APPENDIX II – 2022 QUALITY IMPROVEMENT WORK PLAN

Capital District Physicians' Health Plan Inc.
Capital District Physicians' Healthcare Network, Inc.
CDPHP Universal Benefits,® Inc.
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Overview of Work Plan

The Quality Improvement (QI) Work Plan is organized into the following sections:

- **Part I- New NCQA Standards Activity Development**
  This section of the work plan identifies **new** activities that will be developed or enhanced to meet new National Committee for Quality Assurance (NCQA) 2020 Health Plan accreditation standards requirements

- **Part II- Annual QI Activities**
  This section of the work plan identifies activities that must be completed every 12 months.

- **Part III-Biennial QI Activities**
  This section of the work plan identifies activities completed at least every 24 months.

- **Part IV- Key QI Performance Indicators**
  This section of the work plan identifies the routine QI performance indicators used to monitor clinical and service performance.

Part I- New NCQA Standards Development Activities

QI Development Activities (New requirements or new processes)	Responsible Person	Start Date	Deadline/ Effective Date	Committee and Report Date	Completion Date
New 2022 NCQA Standard Requirements					
Promote Organizational Diversity, Equity, and Inclusion QI 1E-Factor 1; The organization describes how its recruiting and hiring processes promote a diverse workforce.	R. Golderman C. Farrelly N. Harrington	9/1/2021	7/1/2022	Quality Management Committee (QMC) 1/11/2022	6/30/2022
Determine whether there are policies and procedures that explain how the organization promotes diversity in recruiting and hiring and the training offered to employees on cultural competency, bias, or inclusion. The policy must explain the type of training offered and the frequency at which training is offered (QI 1E). If these policies and procedures do not exist, work with appropriate stakeholders to create them.	R. Golderman C. Farrelly N. Harrington	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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QI Development Activities (New requirements or new processes)	Responsible Person	Start Date	Deadline/ Effective Date	Committee and Report Date	Completion Date
Promote Organizational Diversity, Equity, and Inclusion QI 1E-Factor 2; The organization offers at least one training to all employees on cultural competence, bias, or inclusion. The organization determines training type and frequency.	R. Golderman C. Farrelly N. Harrington	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Gather material evidence demonstrating that the organization offers at least one training to all employees on cultural competence, bias, or inclusion (QI 1E-Factor 2).	C. Farrelly N. Harrington	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Promote health equity Population Health Management (PHM) 1A-Factor 6; The organization has a comprehensive PHM strategy that describes its commitment to improving health equity and the actions it takes to promote equity in management of member care. The organization determines how, and in what areas, it will promote health equity, and describes a plan for at least one action.	K. Leyden K. Ballou C. Farrelly Z. Ismail H. Skinner	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Update the PHM strategy by describing the organization's committee to health equity and how the organization promotes health equity in member care (PHM 1A -Factor 6). To meet the requirement, the PHM strategy must explain at least one specific action the organization takes to promote equity in management of member care.	C. Farrelly Z. Magdon Ismail	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Determine whether purchased vendors tools are used to perform the PHM 2A (data integration), 2B (population analysis), or 2D (segmentation) functions. If software vendor tools are used for these functions: ➢ Check to see whether the vendors appear on the list of organizations who have obtained NCQA Prevalidation Health IT Solution designation in organization support. If yes, obtain a dated screenshot of the webpage showing the vendor's status. For vendors that have not obtained or do not plan to obtain NCQA Pre-validated Health IT Solution designation in organization support perform delegation oversight by executing a delegation agreement (PHM 7A) with the vendor and initiate oversight of their performance for the delegated functions as required by PHM 7C.	C. Farrelly Z. Magdon Ismail H. Skinner	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Members of racial or ethnic groups PHM 2B -Factor 5; The organization may use direct or indirect data collection to assess the racial or and ethnic needs groups of its population. The organization may collect data directly at various points of interaction with members or indirectly from third-party sources. The organization describes needs that may be relevant or specific to member experiences or cultures from identified racial or ethnic groups.	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Members of racial or ethnic groups PHM 2B-Factor 6; The organization assesses and describes the needs of its members with limited English proficiency. To assess limited English proficiency, the organization must first collect data on its population's language profile. The organization may use direct or indirect data collection to determine the languages spoken by its members. The organization then utilizes the data to determine the needs of members whose primary language is a language other than English.	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Modify the population analysis, incorporating content to address the two new PHM 2B requirements, Factors 5 and 6: ➢ Assess both the race and ethnicity of the membership population and the race and ethnicity characteristics of the service area community as a whole; identify health care needs specific to races and ethnicities identified in the analysis (PHM 2B-Factor 5). Assess and describe the needs of members with limited English proficiency (PHM 2B-Factor 6). Start with using data collected on the languages spoken by organization members and then use that data to determine needs of individuals	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Incorporate content in the population analysis to address new PHM 2C-Factor 3 by using population assessment results to identify health care disparities by members of racial or ethnic minority groups (or individuals with limited English proficiency). Review and update programs, services, activities, or resources to address those disparities. The report must identify at least one review and update to at least one program, service, activity, or resource to address at least one discovered disparity.	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Obtain documentation either from vendor or internal staff who created tools used to segment and stratify the population that describes the process used to assess for racial bias in the stratification or segmentation methodology (PHM 2D-Factor 2).	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Document findings of racial bias analysis of the segmentation or stratification methods used in a report. If the analysis demonstrates no evidence of racial bias, explicitly state it in the report (PHM 2D-Factor 2).	Z. Ismail H. Skinner S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Determine if the health plan provides network practitioners access to at least one training on health equity, cultural competency, bias, diversity, and inclusion. It this exists, this evidence can be used to meet PHM 3A-Factor 6. The organization provides at least one training to practitioners in its network on topics of health equity, including cultural competence, bias, diversity, and inclusion. The organization chooses the training delivery type and frequency.	R. Golderman K. Leyden K. Ballou C. Farrelly Z. Ismail H. Skinner B. Freer	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Beginning the assessment within 30 calendar days of identification PHM 5D-Factor 12; The organization begins initial assessment within 30 calendar days of identifying a member for complex case management and completes the assessment within 60 calendar days of identifying the member. If the initial assessment begins after the first 30 calendar days of identifying the member, NCQA scores only Factor 12 "No"; the remaining factors are not marked down.	L. Grimshaw J. Wilson	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Conduct an annual analysis of the racial, ethnic, linguistic, and cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs (NET 1A).	P. Bleichert H. Skinner	9/1/2021			
The organization must measure the effectiveness of its actions each year. The organization may measure the same issue for both years and can select a new issue for the second year. (NET 3B-Factor 3)	P. Bleichert C. Ross M. Nitto T. Doherty C. Brown	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Determine if any member and/or provider materials, including denial notices, pharmacy recall notices or NET 4 notice of practitioner primary care provider (PCP), acute or chronic condition specialists, or OB/GYN) terminations are distributed through use of a mail service. If yes, NCQA now considers this delegation of distribution of these materials and delegation oversight requirements apply. Note: Mail services used distribution of member rights statement (ME 1B) and new member materials (ME 2A) is not considered delegation. Execute a delegation agreement with the vendor and initiate oversight of their performance for the delegated functions as required per the applicable standard.	C. Spinner L. Bird C. Collins M. Smith C. Farrelly J. Older	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Nonurgent preservice requests for Medicare and Medicaid product lines, UM 5A and UM 5B-Factor 5.	L. Hannan L. Grimshaw C. Donnelly	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Post service requests for Commercial, Exchange and Medicaid product lines, UM 5A and UM 5B-Factor 6.	L. Hannan L. Grimshaw C. Donnelly	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Medicare Part B and Medicaid urgent concurrent decisions, Medicare Part B and Medicaid urgent preservice decisions, Medicare Part B nonurgent preservice decisions and Medicaid nonurgent preservice decisions, UM 5C-Factors 2,4,6, and 7.	K. Verrelli K. Flanders	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Nonurgent preservice requests for Medicaid product line, UM 5C-Factor 7.	K. Verrelli K. Flanders	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
For post service decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. U 5C-Factor 8.	K. Verrelli K. Flanders	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
For Medicare and Medicaid, allowing at least 60 calendar days after notification of the denial for the member to file an appeal, UM 8A-Factor 2. For Medicaid, the decision for a post service appeal and notification to the member within 30 calendar days of receipt of the request, UM 8A-Factor 10.	C. Ross M. Nitto	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Annually monitoring the UM System Controls Process, UM 12A, UM 12C-Factor 7.	L. Hannan K. Verrelli A. Scialdone C. Ross M. Nitto	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Modify existing UM 12A, and UM 12C policies and procedures to incorporate new audit process requirements which include: ➢ Audit all modifications to denial receipt and notification dates which are done for reasons other than those outlined as acceptable in the policy (UM 12 A). ➢ Audit all modifications to appeal receipt and notification dates which are done for reasons other than those outlined as acceptable in the policy (UM 12C). Audit processes must include corrective action plans when there are findings of modifications done for reasons other than those outlined in your system control policies and quarterly follow-up auditing until results show improvement in at least one finding for three consecutive quarters.	L. Hannan K. Verrelli A. Scialdone C. Ross M. Nitto	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
UM Denial System Controls Oversight; UM 12B-Factors 1 and 2	L. Hannan K. Verrelli K. Flanders A. Scialdone	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Implement monitoring of UM denial system control compliance at least once annually by conducting audits of modifications to denial receipt and notification dates (UM 12B). ➢ Pull a report of all modifications completed for a reason other than those outlined in your policy (UM 12A). ➢ Review every single record which has a modification completed for a reason other than those allowed per policy (UM 12A) at least once a year. ➢ If audit findings reveal any modifications that are not permitted per policy (UM 12B): o Analyze the factors contributing to modifications for reasons not allowed per policy. o Implement actions to prevent a recurrence of unauthorized modifications. Conduct quarterly monitoring until you demonstrate improvement for at least three consecutive quarters.	L. Hannan K. Verrelli A. Scialdone C. Ross M. Nitto	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Implement monitoring of appeal system control compliance at least once annually by conducting audits of modifications to appeal receipt and notification dates (UM 12D). ➢ Pull a report of all modifications completed for a reason other than those outlined in your policy (UM 12C). ➢ Review every single record which has a modification completed for a reason other than those allowed per policy (UM 12D) at least once a year. ➢ If audit findings reveal any modifications that are not permitted per policy (UM 12D): o Analyze the factors contributing to modifications for reasons not allowed per policy (UM 12C). o Implement actions to prevent a recurrence of unauthorized modifications. Conduct quarterly monitoring until you demonstrate improvement for at least three consecutive quarters.	L. Hannan K. Verrelli A. Scialdone C. Ross M. Nitto K. Verrelli	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Amend existing delegation agreements for all Utilization Management (UM) and Care Management (CR) delegates who are performing any UM denials, appeals, or credentialing and recredentialing activities on behalf of the organization, adding the following content: ➢ Delegate's responsibility to meet the system control requirements applicable to the scope of their delegated responsibilities. ➢ Organization's process to annually evaluate both the delegate's system control policies and procedures and conduct an independent audit of delegate compliance with its' system control policies (UM 13 A-Factor 4 and CR 8A-Factor 4). ➢ Provision that delegates must monitor conduct internal audits of compliance with system control requirements (UM 12A and C-Factor 6 and CR 1C-Factor 4) at least annually per UM 12B and D, and CR 1D and report findings to the organization at least annually; and ➢ If either internal or health plan audit findings reveal any modifications that are not permitted per policy, the delegate will: o Analyze the factors contributing to modifications for reasons not allowed per policy. o Implement actions to prevent a recurrence of unauthorized modifications. Conduct quarterly monitoring until delegate demonstrates improvement for at least three consecutive quarters.	C. Farrelly S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Modify existing UM and CR delegation agreements, incorporating new system control responsibilities and reporting requirements for new delegation arrangements: ➢ Delegate's responsibility to meet the system control requirements applicable to the scope of their delegated responsibilities. ➢ Organization's process to annually evaluate both the delegate's system control policies and procedures and conduct an independent audit of delegate compliance with its' system control policies (UM 13 A-Factor 4 and CR 8A-Factor 4) ➢ Provision that delegates must monitor conduct internal audits of compliance with system control requirements (UM 12A and C-Factor 6 and CR 1C-Factor 4) at least annually per UM 12B ad D, and CR 1D and report findings to the organization at least annually. ➢ If either internal or health plan audit findings reveal any modifications that are not permitted per policy, the delegate will: o Analyze the factors contributing to modifications for reasons not allowed per policy. o Implement actions to prevent a recurrence of unauthorized modifications. Conduct quarterly monitoring until delegate demonstrates improvement for at least three consecutive quarters.	C. Farrelly S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Implement oversight of UM and CR delegate compliance with system control requirements applicable to their scope of delegated responsibilities: ➢ Evaluate delegate system control policies and procedures against UM 12A-D or CR 1C and 1D requirements and issue corrective action plans as needed to close gaps. ➢ Collect the delegate's own system control audit report and evaluate the methodology to confirm the process meets NCQA requirements and assess the audit results. If there are findings, assess the corrective action plan implemented to address the findings and schedule quarterly review of follow-up audit results. ➢ Conduct an independent audit of each delegate's system control processes to assess compliance with UM 12A and C, and CR 1C requirements (UM 13C-Factor 5 and CR 8C-Factor 5) at least annually. Compare your results to the results of the delegate's internal audit to determine if the delegate audit results are valid and reliable. If delegation audit finds issues of noncompliance with system control policies, place the delegate on corrective action and conduct quarterly monitoring for at least three consecutive quarters to evaluate whether the corrective action resolved the noncompliance (UM 13C-Factor 6 and CR 8C-Factor 6).	S. Ireland P. Hannan C. Ross M. Nitto M. Smith L. Ricci	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Annually monitors the delegate's UM denial and appeal system security controls and annually acts on all findings from Factor 5 for each delegate and implements a quarterly monitoring process UM 13C-Factors 5 and 6	L. Hannan S. Ireland C. Farrelly	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Annual monitoring of Delegate's UM Systems Control; UM 13C-Factor 5.	L. Hannan S. Ireland C. Farrelly	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Annual actions: the organization identifies and documents all actions it has taken, or plans to take, to address all modifications (findings from Factor 5) that did not meet the delegation agreement or the delegate's policies and procedures UM 13-Factor 6.	L. Hannan S. Ireland C. Farrelly	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Credentialing system controls oversight CR 1D-Factors 1, 2 and 3.	M. Smith C. Brown	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Modify existing CR 1C policies and procedures to incorporate new audit process requirements which include: ➢ Audit all modifications to credentialing records which are done for reasons other than those outlined as acceptable in the policy (CR 1C). Audit processes must include corrective action plans when there are findings of modifications done for reasons other than those outlined in your system control policies and quarterly follow-up auditing until results show improvement in at least one finding for three consecutive quarters.	M. Smith C. Brown	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Implement monitoring of credentialing system control compliance at least once annually by conducting audits of modifications to credentialing records (CR 1D). ➢ Pull a report of all modifications completed for a reason other than those outlined in your policy (CR 1C). ➢ Review every single record which has a modification completed for a reason other than those allowed per policy (CR 1D) at least once a year. ➢ If audit findings reveal any modifications that are not permitted per policy (CR 1D): o Analyze the factors contributing to modifications for reasons not allowed per policy (CR 1D). o Implement actions to prevent a recurrence of unauthorized modifications. Conduct quarterly monitoring until you demonstrate improvement for at least three consecutive quarters.	M. Smith C. Brown S. Ireland	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022

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Annual monitoring of CR systems controls, CR 8C-Factor 5.	M. Smith C. Brown	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Annual actions, CR 8C-Factor 6.	M. Smith C. Brown	9/1/2021	7/1/2022	QMC 1/11/2022	6/30/2022
Confirm that at least one of the email inquiry audit criteria assess the new definition of quality of the response whether the information provided was useful or understandable (ME 6D). If not, modify the criteria to cover this requirement.	D. Knights	7/1/2020	6/30/2021	QMC 1/11/2022	6/30/2021

Part II– Annual QI Activities

Annual QI Activities	Annual Review[1]	Responsible Person	Start Date	Committee and Report Date	Completion Date
Prepare 2021 QM program evaluation (NCQA QI 1)	Yes	C. Farrelly	9/1/2021	QMC 1/12/2022	12/31/2021
Prepare 2022 QM program description (NCQA QI 1) and incorporate the recommendations from the QI program evaluation.	Yes	C. Farrelly	9/1/2021	QMC 1/12/2022	12/31/2021
Prepare the annual 2022 QM work plan (NCQA QI 1)	Yes	C. Farrelly	9/1/2021	QMC 1/11/2022	12/31/2021
Ensure the QM program description explains the relationship between QM and population health management (PHM) program oversight and operations (NCQA QI 1A).	Yes	C. Farrelly	9/1/2021	QMC 1/11/2022	12/31/2021

[1]NCQA's Scoring Guidelines include requirements for completion of a number of activities on an "annual" basis. NCQA defines annual as **at least every 12 months** with a two-month grace period. Annual reviews completed within 14 months of the previous review receive a full compliance designation. Work plan activities with an "annual" requirement are denoted with a "Yes" in the Annual Review Column.

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Monitor previously identified issue (NCQA QI 1): Ongoing monitoring of Drive to 5 quality initiatives and PHM goal performance continue to be a priority focus. Specifically: ➢ Diabetic HbA1c Results- All lines of business (LOB) ➢ Antibiotic Utilization- Appropriate testing for Appropriate Testing for Children with Pharyngitis (CWP), Avoidance of Antibiotic Treatment (AAB), Appropriate Treatment for Children with Upper Respiratory Infections (URI) - All Lines of business (LOB) ➢ Colorectal Cancer Screening- All LOB	Yes	C. Farrelly M. Farina	1/1/2022	QMC 01/2023	12/31/2022
Audit PHM 1B materials for all programs involving interactive contact with members (including those offered by delegates) to ensure they include content for all factors in the element and include effective dates which allow you to demonstrate compliance across the entire survey look-back period (NCQA PHM 1B).	Yes	Z. Magdon Ismail Contributors: PHM Goal Business Owners	1/1/2022	QMC 01/2023	12/31/2022
Monitor at least four aspects of continuity and coordination of care between medical care providers (NCQA QI 3A). Data must be collected on both member movement between practitioners and member movement across settings. ➢ Performance rates for Planned All Cause Readmissions (PCR) ➢ Postpartum Care (PPC) ➢ Use of Opioids from Multiple Providers (UOP) ➢ Comprehensive Diabetes Care (CDC)- Eye Examination ➢ Ensure that the report considers unique barriers applicable to members in each accredited product line	Yes	M. Farina	1/1/2022	QMC 01/2023	12/31/2022
Implement actions to improve three aspects of continuity and coordination of care between medical care providers (QI 3B).	Yes	M. Farina	1/1/2022	QMC 01/2023	12/31/2022
Measure the effectiveness of at least three actions implemented to improve continuity and coordination of care between medical care providers (NCQA QI 3C).	Yes	M. Farina	1/1/2022	QMC 01/2023	12/31/2022

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Monitor the continuity and coordination of medical and behavioral health care, addressing all six requirements in this element. Analyze results and implement at least two actions to address opportunities for improvement (NCQA QI 4A-B). ➢ Exchange of information: Provider Satisfaction Survey ➢ Appropriate diagnosis, treatment and referral of behavioral disorders commonly seen in primary care: Healthcare Effectiveness Data and Information Set (HEDIS®) Measure: Antidepressant Medication Management (AMM) ➢ Appropriate use of psychotropic medication: HEDIS Measure: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) ➢ Management of treatment access and follow-up for members with coexisting medical and behavioral disorders: HEDIS Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) ➢ Primary or secondary preventive behavioral health care program implementation: Postpartum Depression Screening ➢ Special needs of members with severe and persistent mental illness: HEDIS Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Ensure that the report considers unique barriers applicable to members in each accredited product line.	Yes	T. Doherty C. Rorie Alexandrov M. Farina	1/1/2022	QMC 01/2023	12/31/2022
Measure the effectiveness of at least two actions implemented to improve continuity and coordination of care between medical and behavioral health care providers (NCQA QI 4C).	Yes	T. Doherty C. Rorie Alexandrov M. Farina	1/1/2022	QMC 01/2023	12/31/2022
Review and approve the QM program for all QI delegates, regardless of NCQA accreditation or certification status (NCQA QI 5C-Factor 1).	Yes	C. Farrelly S. Ireland	1/1/2022	QMC 01/2023 Joint health committee quarterly and annually monitoring (06/2022)	12/31/2022

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Audit PHM 1B materials for all programs involving interactive contact with members (including those offered by delegates) to ensure they include content for all factors in the element and include effective dates which allow you to demonstrate compliance across the entire survey look-back period.	Yes	Z. Magdon Ismail C. Farrelly Respective Business Owners	1/1/2022	QMC 01/2023	12/31/2022
Conduct an analysis of the needs and characteristics of the entire health plan population. Identify sub-populations that require assistance and determine whether the current population health program services and resources are adequately meeting those needs (NCQA PHM 2B and C).	Yes	Z. Magdon Ismail Contributor: Corporate Analytics	1/1/2022	QMC 01/2023	12/31/2022
Modify the population analysis to identify at least two distinct subpopulations, explain how you determined the subpopulation is relevant to your membership as a whole and considers at least two characteristics or needs for each subpopulation (NCQA PHM 2B Factor 2).		Z. Magdon Ismail Contributor: Corporate Analytics	1/1/2022	QMC 01/2023	12/31/2022
Compile a report that demonstrates your process to at least annually segment and stratify the entire enrolled population into subsets for targeted intervention based on their health needs (NCQA PHM 2D).	Yes	Z. Magdon Ismail Contributor: Corporate Analytics	1/1/2022	QMC 01/2023	12/31/2022
Conduct a comprehensive analysis of PHM strategy activities (NCQA PHM 6A). Complete the data analysis and implement actions to improve performance for at least one opportunity (NCQA PHM 6B).	Yes	Z. Magdon Ismail	1/1/2022	QMC 01/2023	12/31/2022
Measure PCP, high-volume and high impact specialist, and behavioral health practitioner availability against organization standards (NCQA NET 1B-D).	Yes	P. Bleichert	1/1/2022	QMC 01/2023	12/31/2022

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Annual QI Activities	Annual Review[1]	Responsible Person	Start Date	Committee and Report Date	Completion Date
Ensure the cultural needs and preferences analysis considers either data gathered from members or literature on cultural needs and preferences of individuals with similar race, ethnicity and linguistic characteristics of your members and assesses whether your practitioner network meets member needs (NCQA NET 1A). Assess the racial, ethnic, linguistic, and cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs.	Yes	P. Bleichert Corporate Analytics	1/1/2022	QMC 01/2023	12/31/2022
Measure compliance with organization standards for PCP appointment and after-hours accessibility (NCQA NET 2A).	Yes	M. Smith C. Brown	1/1/2022	QMC 01/2023	12/31/2022
Measure compliance with organization standards for behavioral health practitioner appointment accessibility (NCQA NET 2B).	Yes	C. Rorie Alexandrov T. Doherty	1/1/2022	QMC 01/2023	12/31/2022
Measure compliance with organization standards for high volume and high impact specialist appointment accessibility (NCQA NET 2C).	Yes	M. Smith C. Brown	1/1/2022	QMC 01/2023	12/31/2022
Analyze member experience with accessing the network through review of member complaints, appeals, member survey data about access and out-of-network utilization for behavioral health and non-behavioral health services to identify network gaps which could impact member ability to access care (NCQA NET 3A).	Yes	C. Ross T. Doherty M. Nitto	1/1/2022	QMC 01/2023	12/31/2022
Analysis of out-of-network behavioral health requests and utilization for all accredited product lines when evaluating behavioral health network adequacy (NCQA NET 3C).	Yes	C. Rorie Alexandrov T. Doherty P. Bleichert	1/1/2022	QMC 01/2023	12/31/2022
Identify opportunities to improve access to non-behavioral health services through review of data from NCQA NET 1B and C and NET 2A and C analyses plus member complaints, appeals, out-of-network utilization and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results related to non-behavioral health network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions (NCQA NET 3B).	Yes	J. Keohan P. Hannan C. Ross M. Nitto P. Bleichert T. Doherty	1/1/2022	QMC 01/2023	12/31/2022

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Identify opportunities to improve access to behavioral health services through review of data from NCQA NET 1D and NET 2B analyses plus member complaints, appeals, out-of-network utilization and survey results related to behavioral health network adequacy. Implement actions to address at least one opportunity and measure the effectiveness of those interventions (NCQA NET 3C).	Yes	C. Rorie Alexandrov T. Doherty P. Bleichert	1/1/2022	QMC 01/2023	12/31/2022
Evaluate the accuracy of the online physician directory data on office locations and phone numbers, hospital affiliations, accepting new patients and awareness of physician office staff of practitioner network participation status using valid methodology. Analyze results, identify opportunities to improve the accuracy of information in the directory and implement action to improve performance (NCQA NET 5A, 5B, 5C, 5D and 5G).	Yes	A. Bellinger M. Olsen	1/1/2022	QMC 01/2023	12/31/2022
Review and approve the network management procedures for all NET delegates, regardless of NCQA accreditation or certification status (NCQA NET 5E, NET 5H)	Yes	R. Monthony	1/1/2022	QMC 01/2023	12/31/2022
Prepare 2021 UM program evaluation (NCQA UM 1).	Yes	J. Keohan L. Hannan	9/1/2021	QMC 01/2022	12/31/2021
Prepare 2022 UM program description (NCQA UM 1).	Yes	J. Keohan L. Hannan	9/1/2021	Utilization Management Committee (UMC) 03/2022 QMC 05/2022	12/31/2021
Review and update UM criteria (NCQA UM 2).	Yes	J. Keohan L. Hannan	1/1/2022	QMC 01/2023	12/31/2022
Evaluate consistency of UM decision-making by all reviewers (NCQA UM 2). Actions for improvement based on results will be documented.	Yes	J. Keohan L. Hannan	1/1/2022	QMC 01/2023	12/31/2022
Analyze the timeliness of all UM decisions and notifications (both approvals and denials). Report data separately for each UM case type (urgent and non-urgent precertification, urgent concurrent and post-service) for non-behavioral, behavioral and pharmacy services (NCQA UM 5D).	Yes	J. Keohan L. Hannan C. Rorie Alexandrov L. Grimshaw K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022

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Distribute formulary information to all existing practitioners and members (NCQA UM 11B).	Yes	L. Reed T. Thomas K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022
Review and update pharmacy management procedures (NCQA UM 11D).	Yes	L. Reed T. Thomas K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022
Review and update the formulary (NCQA UM 11D).	Yes	L. Reed T. Thomas K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022
Review and approve the UM program for all UM delegates, regardless of NCQA accreditation or certification status (NCQA UM 13C-Factor 1).	Yes	S. Ireland J. Keohan L. Hannan	1/1/2022	QMC 01/2023	12/31/2022
Report data on tracking and trending patterns of complaints and sentinel events/adverse occurrences about individual practitioners at least every six months (NCQA CR 5).	Semi-annual	M. Smith C. Ross	1/1/2022	QMC 01/2023	12/31/2022
Review and approve the CR program for all CR delegates, regardless of NCQA accreditation or certification status (NCQA CR 8C-Factor 1).	Yes	M. Smith S. Ireland	1/1/2022	QMC 01/2023	12/31/2022
Distribute notice informing all existing practitioners and members about the opportunity to request a copy of the Member Rights and Responsibility Statement (NCQA ME 1B).	Yes	C. Spinner	1/1/2022	QMC 01/2023	12/31/2022
Distribute information about how to use benefit plan to all existing members (NCQA ME 2A).	Yes	C. Spinner	1/1/2022	QMC 01/2023	12/31/2022
Ensure that new member communications for members in commercial and Marketplace product lines includes content which informs them about the right to external independent review of appeals (ME 3A).	Yes	T. Boland	1/1/2022	QMC 01/2023	12/31/2022
Measure the quality and accuracy of pharmacy benefit information communicated via the web, assessing each function required in NCQA ME 5A (ME 5C).	Yes	K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022
Measure the quality and accuracy of pharmacy benefit information communicated via the phone (call calibration) (NCQA ME 5C).	Yes	C. Spinner R. Barret	1/1/2021	QMC 01/2023	12/31/2021
Measure the quality and accuracy of PCP change requests submitted via the web (NCQA ME 6C).	Yes	D. Knights	1/1/2022	QMC 01/2023	12/31/2022
Measure the quality and accuracy of information regarding services requiring referral and authorization on the web (NCQA ME 6C).	Yes	C. Spinner	1/1/2022	QMC 01/2023	12/31/2022

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Confirm that all measures for both phone and web quality for ME 5C and ME 6C assess quality and accuracy separately. Quality measures must assess usefulness or understandability of information provided. Accuracy measures must assess how correct or precise the information provided was (NCQA ME 5C and ME 6C).		C. Spinner R. Barret K. Verrelli	1/1/2022	QMC 01/2023	12/31/2022
Measure the quality and accuracy of treatment cost estimator information available on the web (NCQA ME 6C).	Yes	R. Monthony	1/1/2021	QMC 01/2023	12/31/2021
Measure the quality and accuracy of information communicated via the phone regarding which services require referral and authorization and estimated treatment costs (NCQA ME 6B).	Yes	C. Spinner R. Barret	1/1/2022	QMC 01/2023	12/31/2022
Measure email inquiry turnaround time and quality of responses (NCQA ME 6D).	Yes	D. Knights	1/1/2022	QMC 01/2023	12/31/2022
Complete an analysis of non-behavioral health related member complaints, appeals, and CAHPS satisfaction survey results to identify opportunities to address sources of member dissatisfaction (NCQA ME 7C and D).	Yes	C. Ross M. Nitto S. Beck	1/1/2022	QMC 01/2023	12/31/2022
Conduct a separate analysis of member complaints and appeals related to behavioral health services (NCQA ME 7E).	Yes	C. Rorie Alexandrov T. Doherty	1/1/2021	QMC 01/2023	12/31/2021
Conduct a separate survey to measure member satisfaction with behavioral health services (NCQA ME 7E).	Yes	C. Rorie Alexandrov T. Doherty	1/1/2022	QMC 01/2023	12/31/2022
Identify opportunities to improve behavioral health services based on NCQA ME 7E analyses, implement actions to improve performance and measure the effectiveness of the actions (NCQA ME 7F).	Yes	C. Rorie Alexandrov T. Doherty	1/1/2022	QMC 01/2023	12/31/2022
Perform annual delegation site visits, as needed, to evaluate compliance with Health Plan and NCQA standards (QI 5, PHM 7, NET 6, UM 13, CR 8, ME 8).	Yes	S. Ireland C. Farrelly M. Smith	1/1/2022	QMC 01/2023	12/31/2022
Collect HEDIS and CAHPS data for all accredited product lines.	Yes	S. Beck M. Farina	1/1/2022	QMC 01/2023	12/31/2022

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Part III- Biennial QI Activities

Biennial QI Activities[2]	Responsible Person	Start Date	Committee and Report Date	Completion Date
Prepare a report which shows the percent of total payments made during the reporting period that are value-based payments (VBP). Categorize the organization's VBP arrangements into the types outlined in the PHM 3B explanation for reporting (NCQA PHM 3B).	P. Zuchowski	1/1/2022	QMC 01/2023	Next review to be completed by 12/31/ 2022
Assess the racial, ethnic, linguistic, and cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs (NCQA NET 1A).	P. Bleichert	1/1/2022	QMC 01/2023	12/31/2022
Conduct usability testing of the online practitioner directory whenever changes are made to the user interface, but no less than every three years (NCQA NET 6K).	R. Monthony	1/1/2022	QMC 01/2023	12/31/ 2022
Evaluate new member understanding of marketing communications and implement actions to improve (NCQA ME 3C).	C. Spinner	1/1/2022	QMC 01/2023	12/31/2022

[2] This section lists NCQA requirements that must be performed at least every two years. You may perform them annually if desired, but that is not required.

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Part IV– Key QI Performance Indicators (KPI)

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
PHM Management Strategy				
Flu Vaccinations	Keeping members healthy ages through promotion of influenza vaccination. **Goals:** 1. The percentage of the childhood target population who received two influenza immunizations is in the national 90th percentile for each line of business (LOB). 2. The percentage of adults who reported receiving an influenza immunization is in the national 90th percentile for each LOB.	Semi-annually	L. Fox	Quality Management Committee (QMC)
Cancer Screening Awareness Program	Keeping members healthy through promotion of cancer screening for: Women 50-74 years of age in the Healthcare Effectiveness Data and Information Set (HEDIS) Breast Cancer Screening (BCS) measure; or Women 21-64 years of age in the cervical cancer screening (CCS) measure; or Men and women 50-75 years of age in the Colorectal Cancer Screening (COL) measure. **Goals:** 1. The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer is in the national 90th percentile for each LOB. 2. The percentage of women 21–64 years of age who were screened for cervical cancer is in the national 90th percentile for each LOB. 3. The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer is in the national 90th percentile for each LOB.	Semi-annually	L. Pulver K. Leyden	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Behavioral Health Case Management	Promote behavioral health case management for members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes (SMD). **Goal:** The percentage of members 18–64 years of age with SMD who had both an LDL-C test and an HbA1c test during the measurement year is in the national 90th percentile for Commercial LOB, Medicaid and Health and Recovery Plan (HARP) and are at the NYS 90th percentile and Medicare at the 5-star cut point.	Semi-annually	T. Doherty C. Rorie Alexandrov J. Arcuri	QMC
Hypertension Management	Promote hypertension management for members 18-85 years of age who had a diagnosis of hypertension during measurement year. **Goal:** Increase the percent of members adherent to hypertension medication at 80% Proportion Days Covered (PDC) among the targeted population who filled a hypertension medication in the measurement year (applying Medicare Stars RAS Antagonists Adherence measure specifications across all LOBs). Achieve PDC rates of: • Commercial HMO: 75% • Commercial PPO: 67% • Essential Plan: 75% • Marketplace HMO: 67% • Medicaid: 71% • HARP: 71% • Medicare HMO: 86% • Medicare PPO: 88%	Semi-annually	J. Dragon	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Hyperlipidemia Programming	Promote hyperlipidemia management through medication adherence. **Goal:** The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period as follows: • Commercial HMO/POS:74% • Commercial PPO: 77% • Essential Plan: 74% • Marketplace HMO: 87% • Medicaid: 63% • HARP: 56% • Medicare HMO: 83% • Medicare PPO: 86%	Semi-annually	J. Dragon	QMC
Multiple Chronic Condition Management	Promote chronic condition management for members experiencing acute myocardial infarction (acute MI), coronary artery bypass graft surgery (CABG), heart failure, percutaneous cardiac intervention (PCI), and valve procedures with a second chronic condition and requiring cardiac rehabilitation. **Goal:** 25% of eligible members will engage in one or more cardiac rehabilitation visits.	Semi-annually	Z. Magdon Ismail L. Grimshaw	QMC
Member Satisfaction with the Cardiac Rehabilitation Program	Monitor satisfaction for members receiving services through the Cardiac Rehabilitation Program. **Goal:** Achieve an overall satisfaction rate of 75% among members engaged in the Cardiac Rehabilitation Program.	Annually	Z. Magdon Ismail	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Member Satisfaction with the Hospital to Home Program	Monitor satisfaction for members receiving services through the Hospital to Home Program. **Goal:** Achieve an overall satisfaction rate of 75% among members engaged in the Hospital to Home Program. €	Annually	Z. Magdon Ismail	QMC
Behavioral Health Coordination of Care Program	Monitor post hospitalization follow up for members six years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses (FUH). **Goal:** The percentage of discharges for members six years of age and older who were hospitalized for treatment of FUH and who had a follow-up visit with a mental health practitioner within seven days after discharge is in the national 90th percentile for Commercial LOB, Medicaid, and HARP are at the NYS 90th percentile and Medicare at the 5-star cut point.	Semi-annually	C. Rorie Alexandrov T. Doherty J. Arcuri	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Readmission Avoidance	Promote patient safety across the settings for members 18 years of age and older with a high probability of having an unplanned readmission for a medical diagnosis within 30 days of an acute inpatient stay and members 18 years of age and older with a high probability of having an unplanned readmission for a medical diagnosis within 30 days of an acute inpatient stay and engage with the CDPHP Readmission Avoidance program **Goals:** 1. Reduce the risk adjusted readmission rate among members with a high probability of having an unplanned readmission for a medical diagnosis within 30 days of an acute inpatient stay during the measurement year to achieve the following observed to expected readmission ratios: Commercial HMO 0.76, Commercial PPO 0.59, HARP 2.0, Marketplace HMO 1.24, Medicaid 1.54, Medicare HMO 0.78, and Medicare PPO 1.56. 2. Achieve a satisfaction rate of 98% among members in the Readmission Avoidance program when asked how well your case manager helped you understand the steps you need to take to be successful in meeting your health goals.	Semi-annually	Zainab Magdon Ismail Dr. Renzi	QMC
Transition of Care - Hospital Experience	Members admitted to the hospitals are connected with either in person or virtually bedside to ensure that their needs are met, and post-acute discharge needs are taken care of. They are also introduced to an outpatient care manager who will conduct a medication reconciliation, assess barriers to care and ensure follow up with PCP/specialist. **Goal:** Bedside engagement with 90% of hospitalized members.	Semi-annually	Zainab Magdon Ismail	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Acute Hospital and Inpatient Utilization	Monitor inpatient utilization- general hospital/acute care (IPU) for Medicaid and HARP members 10-64 years of age, this measure summarizes utilization of acute inpatient care and services across maternity, surgery, medicine into a total inpatient (the sum of maternity, surgery, and medicine) utilization per 1,000 estimate. **Goal:** Reduce hospital utilization to at or below targeted discharges per 1,000 for each LOB within the measure.	Semi-annually	Zainab Magdon Ismail	QMC
Core Documents				
QM Program Description and Work Plan (NCQA: QI)	Annual QM program's goals, objectives, structure, and work plan for 2022 reviewed, approved by QMC and board of directors.	Annually	C. Farrelly	QMC and Board
QM Program Evaluation (NCQA QI 1- Q5)	Annual QM evaluation reporting the program's progress in meeting established goals and objectives for 2022. Plan for 2023 program activities based on the results from QM 2021 evaluation.	Annually	C. Farrelly	QMC and Board
Patient Safety Plan *(Refer to Appendix II)* Safety Plan 2022	Annual plan on how CDPHP addresses patient safety improvement approved by QMC and the board of directors	Annually	C. Farrelly	QMC and Board
Utilization Management Program Description 2022 (NCQA: UM 1A)	Annual utilization management program description and work plan on how the plan addresses utilization management structure, physician, and BH involvement, behavioral health aspects of the program, and determination of benefit coverage and medical necessity.	Annually	J. Keohan L. Hannan C. Rorie Alexandrov	QMC and Board
Utilization Management Program Evaluation (NCQA: UM 1B)	Annually review and document the effectiveness of the utilization management program and progress toward goals. Plan for 2022 program activities based on the results from utilization management 2021 evaluation.	Annually	J. Keohan L. Hannan	UMC, QMC and Board
Annual Utilization Management Program Policies Procedure Review (NCQA: UM 5)	Annually review/revise the utilization management policy and procedures for the upcoming year.	Annually	L. Snow S. Decker	UMC, QMC and Board

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Assessment of Cultural, Linguistics, and language needs of membership and provider network to meet member needs (NCQA: QI 1, NET 1A; DOH, CMS)	Analysis of all available data [U.S. Census, enrollment, Centers for Medicare & Medicaid Services (CMS), HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), New York State Department of Health (NYSDOH)] to determine if needs of members are being met. Assess the diversity of provider network to meet the needs of our members. Increase staff/provider cultural competency, health literacy, and overall health equity through 2021 focus on LOB member health literacy and cultural competency.	Annually	P. Bleichert	QMC
HEDIS® MY 2022 HEDIS/QARR Submission HEDIS Medicare Submission	Completion of HEDIS® MY 2022 project goals/objectives by the regulatory agencies due date: • Meet HEDIS road map goals. • HEDIS education training-95% inter-rater score. • HEDIS data collection within approved Measle, Mump Rubella Vaccine (MMRV) requirements. • Full Compliance with National Committee of Quality Assurance (NCQA) onsite HEDIS audit. • Complete HEDIS MY 2022 data submission by June 15, 2023.	Annually	M. Farina	QMC and Board
National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Renewal Survey 2024	Ongoing preparedness activities for successful completion of *NCQA HPA renewal Survey by April 2024* and achieve renewal accredited status. CDPHP legal entities: Capital District Physicians' Healthcare Network, Inc. (CDPHN), CDPHP Universal Benefits,® Inc. (CDPHP UBI), and Capital District Physicians' Healthcare Network, Inc. (CDPHN) document fully meets file review standards by March 2024 (survey 24-month lookback period) and fully meets NCQA HPA 2023 requirements for structure, process, and outcome by March 2024. **Goal:** Achieve full points available for overall accreditation score for all accredited products.	Annually	C. Farrelly	QMC and Board

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Implement New NCQA HPA Accreditation Standards for 2022	Published 2022 NCQA standards and guidelines include new standards to be implemented by July 1, 2022. Maintain a constant state of survey readiness by implementing 2022 requirements, updates, corrections, and policy clarifications as distributed by NCQA regarding QI, UM, Network (NET), PHM, Credentialing (CR) and Member Experience (ME) standards/elements/factors. Address any gaps in meeting the requirements and close the gaps prior to July 1, 2022.	Annually	C. Farrelly	QMC and Board
Delegation Oversight (NCQA QI 5, PHM 7, NET 6, UM 13, CR 8, ME 8)	Maintain oversight of First Tier, Down Stream Related Entities (FDRs) and other delegated entities' activities through quarterly reporting and annual documentation oversight by joint health services committee (JHSC) up to QMC and to the board of directors.	Annually	C. Farrelly S. Ireland	QMC and Board

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Community Wellness	Offer Community-based programs and virtual programs that help our healthy members and future members stay healthy and assist those with existing medical conditions in optimizing their health and functional capacity. Improve the health of the community through meaningful participation at various community events and through the planning, development, and implementation of the CDPHP Healthy Neighborhood series, which focuses on improving access to both health and community resources. CDPHP partners with local professionals, businesses, and other resources to offer members and future members free classes and workshops. CDPHP organizes class content each year and promotes the no-cost virtual offerings to our community across our area and virtually on CDPHP.com and in the member portal. **Goals:** **1.** Conduct a minimum of five Healthy Neighborhood events at locations attracting Medicare and commercial populations. **2.** Increase engagement in health-related activities (health assessments, screenings, vaccines, etc.) at community events by 10%. **3.** Gather and document market research and member feedback for continuous improvement of community and virtual programming. **4.** Offer 70 or more free community and/or virtual classes in total.	Annually	M. Reed K. Leyden	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Workplace Wellness	Workplace health services provides CDPHP employer groups health promotion activities and strategic support to help improve employee health and manage health care costs through workplace wellness programs. Groups participating in the shared health program receive additional clinical data management support in combination with financial strategies aimed to increase employee participation and engagement, increase retention, decrease absenteeism, increase productivity, and reduce health care spending. **Goal:** Engage interested employer groups to develop, implement, and analyze customized workplace wellness plans supporting employer group goals.	Annually	K. Leyden A. Reinhardt	QMC
Technology Assessment				
Technology Assessment	Evaluate new technology and/or new uses for existing technology, including medical and behavioral health technologies. **Goal:** The technology assessment team shall meet to review, provide consideration for approval of new and existing medical and behavioral health technologies. Related policies are approved by the policy committee.	Ad Hoc	E. Warner L. Snow	UMC Committee Ad hoc QMC
Utilization Management: Service Indicators				
Receipt/Determination Turnaround (TAT)	Percent of determinations made in three business days or less from date of when complete information is received. **Goal:** TAT => 96%	Four times per year	J. Keohan L. Hannan	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Monitoring for under- and over- utilization	To measure use of services and identify incidences of higher or lower than expected utilization using the following key indicators: Measure rates: days/1000, discharges/1000, Inpatient length of stay, ER/1000 visits. **Goal:** Under- Utilization, HEDIS Data, less than 10th percentile Over- Utilization, HEDIS Data, greater than 90th percentile	Annually	Z. Magdon Ismail	QMC
Behavioral Health: Service Indicators				
Behavioral Health Access Center Telephone Abandonment Rate	Percentage of callers who hang up prior to being connected to a phone representative. **Goal:** <= 5%	Four times per year	C. Rorie-Alexandrov T. Doherty C. Donnelly	QMC
Behavioral Health Access Center Average Speed of Answer (ASA)	Length of time BH caller waits before call is answered **Goal:** ASA < 30 seconds	Four times per year	C. Rorie-Alexandrov T. Doherty C. Donnelly	QMC
Behavioral Health Access Center Call Answer Timeliness Percent	Percentage of member calls answered in 30 seconds or less **Goal:** > 70%	Four times per year	C. Rorie-Alexandrov T. Doherty C. Donnelly	QMC
Behavioral Health Turnaround Time for determinations	Percent of determinations made in 3 business days or less from date of complete information **Goal:** TAT >= 96%	Four times per year	C. Rorie-Alexandrov T. Doherty L. Grimshaw	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Inter-rater Reliability	Each CDPHP staff person who makes decisions on clinical or contractual benefits shall be tested (evaluated) for consistency in applying the criteria. **Department** — **Goal** Ambulatory Review Specialists — 90% Appeals Analysts/Clinical Appeals Specialists — 90% Case Management (Long Term, Social Work) — 90% Inpatient Care Coordinators — 90% Medical Directors — 90% Pharmacists/Certified Pharmacy Technicians — 90% Referral Services (Case Managers/OOA and Specialists) — 90% Quality Review Specialists — 90% Member Complaints and Quality Committees Coordinator — 90% Disease Management — 90% Behavioral Health Services — 90%	Annually	Multiple Contributors: J. Keohan K. Verrelli C. Ross M. Nitto C. Rorie Alexandrov L. Grimshaw P. Hannan C. Murtagh	QMC
Preventive Guidelines-Chronic Disease Practice Guidelines				
Chronic Disease Practice Guidelines- CHF	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due: 01/2022	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Perinatal	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due:11/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Asthma	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due:07/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Hypertension	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due:09/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Diabetes Mellitus	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due:05/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines - Diagnosis of Diabetes: *Criteria and Testing*	**Goal**: Biennial review, revision (as needed) and approval	Biennial review Due:05/2023	C. Murtagh	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Preventive Health Guidelines- Preventive Health: Children 0-12 years Adolescents 13-20 years Women and Men –Use of pneumococcal conjugate vaccine	**Goal:** Annual review, revision (as needed) and approval.	Biennial review Due:03/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Pneumonia	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 07/2022	C. Murtagh	QMC
Chronic Disease Practice Guidelines- COPD	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 05/2023	C. Murtagh	QMC
Preventive Guidelines- Influenza Prevention Control and Reporting	**Goal**: Annual review, revision (as needed) and approval.	Biennial review Due: 03/2023	C. Murtagh	QMC
Preventative Guidelines- Child and Adolescent Overweight and Obesity Guidelines	**Goal:** Annual review, revision (as needed) and approval.	Biennial review Due: 01/2023	C. Murtagh	QMC
Preventive Guidelines- STI Screening Guidelines for sexually active patients	**Goal:** Annual review, revision (as needed) and approval.	Biennial review Due: 03/2023	C. Murtagh	QMC
Preventive Guidelines- HIV Guidelines	**Goal:** Annual review, revision (as needed) and approval.	Biennial review Due: 12/2023	C. Murtagh	QMC
Chronic Disease Practice Guidelines- Use of Atypical Antipsychotic Medications in Children and Adolescents	**Goal:** Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- AACAP's Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents	**Goal:** Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC

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Chronic Disease Practice Guidelines- ADHD	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- ADHD for Primary Care	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- Depression for Primary Care	**Goal:** Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- Bipolar	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- PTSD	**Goal:** Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Chronic Disease Practice Guidelines- Schizophrenia	**Goal**: Biennial review, revision (as needed) and approval.	Biennial review Due: 03/2023	T Doherty M. Susser	QMC
Continuity and Coordination of Care Monitoring				
Continuity and Coordination of Care Studies: *Specialist to Primary Care Physician*	Annual medical record study. The monitoring of care, the communication regarding the care, and the coordination of care from on setting to another. *From a specialist's care back to the PCP* 2020 Result :50% **Goal:** 90%	Annually	C. Murtagh	QMC
Facility to PCP	From a facility/ other setting to practitioner 2020 Result 42% **Goal**: 90%	Annually	C. Murtagh	QMC
AD Hoc Regulatory Audits/Quality of Care Studies	Ad Hoc quality studies as requested by regulatory agencies as NYSDOH, CMS, HEDIS 2022, and 2022 Interim HEDIS Measures. **Goal**: Meet standard.	Annually	C. Murtagh	QMC

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Perinatal Study/ Hysterectomy Sterilization Consents for Medicaid	NYSDOH Article 44 Hysterectomy 2022 Performance: 61.90% **Goal:** 90% Sterilization 2022 Performance: 63.16% **Goal:** 95%	Annually	C. Murtagh	QMC
Programs To Improve Quality				
Enhanced Primary Care (EPC) NCQA: PCMH Level III	Meet or exceed EPC effectiveness measures: Number of imputed members meeting measure (numerator)/number of imputed in measure (denominator) = practice rate.	Four times per year	M. Farina M. Courtney	QMC

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Enhanced Primary Care (EPC) NCQA: PCMH Level III	EPC - Internal medicine effectiveness metrics for 2022 quality measures: 1. Breast Cancer Screening (BCS) 2. Cervical Cancer Screening (CCS) 3. Colorectal Cancer Screening (COL) 4. Chlamydia Screening in Women (CHL) 5. Avoidance of Antibiotic Treatment (AAB) 6. Eye Exam for Patients with Diabetes (EED) 7. Hemoglobin A1c Control for Patients with Diabetes (HBD) 8. Kidney Health Evaluation for Patients with Diabetes (KED) 9. Statin Therapy for Patients With Diabetes (SPD) 10. Statin Therapy for Patients With Cardiovascular Disease (SPC) 11. Persistence of Beta Blocker Treatment After a Heart Attack (PBH) 12. Asthma Medication Ratio (AMR) 13. Controlling High Blood Pressure (CBP) 14. Osteoporosis Management in Women Who Had a Fracture (OMW) 15. Osteoporosis Screening in Older Women (OSW) 16. Transitions of Care (TRC) 17. Antidepressant Medication Management (AMM) 18. Non-Recommended PSA-Based Screening in Older Men (PSA) 19. Plan All-Cause Readmissions (PCR) 20. Emergency Department Utilization (EDU) 21. Cardiac Rehabilitation (CRE)	Four times per year	M. Farina M. Courtney	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Enhanced Primary Care (EPC) NCQA: PCMH Level III	EPC - Internal medicine effectiveness metrics for 2022 quality measures: ***CG – CAHPS Questions:* # 4. Did you get an appointment with your doctor as quickly as you thought you needed to? # 8. (Communication): How often did this doctor seem informed and up to date about the care you got from specialists? (almost always/always) # 9. During your most recent visit, did this provider listen carefully to you? # 11. (Overall rating): Using any number from 0 to 10 where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? (9/10) # 16. In the last 12 months, how often were you able to get the care you needed from this provider's office during the evening, weekends, or holidays? CG CAHPS **Composite of Questions #4, #8, #9, #11, #16	Four times per year	M. Farina M. Courtney	QMC

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Enhanced Primary Care (EPC) NCQA: PCMH Level III	EPC - Pediatric effectiveness metrics for 2022 quality measures: 1. Appropriate Testing for Pharyngitis (CWP) 2. Appropriate Treatment for Upper Respiratory Infection (URI) 3. Avoidance of Antibiotic Treatment (AAB) 4. Follow-up Care for Children Prescribed ADHD Medication (ADD) – New medication start. 5. Follow-up Care for Children Prescribed ADHD Medication (ADD) – Med maintenance 6. Asthma Medication Ratio (AMR) 7. Well-Child Visits in the First 30 Months of Life (W30) – 6 visits in first 15 months 8. Well-Child Visits in the First 30 Months of Life (W30) – 2 visits within 15-30 months 9. Child and Adolescent Well-Care Visits (WCV), 3-11 years 10. Child and Adolescent Well-Care Visits (WCV), 12-17 years 11. Child and Adolescent Well-Care Visits (WCV), 18-21 years 12. Chlamydia Screening in Women (CHL) 13. Childhood Immunization Status (CIS) – by age 2 – Combo10 14. Lead Screening in Children (LSC) 15. Immunizations for Adolescents (IMA) – HPV 16. Immunizations for Adolescents (IMA) – Meningococcal 17. Immunizations for Adolescents (IMA) – Tdap/Td 18. Immunizations for Adolescents (IMA) – by age 13 – Combo2) 19. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 20. Emergency Department Utilization (EDU) 21. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	Four times per year	M. Farina M. Courtney	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Enhanced Primary Care (EPC) NCQA: PCMH Level III	EPC - Pediatric effectiveness metrics for 2022 quality measures: ***CG – CAHPS Questions:* # 4. Did you get an appointment with your doctor as quickly as you thought you needed to? # 8. (Communication): How often did this doctor seem informed and up to date about the care you got from specialists? (almost always/always) # 9. During your most recent visit, did this provider listen carefully to you? # 11. (Overall rating): Using any number from 0 to 10 where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? (9/10) # 16. In the last 12 months, how often were you able to get the care you needed from this provider's office during the evening, weekends, or holidays? CG CAHPS **Composite of Questions #4, #8, #9, #11, #16	Four times per year	M. Farina M. Courtney	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Enhanced Primary Care (EPC) NCQA: PCMH Level III	Family medicine effectiveness metrics for 2022 quality measures: 1. Breast Cancer Screening (BCS 2. Cervical Cancer Screening (CCS) 3. Colorectal Cancer Screening (COL) 4. Chlamydia Screening in Women (CHL) 5. Avoidance of Antibiotic Treatment (AAB) 6. Appropriate Testing for Pharyngitis (CWP) 7. Childhood Immunization Status (CIS) 8. Appropriate Treatment for Upper Respiratory Infection (URI) 9. Immunizations for Adolescents (IMA) 10. Kidney Health Evaluation for Patients with Diabetes (KED) 11. Eye Exam for Patients With Diabetes (EED) 12. Hemoglobin A1c Control for Patients With Diabetes (HBD) 13. Statin Therapy for Patients With Diabetes (SPD 14. Statin Therapy for Patients With Cardiovascular Disease (SPC 15. Asthma Medication Ratio (AMR) 16. Controlling High Blood Pressure (CBP) 17. Osteoporosis Screening in Older Women (OSW) 18. Non-Recommended PSA-Based Screening in Older Men (PSA) 19. Plan All-Cause Readmissions (PCR) 20. Emergency Department Utilization (EDU) 21. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) 22. Cardiac Rehabilitation (CRE)	Four times per year	M. Farina M. Courtney	QMC

<table>
<tr><th>Indicator Name</th><th>Performance Goal</th><th>Frequency of Reporting</th><th>Responsible Person</th><th>Responsible Committee</th></tr>
<tr><td>Enhanced Primary Care (EPC)

NCQA: PCMH Level III</td><td>Family medicine effectiveness metrics for 2022 quality measures:

*CG – CAHPS Questions:

4. Did you get an appointment with your doctor as quickly as you thought you needed to? (NEW)
8. (Communication): How often did this doctor seem informed and up to date about the care you got from specialists? (almost always/always)
9. During your most recent visit, did this provider listen carefully to you?
11. (Overall rating): Using any number from 0 to 10 where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider? (9/10)
16. In the last 12 months, how often were you able to get the care you needed from this provider's office during the evening, weekends, or holidays? (NEW)

CG CAHPS **Composite of Questions #4, #8, #9, #11, #16</td><td>Four times per year</td><td>M. Farina
M. Courtney</td><td>QMC</td></tr>
<tr><td>2023 CMS Medicare Star Ratings Measures</td><td>Part C: (25 Measures)
Medicare HMO and PPO Members</td><td>Annually</td><td>K. Prout</td><td>QMC
Medicare Stars Steering Committee</td></tr>
<tr><td></td><td>
<table>
<tr><th><u>Staying Healthy</u>
<u>Process Measures</u>:</th><th>HMO Goal</th><th>PPO Goal</th></tr>
<tr><td>C01- Breast Cancer Screening (BCS)</td><td>76</td><td>76</td></tr>
<tr><td>C02- Colorectal Cancer Screening (COL)</td><td>80</td><td>80</td></tr>
<tr><td>C03- Annual Flu Vaccine</td><td>80</td><td>80</td></tr>
<tr><td>C04- Monitoring Physical Activity</td><td>57</td><td>57</td></tr>
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</td><td></td><td></td><td></td></tr>
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Managing Chronic Long-Term Conditions *Process Measures:*			
C08- Osteoporosis Management (OMW)	68	68	
C09- Diabetes Care- Eye Exam	79	79	
C10- Diabetes Care- Kidney Disease Monitoring	97	97	
C12- Controlling Blood Pressure (CBP)	81	81	
C13- Reducing the Risk of Falling	72	72	
C14- Improving Bladder Control	53	53	
C15- Medication Reconciliation Post-Discharge (MRP)	82	82	
C16- Statin Therapy for Patients with Cardiovascular Disease (SPC Therapy)	89	89	
Managing Chronic Long-Term Conditions *Intermediate Measures:*			
C11- Diabetes Care- Blood Sugar Controlled	81	81	
CAHPS - Member Experience with Health Plan *Experience/Complaints:*			
C17- Getting Needed Care	85	85	
C18- Getting Appointments and Care Quickly	82	82	
C19- Customer Service	92	92	
C20- Overall Rating of Health Care Quality	89	89	
C21- Overall Rating of Plan	90	90	
C22- Care Coordination	88	88	
Member Complaints and Improvements in Plan's Performance *Experience/Complaints:*			
C23- Complaints about the Health Plan	0.17	0.17	
C24- Members Choosing to Leave the Plan	9	9	

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Indicator Name	Performance Goal			Frequency of Reporting	Responsible Person	Responsible Committee
	Member Complaints and Improvements in Plan's Performance *Outcome Measure*					
	C25- Health Plan Quality Improvement	0.344	0.344			
	Customer Service *Access Measures:*					
	C26- Plan Makes Timely Decisions about Appeals	97	97			
	C27- Reviewing Appeals Decisions	96	96			
	C28- Call Center Foreign Language Interpreters	94	94			

2022 CMS Medicare Star Ratings Measures	Part D: (12 Measures) Medicare HMO and PPO Members	**HMO Goal**	**PPO Goal**	Annually	K. Prout	QMC Medicare Stars Steering Committee
	<u>Drug Plan Customer Service</u> *<u>Access Measures</u>*<u>:</u>					
	D01-Foreign Language Interpreter and Teletypewriter (TTY)	94	94			
	Member Complaints and Improvements in Plan's Performance Experience/Complaints: *<u>Experience/Complaints</u>*					
	D02- Complaints about the Drug Plan	0.17	0.17			
	D03- Members Choosing to Leave Plan	9	9			
	<u>Member Complaints and Improvements in Plan's Performance</u> *<u>Improvement Measure:</u>*					
	D04- Drug Plan Quality Improvement	0.684	0.684			
	<u>Member Experience with Drug Plan</u> *<u>Experience/Complaints:</u>*					
	D05- Rating of Drug Plan	88	88			
	D06- Getting Needed Prescription Drugs	92	92			
	<u>Patient Safety and Drug Pricing Accuracy</u> *<u>Process Measure</u>*<u>:</u>					
	D07- Medicare Plan Finder (MPF) Price Accuracy	96	96			
	D08- MTM Program Completion Rate	89	89			
	D09- Statin Use in Persons with Diabetes (SUPD)	88	88			
	<u>Patient Safety and Drug Pricing Accuracy</u> <u>Intermediate *Measure*</u>:					
	D10- Part D Medication Adherence for Diabetes	91	91			
	D11- Part D Medication Adherence for Hypertension	90	90			

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Indicator Name	Performance Goal			Frequency of Reporting	Responsible Person	Responsible Committee
	D12- Part D Medication Adherence for Cholesterol	91	91			

Medicaid Quality Incentive NOTE: To remain in place until annual performance report received from the NYSDOH.	**Primary Care** 1. Antidepressant Medication Management 2. Asthma Medication Ratio 3. Breast Cancer Screening 4. Cervical Cancer Screening 5. Chlamydia Screening in Women 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care - Eye Exam (retinal) Performed 8. Comprehensive Diabetes Care - HbA1c Poor Control (>9%) 9. Controlling High Blood Pressure 10. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 11. Medication Management for People with Asthma (Ages 5-64) 12. Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 13. Use of Spirometry Testing in the Assessment and Diagnosis of COPD 14. Children's Health 15. Annual Dental Visit (Ages 2-18) 16. Childhood Immunization Status (Combo 3) 17. Immunizations for Adolescents (Combo 2) 18. Well Child Visits in the First 15 Months of Life – Five or more visits 19. Well Child Visits in the 3rd, 4th, 5th, and 6th Year of Life 20. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **Mental Health** 1. Adherence to Antipsychotic Medications for Individuals with Schizophrenia 2. Diabetes Screening for People With Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications 3. Follow-Up After Emergency Department Visit for Mental Illness Within seven Days 4. Follow-Up After Hospitalization for Mental Illness Within seven Days 5. Follow-Up Care for Children Prescribed ADHD Medication 6. Metabolic Monitoring for Children and Adolescents on Antipsychotics	Annually	M. Farina	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
	7. Substance Use 8. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Within seven Days 9. Initiation of Pharmacotherapy upon New Episode of Opioid Dependence **Maternity** 1. Timeliness of Prenatal Care 2. Postpartum Care **HIV** 1. Viral Load Suppression **Satisfaction Measures (30 points)** 1. Rating of Health Plan 2. Getting Care Needed 3. Customer Service **Total Satisfaction Points** **PQIs (20 points)** 1. Adult Prevention Quality Overall Composite (PQI 90) 2. Pediatric Quality Overall Composite (PDI 90) **Total PQI Points** Compliance Measures (20 points for subtraction) • MMCOR • QARR • Access/Availability • Provider Directory • Member Services • Behavioral Health Parity • Claims Payment/Denials			

HARP Quality Incentive NOTE: To remain in place until annual performance report received from the New York State Department of Health	1. Antidepressant Medication Management 2. Asthma Medication Ratio (19-64 years) 3. Breast Cancer Screening 4. Cervical Cancer Screening 5. Chlamydia Screening (21-24 years) 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) 8. Comprehensive Diabetes Screening: Received All Tests 9. Controlling High Blood Pressure 10. Flu Shots for Adults (CAHPS) 11. Medical Assistance with Tobacco Cessation (Composite) 12. Medication Management for People with Asthma (Ages 19-64) (Composite) 13. Statin Therapy for Patients With Cardiovascular Disease- Statin Adherence 80% 14. Use of Spirometry Testing in the Assessment of COPD **HIV Care** 1. Viral Load Suppression **Behavioral Health Measures for HARP Members** 1. Adherence to Antipsychotic Medications for Individuals with Schizophrenia 2. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 3. Follow Up After Hospitalization for Mental Illness- 7-day rate 4. Follow-up after Discharge from the Emergency Department for Mental Health- 7-day rate 5. Potentially Preventable Mental Health Related Readmission Rate 30 Days **Substance Use Measures** 1. Follow-up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence- 7-day rate 2. Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 3. Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence Within 7 Days	Annually	M. Farina	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
	4. Follow-Up After High-Intensity Care for Substance Use Disorder 5. Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence 6. Pharmacotherapy for Opioid Use Disorder 7. Use of Pharmacotherapy for Alcohol Abuse or Dependence			
Department of Health (DOH) and Center for Medicaid and Medicare Services (CMS) Quality Improvement Initiatives				
CMS- Chronic Care Improvement Project (CCIP)	Medicare HMO and PPO contracts with CMS require 3-year CCIP. The CCIP goal aligns with CMS strategic goal for the improvement in health outcomes for members on Statin Therapy. **Goal:** Improve Stain Use for eligible Medicare HMO and Medicare PPO members in the Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD) HEDIS measures and the Statin Use in Persons with Diabetes (SUPD) Medicare Stars measure.	Semi-annually	C. Farrelly	QMC
CMS- Quality Improvement Strategy (QIS): Cervical Cancer Screening	To Improve the Marketplace HMO, EPO, and Essential Plan member completion rate of cervical cancer prevention screening. The QIS will focus on increasing cervical cancer screening to prevent or reduce the incidences of cervical cancer in our Marketplace HMO, EPO, and Essential Plan women members 21-64 years of age through network access to providers to perform cervical cytology or cytology HPV according to the HEDIS CCS measure tech specifications. The QIS includes a market-based provider incentive for marketplace members and all other product lines. CDPHP payment model incentives providers on their overall effectiveness and efficiency through a year-end bonus payment to improve performance on quality measures such as cervical cancer screening. **Goal:** To improve CCS from baseline year CDPHP HEDIS 2016-CY 2015 for HMO and EPO Marketplace rates to the New York statewide average of 79% by the end of the QIS, Dec. 31, 2022.	Semi-annually	C. Farrelly	QMC

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NYS DOH- Adult Preventive Dental Care Performance Improvement Project (PIP) 2022-2023	Improving rates of preventive dental care for Medicaid managed care members and HIV SNP adults ages 21 through 64 years of age. Specifically: • Improve preventive dental care among adult Medicaid members. • Decrease nontraumatic dental visits to the emergency department.	Semi-annually	S. Ireland M. Farina	QMC
NYS DOH Performance Improvement Project (PIP) HARP: Care Transitions Study 2022-2023	Improving cardiometabolic monitoring and outcomes for HARP members with Diabetes Mellitus 2022-2023 Improvement Project	Semi-annually	J. Arcuri T. Doherty M. Farina	QMC
QARR- Quality Performance MATRIX - Compared to Statewide Averages (SWA)				
2021 HEDIS/QARR Matrix Targeted Focus: HARP Population Medicaid Population	HARP Members: To Be Determined (TBD) Medicaid Members: TBD	Semi-annually	M. Farina T. Doherty J. Arcuri	QMC
CAHPS - Annual Satisfaction Surveys				

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Medicaid CAHPS Survey Results	Multiple linear regression analyses were run on the DSS Research Commercial Adult Book of Business to assess which composites are Key Drivers of Rating of Health Plan, Rating of Health Care, and Rating of Personal Doctor to identify opportunities for improvement: • Customer service. • How well doctors communicate. • How well doctors communicate coordination of care. **Goal:** Improvement to the next percentile or to maintain percentile if already 95th for: • Customer Service: National 95th percentile of prior year quality compass. • How well do doctors communicate: National 95th percentile of prior year quality compass. • Coordination of Care: National 90th percentile of prior year quality compass.	Annually	H. Skinner S. Beck M. Farina	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Commercial HMO and PPO Products CAHPS Survey	Improve CAHPS Survey results specific to Areas Identified as "Monitor" or "Opportunity" as compared to DSS Research CAHPS Book of Business *(survey in field 02/2021-05/2021):* • Customer service. • How well doctors communicate. • Coordination of care. **Goal:** Improvement to the next Percentile. **HMO Goals:** • Customer Service: National 90th percentile of prior year quality compass. • How well do doctors communicate: National 95th percentile of prior year quality compass. • Coordination of Care: National 75th percentile of prior year quality compass. **PPO Goals:** • Customer Service: National 95th percentile of prior year quality compass. • How well do doctors communicate: National 75th percentile of prior year quality compass. • Coordination of Care: National 90th percentile of prior year quality compass.	Annually	M. Farina C. Ross M. Nitto Member & Provider Satisfaction Team Corporate Analytics	QMC
Medicare HMO and PPO Products CAHPS Survey	Improve CAHPS Survey results specific to Areas Identified as "Monitor" or "Opportunity" as compared to DSS Research CAHPS Book of Business (survey *in field 02/2021-05/2021):* • Member Experience with Health Plan: *Coordination of Care.* • Getting Care Quickly. • Getting Needed Rx Drug.	Annually	M. Farina K. Prout Member & Provider Satisfaction Team Corporate Analytics	QMC

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Assessing New Member Understanding Survey	Measure new member understanding of benefits and address opportunities for improvement as identified through the 2020 survey results. **Goal:** Improvement that is statistically significant.	Annually	C. Spinner	QMC
Member Satisfaction with PCP	CG-CAHPS survey performed to measure level of member satisfaction with care provided by imputed physician during the survey period. **Goal:** Improvement that is statistically significant.	Semi-annually	S. Beck H. Skinner Corporate Analytics	QMC
Case Management Member Satisfaction	Survey performed to determine how well case management programs are meeting members' needs, specifically related to positive impact on members' recovery. **Goal:** Maintain and improve members overall satisfaction with case management experience at or above 88%	Annually	L. Grimshaw Z. Magdon Ismail	QMC
Physician Satisfaction Survey	Survey performed to measure level of physician satisfaction with the Plan for the previous year **Goal:** Meet or exceed 94.70%	Annually	B. Freer C. Charette	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Qualified Health Plan (QHP) Enrollee Experience Survey	Measure satisfaction of our Marketplace members in HMO and EPO product in 2021. Vendor to conduct survey is DSS Research. Spring 2022 survey in field. **Goals** **Customer Service Goals:** • Customer Service Courtesy and Respect: Percentile of 82%. • Customer Service Provided Needed Information to help: Percentile of 98%. **How well Doctors Communicate Goals:** • Doctor explained things: Percentile of 98%. • Doctor Listened Carefully: Percentile of 99%. • Doctor Showed Respect: Percentile of 98%. • Doctor spent enough time: Percentile of 93%. **Coordination of Care Goals:** • Doctor had medical records and info: Percentile of 78%. • Got test results: Computed percentile of 68%. • Doctor informed about care from specialists: Percentile of 85%. • Doctor discussed all prescription medications: Percentile of 72%. • Got help from doctor's office to manage care: Percentile of 30%.	Annually	M. Farina S. Beck	QMC
HEDIS Effectiveness Quality Measures				
Childhood Immunizations (CIS)	The percentage of two-year-old's who are appropriately immunized on or before the second birthday.	Four times per year	M. Farina	QMC
Combo 10: 4 DTaP, 3IPV, 1MMR, 3 HiB, 3 HepB, 1VZV, 4PCV, 1 HepA, 2 or 3 RV, 2 Flu.	**HMO/POS:** HEDIS MY 2020, 70.48% **Goal:** TBD **Medicaid/CHPs:** QARR MY 2020, 51.82% **Goal:** TBD **PPO:** HEDIS MY 2020, 68.64% **Goal:** TBD	Four times per year	M. Farina	QMC

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Well Child Visits in the first 30 months of Life (W30)	The percentage of members who receive the appropriate number of well-child visits with their PCP during the first 30 months of life. **HMO/POS:** HEDIS MY 2021 15 months, 89.08% **Goal:** TBD **HMO/POS:** HEDIS MY2021 15-30 Months, 97.53% **Goal:** TBD Medicaid/ CHPs: QARR MY2020 15-30 months,85.67% **Goal:** TBD **PPO:** HEDIS MY 2020 15 months,90.16% **Goal:** TBD **PPO:** HEDIS MY2021 15-30 months, 94.11% **Goal:** TBD	Four times per year	M. Farina	QMC
Child and Adolescent Well-Care Visits (WCV)	The percentage of members aged 3-21 who received an annual appropriate visit with their PCP in the calendar year. **HMO/POS:** HEDIS MY 2020, 9.43% **Goal:** 95% **Medicaid/CHPs:** QARR 2020, 67.51% **Goal:** 95% **PPO:** HEDIS MY2020, 71.28% **Goal:** 95%	Four times per year	K. Leyden M. Farina	QMC
Lead Screening (LSC)	The percentage of members who receive lead screening on or before two years of age. **HMO/POS:** HEDIS MY2020, 89.31% **Goal:** 93% **Medicaid/CHPs:** QARR 2020, 88.41% **Goal:** 90% **PPO:** HEDIS MY2020, 91.84% **Goal:**93%	Four times per year	M. Farina	QMC
Immunizations for Adolescents (IMA) (Combo 1)	The percentage of adolescents 13 years of age who had: One dose of meningococcal conjugate or meningococcal polysaccharide vaccine on or between the member's 11th or 13th birthday and one Tdap or TD on or between the member's 10th and 13th birthdays. **HMO/POS**: HEDIS MY2020, 93.67% **Goal:** 96% **Medicaid/CHPs:** QARR 2020, 89.72% **Goal:** 96% **PPO**: HEDIS MY2020, 90.65% **Goal:** 96%	Four times per year	M. Farina	QMC

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Human Papilloma Virus (HPV) for female Adolescents	The percentage of adolescents 13 years of age who had received three doses or two doses at 146 days between the 1st and 2nd dose of the HPV vaccine by their 13th birthday. **HMO/POS:** HEDIS MY2020, 33.58% **Goal:** 40% **Medicaid/ CHPs:** QARR MY2020, 37.23% **Goal:** 40% **PPO:** HEDIS MY2020, 29.96% **Goal:** 40%	Four times per year	M. Farina	QMC
Breast Cancer Screening (BCS) (Addressed in the Cancer Screening Awareness Drive to 5 Clinical Team)	The percentage of women members 50-74 years of age who had a mammogram to screen for breast cancer on or between October 1 two years prior to the measurement year and December 31 of the measurement year. **HMO/POS:** HEDIS MY2020, 77.47% **Goal:** 81% **PPO:** HEDIS MY2020, 76.58% **Goal:** 81% **Medicaid:** HEDIS MY2020, 60.76% **Goal:** 69% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina L. Pulver K. Leyden	QMC
Appropriate Treatment for with Upper Respiratory Infection (URI) (Address in the Antibiotic Stewardship Drive to 5 Clinical Team)	The percentage of members three months and older who were given a diagnosis of URI and who were <u>not</u> dispensed an antibiotic prescription **HMO/POS:** HEDIS MY2020, 88.80% **Goal:** 95% **Medicaid/ CHPs:** QARR MY2020, 93.33% **Goal:** 95% **PPO:** HEDIS MY2020, 85.94% **Goal:** 95%	Four times per year	M. Farina S. Ireland C. Farrelly	QMC
Appropriate Testing for with Pharyngitis (CWP) (Address in the Antibiotic Stewardship Drive to 5 Clinical Team)	The percentage of members three months and older who were given a diagnosis Pharyngitis, dispensed an antibiotic, and who received a group A Strep test for the episode. **HMO/POS:** HEDIS MY2020, 84.67% **Goal:** 95% **Medicaid/ CHPs:** MYQARR 2020, 87.96% **Goal:** 95% **PPO:** HEDIS MY2020, 80.36% **Goal:** 95%	Four times per year	M. Farina S. Ireland C. Farrelly	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Avoidance of Antibiotic Treatment with Acute Bronchitis/Bronchiolitis (AAB) (Address in the Antibiotic Stewardship Drive to 5 Clinical Team)	The percentage of members three months of age and older diagnosed with acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription. **HMO/POS:** HEDIS MY2020, 43.39% **Goal:** 40% **Medicaid/CHPs:** QARR MY2020, 53.37% **Goal:** 50% **PPO:** HEDIS MY2020, 43.18% **Goal:** 40%	Four times per year	S. Ireland C. Farrelly	QMC
Osteoporosis Management in Women Who had A Fracture (OMW)	The percentage of women members 67+ years of age who had a fracture and then had either a bone mineral density test or prescription for a drug to treat or prevent osteoporosis in the six months after the date of the fracture. **Medicare HMO: 29.74%** **Goal:** 50% **Medicare PPO: Small N** **Goal:** 50%	Four times per year	M. Farina K. Prout Medicare STARS Team	QMC
Cervical Cancer Screening (CCS) (Addressed in the Cancer Screening Awareness Drive to 5 Clinical Team)	The percentage of women 21-64 years of age who have had a cervical cytology within the past three years or those aged 30-64 who had cervical cytology/human papilloma virus (HPV) co-testing every five years. *HEDIS 2019 repeated due to impact of the COVID-19 pandemic **HMO/POS:** HEDIS MY2020, 83.41% **Goal:** 83% **PPO: ***HEDIS MY 2020, 81.15% **Goal:** 83% **Medicaid:** HEDIS MY2020, 67.99% **Goal:** 73%	Four times per year	M. Farina L. Pulver K. Leyden C. Farrelly	QMC
Non- Recommended Cervical Cancer Screening in Adolescent Females (NCS)	The percentage of adolescent females ages 16-20 who were screened unnecessarily for cervical cancer. **HMO/POS:** HEDIS MY2020, 1.63% **Goal:** 0.2% **Medicaid:** QARR MY2020, 0.69% **Goal:** 0.1% **PPO:** HEDIS MY2020, 1.15%% **Goal:** 0.2%	Four times per year	M. Farina	QMC

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Adults' Access to Preventive/ Ambulatory Health Services (AAP)	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. **HMO/POS:** HEDIS MY2020, 99.73% **Goal:** 98% **Medicaid:** QARR MY2020,84.81% **Goal:** 90% **PPO:** HEDIS MY2020, 96.00% **Goal:** 98%	Four times per year	M. Farina	QMC
Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia in the calendar year. **HMO/POS:** HEDIS MY2020, 69.34% **Goal:** 75% **Medicaid/CHPs:** QARR MY2020, 67.59% **Goal:** 75% **PPO:** HEDIS MY2020, 64.13% **Goal:** 75%	Four times per year	M. Farina	QMC
Colorectal Cancer Screening (COL) (Addressed in the Cancer Screening Awareness Drive to 5 Clinical Team)	The percentage of adults aged 50-75 who had appropriate screening for colorectal cancer **HMO/POS:** HEDIS MY2020, 74.59% **Goal**: 76% **PPO:** HEDIS MY 2020, 76.35%% **Goal:** 76% **Medicaid:** HEDIS MY2020 56.36% **Goal:** 67% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina L. Pulver K. Leyden	QMC
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)	The percentage of members age 18+ discharged from July 1, 2019-June 30, 2020, with a diagnosis of AMI who received persistent beta blocker treatment for 6 months after discharge. **HMO/POS:** HEDIS MY2020, 93.18% **Goal:** 95% **Medicaid:** QARR MY2020, 83.33% **Goal:** 90% **PPO:** HEDIS MY2020, 98.72 % **Goal:** 95% **Medicare HMO:** HEDIS MY2020, 88.64% **Goal:** 94% **Medicare PPO:** small numerator (N)	Four times per year	M. Farina	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Comprehensive Diabetes Care (CDC) Drive to 5 Clinical Team	The percentage of members age 18-75 with diabetes who have evidence of appropriate diabetes care as measured by the following indicators:	Four times per year	M. Farina	QMC
Hemoglobin A1c Control for members with Diabetes (HBD)) 1. Poor HbA1c Control (>9%)	**HMO/POS:** HEDIS MY2020, 18.03% **Goal:**16% **Medicaid:** QARR MY2020, 35.14% **Goal:** 24% **PPO:** HEDIS MY2020, 22.11% **Goal:** 16% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC
2. Hemoglobin A1c Control for members with Diabetes (HBD) Adequate HbA1c Control (<8%)	**HMO/POS:** HEDIS MY2020, 72.68%% **Goal:** 73% **Medicaid:** QARR MY2020, 55.77% **Goal:** 63% **PPO:** HEDIS MY2020, 69.47% **Goal:** 73% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC
Eye Exam for patients with Diabetes (EED)	**HMO/POS**: HEDIS MY2020, 57.38% **Goal:** 73% **Medicaid:** QARR MY2020, 58.97% **Goal:** 73% **PPO:** HEDIS MY2020, 62.89% **Goal:** 73% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC
Comprehensive Diabetes Care (CDC) Medical Attention for Nephropathy	**Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC
Kidney Health Evaluation (KED)	**HMO/POS**: HEDIS MY2020, 30.52% **Goal:** 62% **Medicaid:** QARR MY2020, 29.71% **Goal:** 59% **PPO:** HEDIS MY2020, 26.89% **Goal:** 62% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Blood Pressure control for Patients with Diabetes (BPD) (<140/90 mm/hg)	**HMO/POS:** HEDIS MY2020, 76.78% **Goal:** 80% **Medicaid:** QARR MY2020, 72.48% **Goal:** 78% **PPO:** HEDIS MY2020, 73.42% **Goal:** 80% **Medicare HMO:** see stars goals above **Medicare PPO:** see stars goals above	Four times per year	M. Farina	QMC
Diabetes Screening for People with Schizophrenia or bipolar Disorder Who Are using Antipsychotic Medications (SSD) NCQA QI4	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. **Medicaid: 85%** **HARP: 85%** 2022 goal is based on the New York state 90th percentile.	Semi-annually	M. Farina C. Rorie Alexandrov T. Doherty	QMC
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) PHM Goal NCQA QI4	The percentage of members 18-64 years of age with schizophrenia and diabetes who had both and LDL-C test and an HbA1c test during the measurement year. **Medicaid:** Goal: 85% **HARP:** Goal: 85% 2022 goal is based on the New York state 90th percentile.	Semi-annually	C. Rorie Alexandrov T. Doherty	QMC
Cardiovascular Monitoring for People with Diabetes with Cardiovascular Disease and Schizophrenia (SMC)	The percentage of members 18-64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year. **Medicaid:** small n **HARP:** small n 2022 goal is based on the New York state 90th percentile.	Semi-annually	C. Rorie Alexandrov T. Doherty	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	The percentage of members 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. The member must have both tests during the measurement year: 1. At least one test for blood glucose or HbA1c 2. At least one test for LDL-C or cholesterol **HMO/POS**: **Goal**: 47% **PPO**: **Goal**:44% **Medicaid**: **Goal:** 51% 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid and HARP are at the New York state 90th percentile.	Semi-annually	M. Farina C. Rorie Alexandrov T. Doherty	QMC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment in the 121-day period from 90 days prior to the Indian Prairie School District (IPSD) through 30 days after the IPSD. **HMO/POS**: **Goal**: 71% **PPO:** **Goal** 69% **Medicaid**: **Goal**: 71% 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid and HARP are at the New York state 90th percentile.	Semi-annually	M. Farina C. Rorie Alexandrov T. Doherty	QMC
Controlling High Blood Pressure (CBP) Drive to 5 Clinical Team	Member percentage with hypertension, ages 18-85, whose blood pressure is adequately controlled (<140/90) during the measurement year. **HMO/POS:** HEDIS MY2020, 78.35% **Goal**: 80% **Medicaid:** QARR MY2020, 71.78% **Goal**: 80% **PPO:** HEDIS MY2020x, 72.75% **Goal**: 80% **Medicare HMO:** HEDIS MY, 77.37% **Goal**: 87% **Medicare PPO:** HEDIS MY2020, 79.56% **Goal**: 87%	Four times per year	M. Farina J. Dragon	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Asthma Medication Ratio (AMR) Drive to 5 Clinical Team	The percentage of members age 5-64 who were identified as having persistent asthma and had a ratio of controller medication to total asthma medication of 0.50 or greater during the measurement year. **HMO/POS:** HEDIS MY2020, 82.08% **Goal**: 88% **Medicaid/CHPs:** QARR MY2020, 66.03% **Goal**: 67% **PPO:** HEDIS MY2020, 81.83% **Goal**: 88%	Semi-annually	M. Farina	QMC
Prenatal and Postpartum care (PPC) 1. Timeliness of prenatal care *2.* Postpartum Care	The percentage of members who gave birth and received appropriate prenatal and postpartum care. 1. The percentage of members who gave birth and received a prenatal care visit in the first trimester: **HMO/POS:** HEDIS MY2020, 96.59% **Goal**: 99% **Medicaid:** QARR MY2020, 94.65% **Goal**: 99% **PPO:** HEDIS MY2020, 96.11% **Goal**: 99% 2. The percentage of deliveries that had a postpartum visit on or between 7 and84 days after delivery. **HMO/POS:** HEDIS MY2020, 95.38%% **Goal**: 95% **Medicaid:** QARR MY2020, 81.75% **Goal**: 95% **PPO:** HEDIS MY2020, 90.75% **Goal**: 95%	Four times per year	M. Farina	QMC
Use of Spirometry Testing in the Assessment and diagnosis of COPD (SPR)	The percentage of members age 40+ with new diagnosis or newly acquired COPD who received appropriate spirometry testing to confirm the diagnosis. **HMO/POS:** HEDIS MY2020,38.49% **Goal**: 51% **Medicaid:** QARR MY2020, 30.80% **Goal**: 41% **PPO:** HEDIS MY2020, 43.52% **Goal**: 51% **Medicare HMO:** HEDISMY 2020, 34.85% **Goal**: 55% **Medicare PPO:** HEDIS MY2020, 32.84% **Goal**: 55%	Four times per year	M. Farina J. Wilson	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Pharmacotherapy Management of COPD Exacerbation (PCE) Two Rates: 1. Dispensed a bronchodilator within 30 days of the event. 2. Dispensed systemic corticosteroid within 14 days of the event. Drive to 5 Clinical Team	The percentage of COPD exacerbations for members 40+ of age who had an acute inpatient discharge or ED visit between January 1 and November 30 of the measurement year and were dispensed appropriate medications. Two rates are reported. **1. HMO/POS:** HEDIS MY2020, 86.36% **Goal**: 91% **1. Medicaid:** QARR MY2020,89.39% **Goal**: 91% **1. PPO:** HEDIS MY2020,77.88% **Goal**: 91% **1. Medicare HMO:** HEDIS MY2020, 82.88% **Goal**: 91% **1. Medicare PPO:** HEDIS MY2020, 80% **Goal**:: 91% **2. HMO/POS:** HEDIS MY2020, 68.18% **Goal**: 87% **2. Medicaid:** QARR MY2020,75.98% **Goal**: 85% **2. PPO:** HEDIS MY2020, 82.54% **Goal**: 87% **2. Medicare HMO:** HEDIS MY2020, 72.50% **Goal**: 83% **2. Medicare PPO:** HEDIS MY2020, 86.67% **Goal**: 83%	Semi-annually	M. Farina	QMC
Potentially Harmful drug-Disease Interactions in the Elderly (DDE) Four Rates: 1. Hx of falls and Rx for tricyclic antidepressants, antipsychotics, or sleep agents 2. Dementia and an Rx for tricyclic antidepressants or anticholinergic agents. 3. CRF and Rx for non-aspirin NSAIDS or COX-2 NSAIDS. Total rate.	The percentage of Medicare members 65 years of age who have evidence of an underlying disease, condition, or health concern and who were dispensed an ambulatory Rx for a potentially harmful medication, concurrent with or after the diagnosis. **Medicare HMO** 1. HEDIS MY2020,31.74% **Goal**: 35% 2. HEDIS MY2020, 35.85% **Goal**: 36% 3. HEDIS MY2020, 4.25% **Goal**: 2% 4. HEDIS MY2020, 28.26% **Goal**: 33% **Medicare PPO** 1. HEDIS MY2020, 35.97% **Goal**: 35% 2. HEDIS MY2020, 41.28% **Goal**: 36% 3. HEDIS MY2020, 3.39% **Goal**: 2% 4. HEDIS MY2020, 31.6% **Goal**: 33%	Four times per year	M. Farina	QMC

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Follow-up Care for Children Prescribed ADHD Meds (ADD) Initiation Phase: one follow-up visit in first 30 days Continuation and Maintenance: on medication for 210 days and had at least two follow-up visits within nine months after the initiation phase ended Drive to 5 Clinical Team	The percentage of children age 6-12 who receive appropriate pharmacological management for the treatment of ADHD. **Initiation Phase:** **HMO/POS:** HEDIS MY 2020 50.34% **Goal**: 50% **PPO:** HEDIS MY2020 48.48% **Goal**: 48% **Medicaid/CHPs:** QARR MY2020 44.43% **Goal**: 61% **Continuation and Maintenance:** **HMO/POS**: HEDIS MY2020 54% **Goal**: 61% **PPO**: HEDIS MY2020 56% **Goal**: 56% **Medicaid/CHPs:** MY2020 54.37% **Goal**: 76% 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid is at the New York state 90th percentile.	Semi-annually	M. Farina T. Doherty C. Rorie Alexandrov	QMC
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) Drive to 5 Clinical Team, NCQA QI 4	The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. **Medicaid:** QARR MY2020 65.92% **Goal**: 66% **HARP:** HEDIS MY2020 71.97**%** **Goal**: 66% 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid and HARP are at the New York state 90th percentile.	Semi-annually	T. Doherty C. Rorie Alexandrov	QMC
Use of Imaging Studies for Low Back Pain (LBP) Drive to 5 Clinical Team	The percentage of members ages 18-50 with primary diagnosis of low back pain who did not receive imaging studies (X-ray, MRI, CT scan) within 28 days of diagnosis. **HMO/POS**: 76.96% **Goal**: 83% **Medicaid**: 72.03% **Goal**: 80% **PPO:** 77.6% **Goal**: 83%	Semi-annually	C. Farrelly P. Vellis	QMC

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Use of High-Risk Medications in the Elderly (DAE) 1. At least two high-risk medications	The percentage of Medicare members aged 66 and older who received two high-risk medication or received at least two different high-risk medications. **At least two High-Risk Medications** Medicare HMO: HEDIS MY2020, 10.1% **Goal**: 5% Medicare PPO: HEDIS MY2020,9.4% **Goal**: 5%	Four times per year	M. Farina	QMC
Follow-up After Hospitalization for Mental Illness (FUH) 2 Rates: 1. Follow up within 30 days of discharge 2. Follow up within seven days of discharge Drive to 5 Clinical Team	The percentage of members aged six and older who were followed up as an outpatient following hospitalization for mental illness. **1. Follow up within 30 days of discharge** HMO/POS **Goal**: 80% PPO: **Goal**: 76% Medicaid/CHPS: **Goal**: 79% HARP: **Goal**: 79% Medicare HMO **Goal**: 46% Medicare PPO: Small n **2. Follow up within 7 days of discharge** HMO/POS **Goal**: 60% PPO: **Goal**: 54% Medicaid/CHP: **Goal**: 62% HARP: **Goal**: 62% Medicare HMO **Goal**: 46% Medicare PPO: Small n 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid and HARP are at the New York state 90th percentile.	Semi-annually	T. Doherty C. Rorie Alexandrov	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) 1. BMI percentile 2. Counseling for Nutrition 3. Counseling for Physical Activity	The percentage of members 3-17 years of age who had outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, counseling for physical activity during the measurement year. **1. <u>BMI Percentile</u>** **HMO/POS:** HEDISMY 2020, 94.19% **Goal**: 99% **Medicaid/CHPs**: QARR MY 2020, 88.4% **Goal**: 95% **PPO:** HEDIS My2020, 92.83% **Goal**: 99% **2. <u>Counseling for Nutrition</u>** **HMO/POS:** HEDIS MY 2020, 91.86% **Goal**: 90% **Medicaid/CHP:** QARR MY2020, 84.00% **Goal**: 90% **PPO:** HEDIS MY2020, 89.25% **Goal**: 90% **3. <u>Counseling for Physical Activity</u>** **HMO/POS:** HEDIS MY2020, 89.53% **Goal**: 90% **Medicaid/CHP:** QARR MY 2020, 83.6% **Goal**: 90% **PPO:** HEDIS MY 2020, 86.02% **Goal**: 90%	Four times per year	M. Farina	QMC

HIV/AIDS Comprehensive Care: • Collection of viral load test results. • Achieve member viral load suppression rates in line with NYS 2020 Ending the Epidemic goals. • Increase the number of individuals using Pre-exposure prophylaxis (PrEP).	Provide quarterly narrative and data reports to DOH/AI demonstrating progress on performance measures, rates of engagement and viral load suppression for the HIV positive membership. Attend and participate at Department of Health (DOH), Aids Institute (AI), Ending the Pandemic (EtE) Managed Care Organization (MCO) Collaborative meetings. Obtain viral load test results for all HIV positive members by building clinical partner relationships, contracting with lab companies, evaluation NYS DOH data and other creative strategies to obtain viral load lab results. Monitor an intensive outreach program to engage or re-engage members back in care through internal staff resources and/or an external community partners. Develop and implement multiple strategies to achieve and maintain viral load suppression of HIV + Medicaid members. Maintain systems to monitor, evaluate and report viral load data, outreach and engagement efforts and detection of early warning signs of members falling out of care. Provide evidence of a strategy for providing information about and access to PrEP. **Goals:** 1. Have viral load suppression rate of 85% or higher for the HIV+ Medicaid members for the 2021 Quality Assurance Reporting Requirements (QARR). 2. Increase the number of members that are virally suppressed by 45% from the Phase IV Medicaid Cohort list of identified unsuppressed member that will be sent to plans in the first quarter of 2021.	Quarterly	J. Wilson	NYS AIDS Institute

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
	3. Increase clinical provider knowledge on PrEP. Increase member awareness and usage of PrEP. Utilize plan data to target at-risk members for PrEP usage.			
Statin Therapy for Patients with Cardiovascular Disease (SPC) Drive to 5 Clinical Team	Percentages of males 21-75 years of age and females 40-75 years of age during measurement year, who were identified as having clinical atherosclerotic CVD and met the following criteria: 1. Received Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin med during the measurement period. **HMO/POS:** HEDIS MY2020, 87.31% **Goal:** 92% **Medicaid/CHP**: QARR MY2020, 83.70% **Goal:** 92% **PPO**: HEDIS MY2020, 83.10% **Goal:** 92% **Medicare HMO**- see Star goals above **Medicare PPO**- see Star goals above 2. Statin Adherence 80%. Members who remained on a high or moderate-intensity statin med for at least 80% of the treatment period. **HMO/POS:** HEDIS MY2020, 82.27% **Goal:** 86% **Medicaid/CHP**: QARR MY2020 73.97% **Goal:** 86% **PPO**: HEDIS MY2020, 83.01% **Goal:** 86% **Medicare HMO-** see star goals above **Medicare PPO**- see star goals above	Semi-annually	M. Farina L. Lincoln	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Pharmacy: Medication Therapy Management (MTM) Program; MedCheck Drive to 5 Clinical Team	The plan's MTMP program for 2021 is designed to ensure that medications prescribed to targeted enrollees are appropriately used to optimize therapeutic outcomes through improved medication use and is aimed at reducing the risk of adverse drug events, including adverse drug interactions. The program is administered by CVS Health and Outcomes MTM who will provide this service to our CMS targeted enrollees. The program will include an individual comprehensive medication review, targeted medication reviews, and additional targeted interventions as appropriate. In addition, CDPHP will continue to utilize our internal pharmacy team to engage membership in all LOBs in the MedCheck service as well as concentrate efforts surrounding the pharmacy care management of members' medical conditions and medication treatment for these conditions. **Goal:** Decreased medication-related adverse events, as well as decreased emergency room utilization and inpatient admissions/readmissions in these groups of targeted enrollees. Increased adherence of chronic medication in MTM enrollees as measured by the Medication Possession Ratio (MPR). Monitor the CMR rate for the plan.	Semi-annually	L. Reed <u>Contributors:</u> J. Montano L. Lincoln Pharmacy and Therapeutics Committee Medicare Stars Team	QMC
Antibiotic Stewardship Drive to 5 Clinical Team	Clinical team to monitor newly re-defined HEDIS measure for AAB-avoidance of antibiotic treatment for acute bronchitis/bronchiolitis, URI-appropriate treatment for upper respiratory infections, CWP-appropriate testing for pharyngitis to maintain the momentum achieved based on the 2020 clinical initiative to improve performance on the HEDIS metric for in appropriate antibiotic utilization. **Goal:** To meet or exceed the national 90th percentile.	Semi-annually	C. Ireland C. Farrelly P. Vellis	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Adherence to Antidepressant Medications (AMM) Drive to 5 Clinical Team, NCQA QI4	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment as follows: 1. Remained on the medication for at least 84 days (12 weeks) HMO/POS **Goal:** 78% PPO: **Goal:** 76% Medicaid/CHP: **Goal:** 54% HARP: **Goal:** 54% Medicare HMO **Goal:** 82% Medicare PPO: **Goal:** 82% 2. Remained on the medication for at least 180 days (6 months) HMO/POS **Goal:** 60% PPO: **Goal:** 62% Medicaid/CHP: **Goal:** 39% HARP: **Goal:** 39% Medicare HMO **Goal:** 67% Medicare PPO: **Goal:** 67% 2022 goal is based on the national 90th percentile for Commercial LOB, Medicaid and HARP are at the New York state 90th percentile.	Semi-annually	C. Rorie-Alexandrov T. Doherty	QMC
Complaints and Appeals				
Complaints and Appeals	Members who express any level of dissatisfaction and who request that a provider or service be reviewed. Acknowledge, review, and respond to all complaints and appeals in accordance with policy and procedure.	Four times per year	C. Ross M. Nitto	QMC
Member Complaint Turnaround Time	Length of time to resolve member complaints <30 calendar days and <45 calendar days for Medicaid and HARP	Four times per year	C. Ross M. Nitto	QMC
Member Appeal Turnaround Time	Length of time to resolve member pre-service appeals <15 calendar days and post service <30 calendar days. *For Medicaid and HARP pre and post <30 calendar days, Medicare Part C pre <30 and post <60 calendar days, Medicare Part D pre <7 calendar days post <14 calendar days.	Four times per year	C. Ross M. Nitto	QMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Complaint and Appeal Analysis	Identify areas of member dissatisfaction and improve performance, and member education of policies, contracts, and benefits. Conduct all level of appeals according to member contract and regulatory requirements.	Four times per year	C. Ross M. Nitto	QMC
External Appeals	Monitor external appeals volume, upheld, and overturn rates monthly. Monitor for any trends. **Goal:** Upheld rate of external appeals 100%.	Four times per year	C. Ross M. Nitto	QMC
Grievance Hearings	Monitor member grievance hearings results monthly. Monitor for trends. **Goal:** Overturn rate of grievance hearings 0%.	Four times per year	C. Ross M. Nitto	QMC
IRE Appeals Report	Monitor appeals volume referred to IRE agency, Maximus and the overturn and upheld rates monthly. Monitor for trends. **Goal:** Overturn rate of IRE appeals 0%.	Four times per year	C. Ross M. Nitto	QMC
Environmental Member Complaints	Monitor for and investigate any member environmental complaint regarding a provider office site. **Goal:** Investigation completed in 30 days of receipt of the complaint and 45 days for Medicaid and HARP.	Four times per year	C. Ross M. Nitto	QMC
Regulatory Agency Closed Complaints	Monitor the investigation of regulatory agency, e.g., DOI, DOH, etc. complaints: type, volume closed, and upheld monthly. **Goal:** Regulatory agency upheld rate 84%.	Four times per year	R. Rothstein	QMC
Membership and Billing: Enrollment				

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Group Application Processing	Weekly monitoring of time standards by manager. Length of time to process 100% of all completed employer group applications to ensure members enrolled with appropriate benefit packages. **Goal:** Five business days. **Accuracy Goal**: 97.5% group quality score.	Four times per year	B. Fournier C. Salzer	QMC
Member Application Processing	Weekly monitoring of Time Standards by Manager Length of time to process 100% of all completed applications to ensure timely delivery of member ID cards. **Goal:** 5 business days. **Accuracy Goal:** 97.5% member quality score.	Four times per year	B. Fournier C. Salzer	QMC
Provider Services				
Average Speed to Answer provider calls	Length of time caller waits before call is answered. Measure and monitor data monthly. **Goal:** ASA less of equal to two minutes.	Four times per year	C. Charette	QMC
Quality Score-Phone Unit	Identify opportunities and trends. **Goal:** Quality Score of 93-98%.	Four times per year	C. Charette	QMC
Correspondence Turnaround Time	Length of time from receipt to completion. Measure and monitor data monthly. **Goal:** TAT within 15 days.	Four times per year	K. Moffre	QMC
Quality Score - Inventory Unit	Identify opportunities and trends. **Goal:** Quality Score of 95%.	Four times per year	K. Moffre	QMC
Member Services				

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Abandonment Rates	Monitor and measures the percentage of callers who hang up prior to being connected to a phone representative. **Goal:** <= 5%	Four times per year	C. Spinner	QMC
Average Speed to Answer	Monitor and measures LOB call center metrics regarding the percentage of calls answered in. **Goal:** <30 seconds	Four times per year	C. Spinner	QMC
Percentage of Calls Answered	Monitor and measures on LOB call center metrics regarding percent of calls answered in 30 seconds or less. **Goal:** ≥80%	Four times per year	C. Spinner	QMC
Quality Scores	Monitor and measures data on LOB call center metrics regarding accurate and appropriate delivery of information to customers as monitored by quality coaching staff. Identify opportunities and trends. **Goal:** 93-98%	Four times per year	C. Spinner	QMC
Correspondence TAT	Monitor and measures data on LOB call center metrics regarding correspondence TAT. **Goal:** resolve <= 21 days	Four times per year	C. Spinner	QMC
Secure email/Responded within one business day	Percent of secure emails responded to within one business day. **Goal:** 95% within one business day.	Four times per year	C. Spinner	QMC
Credentialing				

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Monitor Time to process initial Credentialing application	To ensure that all initial applications are completed and approved within 60 days of receipt of a completed application. **Goal:** 100% are completed in 60 days.	Four times per year	M. Smith	Credentials Committee (CCM) to QMC
Delegation Oversight (*Refer to Section IX for details on each delegate)*	Review of delegate's initial and recredentialing performance against delegation contract criteria by conducting file audits of each delegate, site visits as needed, and annual documentation review.	Four times per year	M. Smith S. Ireland	CCM to QMC
Monthly Recredentialing				
Monitor Time to complete recredentialing	To ensure that all active practitioners in scope are recredentialed at least every 36 months. **Goal:** 100% at least every 36 months	Four times per year	M. Smith	CCM to QMC
Credentialing Policy and Procedure				
Annual review of credentialing policies and procedures	To ensure that all credentialing policies and procedures are reviewed by the credentials committee at least annually and updated as needed through the year.	Four times per year	M. Smith	CCM to QMC
Member Complaint Data- Credentialing				
Member provider/practitioner complaints	Credentialing monitors members who express dissatisfaction with providers and practitioners and reports biannually to credentials committee.	Two times per year	M. Smith	CCM to QMC
Accessibility and Access				

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
After-Hours Accessibility study	Conduct an accessibility study and report findings to the credentials committee. To ensure that members contact a live voice. **Goal:** 85% To ensure the practitioner responds within one hour. **Goal:** 100%	Two times per year, or more frequently as needed.	M. Smith	CCM to QMC
Practice Site Assessment for Appointment Access NCQA NET 2	To ensure that the plan's access standards are met. Monitoring is conducted to identify appointments based on criteria, including high-volume and high-impact specialists or OB/GYN and oncologists. **Goal:** 95% of the providers will meet the following standard: Appointment Access Standard: • Emergency care immediately • Urgent care within 24 hours • Sick care visits within 48 hours • Routine primary care within 4 weeks • Initial prenatal (in first trimester) within 3 weeks • Initial prenatal (in second or third trimester) within a week • Initial family planning within 2 weeks • Initial newborn visit within 2 weeks of hospital discharge	Two times per year, or more frequently as needed.	M. Smith	CCM to QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Practice Site Assessment for Appointment Access NCQA NET 2	**Goal:** 80% of the providers will meet the following standard: Behavioral Health Appointment Access Standards: including BH prescribers and BH non-prescribers: • Emergency care immediately • Non-life-threatening emergency care within 6 hours (may be directed to the ER) • Chemical dependency/urgent care within 48 hours • New Patient initial visit for routine care within 10 business days • Follow-up routine care for an established patient within 20 business days	Annually	C. Rorie Alexandrov P. Bleichert	QSAG/BHUMC

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Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
GeoAccess Monitoring	To ensure geographical distribution availability of primary care and high-volume specialty providers, including behavioral health providers utilizing GeoAccess software. **Goal:** 85% combined average to meet access standards **GeoAccess Availability Standards, Miles/Minutes** • 3 Internal Medicine, 30 miles/30 min. • 3 Family/GM, 30 miles/30 min. • 3 Pediatricians, 30 miles/30 min. • 2 OB/GYNs designated as high volume and high impact, 30 miles/30 min. • 2 Oncology Specialist designated as high volume and high impact, 30 miles/30 min • 2 Specialist from each type as high claims volume • 1 Mental Health/Substance Abuse Treatment, 30 miles/30 min • 2 Social Workers, 30 miles/30 min. • 2 Psychiatrists 30 miles/30 min • 2 Psychologists, 30 miles/30 min • 1 Pharmacy- urban, 3 miles/10 min • 1 Pharmacy- rural/suburban, 10 miles/20 min • 1 24-hour Pharmacy (where available),15 miles/25 min • 1 Hospital, x-ray, MRI, optometrist, inpatient psychiatric, inpatient med rehab, skilled nursing facility, SNF, Home health agency, and ambulatory surgery clinic, 30 miles/30 min • 1 Laboratory- urban, 20 miles/30 min • 1 Laboratory - rural/suburban, 40 miles/60 min • 1 Cardiac Cauterization, kidney transplant, major treatment, neonatal intensive care, and open heart surgery, 60 miles/ 90 min	Twice per year	P. Bleichert C. Ryder	QMC

Indicator Name	Performance Goal	Frequency of Reporting	Responsible Person	Responsible Committee
Ratio Analysis	To conduct a ratio analysis to measure the number of practitioners who serve in primary care and high-volume specialty, including behavioral health. The ratio standard used is realistic for the community and the delivery system and the ratio considers the clinical safety. Focus ration analysis on high-volume and high-impact OB/GYN and oncology specialists. **Ratio Standard:** NY DOH practitioner to member ratio: 1:1500 1 FTE. 1:2400 1 FTE with a mid-level practitioner support.	Annually	P. Bleichert C. Ryder	QMC
Claims and Configuration Service Indicators				
Document Management: Claims Entry TAT	Monthly claims entry TAT: Weekly monitoring and evaluation of the number of days from receipt to entry in the system. **Goal:** 99% in 3 business days 100% in four business days.	Four times per year	K. Moffre	QMC
Claims Department				
Claims Adjudication Turnaround TAT	Monthly monitoring of length of time to adjudicate a claim in the system. **Goal:** 98% within 30 days.	Four times per year	K. Moffre	QMC
Claims Adjudication Accuracy	Percentage of claims adjudicated without processing errors. **Goal:** 95%	Four times per year	K. Moffre	QMC