JANUARY 2018

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 2017

CDPHP®

17-6231

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 400,000 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.

2017 Awards and Recognition

For more than 30 years, CDPHP has taken great pride in its commitment to quality, and that continues to show according to NCQA's Health Insurance Plan Ratings 2017–2018.

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

Below is a breakdown of how all CDPHP plans are rated for 2017-2018.

- **NCQA's Medicaid Health Insurance Plan Ratings 2017-2018**
  - Capital District Physicians' Health Plan, Inc. (HMO): **4.5 out of 5** – *top-rated in NYS*
- **NCQA's Private Health Insurance Plan Ratings 2017-2018**
  - Capital District Physicians' Health Plan, Inc. (HMO): **4.5 out of 5**
  - Capital District Physicians' Healthcare Network, Inc. (HMO/POS): **4.5 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 2017-2018**
  - 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) – 2017- 2018 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 2017 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 2017. 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

CDPHP will continue 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 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 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

Build morale internally and trust externally

In this document, the CDPHP 2017 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 *2018 QM Program Description and 2018 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 2017 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 2018.

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 2017.*

E. Quality Management Program Resources

The following resources were dedicated to the Quality Management Program in 2017.

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
MD—Senior Vice President, Chief Medical Office-MPH	1	0.30	36
MD—Medical Directors	4	1.25	68
MD—Medical Director Behavioral Health—MD, MBA	1	0.35	19
Vice President, Behavioral Health—MBA	1	0.40	39
Director, Behavioral Health	1	0.75	27
Senior Vice President, Chief Pharmacy Officer/Quality—RPh, MBA	1	0.60	37
Vice President, Health Care Quality—MS, RN, NE-BC	1	1.00	31
Senior Vice President, Medical Affairs Operations—RN	1	0.40	38
Vice President, Healthcare Network Strategy	1	0.20	27
Vice President, Corporate Analytics	1	0.25	24
Vice President, Clinical Informatics—MD, MA, MS	1	0.50	29
Managers, Informatics-MPH	2	0.75	40
Manager, Pharmacy Analyst—PhD	1	0.25	11
Lead Health Informatics Analysts	2	1.50	57
Health Informatics Analysts	6	3.75	85
Director, Healthcare Quality—BSN, RN	1	1.00	43
Director, Medicaid Innovation	1	0.75	7
Medicare Stars Administrator	1	1.00	28
Manager, Accreditation and Quality Program—MBA, RN	1	1.00	32
Team Lead Quality Nurse- RN	1	1.00	38
RN—Quality Review Nurses	3	3.00	88
RN—Clinical Quality Improvement Educator	1	2.00	37
Director, Credentialing and Appeals—BS	1	1.00	29
Coordinator, Member Complaints	1	1.00	6
RN—Clinical Appeals Specialists	3	3.00	107
Appeals Specialists	2	2.00	50
Director, Resource Coordination- MNS, RN	1	0.40	35
Director, Care Management—CCM, RM	1	1.00	29
Administrators Care Management—RN, MBA (1); LPN (1)	2	2.00	48
Director Pharmacy/Quality—RPh	1	1.00	27
Medicare Stars Pharmacist	1	0.50	24
RPh—Managed Care Pharmacists	5	2.00	148
Manager, Formulary and Clinical Operations	1	0.30	28
Manager, Medicare Pharmacy Programs	1	0.75	26
Manager, Physician Engagement	1	0.50	-
Physician Engagement Specialists	3	0.75	73
Director, Ancillary Contracting, Healthcare Network Strategy	1	0.50	21
Director, Physician Contracting, Healthcare Network Strategy	1	0.50	21

The following resources are dedicated to the Quality Management Program for 2017 (continued):

Job Title	Number of Staff	Number of FTEs	Aggregate Years of Experience
Director, Physician Engagement/Performance Management	1	0.35	21
Performance Measurement Coordinators	2	0.75	46
Director, Provider Services	1	0.10	23
Manager, Provider Services	1	0.10	17
Manager, Provider Registry	1	0.75	12
Lead Credentialing Specialist	2	2.00	25
Credentialing Specialists	5	5.00	72
Director, Population Health and Wellness—MS, CHES	1	0.50	22
Manager, Population Health and Wellness—MS	1	0.50	20
Health Promotion Team Lead—MS	1	0.25	10
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	0.75	22
Senior Editor—Communications	1	0.15	15
Temporary HEDIS Nurses- RN	17	17.00	255

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 2017) 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) through 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 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 (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 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 health care quality, and the manager of quality 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 2017. 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.

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
    - 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 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
- Submit regular reports of QM activities to the Board of Directors

2017 Quality Management Committee Accomplishments:

- Reviewed and approved the 2016*Quality Management Evaluation* and the 2017 *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 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) and complaint monitoring.
- Reviewed and approved final grading of all CQR quality of care cases initially graded as Level 4 or Level 5; however, no cases fell into 4 or 5 grading in 2017.
- 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 continuity and coordination of care initiatives.
- Reviewed and approved l 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 2018 (measurement year 2017).
- 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.
- Review and approve final grading of all CQR quality of care cases initially graded as Level 4 or Level 5; however, no cases fell into 4 or 5 grading in 2017.
- Provided oversight to the Behavioral Health Management Program.
- Reviewed and approved the Medicaid Health and Recovery Program (HARP), for eligible Medicaid members.
- Reviewed and monitored Centers for Medicare & Medicaid Services (CMS) Quality Improvement Project (QIP), 2017 CMS QIP regarding promoting effective management of chronic disease Study focused on CHF in Landmark engaged cohort.
- Reviewed final report of 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.
- 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.
- Monitored continued compliance with National Committee for Quality Assurance (NCQA) 2017 and 2018 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. 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 project oversight manager and team leader are also on the committee.

<u>2017 Credentials Committee Accomplishments:</u>

- Reviewed and approved all current credentialing program policies and procedures.
- Made recommendations for 2,883 initial credentialing applications.
- Made recommendations for 3,558 recredentialing applications.
- Reviewed and approved all delegated credentialing activities.
- Implemented telephonic credentialing committee meetings.
- Continued to support ongoing network development and recruitment of practitioners and providers into the CDPHP network.

The Credentials Committee met seven times in 2017. 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 as designated by the chief medical officer, senior vice

president medical affairs, 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 medical affairs operations, managers of resource coordination, and vice president of behavioral health serve as staff to the UMC.

2017 Utilization Management Committee Accomplishments:

- Reviewed and approved the 2017 *Resource Coordination Program Description.*
- Reviewed and approved the 2016 *Resource Coordination Program Evaluation.*
- Reviewed and approved use of MCG, Hayes, Inc., ASAM Patient Placement Criteria, LOCADTR 3, and Care Advance Enterprise Standard Content Package for use by our medical management programs for 2017-2018.

- Review and approval of resource coordination external policies as forwarded by the Policy Committee:

    - Reviewed 46 existing policies
    - Revised 79* existing policies
    - Approved three new policies
    - Retired zero existing policies
    - Reviewed and supported the technology assessment team's recommendations on five 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 affects health care as well as health insurance.
- Monitored CDPHP activities related to the Delivery System Reform Incentive Program (DSRIP).
- Monitored Population Health & Wellness activities.
- Monitored CDPHP Medical Affairs division goals for 2017.
- Provided input on the reduction of prior authorization requirements.
- Provided input on the Plan's offering of telemedicine services for 2018.
- Suggested participating providers to serve on Plan specialty related workgroups.
- 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 2017.
- Monitored the utilization trend of urgent care.
- Monitored non-par utilization and the review process associated with such requests.
- Monitored medical affairs service indicators in relation to established goals.
- Monitored inter-rater reliability education/testing for all staff making UM determinations.
- Reviewed 2016 physician satisfaction with the utilization management process and approved all recommendations for 2017.
- Provided oversight of updates to ClaimCheck, a software-based code-auditing tool.
- Stayed informed of Plan's transition from ClaimCheck to ClaimsXten software in 2018.
- Reviewed the 2016 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 2017.
- Monitored the changing populations served by our Medicaid managed care product and CDPHP initiatives associated with these populations.
- Monitored performance of CDPHP Community Health Project.
- Monitored CDPHP standing with multiple accreditation/regulatory organizations.

- Monitored delegation oversight activities for all delegates associated with utilization management, case management, or disease management.

The Utilization Management Committee met six times in 2017. 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

Makes 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>2017 Behavioral Health Utilization Management Committee Accomplishments:</u>

- Reviewed and discussed the OASAS Policy for Interpreting Concurrent and Retro Review for new Opiate Legislation, as well as presented on CDPHP Opioid initiative.
- Reviewed and approved treatment guidelines, payment policies, formulary updates, atypicals and 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 2017 BH rates and received suggestions for improvement initiatives.
- Identified barriers and solutions regarding the BH Clinician Appointment Access Study.
- Reviewed UM key indicators such as Hospital Readmission Rates, Average Length of Stay, Substance Use Inpatient and Residential Levels of Care, ED Utilization and Crisis Services Use.
- Discussed the ambulatory review process, which reviews high-utilization cases and provides recommendations regarding care.
- 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 submits results of its activities to the Utilization Management committee, which reports through the Quality Management committee to the Board of Directors.

2017 HARP Utilization Management Committee Accomplishments:

- Reported on statistics regarding network adequacy, rates of initiation and engagement of members with first episode psychosis, hospital readmission rates, average length of stay, substance abuse inpatient, and residential levels of care, PROS, ACT, HCBS assessments and referrals, ED utilization and crisis services use, and inpatient and outpatient civil commitments performance improvement project
- Reviewed the updated ambulatory review process, which reviews high-utilization cases and provides recommendations regarding care.
- Educated the committee on HARP reports consisting of psychotropic medication and utilization, and addiction medication utilization such as Buprenorphine, Vivitrol, methadone, and members on two or more antidepressants, antipsychotics, and ADHD medications, and introduced reporting on HARP members who smoke.
- Reviewed HEDIS 2017 BH rates and received suggestions for improvement initiatives.
- Reported on the DOH's mandated 2017-2018 performance improvement project for transitions of care.

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.

2017 HARP Quality Stakeholder Advisory Group Accomplishments

- Identified barriers to mitigate such as lack of housing and social support; legal issues; lack of beds and community programming for members needing longer term recovery vs. acute stabilization; lack of incentives for providers and members; lack of knowledge of the HEDIS measures. Action items will include engaging Health Homes, improving discharges processes, facilitating information sharing, and warm hand-offs during transitions.
- Invited various community leaders to speak about their programs and coordinating care for members.
- Demonstrated how CDPHP uses predictive modeling tools and 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.
- Discussed HARP performance improvement project mandated by New York State concerning transitions of care and reviewed action plans for HEDIS quality initiatives.
- Reviewed level of service determination criteria and OMH benchmarks for HCBS, as well as reported on admission and readmission statistics, trends, and performance indicators.
- Received updates on topics and outcomes from the NYS Regional Planning Consortiums.

8. BH 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.

<u>2017 BH Quality Stakeholder Advisory Group Accomplishments</u>

- Demonstrated how CDPHP assists with the coordination and continuity of care between the plan, facilities, providers, and members on multiple quality metrics that target population management.
- Reported on the corporate-wide diabetes initiative, the opioid initiative, and collaboration with the Wellness Department and community events.
- 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, telephonic average speed of answer, telephone abandonment rates, authorization turnaround times, clinical practice guidelines, and OMH benchmarks.
- Reviewed action plans for HEDIS quality initiatives.

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.

2017 Pharmacy and Therapeutics Committee Accomplishments:

- Reviewed new drug entities and new unique drug delivery systems to market for the calendar year 2017.
- 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 2017 Medicare Part D prescription drug formulary updates and the 2018 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 19 policies and the revision of 33 policies. Ten policies made obsolete in 2017 and 13 new policies were created.
- Reviewed and approved the annual CDPHP clinical formulary booklets for 2017 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 2017 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 opioid 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 enrollees' participation in this program.

The Pharmacy and Therapeutics Committee met five times in 2017. 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, credentialing and recredentialing delegates at specific sites, program oversight of NYS health homes, and select vendors.

The accreditation and quality program manager co-chairs with 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.
- 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 agreement.
- 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 2017, 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), disease management vendor (Health Dialog), , and physician and hospital online directories vendor (HealthSparq dba Clarus Health). In addition, program oversight of NYS health homes. 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.

<u>2017 Joint Health Services Committee Accomplishments:</u>

- CDPHP approved continued delegation to Health Dialog, HealthSparq dba Clarus Health, CVS/Caremark, Landmark, DentaQuest, Community Care Behavioral Health (CCBH) and our credentialing delegates for 2017.
- 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, UMAS and St. Elizabeth's Medical Center.
- CDPHP completed one annual comprehensive delegation oversight audit for each delegate, including CVS/Caremark, MedSolutions/eviCore, Landmark Health, Community Care Behavioral Health (CCBH) , DentaQuest, Clarus Health, and Health Dialog,
- 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-program oversight assessment conducted for potential health home delegates as appointed by NYS.
- Reviewed and approved pre-delegation assessment and delegated agreement of Delta Dental for Medicare advantage members' preventive dental services
- CDPHP reviewed health home program compliance with NYS: 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.
- Continued calibrated call monitoring with Health Dialog and CVS Caremark.

- CAPs implemented in Q2 2016 and monitored throughout 2017 for DentaQuest on quarterly reporting of dental network adequacy of oral surgeons, declining HEDIS/QARR ADV performance and declining call center performance metrics in Q2-2017.

The Joint Health Services Committee met four times in 2017. Contemporaneous minutes were recorded for all committee activities. Majority of delegates remained in full compliance, with the exception of DentaQuest, 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 medical affairs division is 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 technology assessment team consist of medical directors (physicians), medical policy analysts (registered nurses), and 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 analyst 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/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. 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

<u>2017 Technology Assessment and Policy Committee Accomplishments:</u>

Technology Assessments

- Completed five medical technology reviews (CDPHP review only)

Resource Coordination External Policies Year-End Total = 94

- Created three new external policies

- Reviewed 46 existing external policies without change
- Revised 79* existing external policies
- Retired zero 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:

2017 Corporate Compliance and Privacy Committee Accomplishments:

- OIG, OMIG, CMS, DFS, and DOH and other compliance program guidelines were reviewed to determine possible gaps and best practices for the CDPHP Corporate Compliance Program.
- CDPHP participated in a CMS Fraud, Waste and Abuse Reporting Pilot Program to determine future CMS reporting requirements.
- Implemented revisions to the new employee Corporate Compliance training, incorporating improvements specified in the Office of Medicaid Inspector General (OMIG) audit.
- Corporate Compliance redesigned the Out-of-Area Grievance/Appeal (G/A) process and letters to ensure compliance with recent government changes.
- Corporate Compliance and Privacy operations transitioned to full paperless operation in 2017. SIU 2017 and 2016 paper files have been transitioned to electronic files and process. Back year files will continue to be transitioned.
- The Corporate Audit Department finalized the 2017 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.
- A self-assessment was conducted using the CMS audit guide for both general compliance requirements and compliance program elements and Fraud, Waste and Abuse Program requirements. Minor technical updates were made and the full assessment was provided to the Medicare Compliance Officer.
- 120 new employees, consultants, and temporary employees attended Corporate Compliance, Privacy and FWA trainings through October 2017.
- Corporate Compliance developed and implemented the 2017 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 approximately $1,500,000 from October 2016 through September 2017 (last time reported). The most significant recoveries/savings are as follows:
  - Recovered $433,377 in an overpayment to a facility discovered to be split billing services for both the facility location and office location.
  - Recovered $211,000 from a facility billing operating room services for wound care services performed in an office setting.
  - $448,524 recoveries and savings of miscellaneous services, such as physical or occupational therapy providers incorrectly billing for a per diem payment, chiropractor billing inappropriately for physical therapy services, and a provider billing over $12,000 for a medication not administered.
  - Recovered $179,000 from multiple providers billing fluoroscopy when incidental to the primary procedure per NCCI edits as well as CDPHP policy.
  - Recovered $77,289 in an overpayment to a facility discovered to be split billing services for both the facility location and office location, as well as billing for surgical assist as a physician when performed by a mid-level provider.
  - Recovery of $65,253 from a facility that was discovered to be split billing urgent care services for both the urgent care and a facility location.
  - Recovery of $42,469 in relation to epidural anesthesia services that were billed under the anesthesia code for a caesarean section barring the claims from meeting the cap assigned to epidural anesthesia.
  - Recovered $34,036 from a provider billing hernia repairs incidental to the primary surgery.
- Through October 2017, SIU has received 613 hotline calls, investigated 379 cases, and referred 34 cases to government oversight agencies.
- SIU has participated in quarterly task force meetings 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. As a result of the task force, CDPHP assisted with investigations into two providers that admitted to committing fraud. One case resulted in the provider's termination from the Medicare program. The second case resulted in the provider being required to pay restitution as ordered by the U.S. Attorney General. SIU also participated in the CMS sponsored fraud, waste and abuse quarterly webinars.
- SIU meets with the NYS Attorney General's Office on a quarterly basis to discuss CDPHP cases referred to the Medicaid Fraud Control Unit by the SIU, as well as potential new cases and trends.
- Responsibility for creating and maintaining documentation of business associate contracts was transitioned to the CDPHP Strategic Sourcing department. The Corporate Compliance department maintains responsibility for all questions concerning the applicability of the business associate contract, reviewing, and coordinating any requested changes to a business associate contract and monitoring of the business associate contract process.
- Updated the Model CDPHN HRA/FSA Administration Agreement, which includes the Notice of Privacy Practices and HIPAA Certification.
- Updated the Model Plan Sponsor HIPAA Certification documentation governing plan-administration related disclosures of PHI.
- The CDPHP Confidentiality of HIV Information policy was updated to detail the required handling and reporting provisions for HIV/AIDS registry data in accordance with the NYS Ending the Aids Epidemic (ETE) initiative and NYS PHL Section 2135.
- Detailed policy and process was developed to improve ongoing monitoring and assessment of privacy-related rules and operations, with a specific focus on identifying, correcting, and mitigating privacy-related risks and member privacy rights.

- Updated the CDPHP Notice of Privacy Practices to include changes such as posting of revisions to notice, access member right provisions, and additional non-routine disclosure descriptions.
- Initiated comprehensive self-assessment of the HIPAA Privacy Rule utilizing an external tool to identify potential gaps and/or best practices and implement corrections and improvements, as needed.
- Ongoing review of privacy member rights usage (access, accounting, confidential address, and restriction/amendment requests) to ensure proper functioning and compliance of the privacy program.

13. Clinical 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 2017 included, Avoidance of Antibiotics for Acute Bronchitis, ADHD, and 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 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 (9/30/15)	Number (12/31/16	Number (12/18/17)
Primary Care Physicians	3,471	3,133	2,898	3,745
Specialists Including OB	8,937	9,266	5,525	10,788
Adjunct Practitioners	3,090	4,220	3,913	4,677
EPC Practitioners*	485*	836*	850*	873*

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

Providers

Providers	Number (12/31/14)	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)
Hospitals	80	74	76	71
Skilled Nursing Facility	110	117	117	92
Home Health Agencies	96	93	88	61
Outpatient Surgery Centers	31	30	29	30
Other Including DME, Lab, Radiology, and Pharmacy	7,014	7,016	4,820	235

Behavioral Health Providers/Practitioners

Practitioners	Number (12/31/14)	Number (9/30/15)	Number (12/31/16)	Number (12/18/17)
Behavioral Health	2,258	2,269	2,075	2,548

CDPHP continues to maintain a 24-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 Triple Aim (patient experience, 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 2017, 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 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 2017, the EPC program included 170 provider practices and over 200,000 CDPHP members. Since its inception, the EPC program realized over $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

I. Effectiveness of Quality Program

Based on the comprehensive review and evaluation of our performance, the overall effectiveness of the 2017 Quality Management Program, including adequacy of resources, progress toward influencing network-wide safe clinical practices, QI 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 2017, CDPHP allocated 102 diverse employees, including staff, managers, directors, medical directors, and vice presidents, whose collective time comprised 70.40 FTE dedicated to the quality program. Our employee talent resources represented over 2158 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 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, 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 2017, 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 2017, 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, requests for high tech imaging, 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.

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; Identify Overuse, Misuse and Fraud; and Building Community Coalitions.

The 2017 accomplishments of the Opioid Strategy included:

- Aligned the Commercial and Medicaid formularies with regard to opioid coverage
- Made formulary and quantity limit changes that aligned with consensus guidelines
- Identified cases for clinical quality review to address cases whereas a member experienced an overdose and continued to fill opioid prescriptions following their overdose
- Developed the "Opioid Medications for the Treatment for Pain" pharmacy policy

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 Triple Aim. 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 six 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 Enhanced Primary Care (EPC) program and payment model..
All departments participate in the ongoing quality improvement process through active involvement in the internal team structure, which links quality management activities with other management functions. The internal team structure supports ad hoc end-to-end quality improvement efforts through the continuous quality improvement model of W. Edwards Deming's Plan-Do-Study-Act (PDSA). The team also monitors

clinical and service quality through established quality indicators, which are reported quarterly to QMC and the board of directors.

The QMC, UMC, BH Committee, Credentialing Committee, Pharmacy and Therapeutics Committee (P&T) and the Board of Directors include a broad representation of clinical and practicing practitioners from our network. Our community physicians actively participate in our quality program as evidenced by a total of seventy-nine (79) practitioners actively participating in 2017 on the following committees: fourteen (14) practicing physicians served on QMC; sixteen (16) practitioners on P&T Committee, seventeen (17) on UMC, ten (10) on Credentialing Committee, twelve (12) on BH UM committee and ten (10) on BH QSAH Committee.

Need to restructure or change the QI Program for 2018: After reviewing and evaluating overall performance and program effectiveness of the 2017 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 2018. While resources dedicated to the QI program are currently adequate, CDPHP continually monitors those resources to ensure they remain adequate.