JANUARY 2019

CDPHP Medicare Choices HMO and PPO plans were rated 4.5 out of a possible 5 stars by the Centers for Medicare & Medicaid Services (CMS).
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 365,000 members in 26 counties across New York.

The CDPHP family of products includes three business lines:

- **Capital District Physicians’ Health Plan, Inc.** HMO, Healthy New York, Medicare Choices (HMO), Medicaid, Child Health Plus, and Marketplace HMO.

- **CDPHP Universal Benefits,® Inc.** Preferred provider organization (PPO) and high deductible PPO (HD PPO) 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.

2018 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 2018-2019.

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 2018-2019.

- **NCQA’s Medicaid Health Insurance Plan Ratings 2018-2019**
  - Capital District Physicians’ Health Plan, Inc. (HMO): 4.5 out of 5 – top-rated in NYS

- **NCQA’s Private Health Insurance Plan Ratings 2018-2019**
  - 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 2018-2019**
  - Capital District Physicians’ Health Plan, Inc. (HMO): 4.5 out of 5
  - CDPHP Universal Benefits, Inc. (PPO): 4.5 out of 5
EXECUTIVE SUMMARY

Centers for Medicare & Medicaid Services (CMS) – 2018-2019 Medicare Overall Stars Ratings
- CDPHP Medicare PPO earned quality rating of 4.5 out of 5 Stars
- CDPHP Medicare Choices HMO earned quality rating of 4.5 out of 5 Stars

The National Committee for Quality Assurance (NCQA) annually evaluates health plan accreditation status based on a recalculation of HEDIS and CAHPS scores, and in 2018, 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 2018. The CDPHP NCQA Health Plan Accreditation for all accredited entities is effective through May 2021.

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

Capital District Physicians’ Health Plan, Inc. received the highest score in New York in the J.D. Power 2017-2018 U.S. Member Health Plan Satisfaction Studies of customers’ satisfaction with their commercial health plan.

CDPHP received the American Heart Association Workplace Health “Gold Level” Recognition.

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

CDPHP continued to work with employers, members, providers, as well as CDPHP employees, to ensure the provision of quality health care at reasonable costs and operate CDPHP as a model for the delivery, financing, and administration of health care services. CDPHP is an innovator in health care transformation and payment reform and remains committed to offering more choice and flexibility to employer groups, ultimately providing health care solutions and value through all stages of our members’ lives. CDPHP continued to introduce and promote innovations in care and population management, leading the move to value-based payment as the true partner with our physician network and providing expertise and resources to aid in their move to new payment methodologies. CDPHP has emerged as a leader for practice transformation and training care management resources by offering unique approaches to population health. CDPHP seeks to continue to form partnerships with organizations that can bring value in the shared goals of the Triple Aim while preparing for transition to a focus on the Quadruple Aim, which is inclusive of physician satisfaction. CDPHP is committed to driving a strategy focused on population health to deliver better care and improved outcomes to our membership across a wide variety of disease states and health conditions.

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

Basic tenets of health value are:
- Goals are aligned with the Triple Aim of improved health, improved member experience, and control of cost increases with anticipation of transition to the Quadruple Aim in 2019.
- 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.
EXECUTIVE SUMMARY

- Identification of populations with similar health care needs and organizing resources to address those needs effectively and efficiently.
- Payment reform is focused on value over volume, with comprehensive payment for comprehensive care.
- Population Health Management is centered on improving the quality of care and outcomes of our membership across many different disease states and health conditions.

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

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

In this document, the CDPHP 2018 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 2019 QM program description and 2019 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 2018 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 2018 were completed and yearly objectives were met. Thus, the quality management program was effective and does not require any restructure in 2019.

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 2018.
E. Quality Management Program Resources

The following resources were dedicated to the quality management program in 2018:

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Number of Staff</th>
<th>Number of FTEs</th>
<th>Aggregate Years of Experience</th>
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<tr>
<td>Executive vice president, chief medical officer-MPH, MD</td>
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<td>VP of primary care medical services, MD</td>
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<td>Senior vice president, corporate analytics</td>
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<td>Senior vice president, consumer experience solutions</td>
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<tr>
<td>Manager, care management &amp; Medicaid LTS &amp; support LPN</td>
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<td>1.00</td>
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</tbody>
</table>
**EXECUTIVE SUMMARY**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Number of Staff</th>
<th>Number of FTEs</th>
<th>Aggregate Years of Experience</th>
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<td>Director, pharmacy/quality—RPh</td>
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<td>Manager, Medicare pharmacy programs</td>
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<td>Director, strategic physician engagement</td>
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<td>Web-master manager</td>
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In addition to staff resources, data resources include claims, encounters data, enrollment, HRAs, complaints, grievances and appeals, UM and pharmacy data, Medication Therapy Management Program (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 2018) to run an actionable gap list to help move low-performing practitioners on high impact HEDIS measures, particularly our EPC practices, within the measurement year. The analytical data warehouse (ADW) continues to improve the efficiency of data analysis. Corporate analytics staff expertise in statistical analysis and utilization of other advance statistical tools continues to improve the QM program accuracy, reliability, and validity testing regarding data collection, sampling, and analysis for our HEDIS, QARR, and EPC performance metrics; Network GeoAccess reporting, Practitioner to Member Ratio Analysis reporting, practitioner gap lists, and practitioner quality performance profiling.

All departments participate in the ongoing quality improvement process through active involvement in the internal team structure, which forms the mechanism to link quality management activities with other management functions. Internal team structure supports ad hoc end-to-end quality improvement efforts through the continuous quality improvement model of W. Edwards Deming’s Plan-Do-Study-Act (PDSA)
and monitors clinical and service quality through established quality indicators, which are reported quarterly to QMC and the board of directors.

Clinical Care Advance Enterprise (CAE) application continues to improve care management workflows and personalized member communications (e.g., targeted campaign member mailings, telephone outreaches) in support of care management and population identification. Population health and wellness focused on member-centric quality initiatives, while our performance measurement and physician engagement teams focused on practitioner/provider-centric quality initiatives. Pharmacy team supports our members through the MTMP, through the Enhanced MTM service, known as Med Check, and the pharmacy analytics team facilitated data analysis to improve quality and impact cost and utilization for all lines of business. Medicare Stars team actively engaged Medicare members in managing their health care to achieve the best possible outcomes.

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

F. Committee Structure: Roles, Responsibilities, and Accomplishments

1. Board of Directors

The CDPHP board of directors, as the governing body, maintains overall accountability and responsibility for the quality management program. The board delegates the responsibility and accountability for the day-to-day operation and administration of the program to the quality management committee (QMC) and to the chief medical officer (CMO). The CMO, who reports to the chief executive officer (CEO), is responsible for the implementation and operation of the program and for ensuring responsible reporting and communication of plan progress and evaluation from the quality management committee to the board of directors, and back to the quality management committee.

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

2. Quality Management Committee

The board of directors has designated the quality management committee (QMC) as the responsible entity for the oversight and management of all quality-related activities, including developing, implementing, and overseeing the quality improvement program. The QMC, chaired by the medical director, is comprised of fully credentialed physicians representing primary care and high-volume specialties, including OB/GYN and behavioral health, as well as representatives from CDPHP, behavioral health committee, community leader, board member, and adjunct providers.
The committee members are appointed by the executive vice president/chief medical director, subject to board approval, for a three-year term and may be reappointed. The senior vice president of health care quality, the accreditation and quality program manager, the director of health care quality, and the director of quality analytics are also on the committee. Additional plan staff serve as ad hoc staff to the committee as needed.

The QMC met six times in 2018. Contemporaneous minutes are recorded for all committee activities. The QMC reports regularly to the board of directors, which has ultimate responsibility for the quality management program. The QMC is accountable to and receives regular recommendations from the board.

Responsibilities of the quality management committee include:

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

2018 Quality Management Committee Accomplishments

- Reviewed and approved the 2017 quality management evaluation and the 2018 quality management program description and work plan.
- Regularly evaluated organization’s progress toward meeting goals as outlined in the program description and work plan.
EXECUTIVE SUMMARY

- Reviewed and approved all submitted meeting minutes and policy reviews from reporting committees.
- Reviewed and approved all quality management and appeals policies and procedures.
- Approved objectives to address overall health equity of language, cultural, and linguistic needs of members, staff and network.
- Established clinical quality indicators, quality teams, and physician work groups to address specific clinical issues.
- Reviewed and approved all clinical, safety, and service quality management initiatives, programs, and activities.
- Reviewed and approved service indicator quarterly reports.
- Reviewed and approved quarterly potential clinical quality concerns via clinical quality reviews (CQR) – peer review and complaint monitoring.
- Reviewed and approved final grading of all CQR quality of care cases initially graded as Level 4 or Level 5; however, no cases fell into 4 or 5 grading in 2018.
- Reviewed and approved pre-delegation assessment audits, delegation agreements, on-site reviews, and ongoing delegation oversight activities for all delegated entities, including first-tier downstream and related entities (FDRs).
- Reviewed and approved evidence-based medical and behavioral health clinical practice and preventive health guidelines for distribution and monitoring.
- Reviewed and monitored practitioner/provider sanctions as a result of quality monitoring activities through committee minutes and reports.
- Reviewed and approved continuity and coordination of care initiatives.
- Reviewed and approved patient safety initiatives.
- Reviewed annual physician and member satisfaction survey results and evaluated member complaints and appeals quarterly.
- Quality management committee members recommended changes to quality management studies, including studies involving the coordination and continuity of medical care across the health continuum to improve data validity and demonstrate improvement.
- Reviewed progress of CDPHP Enhanced Primary Care (EPC).
- Monitored and made recommendations for improving Healthcare Effectiveness Data and Information Set (HEDIS) results.
- Monitored progress on interim HEDIS 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.
- 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), 2018 CMS QIP regarding promoting effective management of chronic disease study focused on CHF in Landmark engaged cohort.
- Reviewed and monitored Quality Improvement Strategy (QIS) of the New York State of Health (NYSOH) Marketplace regarding improving performance of cervical cancer screening (CCS) for our HMO and EPO marketplace members to be continued through year 3 in 2019.
- Monitored continued compliance with National Committee for Quality Assurance (NCQA) 2018 and 2019 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.
EXECUTIVE SUMMARY

- Monitored the progress of Federal Employee Health Benefits (FEHB) Program: Plan of Correction (POC) for UBI product line.
- Reviewed and approved selection of the 2019 CMS Chronic Conditions Improvement Project (CCIP) which will focus on Chronic Kidney Disease.

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 chaired by a medical director, as designated by the executive vice president/chief medical officer. The committee membership meets at least six times per year and is appointed by the executive 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 the credentialing team manager are also on the committee.

### 2018 Credentials Committee Accomplishments

- Reviewed and approved all current credentialing program policies and procedures.
- Made recommendations for 2,191 initial credentialing applications.
- Made recommendations for 3,463 recredentialing applications.
- Reviewed and approved all delegated credentialing activities.
- Continued to support ongoing network development and recruitment of practitioners and providers into the CDPHP network.

The credentials committee met nine times in 2018. 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 chief medical officer, executive vice president/chief medical officer, and consists of participating primary care and specialist physicians. The committee reports through the QMC to the board of directors. The senior vice president of medical affairs
operations, and directors of resource coordination, and behavioral health serve as staff to the UMC.

2018 Utilization Management Committee Accomplishments

- Reviewed and approved the 2018 Resource Coordination Program Description.
- Review and approval of resource coordination external policies as forwarded by the policy committee:
  - Reviewed 55 existing policies
  - Revised 105* existing policies
  - Approved two new policies
  - Retired zero existing policies
  - Reviewed and supported the technology assessment team’s recommendations on seven 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.
- Provided input on the plan’s offering of telemedicine services.
- Monitored activities of the behavioral health subcommittees.
- Approved the monitoring of plan-wide, product-specific, and practitioner site under- and over-utilization, including actions taken and recommendations for 2019.
- Monitored the utilization trend of urgent care.
- Monitored medical affairs service indicators in relation to established goals.
- Monitored inter-rater reliability education/testing for all staff making UM determinations.
- Reviewed physician satisfaction with the utilization management process and approved all recommendations for 2018.
- Provided oversight of updates to ClaimCheck, a software-based code-auditing tool.
- Stayed informed of plan’s transition from ClaimCheck to ClaimsXten software in 2018/2019.
- Reviewed member satisfaction with the UM process and approved actions taken and those recommended for 2018.
- Monitored CDPHP standing with multiple accreditation/regulatory organizations.
- Monitored delegation oversight activities for all delegates associated with utilization management, case management, or disease management.
- Evaluated new chronic conditions program.
- Monitored utilization metrics on a year-to-date basis for both medical and behavioral health.
- Monitored plan’s activities related to our health and recovery plan (HARP), including the insourcing of case management services for this population.
- Monitored plan’s activities related to utilization oversight of high tech radiology services.
- Provided input on further reductions in prior authorization requirements.
- Review/feedback of plans efforts to positively impact the opioid crisis.
- Monitored School 2 embedded case management program.
- Monitored medical director inpatient rounding initiative to positively impact length of stay.
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- Monitored efforts of ophthalmology workgroup.
- Monitored plan’s efforts to transition to a population health management approach.
- Review of newly created preventive services guidelines.
- Monitored efforts related to readmission avoidance.
- Monitored results of experience of care and health outcomes (ECHO) survey.

The utilization management committee met six times in 2018. 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

BH UMC makes recommendations concerning utilization management related to behavioral health, and provides expert opinions on behavioral health issues. Discussions include the development, approval, and review of policies; recommending procedures for benefit coverage by assessing technologies, medical interventions, and drugs in terms of efficacy and safety; recommending revisions to the member benefit package; monitoring utilization trends; development/selection of industry-standard medical necessity/clinically appropriate screening criteria used for UM decision-making; and monitoring timely resolution of UM determinations and service indicators.

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

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

2018 Behavioral Health Utilization Management Committee Accomplishments

- Acknowledged NCQA’s new population health management standards and the impact on current programming.
- Identified barriers to registering to accept fee for service Medicaid and the impact on patients filling prescriptions. Concerns were brought to state programs department and regional planning consortiums.
- Reviewed and approved treatment guidelines, payment policies, formulary updates, addiction medication, atypicals and antipsychotic, antidepressant, and ADHD medication utilization trends, step through policies, prior authorization rules, emergency department and crisis service utilization, hospital readmission rates, average length of stay, substance use inpatient and residential levels of care utilization data, authorization turnaround time, telephonic abandonment rates and average speed of answer.
- Recommendations for readmission avoidance interventions and strategies included increasing the communication between the prescriber, PCPs, and pharmacies.
- Analyzed the Restricted Recipient Program and the impact of the program on the utilization of opioids.
- Discussed interim HEDIS 2019 and final HEDIS 2018 BH rates and received suggestions for improvement initiatives concerning continuity and coordination of care between medical and BH practitioners.
- Held solution focused discussions regarding long term bed availability, complex co-morbidity and homelessness.
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- Educated the committee on pilot housing initiatives and partnerships funded through Medicaid redesign.
- Discussed the ECHO member satisfaction survey results and suggestions to improve coordination of care between provider specialties.

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.

2018 HARP Utilization Management Committee Accomplishments

- Discussed readmission avoidance strategies, ED and crisis service utilization, Home and Community Based Services (HCBS) and 820 utilization, inpatient and outpatient civil commitments, hospital readmission rates, average length of stay, substance use inpatient and residential levels of care trends.
- Educated the committee on the successful engagement with seven high volume hospitals/SUD programs to participate in the NYSDOH HARP PIP and explored ways to address the housing needs within the community that impact discharge and readmission.
- Pharmacy introduced a medication reconciliation process to identify potential issues upon discharge from an inpatient facility.
- Case management redesigned member and provider workflows to increase engagement earlier in the discharge planning process.
- Completed root cause analysis of enrollment delays with health homes.
- Committee approved adding HARP case review to existing behavioral health daily rounds sessions to improve communication between settings and providers, and decrease readmissions.
- Committee discussed challenges, barriers, and next steps for the HARP population:
  - Limited access for case managers on inpatient units in several facilities prevented early interventions.
  - Communication gaps existed regarding notice of hospital admissions between in-house and field case management teams.
  - Limited health home engagement and lack of follow-up to connect and enroll members resulted in gaps in care.
  - Limited housing options in the community and limited inpatient beds for HARP members who require longer acute care stays in order to stabilize.
  - Work with our seven high volume partners to improve the process of transitions in care, using the FUH measure as the marker.
  - Pursue automation of processes to track and measure the effectiveness of all interventions, specifically case management and health homes.
  - Investigate ways to increase community housing options and utilization.
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- Facilitate bridger appointments for all members discharged from the inpatient setting.
- Offer all members discharged from an inpatient setting follow up by a CDPHP behavioral health case manager.
- Explore utilization of member financial incentives for completion of their scheduled outpatient appointment.
- Educate hospital staff during the member’s inpatient stay about the importance of comprehensive discharge planning and medication reconciliation. Work with PIP partners to embed CDPHP staff in their facilities to coordinate the transition process and referrals for bridger appointments.

7. HARP Quality Stakeholder Advisory Group

The HARP quality stakeholder advisory group (QSAG) is chaired by the behavioral health medical director and led by the behavioral health quality management administrator; meets at least quarterly; reports to the HARP UM committee; and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the HARP behavioral health quality management program and is accountable to and reports regularly to the HARP behavioral health UM committee concerning BH QM activities for the Medicaid HARP line of business only.

The HARP QSAG members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and case management activities. They provide expert opinions on behavioral health issues, encourage and promote communication between CDPHP and the BH provider network, review and provide input for satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations for effecting better outcomes with specific populations. The committee’s mission is to exchange ideas on how to effect better treatment outcomes and review the findings of BH-specific quality improvement initiatives, performance improvement projects, and focused studies.

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

2018 HARP Quality Stakeholder Advisory Group Accomplishments

- Solicited feedback on improvement opportunities for NYSDOH HARP performance improvement project regarding coordination of care, such as embedding in hospitals and EDs, increasing communication with area providers and promoting existing home visit services, while monitoring referral volumes.
- Offered solutions regarding lack of accessibility of outpatient counselors after business hours and overnight, such as promoting the after-hours telephonic crisis line staffed by licensed clinicians, and partnerships with peer services.
- Key stakeholders identified challenges concerning slower than anticipated access to BH HCBS for HARP such as: difficulty enrolling HARP members in health home; locating enrollees and keeping them engaged throughout the lengthy assessment like the plan of care development process; ensuring care managers have an understanding of BH HCBS; capacity for care managers to effectively link members to HCBS; difficulty launching BH HCBS due to low numbers of referrals to BH HCBS providers. Concerns were brought to the attention of NYS Regional Planning Consortium (RPC).
- The committee offered suggestions to increase the availability of community housing, as there is a recognized need for permanent and respite housing.

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- The group discussed issues with the Medical Answering Service (MAS), ER and inpatient diversion. A smaller workgroup consisting of community hospital and housing directors, and CDPHP management is planning to create a work group to discuss common challenges and solutions, such as developing urgent and rapid access models of care to help alleviate the use of the ER and reduce inpatient stays.
- The group discussed coding for care planning meetings. The committee members shared the concern that care plan meetings are not a billable service so they often don’t send clinicians to these meetings. CDPHP certified coders will provide suggestions for appropriate codes to use to capture the efforts.

8. Behavioral Health Quality Stakeholder Advisory Group

The Behavioral Health Quality Stakeholder Advisory Group (QSAG) is chaired by the Behavioral Health Medical Director and led by the Behavioral Health Quality Management Administrator; meets at least quarterly; reports regularly to the Behavioral Health UM Committee; and maintains records documenting attendance, findings, recommendations, and actions. It is responsible for carrying out the planned activities of the Behavioral Health Quality Management program and be accountable to and report regularly to the Behavioral Health UM Committee concerning BH QM activities for all lines of business except HARP.

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

2018 Behavioral Health Quality Stakeholder Advisory Group Accomplishments

- Reviewed initiatives on psychotropic medication management, and received feedback concerning the NYSDOH QARR Plan of Correction measuring antipsychotic medication adherence.
- Reviewed NCQA’s guidelines for population health management and shared the business decision to hire statisticians and informatics staff who will accumulate and analyze data.
- Reported and strategized on the use of rising risk data, chronic conditions, complex cases, and health and wellness. Discussed new treatment modalities within the network.
- Reviewed efforts of the CDPHP opioid initiative, such as piloting with pain management programs, prescriber learning collaboratives, MAT, and aligning the formulary with CDC recommendations.
- Discussed the ECHO member satisfaction survey results and suggestions to improve coordination of care between provider specialties.
- The group discussed better coordination of care which included the need for shared EMRs and greater integration.
- Shared information on BH incentive programs that include individual prescribers, clinics, and hospitals. Program participants are incentivized to use the CDPHP formulary and to follow HEDIS measures.
- Hosted peer advocate presenters to discuss services and how to facilitate their use. Discussed how OASAS had provided a waiver to the COTI Project to provide telehealth services for MAT, and how they work closely with another peer based program, Healing Springs. Peer advocate groups, such as The COTI Project (an OASAS funded program) presented on services available to uninsured and underinsured members. The team provides assessments within the community and creates treatment plans/engagement opportunities that work around the individual.
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 senior 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.

2018 Pharmacy and Therapeutics Committee Accomplishments

- Reviewed new drug entities and new unique drug delivery systems to market for the calendar year 2018.
- 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 2018 Medicare Part D prescription drug formulary updates and the 2019 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 37 policies and the revision of 29 policies. Five policies made obsolete in 2018 and 8 new policies were created.
- Reviewed and approved the annual CDPHP clinical formulary booklets for 2018 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 2018 Medicaid formulary and utilization management details, which are available on the website for plan enrollees and practitioners and printed as requested.
- Reviewed and recommended updates for quantity limits for the plan's commercial and Medicaid formularies.
- Reviewed and discussed current trends in the pharmaceutical manufactures set price points for new drugs.
- Reviewed the plan's new claim system.

The pharmacy and therapeutics committee met six times in 2018. 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 the senior vice president of healthcare quality the JHSC meeting and other members include representatives from the delegated entities and the CDPHP delegation team, including a medical director, quality, pharmacy, appeals/grievances, resource coordination, behavioral health, care management, credentialing, customer service, government programs, corporate compliance, information technology security, sourcing/contracting, vendor management, corporate analytics and member services staff. CDPHP FDRs and delegates develop agendas in consultation with and approval by the CDPHP delegation team.

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

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

- Approve pre-delegation assessment evaluation audit, including on-site visit.
- Approve mutually executed delegation agreements, quality management evaluations, programs, and work plans.
- 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 2018, the JHSC required the following delegates to report to the committee: pharmacy vendor (Caremark), high tech radiology (MedSolutions/eviCore), dental vendor (DentaQuest) which transitioned to Delta...
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Dental in July 1, 2018, care management (Landmark), disease management vendor (Health Dialog), Community Care Behavioral Health (CCBH) 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.

2018 Joint Health Services Committee Accomplishments:

- CDPHP approved continued delegation to Health Dialog, HealthSparq dba Clarus Health, CVS/Caremark, Landmark and our credentialing delegates for 2018.
- Delegate representatives presented their respective quarterly reports on their progress with managing the delegated functions and responsibilities as outlined in their delegation agreements with CDPHP for discussion and acceptance by the CDPHP committee oversight members.
- CDPHP completed one annual comprehensive delegation audit for all delegated credentialing functions at Albany Medical Center (AMC), Bassett Hospital, Health Alliance Physicians Organization, MagnaCare, Slocum Dickson, University of Vermont Health Network Credentialing and Enrollment (UVMHN C&E), Hudson Headwaters, University Medical Associates of Syracuse (UMAS) and St. Elizabeth’s Medical Center.
- Pre-delegation assessments and audits for credentialing were conducted for Delta Dental Medicaid and Doctor on Demand and deemed to be fully acceptable in the second and third quarters respectively.
- Onsite visit and predelegation assessment was performed for eHealth, recognized FDR CMS delegate for telesales for Medicare Advantage, and found to have met all regulatory requirements.
- CDPHP completed one annual comprehensive delegation oversight audit for each delegate, including CVS/Caremark, MedSolutions/eviCore and Landmark Health, Community Care Behavioral Health (CCBH), DentaQuest, Clarus Health, and Health Dialog. The delegation relationship with MedSolutions/eviCore will end on December 31, 2018 and DentaQuest terminated on June 30, 2018. CCBH delegation services were terminated as July 1, 2018 with BH case management services being conducted in-house after that time.
- 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 Medicaid members’ 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. Also, in 2018, NYS Health Homes oversight moved to Medicaid innovation team which will report up through, UMC, QMC and the board of directors.
- Continued calibrated call monitoring with Health Dialog and CVS Caremark.
- Continued monitoring of adequacy of dental network and HEDIS/QARR Annual Dental Visits (ADV) rates. In quarters one and two of 2018, CDPHP developed initiatives aimed at improving outreach to members. In quarters three and four outreach efforts expanded to focus on new dental vendor, Delta Dental. Delta Dental provides monthly network build reports and CDPHP monitors monthly HEDIS/QARR rates.

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- CAPs implemented in third quarter 2018 and monitored throughout 2018 on Delta Dental for identified deficiencies with UM process performance in making timely determinations, timely notifications to members and providers, and a need for the organization to make corrections to letter templates in accordance with DOH regulatory standards.

The joint health services committee met four times in 2018. Contemporaneous minutes were recorded for all committee activities. Majority of delegates remained in full compliance, with the exception of DentaQuest and Delta Dental, who is approved with CAP compliance monitoring. The joint health services committee reports directly to the quality management committee.

11. Technology Assessment and Policy Development Committee

The CDPHP 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 technology assessment team. Board-certified consultants in medicine and behavioral health are used during the review process when additional expertise is needed regarding a newly emerging medical technology. Draft policies developed to address coverage or non-coverage of a technology are presented to the CDPHP policy committee for review and approval.

The CDPHP policy committee is a multidisciplinary team, chaired by the medical director with responsibility for the development, review, and revision of all CDPHP resource coordination, pharmacy, and payment policies. It is supported by provider consultants in medicine and behavioral health, and workgroups as needed, to lend clinical expertise to the review activities. Addition of new policies, deletion of outdated, and revision of current policies is based on input from members, providers, and staff, in addition to current trends in medical treatment and review of peer-reviewed literature. All draft policies are forwarded for review to the policy committee. After approval by the policy committee, the formal draft is presented to the utilization management committee or the pharmacy and therapeutics committee for review and approval. Minutes from these respective committees are reported to the quality management committee and board of directors for final approval. All resource coordination and pharmacy policies are reviewed at least annually and revised as recommended by the utilization management and/or pharmacy and therapeutics committee.

2018 Technology Assessment and Policy Committee Accomplishments:

Technology Assessments
- Completed seven medical technology reviews

Resource Coordination External Policies Year-End Total = 96
- Approved two new external policies
- Reviewed 55 existing external policies without change
- Revised 105* existing external policies
- Retired zero existing policies
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*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:

**2018 Accomplishments**

- A proactive review and drafting of documentation to meet CMS Medicare requirements, under the responsibility of the corporate compliance department, was completed.

- The corporate compliance regulatory complaint case tracking database was revised and simplified to better utilize internal compliance resources.

- Corporate Compliance department revised its policies to meet the NYS Medicaid contract provisions related to OMIG’s FWA reporting requirements.

- The Corporate Audit Department finalized the 2018 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 corporate compliance department review of Delta Dental’s FWA, privacy, and compliance program obligations were completed as they prepare to serve the CDPHP Medicaid population.

- CDPHP government programs submitted the required 2018 OMIG Annual Program Integrity Report. A significant portion of this report contains detailed compliance procedures and data under the purview of the corporate compliance and SIU FWA programs.

- 137 new employees, consultants and temporary employees attended corporate compliance, privacy and FWA trainings through October 2018.

- Corporate compliance developed and implemented the 2018 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.
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- 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 $787,752 from October 2017 through October 2018. The most significant recoveries/savings were as follows:
  - $351,059 recoveries and savings of miscellaneous services, such as unsupported services, duplicate billing and unbundling of global charges.
  - $42,663 recoveries and savings identified relating to multiple providers billed and reimbursed for non-covered cosmetic procedures.
  - $29,835 recoveries related to a methadone treatment program billing inconsistent with contractual requirements.
  - $25,818 recoveries relating to a behavioral health nurse practitioner for up-coding.
  - $25,418 recoveries related to improper anesthesia coding.

- SIU participated in the investigation of a Glens Falls oncologist, coordinated by the Northern District of NY US Attorney’s Health Care Task Force, which resulted in a guilty plea for violating the false claims act by submitting false claims to Medicare for unapproved chemotherapy drugs.

- Thorough September 2018 SIU has received 567 hotline calls, investigated 312 cases, and referred six cases to government oversight agencies.

- Revised the Privacy Authorization to Release Health Information Form to provide a singular option for a specified date span (“from” and “to”) as the time period for the authorization to be in effect.

- Revised the Privacy HIPAA Inspection and Copy Request Form to include options to receive information requests via e-mail and to direct response to a third party recipient in compliance with an individual’s right to access their health information under the HIPAA Privacy Rule.

- Additional content was added to the Privacy New Employee Orientation presentation related to HIV/AIDS Confidentiality and Article 27-F of New York State Public Health Law.

- Added the Privacy Program Assessment and Monitoring policy to detail the privacy program metrics used to evaluate and assess the efficacy of corporate privacy policies, procedures and related activities and the Use and Disclosure of Social Security Numbers policy to detail the prohibitions and restrictions of the NYS SSN Protection Law (NYS GBL 399.dd).

- Performed a comprehensive assessment of the corporate privacy program policies and procedures related to the HIPAA Privacy Rule and updates/additions to policies/procedures were completed including individual policies for Uses and Disclosures of PHI for Specialized Government Functions and to Avert Threats to Health and Safety.

- Updated the CDPHP plan sponsor notice of privacy practices to add language concerning health care operation disclosures related to the Organized Health Care Arrangement between CDPHP the insurer and CDPHN the third party administrator such as may occur with health flexible spending account (FSA) and/or a health reimbursement arrangement (HRA).
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- Documentation concerning CDPHP compliance with NY Regulation. 169 - Privacy of Consumer Financial and Health Information was provided in response to the DFS Market Conduct Privacy Practices related audit.

- 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 2018 included, Avoidance of Antibiotics for Acute Bronchitis, Improving Perinatal Care, HARP Transition of Care, All Cause Readmission, Increasing Cervical Screening in Women Age 21 to 64 to prevent or Reduce Incidences of Cervical Cancer, Management of Chronic Disease-CHF, HEDIS/QARR Measures Plan Results compared to State-wide Averages and the Diabetes Prevention Program.

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, clinical team 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

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>Number (9/30/15)</th>
<th>Number (12/31/16)</th>
<th>Number (12/18/17)</th>
<th>Number (12/01/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care physicians</td>
<td>3,133</td>
<td>2,898</td>
<td>3,745</td>
<td>3,693</td>
</tr>
<tr>
<td>Specialists including OB</td>
<td>9,266</td>
<td>5,525</td>
<td>10,788</td>
<td>6,680</td>
</tr>
<tr>
<td>Adjunct practitioners</td>
<td>4,220</td>
<td>3,913</td>
<td>4,677</td>
<td>2,190</td>
</tr>
<tr>
<td>EPC practitioners *</td>
<td>836*</td>
<td>850*</td>
<td>873*</td>
<td>1,002</td>
</tr>
</tbody>
</table>

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

Providers

<table>
<thead>
<tr>
<th>Providers</th>
<th>Number (9/30/15)</th>
<th>Number (12/31/16)</th>
<th>Number (12/18/17)</th>
<th>Number (12/01/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>74</td>
<td>76</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>117</td>
<td>117</td>
<td>92</td>
<td>116</td>
</tr>
<tr>
<td>Home health agencies</td>
<td>93</td>
<td>88</td>
<td>61</td>
<td>64</td>
</tr>
<tr>
<td>Outpatient surgery centers</td>
<td>30</td>
<td>29</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Other Including DME, lab,</td>
<td>7,016</td>
<td>4,820</td>
<td>235</td>
<td>1,431</td>
</tr>
<tr>
<td>radiology, and pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Behavioral Health Providers/Practitioners

<table>
<thead>
<tr>
<th>Practitioners</th>
<th>Number (12/31/14)</th>
<th>Number (9/30/15)</th>
<th>Number (12/31/16)</th>
<th>Number (12/18/17)</th>
<th>Number (12/01/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health</td>
<td>2,258</td>
<td>2,269</td>
<td>2,075</td>
<td>2,548</td>
<td>2,390</td>
</tr>
</tbody>
</table>

CDPHP continues to maintain a 26-county service area. The overall strategic goal of the healthcare network strategy (HNS) department is to align with providers in progressive population management payment models, which promote and incentivize pay-for-value, cost efficiencies, patient satisfaction, and quality care, while maximizing operational effectiveness and lower medical cost trend.

Healthcare network strategy continues to advance the objectives of the 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 2018, HNS continued enhancements with the network operations team to identify and develop interdepartmental processes and improve operational efficiencies. HNS continued success in provider recruitment, provider network exchange filing, implementation of several regulatory mandated initiatives, and the successful pilot of our first primary care total cost of care shared savings program.

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

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

H. Confidentiality

Overview
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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 2018 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 2018, CDPHP allocated 111 diverse employees, including staff, managers, directors, medical directors, and vice presidents, whose collective time comprised 78.25 FTE dedicated to the quality program. Our employee talent resources represented over 2,044 years of combined health care experience and was designed to lead, support, and drive our company-wide clinical
EXECUTIVE SUMMARY

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, QARR, NCOA, 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 2018, 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 2018, 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; identifying overuse, misuse, and fraud; and building community coalitions.

The 2018 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.
- 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 while preparing for a transition to a focus on the Quadruple Aim on 2019. There is information flow and integration between quality and operations activities to ensure initiatives are implemented to achieve quality objectives and meet goals. CDPHP finds its QI committee structure to be effective as it promotes organization-wide accountability for quality.

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

The senior VP, CMO, and the 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 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-six (76) practitioners actively participating in 2018 on the following committees: fourteen (14) practicing physicians served on QMC; fifteen (15) practitioners on P&T committee, sixteen (16) on UMC, ten (10) on credentialing committee, eleven (11) on BH UM committee and ten (10) on BH QSAH committee.

**Need to restructure or change the QI Program for 2019**: After reviewing and evaluating overall performance and program effectiveness of the 2018 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 2019. While resources dedicated to the QI program are currently adequate, CDPHP continually monitors those resources to ensure they remain adequate.