JANUARY 2020

CDPHP Medicare Choices HMO and PPO plans were rated 4.5 out of a possible 5 stars by the Centers for Medicare & Medicaid Services (CMS).

Capital District Physicians' Health Plan, Inc.

Quality Management Program Evaluation 2019

CDPHP®

20-13225

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

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.

CDPHP was founded by Capital District physicians in 1984 as a not-for-profit health maintenance organization (HMO) in Albany, NY. More than 34 years later, CDPHP has grown to be the leading health benefits provider in the region, with a full suite of commercial, self-funded, and government program offerings. CDPHP and its affiliates serve more than 361,935 members in 26 counties across New York.

The CDPHP family of products includes three business lines:

- **Capital District Physicians' Health Plan, Inc.** HMO, Healthy New York, Medicare Choices (HMO), Medicaid, Child Health Plus, Essential Plan and Marketplace HMO.
- **CDPHP Universal Benefits,® Inc.** 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), Healthy Direction plans (EPO and PPO), Medicare Choices (PPO), Medicare Choices Medicare Supplemental insurance, and Marketplace EPO.
- **Capital District Physicians' Healthcare Network, Inc.** Administrative services only (ASO), self-insured plans, and funding accounts.

2019 Awards and Recognition

For more than 35 years, CDPHP has taken great pride in its commitment to quality, and that continues to show according to National Committee for Quality Assurance's (NCQA) Health Insurance Plan Ratings 2019-2020.

In fact, our Medicaid plan is among the highest-rated in New York State.

Below is a breakdown of how all CDPHP plans are rated for **2019-2020**.

- **NCQA's Medicaid Health Insurance Plan Ratings 2019-2020**
  - Capital District Physicians' Health Plan, Inc. (HMO): **4.5 out of 5**
- **NCQA's Private Health Insurance Plan Ratings 2019 - 2020**
  - Capital District Physicians' Health Plan, Inc. (HMO): **5 out of 5**
  - Capital District Physicians' Healthcare Network, Inc. (HMO/POS): **5 out of 5**
  - Capital District Physicians' Healthcare Network, Inc. (PPO): **4.5 out of 5**
  - CDPHP Universal Benefits, Inc. (PPO): **4.5 out of 5**
- **NCQA's Medicare Health Insurance Plan Ratings 2019-2020**
  - 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)-2020 Medicare Overall Stars Ratings

- CDPHP Medicare PPO earned quality rating of 4.5 out of 5 Stars
- CDPHP Medicare Choices HMO earned quality rating of 4.5 out of 5 Stars

NCQA annually evaluates health plan accreditation status based on a recalculation of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, and in 2019, CDPHP maintained its "Excellent" Health Plan Accreditation status, the highest accreditation status for all accredited entities: CDPHP, CDPHN, and CDPHP Universal Benefits and its products. Marketplace products (HMO and EPO) maintained accredited status in 2019. The CDPHP NCQA Health Plan Accreditation for all accredited entities is effective through May 2021.

For eleven consecutive years, CDPHP has been named one of the Best Companies to Work for in New York by the New York State Society for Human Resource Management and the Best Companies Group.

Capital District Physicians' Health Plan, Inc. received the highest score in New York in the J.D. Power 2018-2019 U.S. Member Health Plan Satisfaction Studies of customers' satisfaction with their commercial health plan.

CDPHP received the American Heart Association Workplace Health "Gold Level" Recognition for the second year in a row.

CDPHP made the Albany Business Review's list of Healthiest Employers.

CDPHP Medicare Advantage plans have once again been rated among the best in the country by U.S. News & World Report.

CDPHP ranks No. 2 in the nation for federal employee health benefits (FEHB). The rankings were released as part of the 2018 FEHB Plan Performance Assessment, which rates 83 health plans across the country in the areas of quality and customer satisfaction.

CDPHP became an NCQA recognized participant in the 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.

C. 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. 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.

I. EXECUTIVE SUMMARY

CDPHP seeks to continue to form partnerships with organizations that can bring value in the shared goals of the Quadruple Aim which is inclusive of physician satisfaction. CDPHP is committed to driving a strategy focused on population health to deliver better care and improved outcomes to our 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, 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 that 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 is centered on improving the quality of care and outcomes of our 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.
- 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.
- 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 2019 quality management 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; quality management, 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; 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 *2020 QM program description and 2020 QM work plan*. Through the annual Quality Management 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 2019 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 and board of directors that all planned activities in 2019 were completed and yearly objectives were met. Thus, the quality management program was effective and does not require any restructure in 2020.

D. Quality Management (QM) Program

CDPHP maintains a comprehensive, proactive quality management 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 quality management 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 quality management program activities are evaluated and reported here in the *CDPHP annual quality management program evaluation for 2019.*

The QM program monitors Population Health Management activities and reports progress towards goal four times per year to the quality management committee (QMC). QMC reviews Population Health Management (PHM) strategy effectiveness and the impact on our members. Recommendations are made accordingly.

As new lines of business are offered such as the Essential Plan which grew to 3,934+ in membership over 2019, 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.

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 and 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. Medicare Stars is a measure of quality from CMS which is comprised of 44 measures from both Medicare Part C (medical) and Part D (pharmacy). These measures include results from HEDIS, CAHPS, Health Outcomes Survey (HOS), Appeals, Prescription Drug Events (PDE) and CMS Administrative Measures.

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.

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.

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 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 have 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 has been named "Drive to 5."

Drive to 5 work teams include but are not limited to Plan All Cause Readmissions-Hospital Experience, Medication Management which includes asthma, diabetes, cardiovascular disease (CVD), Attention deficit/Hyperactivity disorder (ADHD), depression, schizophrenia, Medication Therapy Management (MTM), Consumer Assess of Healthcare and Provider Systems (CAHPS) and Healthcare Outcome Survey (HOS), low back pain (LBP), breast, cervical and colorectal cancer screening, rheumatoid arthritis (RA), osteoporosis, antibiotic stewardship (AAB). A priority focus for 2020 will be the integration of gap list reconciliation, Health Information Xchange of New York (Hixny), Electronic Clinical Data System (ECDS) and Integrated Delivery Systems activities.

Approaches taken by the Drive to 5 teams to gain momentum in meeting targeted goals included member education through printed health tracker distribution, flyers posted in provider practices, email journey campaigns, claims reconciliation following medical record chart review, member gift card incentives, and direct phone call outreach.

The 2019 Population Health Management goals are reported out in keeping with NCQA nomenclature utilizing HEDIS 2019 (Measurement Year 2018) validated data. Quality and regulatory initiatives are reported out utilizing interim HEDIS 2020 and year-end 2019 data.

E. Quality Management Program Resources

The following resources were dedicated to the quality management program in 2019

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Executive vice president, chief medical officer-MPH, MD	1	0.30	38
VP of primary care medical services, MD	1	0.30	31
Medical directors, MD	4	1.25	74
Medical director behavioral health, MBA, MD	1	0.35	21
Director, behavioral health	1	0.75	29
Behavioral health quality specialist	1	1.00	5
Manager, behavioral health inpatient programs	1	0.35	5
Senior vice president, chief pharmacy officer—RPh, MBA	1	0.60	39

I. EXECUTIVE SUMMARY

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Senior vice president, chief quality officer—MS, RN, NE-BC	1	1.00	33
Senior vice president, member health operations—RN	1	0.40	40
Senior vice president, healthcare network strategy	1	0.20	29
Senior vice president, corporate analytics	1	0.05	20
Senior vice president, consumer experience solutions	1	0.5	24
Vice president, clinical informatics and data governance- MD,	1	0.75	31
Vice president, physician contracting	1	0.10	16
Vice president, healthcare economics-MBA	1	0.25	14
Director, clinical quality and behavioral analytics	1	0.85	19
Director, Healthcare Economics-MPH, MSc	1	0.5	15
Manager, informatics- MBA	1	0.25	9
Senior informatics analysts	3	1.50	32
Health informatics analysts	3	3.00	52
Manager, accreditation and quality program—BSN	1	1.00	40
Director, community engagement	1	0.75	9
Director, healthcare quality, RPh	1	1.00	44
Manager, healthcare quality	1	1.00	24
Team lead quality nurse- RN	1	1.00	40
Quality improvement nurse specialists —RN	4	4.00	103
Temporary HEDIS nurses- RN	21	5.0	315
Medicare Stars administrator	1	1.00	30
Delegation specialist	1	1.00	2
Vice President member health operations	1	1.00	31
Director, credentialing and appeals	1	1.00	31
Manager, credentialing	1	1.00	19
Project Oversight Manager, credentialing	1	1.00	24
Expansion Oversight Lead, credentialing	1	1.00	20
Team lead, credentialing	1	1.00	7
Credentialing Specialists	5	5.00	89
Project Oversight Manager, appeals	1	1.00	25
QCC and Delegated Vendor Analyst	1	1.00	8
Clinical appeals specialists —RN	3	3.00	98
Appeals specialist	1	1.00	28
Medicare Appeals Analyst	1	1.00	25
Director, utilization management-RN, MSN	1	0.40	37
Director, care management—CCM, RN, MPA	1	1.00	31
Manager, chronic condition program – RN, MBA	1	1.00	18
Manager, care management & Medicaid LTS & support LPN	1	1.00	15
VP, Pharmaceutical Care Program—RPh	1	1.00	28
Manager of Pharmacy Care Management/ Residency Program Director	1	0.50	24

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Managed care pharmacists— RPh	5.2	1.75	155
Director, Clinical Pharmacy Operations	1	0.30	30
Director, Community Pharmacy Programs and Medicare Part D	1	0.75	28
Manager, Medicaid Pharmacy Program	1	0.75	21
Vice President, strategic physician engagement	1	0.50	7
Physician engagement quality educator	1	1.00	16
Physician engagement specialists	4	2.00	60
Population health engagement specialists (PHES)	4	2.00	55
Vice President, population health network strategy	1	0.50	22
Director, ancillary contracting, healthcare network strategy	1	0.20	23
Network operations coordinator	1	0.20	1
Vice President, customer service	1	0.10	25
Manager, provider relations	1	0.10	19
Manager, provider registry configuration	1	0.50	14
Manager, member services communication contact center	1	0.25	9
Supervisors, member services	1	0.25	4
Population health strategy manager	1	0.3	6
Director, product innovation and research commercial sales	1	0.20	14
Portfolio manager II- population health and wellness	2	1.00	24
Portfolio manager I- population health and wellness	1	0.5	1
Communications specialist	1	0.10	15
Web-master manager	1	0.10	11

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 2019) 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.

Clinical Care Advance Enterprise (CAE) application 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. 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. Pharmacy team supports our members through the MTMP, through the Enhanced MTM service, known *as Med Check*, and the pharmacy analytics team facilitated data analysis to improve quality and impact cost and utilization for all lines of business. 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 Enhanced Primary Care (EPC) practices, MTMP pharmacists, performance management coordinators, Medicaid innovation 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.

F. 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 chief medical officer (CMO). The CMO, who reports to the chief executive officer (CEO), is responsible for the implementation and operation of the program and for ensuring responsible reporting and communication of plan progress and evaluation from the quality management committee to the board of directors, and back to the quality management committee.

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 CMO and the quality management committee.

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

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 leader, board member, and adjunct providers.

The committee members are appointed by the executive vice president/ 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 director of health care quality, and the director of quality analytics are also on the committee. Additional plan staff serve as ad hoc staff to the committee as needed.

The QMC met six times in 2019. 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, language, 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 Population Health Management strategy implementation, monitors Population Healthy Management goal performance and makes recommendations accordingly
- Submit regular reports of QM activities to the board of directors

2019 Quality Management Committee Accomplishments

- Reviewed and approved the 2018 *quality management evaluation* and the 2019 *quality management 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 2019 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; one case fell into Level 4 and zero level 5 grading in 2019.
- Reviewed and approved pre-delegation assessment audits, delegation agreements, on-site 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 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 2019 (measurement year 2018).
- 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 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, approved and monitored the Centers Medicare & Medicaid Services (CMS) 2019 Chronic Conditions Improvement Project (CCIP), promoting effective management of chronic kidney disease
- Reviewed and monitored Quality Improvement Strategy (QIS) of the New York State of Health (NYSOH) Marketplace regarding improving performance of cervical cancer screening (CCS) for our HMO and EPO marketplace members to be continued through year 4 in 2020.
- Reviewed and monitored the New York State Department of Health Kids Quality Performance Improvement Project (PIP) related to optimizing health development trajectory to improve long term outcomes for Medicaid managed care children at risk for lead poisoning, hearing loss and developmental delay.
- Monitored continued compliance with National Committee for Quality Assurance (NCQA) 2019 and 2020 health plan accreditation standards and requirements.
- Monitored the progress of NYS Performance Improvement Project (PIP) on Perinatal Care Study.
- Monitored the progress of NYS Performance Improvement Project (PIP) on HARP: Care Transitions Study
- Monitored the progress of Federal Employee Health Benefits (FEHB) Program: Plan of Correction (POC) for UBI product line.

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, 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 chief medical officer or his designee. The committee membership meets at least six times per year and is appointed by the chief medical officer or his 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 and to the board of directors. The credentialing manager serves on the committee and additional plan staff such as tier II specialists and/or credentialing specialists participate as needed.

The credentials committee reports to the quality management committee.

<u>2019 Credentials Committee Accomplishments</u>

- Reviewed and approved all current credentialing program policies and procedures.
- Made recommendations for 2,810 initial credentialing applications.
- Made recommendations for 3,606 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 nine times between October 2018 and September 2019. Contemporaneous minutes were recorded for all committee activities.

4. Utilization Management Committee

The utilization management committee (UMC) is responsible for the development, approval, and review/revision of resource coordination policies; 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 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 under-utilization on a plan-wide, product-specific, and practitioner-site level, with recommendation of corrective action as appropriate. The utilization management committee 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 chief medical officer, executive vice president/ chief medical officer, and consists of participating primary care and specialist physicians. The committee reports through the QMC to the board of directors. The senior vice president of member health operations, and directors of resource coordination, and behavioral health serve as staff to the UMC.

<u>2019 Utilization Management Committee Accomplishments</u>

- Reviewed and approved the 2019 *Resource Coordination Program Description.*
- Reviewed and approved use of Milliman Care Guidelines (MCG, Hayes, Inc.), American Society of Addiction Medicine (ASAM) Patient Placement Criteria, LOCADTR 3, and Care Advance Enterprise Standard Content Package for use by our medical management programs for 2020.

- Review and approval of resource coordination external policies as forwarded by the policy committee:

    - Reviewed 44 existing policies
    - Revised 84* existing policies
    - Approved 7 new policies
    - Retired 2 existing policies
    - Reviewed and supported the technology assessment team's recommendations on 2 new technology reviews

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

- Monitored the legislative landscape and how it impacts health care as well as health insurance.
- Provided updates and quality metrics on the plan's telemedicine services vendor.
- Monitored activities of the behavioral health subcommittees.
- Reviewed genetic test utilization and potential plan to partner with a delegated genetics benefit manager.
- Approved the monitoring of plan-wide, product-specific, and practitioner site under- and over-utilization, including actions taken and recommendations for 2020.
- Monitored the utilization trend of urgent and emergency care.
- Monitored member health service indicators in relation to established goals.
- Reviewed the CDPHP partnership with Landmark in providing home-based care to qualified members.

- Monitored inter-rater reliability education/testing for all staff making UM determinations.
- Reviewed physician satisfaction with the utilization management process and approved all recommendations for 2019.
- Reviewed member satisfaction with the UM process and approved actions taken and those recommended for 2020.
- Monitored CDPHP standing with multiple accreditation/regulatory organizations.
- Monitored delegation oversight activities for all delegates associated with utilization management, case management, or disease management.
- Monitored utilization metrics on a year-to-date basis for both medical and behavioral health.
- Monitored plan's activities related to our health and recovery plan (HARP), including the insourcing of case management services for this population.
- Provided input on further reductions in prior authorization requirements.
- Reviewed Hospital Experience Program to positively impact hospitalized member experience, length of stay, and readmissions.
- Monitored plan's progress as we transition to a population health management approach.
- Monitored efforts related to readmission avoidance, including the Enhanced Readmission Avoidance Program.
- Monitored results of Experience of Care and Health Outcomes (ECHO) survey.

The utilization management committee met five times in 2019, with a sixth meeting substituted with electronic approvals due to low predicted attendance for the July meeting. Recognizing that this can be a difficult time to get quorum due to summer vacations, the meeting requirement is now set at five per year starting in 2020. Contemporaneous minutes were recorded for all committee activities. The utilization management committee reports directly to the quality management committee.

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.

<u>2019 Behavioral Health Utilization Management Committee Accomplishments</u>

- Discussed pharmacy updates and shared information on psychotropic medications and their utilization, specifically Clozapine.

- Reviewed progress reports regarding contracting with Valera and their tele-mental health phone app.
- Reviewed and monitored the progress of the Children's Medicaid transformation and the 1915C Waiver Program.
- Reviewed and apprised the committee about the NYS Performance Opportunity Project (POP), and brainstormed about how to integrate Medical and Behavioral Health Services using the collaborative care model.
- Monitored progress and received feedback regarding the Medicaid Plan of Correction concerning the transitions of care from the emergency room (ER) and inpatient.
- Reviewed and discussed CAHPS and ECHO member satisfaction results with the Committee.
- Monitored and made recommendations for integrating behavioral health into the PCP setting and why this would be beneficial to our member population.
- Community providers from primary care presented their collaborative care model, and shared many of the successes achieved due to this model.
- Discussed how CDPHP is working with a value based team to bring the organization further in line with NYS Parity laws.
- Shared the vision for the member hospital experience and the goal to reduce readmission rates, length of stay, and increasing member experience.
- Shared disease prevalence by Medicaid line of business: 39.1 percent depression, 11.1 percent anxiety disorder, 27.3 percent bipolar disorder, and 22.7 percent schizophrenia.
- Discussed and shared data about NCQA Timeliness Standards, BH utilizations trends, and 30 day readmission rate by quarter. Committee suggestions to address trends included using readmission risk scoring, daily clinical rounds, daily review of the HEDIS gap list, focus on population health and co-occurring diseases that lead to readmission, bedside visits with member and home visits, and after-action review.

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 utilization management committee, which reports through the quality management committee to the board of directors.

<u>2019 HARP Utilization Management Committee Accomplishments</u>

- Provided an overview of the housing initiative partnership between CDPHP and St. Catherine's.
- Received feedback and monitored progress of the HARP Plan of Correction (POC), HARP Performance Improvement Project (PIP), and HARP CAHPS quality performance results. Shared new HIXNY ER report from analytics and urged electronic documentation of medical records to increase ease of sharing information across the continuum of care.

The committee approved the action plan, and requested sharing the ER reports with clinicians involved in a member's care.

- Discussed inpatient detox level of care being utilized more than ambulatory detox. Feedback from committee included increasing X waiver licensure in the community to increase ambulatory visits
- Shared program that incentivizes hospitals and clinics through the CCHIP (County Clinic and Hospital Incentive Program), which creates processes and dedicates staff to coordinate care with outpatient providers.
- Discussed the shortage of providers for the HARP line of business and the steps being taken by CDPHP.
- Shared and discussed reports about disease prevalence and co-morbidity by line of business, showing the CDPHP HARP population with a 39.1 percent rate of depression, 27.3 percent bipolar, 22.7 percent schizophrenic, and 11.1 percent anxiety disorders.
- Discussed pharmacy updates and shared information on psychotropic medications and their utilization, specifically Clozapine, which should be offered to those who have failed other anti—psychotic medications. ADHD medication utilization in the HARP population were also discussed.
- Discussed the Asthma Plan of Correction, sharing that an incentive program will be initiated for those members who complete the program.
- Monitored trends regarding HARP ER utilization, home and community based services (HCBS) utilization, infrastructure, and funding.
- Discussed prior authorization requirements have been removed from ACT, PROS, continuing day treatment, IOP and PHP.

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 at least 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 case 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.

<u>2019 HARP Quality Stakeholder Advisory Group Accomplishments</u>

- Solicited feedback on improvement opportunities for NYSDOH HARP PIP and POC regarding coordination of care, such as embedding in hospitals and ERs, increasing

communication with area providers and promoting existing home visit services, while monitoring referral volumes. The goal is to improve status and outcomes among the most vulnerable CDPHP members who are living with serious mental and physical conditions, likely to be highly impacted by several social determinants of health, and likely to encounter barriers when it comes to accessing high quality healthcare.

- Committee discussed the Social Determinants of Health AHIP conference. The discussion included social isolation as a contributor to poor health status, and exploring opportunities with case management to address this issue by utilizing peers and social clubs.
- Discussed interim HEDIS rates and shared how EPC involvement may explain the commercial and Medicaid trends. Shared how CDPHP is working with providers on adherence to anti-depressant medication.
- Solicited feedback from the committee regarding their reception to telemedicine. Discussed Doctor on Demand for the commercial LOB, and advised that CDPHP is looking for providers to offer telemedicine for the Medicaid and HARP population for mental health needs.
- Discussed how the prior authorization changes flow into parity, as CDPHP has removed the prior authorization requirement for partial hospitalization as well as intensive outpatient services.
- Discussed the ECHO Member Satisfaction survey results. The committee referenced the value based payment conversation in the QSAG (all LOB) discussion, and how creative programming may offer a solution to the access issue.
- Updated the committee on the member hospital experience, a major initiative to look at how CDPHP interacts with the in network hospital systems, and what CDPHP members experience while in an inpatient setting. CDPHP will conduct a study to see from a member perspective what could be improved during an inpatient stay.
- A representative from St. Peter's Health Partners' behavioral health program shared a vision of the hospital of the future and their behavioral health program.

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 at least 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.

<u>2019 Behavioral Health Quality Stakeholder Advisory Group Accomplishments</u>

- Discussed interim HEDIS rates and shared how EPC involvement may explain the commercial and Medicaid trends. Shared how CDPHP is working with providers on adherence to anti-depressant medication.
- Provided updates on long term respite beds and shared that CDPHP currently has entered into a partnership with Catholic Charities to provide housing based on social determinants. RSS, whom CDPHP has also entered into partnership with, will purchase three beds for members who are symptomatic but not at risk.

- Discussed investing in Albany Med in an effort to coordinate a housing effort, which will eventually allow CDPHP to house members as opposed to remaining inpatient at a psychiatric ward. By housing those in need, it will reduce the overall cost of care in the long run.
- Shared ideas about value based payment and shared risk. The committee highlighted other managed care organizations and primacy care offices who were successful in implementing this platform; providers paid fee for service receive bonuses for achieving quality initiatives. Discussed how behavioral health providers have not moved on to this platform at this time. The CDPHP mission with the Medicaid redesign is to move to a value based program to fall in line with other areas of CDPHP, such as the medical unit.
- Monitored and received feedback regarding Medicaid's POC for Follow up after Emergency Department Discharge within 7 days (FUM), and educated on QARR matrixes. The committee suggested advertising HIXNY to provider offices, and embedding a CDPHP case manager in the ER at local hospitals.
- Discussed challenges of available providers for Medicaid members, and the lack of timely access to appointments. Suggestions from the committee included value based payment, rate increases for providers, and utilizing tele-mental health services to expand access and reduce no show rates and allow members' needs to be met from their home.
- Shared feedback and trends from members in the ECHO member satisfaction survey.
- Discussed the Committee Coalition, Prescription for Progress. Community partners work towards training and education for health care providers, pharmacists, and physicians on how to safely prescribe opioids as well as how to treat those who develop an addiction. CDPHP has developed a strategic plan modeled after the Health Plan of California to combat the opioid epidemic. Committee discussed how this effort includes utilizing long acting injectables and engaging members in obtaining treatment.
- Shared historical improvements in the opioid goals for CDPHP in 2017 and 2018.
- Received feedback from the committee regarding how to increase incentive offering to members. Members who qualify are targeted and offered an incentive to schedule a follow up visit within in 7 days of an emergency room visit for a mental health diagnosis. By doing this, they can receive a $50 gift card. The committee suggested sharing copies of the flyer with offices to advise CDPHP members that they can be receiving a gift card when offices call to confirm the appointment. Facilities can call CDPHP and advise of members who are coming in for follow up and exchange the card.

9. 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 P&T committee consists of practicing physicians 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 quality management committee to the board of directors.

2019 Pharmacy and Therapeutics Committee Accomplishments

- Reviewed new drug entities and new unique drug delivery systems to market for the calendar year 2019.
- 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 2019 Medicare Part D prescription drug formulary updates and the 2020 Medicare Part D formulary and utilization management tools.
- Reviewed and approved pharmacy department policies as forwarded by the policy and decision workgroup, including the review of 54 policies and the revision of 22 policies. Six policies made obsolete in 2019 and 13 new policies were created.
- Reviewed and approved the annual CDPHP clinical formulary booklets for 2019 for the commercial line of business, which are available on the public website for plan enrollees and practitioners and printed as requested.
- Reviewed the plan's 2019 Medicaid formulary and utilization management details, which are available on the website for plan enrollees and practitioners and printed as requested.
- Reviewed and approved drug utilization programs for the Medicaid formulary.
- Performed therapeutic drug class reviews for the following drug classes: treatment agents for asthma, constipation, multiple sclerosis, colony stimulating factors, pulmonary arterial hypertension and erythropoiesis stimulating agents.
- Adopted a P&T committee charter document which will be reviewed and approved annually.

The pharmacy and therapeutics committee met five times in 2019. Contemporaneous minutes were recorded for all committee activities. P&T reports directly to the Quality Management Committee.

10. 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 case 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 co-chairs with the senior vice president of healthcare quality 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 respond 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 with corrective action plan, 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 2019, the JHSC required the following delegates to report to the committee: pharmacy vendor (Caremark), dental vendor (Delta Dental for Essential Plan, State Programs and Medicare Preventive), care management (Landmark), eHealth and physician and hospital online directories vendor (HealthSparq dba Clarus Health). The committee approved 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.

2019 Joint Health Services Committee Accomplishments:

- CDPHP approved continued delegation to HealthSparq dba Clarus Health, CVS/Caremark, Landmark and our credentialing delegates and eHealth, recognized FDR CMS delegate for telesales for Medicare Advantage.
- New delegates for 2019 included Brook, WellTok, and Commission for Economic Opportunity (CEO) and Catholic Charities.
- 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, Health Alliance Physicians Organization, MagnaCare, Slocum Dickson, University of Vermont Health Network Credentialing and Enrollment (UVMHN C&E), Hudson Headwaters, University Medical Associates of Syracuse (UMAS), St. Elizabeth's Medical Center, Delta Dental, and Doctor on Demand.
- Predelegation was completed for Guthrie Medical Group (credentialing) and Hearing Care Solutions (claims management and member services)
- CDPHP completed one annual audit for Landmark Health, Delta Dental, Clarus Health, and eHealth
- CDPHP reviewed 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 fraud, waste, and abuse.
- 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 and CVS Caremark.
- Continued monitoring of adequacy of dental network and HEDIS/QARR Annual Dental Visits (ADV) rates. Delta Dental provides monthly network build reports and CDPHP monitors monthly HEDIS/QARR rates.
- CAPs implemented in third quarter 2018 and monitored throughout 2019 on Delta Dental for identified deficiencies with UM process performance in making timely determinations, timely notifications to members and providers, and a need for the organization to make corrections to letter templates in accordance with DOH regulatory standards.
- Monitored delegate notification of the process for providing member experience and clinical performance data
- Monitored delegate request for member experience and clinical performance data request.

The joint health services committee met four times in 2019. Contemporaneous minutes were recorded for all committee activities. Delegates remained in full compliance, with the exception of Delta Dental, who is approved with CAP compliance monitoring. The joint health services committee reports directly to the quality management committee.

11. 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, 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

2019 Technology Assessment and Policy Committee Accomplishments:

Technology Assessments

- Completed 2 medical technology reviews

Resource Coordination External Policies Year-End Total = 101

- Approved 7 new external policies
- Reviewed 44 existing external policies without change
- Revised 84* existing external policies
- Retired 2 existing policies

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

12. 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.

Major accomplishments of the corporate compliance and privacy programs and committee are as follows:

2019 Corporate Compliance and Privacy Committee Accomplishments:

- Corporate Compliance and SIU have formed a strategic partnership with the Healthcare Network Strategy department focused on proactive FWA concerns prior to contract negotiation with hospitals and large group practices.

I. EXECUTIVE SUMMARY

- The Office of the Medicaid Inspector General (OMIG) is currently performing a 2018 Medicaid Contract Obligations and Performance Standards Audit. Significant parts are under the responsibility of Corporate Compliance and SIU. All requested documentation was provided to New York State.
- The corporate audit department finalized the 2019 annual audit of the CDPHP corporate compliance program. Fundamental elements required by state OMIG and federal OIG and CMS law, regulations and guidelines were reviewed and tested. The audit results indicate that the current corporate compliance program environment and controls related to compliance with Medicare, Medicaid and commercial product regulations, as well as corporate policies and procedures, are satisfactory.
- The board of directors' fraud, waste, and abuse and general compliance training was conducted and board member attestations received.
- CDPHP government programs submitted the required 2019 OMIG Annual Program Integrity Report. A significant portion of this report contains detailed compliance procedures and data.
- 130 new employees, consultants, and temporary employees attended corporate compliance, privacy and FWA trainings through October 2019.
- Corporate compliance developed and implemented the 2019 online corporate compliance, FWA, and privacy training and testing module to ensure employee-wide corporate compliance competence. Continuing education was also provided throughout the year.
- Review and updates of the standards of conduct, corporate compliance, FWA, and privacy policies to ensure compliance with applicable state, federal, and accreditation requirements continue.
- Corporate compliance continues ongoing monitoring of key corporate-wide compliance, privacy, and FWA indicators/reports to assess potential non-compliance red flags.
- Ongoing investigation, documentation and corrective action of compliance, FWA, and privacy complaints and inquiries continue.
- Signed a contract with FraudScope, a vendor that uses analytics and artificial intelligence to assist with the detection of potential FWA.
- SIU has recovered and saved approximately $1,310,139 from January 2019 through September 2019. The most significant recoveries/savings were as follows:
    - $787,925 recoveries and savings relating to the split billing of hospital-owned clinic services.
    - $204,865 recoveries and savings of Ambulatory Surgery Center services that were incorrectly billed to allow payment for incidental services.
    - $174,613 recoveries and savings of miscellaneous services, such as unsupported services, duplicate billing, and unbundling of global charges.
    - $61,404 recoveries and savings from the incorrect billing of vaccines provided to children on our Medicaid plans.
    - $55,476 recoveries and savings from ambulance and paramedic services being double billed.
- Thorough September 2019 SIU has received 423 hotline calls, investigated 345 cases, and referred 20 cases to government oversight agencies.
- Detailed training concerning minor confidentiality provisions was provided to the staff and management of the CDPHP appeals and complaints department including discussions of the Federal Part 2 substance abuse regulation, the HIV/AIDS PHL provisions, and the NYS Mental Hygiene Law.
- Purpose specific privacy training was provided to CDPHP community outreach program vendors.
- Service Organization Controls (SOC) 2 certification received indicating privacy related controls were suitably designed and operated effectively during the review period with no exceptions.
- Compliance risk assessment of the HIPAA Privacy Rule conducted by Kardon, an independent third party vendor, resulting in minor edits to privacy policies/procedures.

- The annual review of CDPHP corporate privacy policies and procedures was conducted and updates/edits were made as necessary
- Additional activities added to the privacy program assessment and monitoring annual metric, including quarterly audits of privacy member rights processes and business associate contracting provisions.
- Completed further modifications to the member portal online CDPHP Release of Information Authorization form including implementation of date specific restrictions.

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

Clinical service quality teams function on an ad hoc basis for the plan and have been absorbed into a broader initiative known as Drive to 5. Participating practitioners, representing the major medical, surgical, specialties, and behavioral healthcare practitioners are available to assist and support quality activities within the plan.
These board-certified practitioners/providers may function independently, in multi-disciplinary clinical quality teams, or as a workgroup comprised of a particular specialty as needed. All other practitioner/provider types are called on as needed for quality management activities. Teams for 2019 included, Antibiotic Stewardship, medication management of people with asthma (MMA), osteoporosis screening and management after fracture (OMW), anti-rheumatic drug therapy for rheumatoid arthritis (RA) , all cause readmission (PCR), low back pain (LBP), ADHD medication management (ADD), diabetes mellitus-dilated eye exams, cancer screening for cervical, breast and colorectal, medication therapy management (MTM) for all lines of business, CMS chronic conditions improvement project (CCIP) - chronic kidney disease, NYS Kids Quality Performance Improvement Project (PIP) focused on lead and hearing and developmental assessment, and schizophrenia antipsychotic adherence (SAA), anti-depressant medication management (AMM), Follow-Up After Hospitalization for Mental Illness within 7 days (FUH), and Flu immunization. Additionally, areas of focus will include Hospital Experience, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcome Survey (HOS), Data integration with Hixny, Non-recommended Prostate Specific Antigen (PSA) screenings, HEDIS Electronic Clinical Data System (ECDS) HEDIS/QARR Measures and HARP Transition of Care.

The practitioners/providers actively assist the QMC and other quality-related committees in:

- Developing and revising preventive and clinical practice guidelines and protocols.
- Reviewing and recommending medical policies and procedures for benefit coverage by assessing medical technologies, medical intervention, or drugs in terms of effectiveness, efficacy, safety, and outcome.
- Providing expert opinions on specific specialty issues or cases.
- Performing peer review and consulting functions.
- Integrating quality activities with performance management, physician engagement, case management, disease management, and population health and wellness departments.

G. Practitioner and Provider Network

Practitioners

Practitioners	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)	Number (12/01/18)	Number (12/01/19)
Primary care physicians	3,133	2,898	3,745	3,693	3,989
Specialists including OB	9,266	5,525	10,788	6,680	8,229
Adjunct practitioners	4,220	3,913	4,677	2,190	2,517

I. EXECUTIVE SUMMARY

Practitioners	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)	Number (12/01/18)	Number (12/01/19)
EPC practitioners*	836*	850*	873*	1,002	1,100

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

Providers

Providers	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)	Number (12/01/18)	Number (12/01/19)
Hospitals	74	76	71	71	73
Skilled nursing facility	117	117	92	116	113
Home health agencies	93	88	61	64	64
Outpatient surgery centers	30	29	30	29	33
Other Including DME, lab, radiology, and pharmacy	7,016	4,820	235	1,431	562

Behavioral Health Providers/Practitioners

Practitioners	Number (12/31/14)	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)	Number (12/01/18)	Number (12/01/19)
Behavioral health	2,258	2,269	2,075	2,548	2,390	2,496

CDPHP continues to maintain a 26-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 (member experience, provider satisfaction, effectiveness, and efficiency) 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 2019, HNS continued enhancements with the network operations team to identify and develop interdepartmental processes and improve operational efficiencies. HNS continued success in provider recruitment, provider network exchange filing, implementation of several regulatory mandated initiatives, and the successful pilot of our first primary care total cost of care shared savings program.

The EPC initiative is a patient centered medical home (PCMH) model that rewards physicians for spending more time with their sickest patients by providing continuous, comprehensive, and coordinated care. In 2018, our EPC program included 195 network practice sites and 873 network clinicians caring for nearly 250,000 members across all product lines. Since its inception, the EPC program realized $20.7 million in cost savings. Approximately 60 percent of this savings was experienced by members in commercial products and 20 percent savings experienced by the sickest 10 percent of members in the Medicaid and Medicare markets.

CDPHP engages the EPC sites with physician engagement specialists (PES) to work with the providers on quality and cost of care metrics for CDPHP members.

1. Value-Based Payment Arrangements

   CDPHP is satisfied that Value Based Payment (VBP) arrangements support the needs of our network providers at this time. We will continue work to expand our VBP arrangements as opportunities for improvement are identified.

H. 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.

I. Effectiveness of Quality Program

Based on the comprehensive review and evaluation of our performance, the overall effectiveness of the 2019 quality management program, including adequacy of resources, progress toward influencing network-wide safe clinical practices, QM 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 2019, CDPHP allocated 118 diverse employees, including staff, managers, directors, medical directors, and vice presidents, whose collective time comprised 66 FTE dedicated to the quality program. Our employee talent resources represented over 2,285 years of combined health care experience and was 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 and pharmacy analytics, Enhanced Primary Care (the CDPHP PCMH model of primary care), and Clinical Care Advance (CAE) staff. Corporate analytics leads and supports all quality measurement activities, including but not limited to HEDIS, QARR, NCQA, CAHPS, HOS, ECHO, QHP and CG-CAHPS surveys EPC payment metrics, network access monitoring, practitioner gap list, and quality performance practitioner profiling.

Clinical Care Advance (CAE) application resources help improve care management workflows of medical and behavioral health management and personalized member communications (e.g., targeted campaign member mailings, telephone outreaches). Population health and wellness staff focus on member-centric quality initiatives, while our performance measurement and physician engagement teams manage practitioner/provider-centric quality initiatives. The pharmacy team supports our members through *MedCheck* (formerly known as medication therapy management program MTMP) and the pharmacy analytics team facilitated data analysis to improve quality and impact cost, formulary design, and utilization for all lines of business. The Medicare Stars team actively engaged Medicare members in managing their health care through community events and targeted member outreaches to achieve the best possible outcomes.

In addition, embedded behavioral health social workers and care managers in select EPC practices, *MedCheck* pharmacists, performance management coordinators and Medicaid innovation 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. This is evidenced by improvements in resource utilization, HEDIS, and QARR scores, and member experience survey results.

Network-Wide Safe Clinical Practices to Ensure Patient Safety: Patient safety is taken seriously by the plan. Throughout 2019, 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's or 5's (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 2019, our medical directors and 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 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.

I. EXECUTIVE SUMMARY

An added benefit to our members is *MedCheck*, a comprehensive medication safety review program conducted by a network pharmacist and is offered to all members in all product lines, not solely to Medicare members, as in previous years. Another example of improving safe clinical practice of our network is the adoption of a company-wide 2017 opioid strategy, which consists of four core elements (as adopted by the California Health Care Foundation): promoting judicious prescribing practices; promoting improved outcomes for members; identifying overuse, misuse, and fraud; and building community coalitions.

The 2019 accomplishments of the opioid strategy included:

- Development of an opioid specific prior authorization form
- Implementation of edits to heightened awareness and warn against harm of consecutive use of medications that increase the risk of respiratory depression and/or overdose
- Implemented quantity limits for benzodiazepines on the commercial and Medicaid formularies
- Partnered with Delta Dental to provide resources and education opportunities to their provider network
- Implemented an outreach program for members with a documented overdose
- Adjusted criteria used to identify providers for targeted outreach
- Implemented a process to monitor adherence to Vivitrol (injectable naltrexone) and methadone

Based on the aforementioned, CDPHP effectively promotes network-wide safe clinical practices to ensure patient safety for our members and our community.

QI Committee Structure: The CDPHP QI committee structure is comprehensive in scope, monitoring all aspects of the Quadruple Aim in 2019. 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 senior VP, CMO, and the ten 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, NYS DOH QARR Medicaid Quality Performance Action Plans, 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.

I. EXECUTIVE SUMMARY

Our community physicians actively participate in our quality program as evidenced by a total of seventy (70) practitioners actively participating in 2019 on the following committees: fourteen (14) practicing physicians served on QMC; fourteen (14) practitioners on P&T committee, eleven (11) on UMC, ten (10) on credentialing committee, eleven (11) on BH UM committee and ten (10) on BH QSAH committee.

Need to restructure or change the QI Program for 2020: After reviewing and evaluating overall performance and program effectiveness of the 2019 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 2020. While resources dedicated to the QI program are currently adequate, CDPHP continually monitors those resources to ensure they remain adequate.