and member services, and all credentialing delegates as well as the physician and hospital online directories vendor (Kyruus Health dba HealthSparq). The committee approves the written pre-delegation and delegation agreement documents, the quality management evaluations, programs, and work plans, and receives quarterly and annual reports containing results and action plans regarding delegated activities.

2024 Joint Health Services Committee Accomplishments:

- CDPHP approved continued delegation to Kyrus Health (formerly HealthSparq), Trinity Alliance, Capital Rx, Catholic Charities, Davis vision, Avalon, Landmark Health, Hearing Care Solutions, Delta Dental, Virgin Pulse-Transform (Diabetes Prevention Program), Ovia Health and our credentialing delegates.
- New credentialing delegates for 2024 included Crystal Run Healthcare Physicians and Vituity. Delegate representatives presented their respective quarterly reports on their progress with managing the delegated functions and responsibilities as outlined in their delegation agreements with CDPHP for discussion and acceptance by the CDPHP committee oversight members.
- CDPHP completed one annual comprehensive delegation audit for all delegated credentialing functions at Albany Medical Center (AMC), Bassett Hospital, Davis Vision, Delta Dental, Doctor on Demand, Guthrie Medical Group, Health Alliance Physicians Organization, Hudson Headwaters, MagnaCare, MinuteClinic, Slocum Dickson, University of Rochester Medical Faculty Group, Valera Health, University Medical Associates of Syracuse (UMAS) and University of Vermont Health Network Credentialing and Enrollment (UVMHN C&E).
- CDPHP completed one annual comprehensive delegation audit for Avalon, Davis Vision, Landmark Health, Delta Dental, Kyrus Health, Catholic Charities, Trinity Alliance, Virgin Pulse-Transform, Ovia Health, Capital Rx and Hearing Care Solutions.
- Pre-delegation was completed for Crystal Run Healthcare Physicians, Health Help and Vituity.
- CDPHP reviewed protected health information (PHI) disclosures from all delegates; any disclosures were handled in an acceptable manner. Quarterly monitoring of corporate compliance, compliance with Medicare debarred sanctioning, HIPAA HITECH breaches, privacy, and FWA.
- Annually reviews delegates SSAE16, SOC 1 and SOC 2, disaster recovery event plans, and annual corporate compliance education of delegate staff.
- Continued calibrated call monitoring with Delta Dental, Hearing Care Solutions, Davis Vision, and Capital Rx.
- Continued monitoring of adequacy of dental network and HEDIS/QARR Oral Evaluation Dental services (OED), Topical Fluoride for Children (TFC) annual rates. Delta Dental provides monthly network build reports and CDPHP monitors monthly HEDIS/QARR rates.
- Delta Dental corrective action plan was removed for the area of complaints grievance and appeals around missed TAT and case processing.
- Monitored delegate member experience and clinical performance data requests.
- No delegation relationships were terminated.

The JHSC met four times in 2024. Contemporaneous minutes were recorded for all committee activities. All delegates remained in good standing with full compliance. The JHSC reports directly to the QMC.

12. Technology Assessment and Policy Development Committee

The CDPHP member health division is responsible for ensuring the systematic and timely review of evolving medical and behavioral health technologies provided to the CDPHP membership. This includes evaluation of new medical and behavioral health technologies, as well as new applications for existing technologies.

The CDPHP technology assessment team consist of medical directors (physicians), medical policy program manager (registered nurses), and specialist, with additional appointees as directed. The medical technology assessment team, chaired by a CDPHP medical director, is responsible to determine the effectiveness of the technology based on scientific evidence from published clinical research and the need for development of a new policy.

The medical policy program manager/specialist is responsible for researching and compiling up-to-date information from computerized searches from various sources of evidence, such as evidence-based peer-reviewed literature, government agencies, and professional societies and associations, for review and consideration by the CDPHP technology assessment team. Board-certified consultants in medicine and behavioral health are used during the review process when additional expertise is needed regarding a newly emerging medical technology.

Draft policies developed to address coverage or non-coverage of a technology are presented to the CDPHP policy committee for review and approval. The CDPHP policy committee is a multidisciplinary team, chaired by the medical director with responsibility for the development, review, and revision of all CDPHP resource coordination, pharmacy, and payment policies.

It is supported by provider consultants in medicine and behavioral health, and workgroups as needed, to lend clinical expertise to the review activities. Addition of new policies, deletion of outdated, and revision of current policies is based on input from members, providers, and staff, in addition to current trends in medical treatment and review of peer-reviewed literature. All draft policies are forwarded for review to the policy committee.

After approval by the policy committee, the formal draft is presented to the utilization management committee or the pharmacy and therapeutics committee for review and approval.

Minutes from these respective committees are reported to the quality management committee and board of directors for final approval. All resource coordination and pharmacy policies are reviewed at least annually and revised as recommended by the utilization management and/or pharmacy and therapeutics committee.

2024 Technology Assessment and Policy Committee Accomplishments:

Resource Coordination External Policies Year-End Total = 143

- There were 7 new external policies.
- Reviewed 41 existing external policies without change.
- Revised 92* existing external policies.
- Retired 3 existing policies.

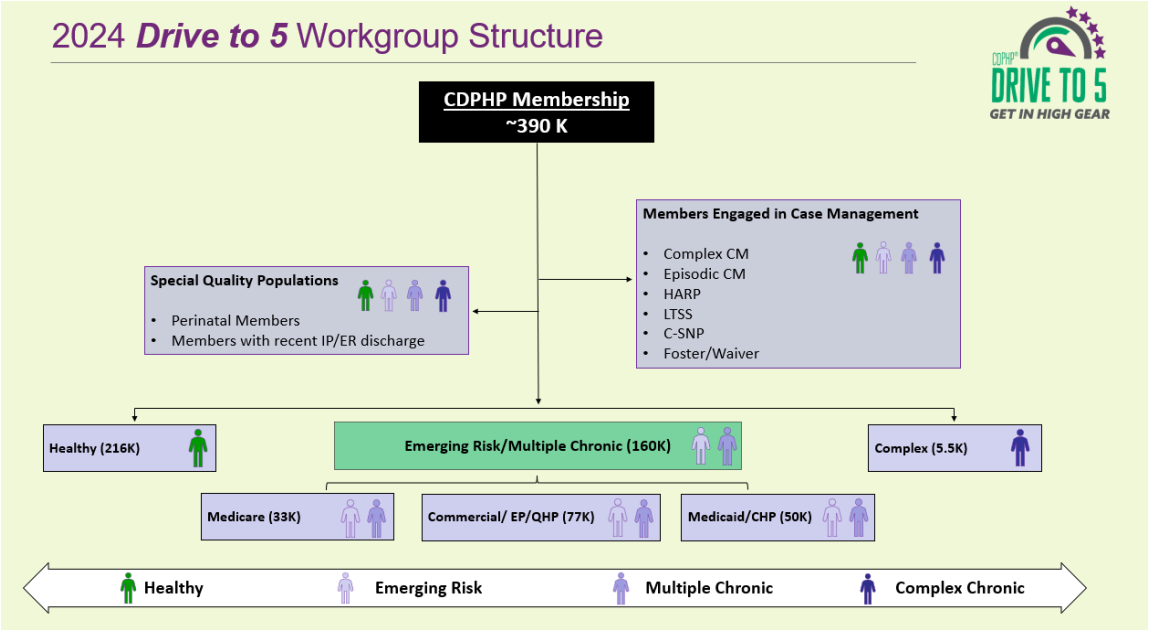
***This number represents the number of times policies were revised. Multiple policies were revised more than once during the calendar year.*

13. Corporate Compliance and Privacy Committee

The corporate compliance and privacy committee is responsible for the oversight of the CDPHP corporate compliance and integrity program and privacy program. The CDPHP corporate compliance and integrity and fraud, waste, and abuse (FWA) programs are designed as proactive and reactive systems to prevent, detect, and correct FWA or non-compliance. The CDPHP privacy program provides for ongoing activities related to the development, implementation, maintenance of, and adherence to CDPHP policies and procedures governing the privacy of, and access to member health information. This includes the investigation, documentation, and response to member privacy inquiries and complaints and responses to all HIPAA member rights matters.

14. Clinical Quality Teams- Transition to Drive to 5 Initiative

The following image depicts the member-centric Drive to 5 workgroup structure introduced in 2024.



DT5 workgroups were created in alignment with our segmentation approach to execute the CDPHP member-centric DT5 strategy: Healthy, Emerging Risk/Multiple Chronic – Medicare, Emerging Risk/Multiple Chronic -Commercial, Emerging Risk/Multiple Chronic - Medicaid, Complex Chronic. Members identified as meeting criteria for a special quality population or members actively engaged in care management were excluded from this broader segmentation approach and assigned to specialized quality teams with experience addressing and meeting the unique care quality needs of these special populations.

Healthy Members

CDPHP defines Healthy members as those members that do not have any evidence of one or more emerging risk factors or chronic conditions. Based on review of historic quality performance in this population, current performance targets and consideration of preventive medicine priorities, the following are the quality measures and indicators identified as high priority for our Healthy Adult Members in 2024 by LOB:

Quality Measures/Indicators	Medicare HMO/PPO/ C-SNP	Commercial HMO/PPO/ EP/QHP	Medicaid/ Child Health Plus
BCS-E – Breast Cancer Screening (ECDS)	X	X	X
COL-E – Colorectal Cancer Screening (ECDS)	X	X	X
CCS-E – Cervical Cancer Screening (ECDS)		X	X
CHL – Chlamydia Screening			X
Medicare Annual Well Visit (AWV) Completion	X		
Annual Physical Examination Completion		X	X

Emerging Risk and Multiple Chronic Members

CDPHP defines Emerging Risk members as those members with evidence of one or more emerging risk factors or one chronic condition; Multiple Chronic members are those with two to five chronic conditions. While our initial intention was to develop distinct workgroups for each of these segments, an initial review of member profiling and quality dashboards indicated similarities in the (evolving) clinical profiles of these members, as well as evidence of similar patterns of quality performance and highest priority quality targets. Based on that, the decision was made to align one larger team around development of a strategy to drive towards shared quality goals for this population.

The following are the quality measures identified as highest priority for our Emerging Risk and Multiple Chronic Member in 2024 by LOB:

Quality Measures/Indicators	Medicare HMO/PPO/ C-SNP	Commercial HMO/PPO/ EP/QHP	Medicaid/ Child Health Plus
BCS-E – Breast Cancer Screening (ECDS)	X		X
COL-E – Colorectal Cancer Screening (ECDS)	X	X	X
CCS-E – Cervical Cancer Screening (ECDS)		X	X
CHL – Chlamydia Screening			X
CBP – Controlling Blood Pressure	X	X	X
HBD – Hemoglobin A1c Control for Patients with Diabetes	X	X	X
BPD – Blood Pressure Control for Patients with Diabetes	X	X	
EED – Eye Exam for Patients with Diabetes	X	X	X
KED – Kidney Health Evaluation for Patients with Diabetes		X	X
SPD – Stain Therapy for Patients with Diabetes		X	
SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic medications			X
STARS Adherence Rasa - Adherence to Renin-Angiotensin Agonists	X		
STARS Adherence Statin – Adherence to Statins	X		
STARS Adherence Diabetes – Adherence to Noninsulin Diabetes Medications	X		
Medicare Annual Well Visit (AWV) Completion	X		
Annual Physical Examination Completion		X	X

Complex Chronic Members

CDPHP defines Complex Chronic members as those members with evidence of six or more chronic conditions, members that are either HARP, Landmark eligible, or members that are already engaged in care management (CM) with a member of the CM team. Based on review of historic quality performance in this population, current performance targets and consideration of complex member management priorities, the following are the quality measures identified as high priority for our Complex Members in 2024 by LOB:

Quality Measures/Indicators	Medicare HMO/PPO/ C-SNP	Commercial HMO/PPO/ EP/QHP	Medicaid/ HARP/ Child Health Plus
CBP – Controlling Blood Pressure	X	X	X
HBD – Hemoglobin A1c Control for Patients with Diabetes	X	X	X
BPD – Blood Pressure Control for Patients with Diabetes	X	X	X
EED – Eye Exam for Patients with Diabetes	X	X	X
SPD – Stain Therapy for Patients with Diabetes	X	X	
SPC – Stain Therapy for Patients with Cardiovascular Disease	X	X	
AMM – Antidepressant Medication Monitoring			X
STARS Adherence Rasa - Adherence to Renin-Angiotensin Agonists	X		
STARS Adherence Statin – Adherence to Statins	X		
STARS Adherence Diabetes – Adherence to Noninsulin Diabetes Medications	X		
Medicare Annual Well Visit (AWV) Completion (In-house claims-based indicator)	X		
Annual Physical Examination Completion		X	X

Approaches taken by the member-centric Drive to 5 teams to get into high-gear and meet targeted goals in 2024 included email journey campaigns, member newsletters, assisting primary and specialty care providers with identifying imputed patients with multiple quality gaps, working with community based organizations (CBO) and care management partners to engage members with multiple care gaps, quality education tabling at community events, flyers posted in provider practices, member gift card incentives, direct phone call outreach and claims-based reconciliation to close identified gaps.

K. Practitioner and Provider Network

Practitioners

Practitioners	Number 12/1/2022	Number 12/1/2023	Number 12/1/2024
Primary Care	4,594	5,708	7,112
Specialist, Including OB	16,533	16,825	19,516
Adjunct practitioners	3,065	7,022	8,520
*EPC practitioners	1010	1,006	1124

**EPC practitioner numbers are included in the primary care physician counts*

Providers

Providers	Number 12/1/2022	Number 12/1/2023	Number 12/1/2024
Hospitals	81	81	81
Skilled Nursing Facility	107	125	122
Home Health Agencies	82	81	79
Outpatient Surgery Centers	37	339	40
Other, including DME, Lab, Radiology, Pharmacy	5450	126	1255

Behavioral Health Providers/Practitioners

Practitioner	Number 12/1/2022	Number 12/1/2023	Number 12/1/2024
Behavioral Health	3,563	5,119	5140

CDPHP continues to maintain a 29-county service area. The overall strategic goal of the healthcare network strategy (HNS) department is to align with providers in progressive population management payment models, which promote and incentivize pay-for-value, cost efficiencies, patient satisfaction, and quality care, while maximizing operational effectiveness and lower medical cost trend.

Healthcare network strategy continues to advance the objectives of the Quadruple Aim (1) managing population health, (2) reducing or controlling per capita cost, (3) improving member care experience and outcomes, and (4) supporting health care team member and practitioner job satisfaction) through our specialized vertical approach. Our specialized teams work on contracts within their provider communities to bring the most efficient and effective strategies while creating value for the providers and the plan. In 2024, HNS continued enhancements with the network operations team to identify and develop interdepartmental processes and improve operational efficiencies. HNS continued success in provider recruitment, expansion, implementation of several regulatory mandated initiatives, and the successful enhancements to our EPC program.

In 2024, our EPC program includes 176 network practice sites caring for nearly 235,000 members across all product lines. Nearly 90 percent of all primary care imputed members seek care at an EPC location.

CDPHP engages the EPC sites with physician engagement specialists (PES) to work with the providers on the principles of the Quadruple Aim.

CDPHP continues to evaluate our existing value-based programs and to develop new initiatives to meet the needs of our provider network. Additionally in 2024, we continue to work on Specialty Care Value Based Programs for Renal, Cardiology and Behavioral Health.

Data share and practice transformation activities continue to strengthen the EPC and value-based models as well as provider engagement activities.

Population health and wellness focused on member-centric quality initiatives, while our performance measurement and physician engagement teams focused on practitioner/provider-centric quality initiatives.

CDPHP continues to participate in the NCQA (National Committee for Quality Assurance) recognized Partner in Quality Program. This distinction recognizes organizations that provide financial incentives or support services to practices seeking recognition through NCQA Patient Centered Medical Home (PCMH) programs.

PCMH is a health care setting that facilitates partnerships between patients and their personal physicians and, when appropriate, the patient’s family. Care is facilitated by registries, information technology, the exchange of health information, and by other means to ensure that patients get the care necessary, when and where they need and want it, in a culturally and linguistically appropriate manner.

NCQA Partner in Quality participation allows CDPHP to pass financial savings on to those Enhanced Primary Care (EPC) practices seeking PCMH recognition. Specifically, participating practices will receive a 20 percent initial application discount.

L. Confidentiality

Overview

CDPHP quality management program activities are privileged, confidential, and conducted in a manner that ensures the confidentiality of member and practitioner/provider information. Employees and committee members are required to handle data responsibly and take the necessary steps to protect the privacy of the involved individuals.

All documents are appropriately redacted when sent for external review. In addition, as a condition of employment, each employee is subject to a confidentiality agreement. Any breach in confidentiality will result in disciplinary action as described in the employee handbook. A strong privacy policy is in place outlining the standards for the protection, use, and disclosure of member health information in accordance with HIPAA and applicable New York state laws and regulations and is detailed in the CDPHP *Standards of Conduct.* The corporate compliance committee is responsible for the review, revision, and evaluation of the CDPHP privacy program.

Actions Taken to Ensure Confidentiality:

- All employees receive training on CDPHP privacy and security standards.
- Privacy personnel are designated within a defined privacy infrastructure.
- A detailed corporate-wide privacy policy is included in the CDPHP *Standards of Conduct.*
- All employees and committee members sign a confidentiality agreement.
- CDPHP limits employees' system access to protected health information in accordance with employees' job functions and responsibilities (role-based access).
- Written policies and procedures have been established for fulfilling member requests to access and control their health information.
- Policies and procedures have been implemented for the release of protected health information to plan sponsors.
- The CDPHP *Notice of Privacy Practices* is distributed upon request, upon enrollment, and annually. The *Notice of Privacy Practices* is also available on the CDPHP website at www.cdphp.com.
- All members receive information regarding CDPHP corporate privacy policies and practices in their member handbooks.
- CDPHP uses a HIPAA-compliant authorization form for uses and/or disclosures of protected health information otherwise not permitted or required by law.
- Access is restricted to the CDPHP premises through the use of an electronic security system.
- Provider office confidentiality procedures are evaluated during site evaluations.
- Member service personnel use a confidentiality grid to verify the appropriateness of requests for information prior to releasing information.
- CDPHP maintains written contractual agreements with other entities that are considered to be business associates under HIPAA.

M. Effectiveness of Quality Program

Based on the comprehensive review and evaluation of our performance, the overall effectiveness of the 2024 quality management (QM) program, including adequacy of resources, progress toward influencing network-wide safe clinical practices, quality management (QMC) committee structure, and network practitioner's participation and leadership involvement, proved to be strong. The following outlines each of the aforementioned areas and evidence to support our effectiveness.

Adequacy of QI Program Resources: In 2023, CDPHP allocated 108 diverse employees, including staff, managers, directors, medical directors, and vice presidents, whose collective time comprised 145.5 FTE dedicated to the quality program. Our employee talent resources represented over 2,443 years of combined health care experience and were designed to lead, support, and drive our company-wide clinical quality initiatives, quality programs with our physician network and our member community. These resources are adequate to support quality improvement (QI) program efforts.

Quality program resources include corporate analytics, Enhanced Primary Care (EPC) (the CDPHP PCMH model of primary care), Population Health Management (PHM), care management and pharmacy staff. Corporate analytics leads and supports all quality measurement activities, including but not limited to Healthcare Effectiveness Data and Information Set (HEDIS), Quality Assurance Reporting Requirements (QARR), National Committee for Quality Assurance (NCQA), Consumer Assessment of Healthcare Providers & Systems (CAHPS), Health Outcome Survey (HOS), Experience of Care and Health Outcomes (HOS), Qualified Health Plan (QHP) and Clinician & Group Survey (CG-CAHPS) surveys EPC payment metrics, network access monitoring, practitioner gap list, and quality performance practitioner profiling.

Network-Wide Safe Clinical Practices to Ensure Patient Safety: Patient safety is taken seriously by the plan. Throughout 2024, CDPHP continued to monitor adverse events, quality, and safety of clinical care provided by our network as measured by our QA confidential clinical quality review process (CQR). The CQR process resulted in no level 4 and no level 5 (grading of highest severity) after extensive review and investigation by the quality nursing staff and the medical directors. CQR process reviewed for improvement opportunities and, if identified, were addressed accordingly. All results remain confidential and are reported to QMC and to the board of directors.

Another way CDPHP ensures patient safety is evaluation of new technologies and the impact of these technologies to provide safe clinical practice. Throughout 2024, our medical directors and EVP/CMO were actively involved in evaluating new medical and behavioral health technologies and therapies based on sound clinical evidence and cutting-edge research; further supported through consultation with local and national medical experts. Recommendations are reviewed and approved by QMC and the board. Clinical safety is taken into consideration during pharmacy and therapeutic evaluations, clinical case review, and medical necessity review. The medical directors seek out medical consultation with our EVP/CMO, particularly in his area of expertise; or if expertise is not in-house, then an external medical review is conducted to assure objective, clinically acceptable, safe clinical practice.

Further progress toward influencing network-wide safety has been achieved through our pharmacy department's efforts to review medication safety and effectiveness. This is achieved through administration and management of pharmacy benefits across all lines of business in conjunction with our pharmacy and therapeutics committee and in partnership with our PBM; including development, maintenance, and communication of the plan's formularies, (Commercial, Medicare Part D, and Medicaid); the formulary exception request process and the utilization management rules; drug utilization reviews; new drug review; changes to labeling and indications; and safety information.

An added benefit to our members is *MedCheck*, a comprehensive medication safety review program conducted by a network pharmacist and offered to all members in all product lines, not solely to Medicare members, as in previous years.

QI Committee Structure: The CDPHP QI committee structure is comprehensive in scope, monitoring all aspects of the Quadruple Aim in 2024. There is information flow and integration between quality and operations activities to ensure initiatives are implemented to achieve quality objectives and meet goals.

CDPHP finds its QI committee structure to be effective as it promotes organization-wide accountability for quality.

Practitioner's participation and leadership involvement in QI program: There is participation by a broad range of network practitioners and organizational clinical and non-clinical leaders in the QI program. Active participation promotes ownership and investment in providing 'quality care and service' to our members, patients, and the community.

The executive vice president/ chief medical officer (EVP/CMO), senior vice president (SVP), specialty transformation, VP, behavioral health operations and integration, VP, member health-senior medical director, and the four medical directors all participate on quality committees, clinical teams, and quality initiatives**.** They are involved in root cause analyses, brainstorming, and developing action plans to address the barriers and make improvements in: HEDIS measures, CAHPS, CG-CAHPS survey performance, Medicare Stars, NYSDOH QARR Medicaid Quality performance action plans, Centers for Medicare & Medicaid Services (CMS) QIP/CCIP, NYSOH QIS, clinical quality peer reviews (CQR), quality informatics, pharmacy, reviewing new technologies, key strategic projects such as the opioid crisis, designing the integration of population health, wellness, case/disease management into population health management, and continued growth of physician engagement in the CDPHP EPC program and payment model. All departments participate in the ongoing quality improvement process through active involvement in the internal team structure, which links quality management activities with other management functions. The internal team structure supports ad hoc end-to-end quality improvement efforts through the continuous quality improvement model of W. Edwards Deming's Plan-Do-Study-Act (PDSA). The team also monitors clinical and service quality through established quality indicators, which are reported quarterly to QMC and the board of directors.

The QMC, UMC, BH committee, credentialing committee, pharmacy, and therapeutics committee (P&T), and the board of directors include a broad representation of clinical and practicing practitioners from our network.

Our community physicians and providers actively participate in our quality program as evidenced by a total of 74 practitioners actively participating in 2024 on the following committees: 12 practicing physicians served on the Quality Management; 14 practitioners on Pharmacy & Therapeutics; 12 on Utilization Management; 11 on Credentialing; 12 on Children's Advisory, and 13 on Behavioral Health Utilization Management/Behavioral Health Quality Stakeholder Advisory Group.

Need to restructure or change the QI Program for 2025: After reviewing and evaluating overall performance and program effectiveness of the 2024 QI program, adequacy of QI program resources, QI committee structure, and practitioner participation and leadership involvement in the QI program, CDPHP concludes there is no need to make changes to the QI committee structure, practitioner participation, or leadership involvement in 2025. While resources dedicated to the QI program are currently adequate, CDPHP continually monitors those resources to ensure they remain adequate.