JANUARY 2017

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

Capital District Physicians' Health Plan, Inc.

Quality Management Program Evaluation 2016

CDPHP®

16-2661

2016 QM PROGRAM EVALUATION
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 30 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 420,000 members in 24 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, 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.

2016 Awards and Recognition

For more than 30 years, CDPHP has taken great pride in its commitment to quality, and that continues to show as six of the company's health plans are among the top-rated in the nation according to NCQA's Health Insurance Plan Ratings 2016–2017.

In fact, two of the plans – Capital District Physicians' Health Plan, Inc. (HMO) and Capital District Physicians' Healthcare Network, Inc. (HMO/POS) – are the only private plans in New York State to receive an overall 5 out of 5 rating.

Below is a breakdown of how all CDPHP plans are rated for 2016-2017.

NCQA's Private Health Insurance Plan National Ratings 2016-2017

- Capital District Physicians' Health Plan, Inc. (HMO): 5 out of 5 – top-rated in NYS
- Capital District Physicians' Healthcare Network, Inc. (HMO/POS): 5 out of 5 – top-rated in NYS
- Capital District Physicians' Healthcare Network, Inc. (PPO): 4.5 out of 5
- CDPHP Universal Benefits, Inc. (PPO): 4.5 out of 5

NCQA's Medicaid Health Insurance Plan National Ratings 2016-2017

- Capital District Physicians' Health Plan, Inc. (HMO): 4.5 out of 5 – top-rated in NYS

NCQA's Medicare Health Insurance Plan Ratings 2016-2017

- Capital District Physicians' Health Plan, Inc. (HMO): 4.5 out of 5
- CDPHP Universal Benefits, Inc. (PPO): 4 out of 5

Centers for Medicare & Medicaid Services (CMS) – 2016- 2017 Medicare Overall Stars Ratings

- CDPHP Medicare PPO earned quality rating of 5.0 out of 5 Stars
- CDPHP Medicare Choices HMO earned quality rating of 4.5 out of 5 Stars

The National Committee for Quality Assurance (NCQA) annually evaluates health plan accreditation status based on a recalculation of HEDIS and CAHPS scores, and in 2016 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 2016. The CDPHP NCQA Health Plan Accreditation for all accredited entities is effective through May 2018.

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

CDPHP continues 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 will continue to introduce and promote innovations in care and population management, leading the move to value-based payment as the true partner with our physician network and providing expertise and resources to aid in their move to new payment methodologies. CDPHP has emerged as a leader for practice transformation and training care management resources by offering unique approaches to population health. CDPHP seeks to form partnerships with organizations that can bring value in the shared goals of the Triple Aim.

Health Value

The CDPHP board of directors and management team are committed to making CDPHP one of the leading not-for-profit health plans in the country that's 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 Triple Aim of improved health, improved member experience, 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.

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 and grow enrollment
- Improve the health and economic well-being of our community
- Be a leader in service, quality, and clinical management and keep pace with innovation in customer tools
- Build on our trust with internal and external stakeholders

In this document, the CDPHP 2016 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 management. 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 *2017 QM Program Description and 2017 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 2016 QI 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 2016 were completed and yearly objectives were met. Thus, the quality management program is effective and will not require any restructure in 2017.

D. Quality Management 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 2016.*

E. Quality Management Program Resources

The following resources were dedicated to the Quality Management Program in 2016.

Job Title	**Number of Staff**	**Number of FTEs Dedicated**	**Aggregate Years of Experience**
MD—Senior Vice President, Chief Medical Office	1	0.30	33
MD—Vice President, Senior Medical Director-MPH	1	0.75	35
MD—Medical Directors	3	1.00	68
MD—Medical Director Behavioral Health—MD, MBA	1	0.35	18
Vice President, Behavioral Health—MBA	1	0.40	38
Director, Behavioral Health	1	0.75	26
Senior Vice President, Chief Pharmacy Officer/Quality—RPh, MBA	1	0.60	36
Vice President, Health Care Quality—MS, RN, NE-BC	1	1.00	30
Senior Vice President, Medical Affairs Operations—RN	1	0.40	37
Vice President, Healthcare Network Strategy	1	0.20	26
Senior Vice President, Corporate Analytics—MBA	1	0.25	28
Director, Clinical Informatics—MD, MA, MS	1	0.50	28
Managers, Informatics-MPH	2	0.75	38
Lead Pharmacy Analyst—PhD	1	0.25	10
Lead Health Informatics Analysts	2	1.50	55
Health Informatics Analysts	6	3.75	79
RN—Director, Quality Review and Measurement—BSN	1	1.00	42
LMSW- Director, Quality Medicaid Innovation	1	0.75	6
Medicare Stars Administrator	1	1.00	27
RN—Manager, Accreditation and Quality Programs—MBA	1	1.00	31
RN—Medicare Stars Nurse	1	1.00	37
RN—Quality Review Nurses	3	3.00	84

RN—Clinical Quality Improvement Educators	1	2.00	36
Director, Credentialing and Appeals—BS	1	1.00	28
Coordinator, Member Complaints	1	1.00	5
RN—Clinical Appeals Specialists	3	3.00	104
Appeals Specialists	2	2.00	48
RN—Director, Utilization Review and Ambulatory Coding—CPHQ	1	0.40	35
RN—Director, Care Management—CCM	1	1.00	28
Administrators Care Management—RN, MBA (1); LPN (1)	2	2.00	46
Director, Pharmacy/Quality—RPh	1	1.00	26
Medicare Stars Pharmacist	1	0.50	23
RPh—Managed Care Pharmacists	5	2.00	143
Manager, Formulary and Clinical Operations	1	0.30	27
Manager, Medicare Pharmacy Programs	1	0.75	25
Job Title	**Number of Staff**	**Number of FTEs Dedicated**	**Aggregate Years of Experience**
Manager, Physician Engagement	1	0.50	25
Physician Engagement Specialists	3	0.75	70
Director, Ancillary Contracting, Healthcare Network Strategy	1	0.50	20
Director, Physician Contracting, Healthcare Network Strategy	1	0.50	20-
Physician, Facility Contract Negotiators	4	0.15	40
Director, Performance Management	1	0.35	30
Performance Measurement Coordinators	6	3.00	90
Director, Provider Services	1	0.10	22
Manager, Provider Services	1	0.10	16
Manager, Provider Registry	1	0.75	16
Manager, Credentialing	1	0.75	29
Lead Credentialing Specialist	2	2.00	25
Credentialing Specialists	5	5.00	70
Provider Registry Specialists	6	6.00	51
Director, Population Health and Wellness—MS, CHES	1	0.50	21
Manager, Population Health and Wellness—MS	1	0.50	19
Health Promotion Team Lead—MS	1	0.25	9
Health Promotion Specialists—MS (2), CHES(3); MPH (1) CDE(1); MBA(1); BS(1) RD(2)	5	2.50	70
Health Promotion Coordinator—LPN	1	0.50	15
Population Health and Wellness Specialists—MPH	2	0.755030	22
Population Health Assistant—MPH	1	1.0	5
Senior Editor—Communications	1	0.15	14

In addition to staff resources, data resources include claims, encounters data, enrollment, HRAs, complaints, grievances and appeals, UM and pharmacy data, MTMP, utilization of services, medical record data elements, HEDIS, QARR, enhanced primary care (EPC) performance

metrics, member satisfaction data, including Medicare and Medicaid, practitioner surveys, HOS, ECHO, CAHPS, QHP and 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 improved interim HEDIS reports (MY 2016) to run an actionable gap list to help move low-performing practitioners on high impact HEDIS measures, particularly our Enhanced Primary Care (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 Enhanced Primary Care (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 Medication Therapy Management Programs (MTMP) 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 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 vice president of health care quality 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 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 as the responsible entity for the oversight and management of all quality-related activities, including developing, implementing, and overseeing the quality improvement program. The Quality Management Committee, 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 vice president/senior medical director, subject to board approval, for a three-year term and may be reappointed. The vice president of health care quality, the accreditation and quality program manager, the director of quality review and measurement, and the manager of informatics are also on the committee. Additional plan staff serve as ad hoc staff to the committee as needed.

The Quality Management Committee met six times in 2016. Contemporaneous minutes are recorded for all committee activities. The Quality Management Committee reports regularly to the Board of Directors, which has ultimate responsibility for the Quality Management Program. The Quality Management Committee is accountable to and receives regular recommendations from the Board.

<u>Responsibilities of the Quality Management Committee include:</u>

- 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
    - Physician and specialist incentive programs
    - Member accessibility to the plan
    - Clinical quality safety measures
    - Service quality measures
    - Clinical quality review (CQR) of practitioners
    - 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 down steam entities (FDRs)
    - Practitioner medical record and 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
- Submit regular reports of QM activities to the Board of Directors

<u>2016 Quality Management Committee Accomplishments:</u>

- Reviewed and approved the 2015 *Quality Management Evaluation* and the 2016 *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 all submitted meeting minutes and policy reviews from reporting committees.
- Reviewed and approved all quality management 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 pre-delegation assessment audits, delegation agreements, on-site reviews, and ongoing delegation oversight activities for all delegated entities, including first down steam 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 all continuity and coordination of care initiatives.
- Reviewed and approved all patient safety initiatives.
- Reviewed and approved utilization of Ingenix Impact Intelligence® for financial, clinical, and provider network management.
- 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 and approved quality studies regarding the continuity and coordination and of care between medical and behavioral healthcare providers.
- 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 2017 (measurement year 2016).
- 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 (see section X).
- Reviewed and approved final grading of all CQR quality of care cases initially graded as Level 4 or Level 5.
- Provided oversight to the Behavioral Health Management Program.
- Reviewed and approved the implementation of the Medicaid Health and Recovery Program (HARP), for eligible Medicaid members.
- Reviewed progress on the high-tech imaging medical necessity program as managed through eviCore Health Services.
- Reviewed and monitored Centers for Medicare & Medicaid Services (CMS) Quality Improvement Project (QIP), 2016 CMS QIP regarding promoting effective management of chronic disease. Recommended focus on CHF.
- Reviewed and monitored CMS Chronic Care Improvement Project (CCIP), a five-year study with Health Dialog on reducing cardiovascular risk in Medicare members with diabetes mellitus and coronary heart disease who are at moderate/low risk.
- Monitored continued compliance with National Committee for Quality Assurance (NCQA) 2016 and 2017 health plan accreditation standards and requirements.
- Provided suggestions and changes to be incorporated into the EPC and providers online public reporting of member satisfaction with PCP and hospital performance data.
- Monitored the progress of NYS Performance Improvement Project (PIP) on smoking cessation for Medicaid members.

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. The Credentials Committee reports to the Quality Management Committee. This committee also establishes and monitors practitioner and provider access and availability standards.

The Credentials Committee is co-chaired by a medical director, as designated by the Senior Vice President, Chief Medical Officer. The committee membership meets at least six times per year and is appointed by the Senior Vice President, Chief Medical Officer, 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 director of credentialing and appeals along with the credentialing supervisor and team leader are also on the committee.

2016 Credentials Committee Accomplishments:

- Reviewed and approved all current credentialing program policies and procedures.
- Made recommendations for 2,327 initial credentialing applications.
- Made recommendations for 3,700 recredentialing applications.
- Reviewed and approved all delegated credentialing activities.
- Implemented Docusign for electronic signature to obtain quorum when needed.
- Continued to support ongoing network development and recruitment of practitioners and providers into the CDPHP network.

The Credentials Committee met eight times in 2016. 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 for corrective action as appropriate.

The UMC also serves as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.

The UMC meets on a bi-monthly basis and is chaired by a medical director who has a primary focus in UM, as designated by the senior medical director, and consists of participating primary care and specialist physicians. The committee reports through the QMC to the board of directors. The vice president of medical affairs operations, managers of resource coordination, and vice president of behavioral health serve as staff to the UMC.

<u>2016 Utilization Management Committee Accomplishments:</u>

- Reviewed and approved the 2016 *Resource Coordination Program Description.*
- Reviewed and approved the 2015 *Resource Coordination Program Evaluation.*
- Reviewed and approved use of MCG, Hayes, Inc. including the addition of Hayes Technology Prognosis Service, ASAM Patient Placement Criteria, and Care Advance Enterprise Standard Content Package for use by our medical management programs for 2016.

- Review and approval of resource coordination external policies as forwarded by the Policy Committee:
    - Reviewed 35 existing policies
    - Revised 89* existing policies
    - Approved two new policies
    - Retired two existing policies
    - Reviewed and supported the technology assessment team's recommendations on six 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 case management program activities.
- Monitored disease management program activities.
- Monitored activities of the Behavioral Health subcommittee.
- Monitored inpatient, ER, and ambulatory office visit utilization on a year-to-date basis for both medical and behavioral health.
- Approved the monitoring of plan-wide, product-specific, and practitioner site under- and over-utilization, including actions taken and recommendations for 2016.
- Monitored medical affairs service indicators in relation to established goals.
- Reviewed 2015 physician satisfaction with the utilization management process and approved all recommendations and goals for 2016.
- Provided oversight of updates to ClaimCheck, a software based code-auditing tool.
- Monitored ICD-10 compliance activities.
- Reviewed the 2015 member satisfaction survey results (member satisfaction with the UM process) for our HMO/POS, PPO, Medicaid, and Medicare lines of business and approved actions taken and those recommended for 2016.
- Monitored the changing populations served by our Medicaid managed care product and CDPHP initiatives associated with these populations.
- Reviewed and approved the behavioral health ECHO survey results and proposed actions to be taken.

- Monitored Landmark Health, a new participating provider program that provides in-home health care services to those with poly-chronic health conditions.
- Reviewed CDPHP utilization of sleep management services and approved a plan to revise our current policy.
- Monitored negotiations with our highest volume oncology group to ensure adequate patient access for services.
- Monitored activities of our delegated partner, MedSolutions, related to medical necessity review of high-tech imaging.
- Monitored the escalating pharmaceutical trends and actions taken by the plan.
- Evaluated multiple utilization trends, including procedure-specific audit results.
- Monitored CDPHP's standing with multiple accreditation/regulatory organizations.

The Utilization Management Committee met six times in 2016. 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

Participating providers, representing the behavioral health specialties, provide advice and recommendations concerning utilization management related to behavioral health, as well 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 abuse treatment. Committee minutes are reported to the UMC, QMC, and then to the board of directors.

<u>2016 Behavioral Health Utilization Management Committee Accomplishments:</u>

- Reviewed and discussed the Medicaid redesign overview.
- Reviewed payment policies, formulary updates, antipsychotic, antidepressant, and ADHD medication utilization trends, step through policies, and prior authorization rules.
- Reported QARR results have increased significantly enough to show an upward trend compared to health plan peers across New York state.

- Reviewed HEDIS 2016 BH rates and received suggestions for improvement initiatives.
- Reviewed the updated ambulatory review process, which reviews high-utilization cases and provides recommendations regarding care.
- Reviewed UM key indicators.
- Reviewed ECHO survey results.

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 shall submit results of its activities to the Utilization Management committee, which reports through the Quality Management committee to the Board of Directors.

<u>2016 HARP Utilization Management Committee Accomplishments</u>

- Reviewed and discussed the Medicaid redesign HARP overview and all new services covered by CDPHP.
- Reviewed the updated ambulatory review process, which reviews high-utilization cases and provides recommendations regarding care.
- Educated the committee on new HARP reports consisting of utilization of Buprenorphine, Vivitrol, methadone, and members on two or more antidepressants, antipsychotics, and ADHD medications. Also created reports to identify HARP members who smoke.

7. HARP Quality Stakeholder Advisory Group

The HARP Quality Stakeholder Advisory Group (QSAG) shall be chaired by the Behavioral Health Medical Director and led by the Behavioral Health Quality Management Administrator; will meet at least quarterly; will report to the HARP UM Committee; and will maintain records documenting attendance, findings, recommendations, and actions. It will be responsible for carrying out the planned activities of the HARP Behavioral Health Quality Management program and be accountable to and report 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, RPC, and/or other member-serving agencies. Satisfaction of this requirement is met by the creation of the HARP QSAG, which will report to the HARP UM Committee.

2016 HARP Quality Stakeholder Advisory Group Accomplishments

- Reviewed and discussed the Medicaid redesign HARP overview.
- Demonstrated how CDPHP assists with the coordination and continuity of care between behavioral health providers, medical providers, and HARP members. The Advisory Group also discussed how CCBH behavioral health and CDPHP medical case managers and inpatient care coordinators are integrated internally through clinical rounds, sharing co-managed/comorbid cases, and working with Health Homes.
- Reviewed the purpose of the behavioral health HARP member satisfaction survey.
- Discussed HARP performance improvement project that will be announced by New York State concerning transitions of care.
- Reviewed level of service determination criteria and OMH benchmarks for HCBS.

8. Quality Stakeholder Advisory Group

The Quality Stakeholder Advisory Group (QSAG) shall be chaired by the Behavioral Health Medical Director and led by the Behavioral Health Quality Management Administrator; will meet at least quarterly; will report regularly to the Behavioral Health UM Committee; and will maintain records documenting attendance, findings, recommendations, and actions. It will be 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 shall review the findings of BH-specific quality improvement initiatives (QIAs), performance improvement projects and focused studies.

2016 Quality Stakeholder Advisory Group Accomplishments

- Reviewed and discussed the Medicaid redesign HARP overview.
- Demonstrated how CDPHP assists with the coordination and continuity of care between behavioral health providers, medical providers, and members. The Advisory Group also discussed how behavioral health and medical case managers and inpatient care coordinators are integrated internally through

clinical rounds, sharing co-managed/co-morbid cases, and working with Health Homes.
- Reviewed the purpose of the behavioral health member satisfaction ECHO survey.
- Discussed CDPHP performance improvement projects, how policies are developed, and telephonic average speed of answer, telephone abandonment rates, authorization turnaround times, clinical practice guidelines, and OMH benchmarks.

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 medical affairs representatives, the vice president of clinical integration/chief pharmacy officer, director 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 every other month with a recess in August. Committee minutes are forwarded through the Quality Management Committee to the board of directors.

<u>2016 Pharmacy and Therapeutics Committee Accomplishments:</u>

- Reviewed new drug entities and new unique drug delivery systems to market for the calendar year 2016.
- 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 2016 Medicare Part D prescription drug formulary updates and the 2017 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 20 policies and the revision of 34 policies. No policies were made obsolete in 2016 and five new policies were created.
- Reviewed and approved the annual CDPHP clinical formulary booklets for 2016 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 2016 Medicaid formulary and utilization management details, which are available on the website for plan enrollees and practitioners and printed as requested.
- Evaluated the need for an oncology and rheumatology workgroup to be formed with Plan specialists in these fields to examine treatment options for enrollees needing these services.
- Reviewed the current and future Federal and New York State legislation for the prevention of opioide abuse and the treatment of enrollees with substance abuse disease. Approved updates to the Plan's formularies to meet this legislation and treatment needs for enrollees.
- Continued to review and evaluate treatment diabetic treatment options including the anticipated availability of a biosimilar product for Lantus.
- Reviewed biosimilar technology and product availability.
- Evaluated the Plan's Medication Therapy Management program with input from committee members on ways to increase the Plan enrollees' participation in this program.

The Pharmacy and Therapeutics Committee met five times in 2016. 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, high-tech imaging medical necessity program, Medicaid dental services, NYS health homes, credentialing and recredentialing delegates at specific sites, and select vendors.

The vice president of healthcare quality or designee leads the JHSC meeting and other members include representatives from the delegated entities and the CDPHP delegation team, including a medical director, quality, appeals/grievances, resource coordination, behavioral health, credentialing, customer service, government programs, corporate compliance, information technology security, vendor management, corporate analytics and network 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. 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.
- 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 (SIU) and information security and 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.
- Review annual oversight reports of delegated activities, including disaster plans, HIPAA HITECH breaches, SSAE16 SOC1 and SOC2, corporate compliance program, FWA, and privacy programs.

As part of delegation oversight and coordination of delegated activities, in 2016, the JHSC required the following delegates to report to the committee: pharmacy vendor (Caremark), high tech radiology (MedSolutions/eviCore), dental vendor (DentaQuest), care management (Landmark), NYS health homes, disease management vendor (Health Dialog), rare chronic disease vendor (Accordant), and physician and hospital online directories vendor (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.

2016 Joint Health Services Committee Accomplishments:

- CDPHP approved continued delegation to Health Dialog, Healthplex, Accordant, Clarus Health, CVS/Caremark, Landmark, NYS health homes, DentaQuest and our credentialing delegates for 2016.
- CDPHP approved an updated delegated agreement in 2016 for eviCore to review clinical information for requested high-tech radiology services and render a medical necessity decision; approval or denial of service regarding

whether a service meets evidence-based radiology UM clinical criteria for all product lines including Medicare.

- CDPHP reviewed and approved new programs/initiatives pertaining to collaboration of care and disease management.
- 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, Private Healthcare Systems (PHCS), Slocum Dickson, Vermont Managed Care/VMC, Hudson Headwaters, UMAS and St. Elizabeth's Medical Center.
- CDPHP completed one annual comprehensive delegation oversight audit for each delegate, including CVS/Caremark, MedSolutions/eviCore, DentaQuest, Clarus Health, Health Dialog, Accordant, and the NYS health homes.
- 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.
- Pre-delegation assessment conducted for potential health home delegates.
- Reviewed and approved pre-delegation assessment and delegated agreement of Community Care Behavioral Health (CCBH) to case manage BH care of our Medicaid HARP population
- CDPHP reviewed health home delegates: Ellis Care Central, Schenectady VNA, Capital Region Health Connection (Samaritan/Troy) Health Home, and St. Mary's Health Home for CDPHP NYS Medicaid-eligible members.
- CDPHP implemented calibrated call monitoring with Health Dialog, Accordant, and CVS Caremark.
- MagnaCare remains in a CAP regarding the recredentialing files; ongoing audits conducted by CDPHP throughout 2016, with noted improvement.
- In Q 2 2016, implemented and monitored throughout 2016 CAPs for eviCore regarding the required content in Medicare initial denial decision letters, including P2P, and required content in appeal letters.
- In Q2 2016, CAPs implemented and monitored throughout 2016 for DentaQuest on quarterly reporting of dental network adequacy, submission of duplicate claims causing the file to error and removing terminated dentists from the online dental network directory.
- Non-renewal on Accordant's vendor and delegation contracts due to ROI performance, effective 12/31/16.

The Joint Health Services Committee met four times in 2016. Contemporaneous minutes were recorded for all committee activities. Majority of delegates remained in full compliance, with the exception of MagnaCare, eviCore and DentaQuest, who are approved with CAP compliance monitoring. The Joint Health Services Committee reports directly to the Quality Management Committee.

11. Technology Assessment and Policy Development Committee

CDPHP has partnered with Independent Health (IH), a Buffalo based non-for-profit health plan, to combine efforts in seeking innovative ways to improve our technologies and manage resources effectively. As a result, the process for review of emerging medical and behavioral health technologies is a collaborative effort shared by both health plans.
The CDPHP medical affairs division and IH medical management-health care services are responsible for ensuring the systematic and timely review of evolving medical and behavioral health technologies provided to the CDPHP/IH membership. This includes evaluation of new medical and behavioral health technologies, as well as new applications for existing technologies.

The CDPHP and IH technology assessment teams consist of medical directors (physicians), medical policy analysts (registered nurses), and additional appointees as directed for each respective team. The team is chaired by a medical director from both organizations and is performed on a rotating basis, depending on whose turn the responsibility for presentation of research lies with. The medical policy analyst from each organization share, on a rotating basis, responsibility 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/IH technology assessment teams. 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. Determining the effectiveness of technology based on scientific evidence from published clinical research, and the need for development of a new policy, is based upon consensus from both teams. Draft policies developed to address coverage or non-coverage of a technology are presented to and reviewed by each organization's individual policy committee for approval.

The CDPHP Policy Committee is a multidisciplinary team, chaired by the vice president of medical affairs operations, 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

2016 Technology Assessment and Policy Committee Accomplishments:

Technology Assessments

- Completed six medical technology reviews (CDPHP review only)

Resource Coordination External Policies Year-End Total = 91

- Created six new external policies
- Reviewed 47 existing external policies without change
- Revised 79* existing external policies
- Retired three 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:

2016 Corporate Compliance and Privacy Committee Accomplishments:

- The New York State Office of the Medicaid Inspector General (OMIG) conducted a comprehensive desk audit review of the CDPHP Compliance Program. No findings were cited.
- Rescission policy and procedure was established documenting current practice regarding the prohibition of rescissions of enrollment in accordance with Federal Affordable Care Act (ACA) and applicable state and federal regulations.
- Mandated CMS changes to the Corporate Compliance and Fraud, Waste and Abuse training were implemented for employees and delegates.
- OMIG has developed a new Managed Care Organization Annual Program Integrity Report. The first annual report covering the 2016 calendar year is due by January 31, 2017. This report requires reporting from Corporate Compliance, Medicaid Compliance and Operations, SIU and Corporate Audit on a myriad of the Medicaid state contract compliance program and FWA activities. Preliminary report is drafted and will be finalized with end-of-year data.
- A cross-departmental team was assembled and requirements implemented to comply with the ACA non-discrimination rule.
- The employee, board, and vendor debarred check process was redesigned and implemented.

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- Approximately 170 new employees, consultants, and temporary employees attended Corporate Compliance, Privacy, and FWA trainings through October 2016.
- Corporate Compliance developed and implemented the 2016 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.
- SIU has recovered and saved $1,416,000 year-to-date 2016. The most significant recoveries/savings are as follows:

    - Recovered $406,475 in an overpayment to a facility discovered to be split billing services for both the facility location and office location.

    - Recovered $210,000 from a facility billing operating room services for wound care services performed in an office setting. Adjustments of an additional $100,000 will be recovered in the beginning of 2017.
    - $233,791 in recoveries and savings of miscellaneous services such as providers billing for self-treatment, up-coding of E&M services, billing for injectable not provided, and facility non-covered cosmetic services.
    - Recovered $150,000 from an Anesthesia group billing minutes for anesthesia when not in attendance during labor.
    - Recoveries for services billed beyond the capped rental oxygen concentrator policy totaled $87,268.
    - Recovered $73,163 from multiple DME providers billing beyond the rental-to-purchase policy limitations.
    - Recovered $22,000 from the Medicaid consumer-directed personal care aide program for billed dates that members were inpatient.

- Through October 2016, SIU has received 478 hotline calls, investigated 326 cases, and referred 63 cases to government oversight agencies.
- SIU has participated in quarterly task force meetings to coordinate activities with the following agencies: Office of the NYS Medicaid Inspector General, Northern District of NY US Attorney's Health Care Task Force, FEHB Task Force and the NYS Attorney General's Office. Participated in CMS fraud, waste and abuse quarterly webinars.
- A specific HIPAA compliant Authorization to Release Health Information for HSA Account Claims Disclosures form was developed to enable the necessary exchange of member claims-specific information from CDPHP to HealthEquity, a third-party Health Savings Account (HSA) vendor.
- The Confidentiality of Behavioral Health Information policy was created to ensure the confidentiality of substance abuse and mental health information with detailed provisions on minor confidentiality, specific written authorizations, and appropriate safeguards.
- The CDPHP Corporate Compliance department initiated a comprehensive inventory of CDPHP business associates' files to update the associated business owners, verify the status of respective service agreements, and collect, where appropriate, finalized contractual documentation.

- Ongoing review of privacy member rights usage (access, accounting, confidential address, and restriction/amendment requests) to ensure proper functioning and compliance with the privacy program continues.

13. Clinical Service Quality Teams

Clinical service quality teams function on an ad hoc basis for the plan. 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 2016 included the Radiology Workgroup, Avoidance of Antibiotics for Acute Bronchitis, ADHD, and the in Q3 started a team on the Use of Medical Imaging for Low Back Pain.

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

The Radiology Workgroup continued efforts on addressing cost and utilization of high-tech medical imaging, which impacts the quality of care and services delivered by our network. A full medical necessity program for high-tech medical imaging was successfully implemented by eviCore (formerly MedSolutions) in the spring of 2015. On 1/1/16 the Medicare line of business was added to this medical necessity program. The work group remains vigilant in monitoring the clinical criteria based upon acceptable clinical-based evidence and the progress of the implementation throughout the provider network with a multidisciplinary team and eviCore.

The Avoidance of Antibiotics for Acute Bronchitis, ADHD, and Use of Medical Imaging for Low Back Pain clinical teams focused on the practitioner clinical performance data, HEDIS measure specifications and exclusions in order to better understand how to improve EPC and Non-EPC practitioner performance and member compliance with meeting these clinical measures to ultimately improve member outcomes.

G. Practitioner and Provider Network

Practitioners

Practitioners	Number (12/31/14))	Number (9/30/2015)	Number (12/31/2016
Primary Care Physicians	3,471	3,133	2,898
Specialists Including OB	8,937	9,266	5,525
Adjunct Practitioners	3,090	4,220	3,913
EPC Practitioners*	485*	836*	850*

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

Providers

Providers	Number (12/31/14)	Number (9/30/2015)	Number (12/31/2016)
Hospitals	80	74	76
Skilled Nursing Facility	110	117	117
Home Health Agencies	96	93	88
Outpatient Surgery Centers	31	30	29
Other Including DME, Lab, Radiology, and Pharmacy	7,014	7,016	4,820

Behavioral Health Providers/Practitioners

Practitioners	Number (12/31/14)	Number (9/30/2015)	Number (12/31/2016)
Behavioral Health	2,258	2,269	2,075

CDPHP continues to maintain a 24-county service area. During 2016, the overall strategic goal was to align with providers in progressive population management payment models that promote and incentivize pay for value, cost efficiencies, patient satisfaction, and quality care, while maximizing operational effectiveness and lower medical cost trend. We also implemented quality incentive programs to work closely with our hospital provider to enhance the quality of care.

The Enhanced Primary Care (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 2015, our EPC program included 193 network practice sites and 836 network clinicians caring for 242,066 members across all product lines. Final EPC data for 2016 is pending as of the writing of this report. Since its inception, the EPC program realized $20.7 million in cost savings. Approximately, 60% of this savings was experienced by members in commercial products and 20% savings experienced by the sickest 10 percent of members in the Medicaid and Medicare markets.

CDPHP engages the EPC sites with performance management coordinators (PMC) to work with the providers on quality and cost-of-care metrics for CDPHP members. In addition, physician engagement specialists engage and educate the provider offices on lower pharmacy spend opportunities and strategic CDPHP cost-of-care initiatives.

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.

2016 QM PROGRAM EVALUATION
EXECUTIVE SUMMARY

I. Effectiveness of Quality Program

Based on the comprehensive review and evaluation of our performance in all aspects of the QI program, the overall effectiveness of the 2016 Quality Management Program, including progress toward influencing network-wide safe clinical practices and oversight of first-tier downstream and related delegated entities (FDRs), proved to be strong.

Our Quality Management Committee and organizational committee structure continue to provide comprehensive review, oversight, and planning of our QI program and quality initiatives through effective physician involvement and leadership for the organization and its affiliates. All of our quality improvement initiatives functioned well and resources were adequately allocated to carry out our QI work plan goals for 2016, including the programs that deal with safe clinical practices of our network—e.g., pharmacy and therapeutics, practitioner access and availability, site evaluations, medical staff review of new and evolving medical and behavioral health technology, high tech medical imaging, health homes, enhanced primary care, focused care to our sickest member population through Landmark and EPC practices, complaints and appeals, clinical quality reviews, member satisfaction, and ongoing credentialing monitoring of our clinical network.