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CDPHP® Medicare Choices HMO and PPO awarded 4.5 out of a possible 5 stars by the Centers for Medicare & Medicaid Services (CMS). www.medicare.gov, October 2015

Capital District Physicians' Health Plan, Inc.

Quality Management Program Description 2016

16-0055

2016 QM PROGRAM DESCRIPTION

I. GOAL STATEMENT

Capital District Physicians' Health Plan, Inc., Capital District Physicians' Healthcare Network, Inc., and CDPHP Universal Benefits,® Inc., (collectively known as "CDPHP®") Quality Management ("QM") Program is a comprehensive, proactive program that provides the required structure and process components necessary to systematically define, evaluate, monitor, and ensure that medically appropriate and cost-effective care and service are provided to members of CDPHP, while ensuring patient safety. *The program is a commitment to continuous quality improvement and requires participation of all members of the CDPHP board of directors, CDPHP practitioners, providers, and members of CDPHP staff.

This is accomplished through a continuous, objective, and systematic process that identifies problems and opportunities for improvement and implements actions to change process and behavior patterns to prevent future occurrences. The result of all process and monitoring activities will be evaluated at least annually to determine the overall effectiveness of the quality program.

**Unless otherwise indicated, references to CDPHP throughout this document pertain to all three legal entities: Capital District Physicians' Health Plan, Inc., Capital District Physicians' Healthcare Network, Inc., and CDPHP Universal Benefits,® Inc.*

II. QUALITY MANAGEMENT OBJECTIVES

The objectives of the CDPHP® Quality Management Program are:

- To continue to transform the delivery of health care through the Institute of Healthcare Improvement's Triple Aim and CDPHP Health Value Strategy of managing population health to reduce per capita cost and improve member experience of care and health outcomes.
- To ensure and continually improve the value (as measured by member and practitioner satisfaction) of quality, safety, availability, accessibility, appropriateness, and effectiveness of medical and behavioral health care services.
- To assess health services provided to the enrolled population through the use of appropriate data collection, sampling, validation, and analysis techniques to identify opportunities for improvement.
- To establish areas of clinical priority, establish and update related preventive service and clinical practice guidelines based on nationally recognized guidelines and members' complex health needs, and in conjunction with state and local coalitions, disseminate the guidelines and promote and ensure compliance with the guidelines.
- To develop data-driven disease and population management strategies to improve practitioner, provider, and member compliance with clinical guidelines and standards, thus enhancing members' health and outcomes.
- To engage in health promotion and education for practitioners, providers, and members in areas of clinical priority to enhance members' health and encourage active self-management.
- To regularly evaluate the health plan's practitioner and provider qualifications and competence through credentialing and recredentialing programs, peer review activities, performance monitoring and investigation, quality improvement activities, and to recognize and reward quality performance.
- To actively seek out and participate in state, national, and local collaboration and recognition programs to improve performance and achieve recognition as a quality leader and to participate in and lead initiatives to measure and disclose performance in the areas of quality, safety, utilization, access, and satisfaction.
- To support practices as they transform to patient-centered medical homes and improve quality and efficiency of care coordination and delivery, while restructuring payment to be commensurate with value, through the CDPHP Enhanced Primary Care (EPC) model of care.

III. PROGRAM SCOPE

The Quality Management Program is dedicated to fulfilling its commitment by working with the physician and provider community to establish evidence-based clinical practice guidelines and service standards. The guidelines and measures are used to develop tools to provide feedback to patients and physicians to drive quality improvement.

Components of the Quality Management Program include annual goals and objectives and the safety plan and include but are not limited to evaluation of the following:

- Accessibility and availability of network practitioners and providers
- Member and provider access to plan services
- Member CAHPS satisfaction surveys
- Complaints/appeals/grievances monitoring and timely resolution
- HEDIS/QARR reporting and analysis
- Practice guideline development and compliance monitoring
- Medical record documentation and site visit reviews
- Continuity and coordination of care across settings and transitions in care, including PCPs, OBs, specialty providers, and behavioral health facilities, health care practitioners, and facility providers
- Under- and over-utilization plan-wide, product-specific, and individual practitioners/practice sites
- Credentialing and recredentialing of network practitioners and providers
- Provider satisfaction surveys
- Consistent application of criteria in rendering UM determinations
- Technology assessment and medical policy development
- Identification and monitoring of select indicators of clinical care and service
- Member rights and responsibilities
- Confidentiality and protection of member information and records
- Pharmaceutical management
- Appropriateness and availability of marketing materials for potential members
- Population management, including health education and wellness programs
- Disease management programs
- Case management and complex care management programs
- Medication Therapy Management Programs
- Medicare CMS Quality Improvement Project (QIP) and Chronic Care Improvement Project (CCIP)
- Preventive health promotion, including web-based tools, self-management tools
- Quality and safety of clinical care including behavioral health
- Quality of service
- Management and oversight of delegation
- Health equity: Cultural/linguistic, language diversity, and health literacy needs of members
- Enhanced Primary Care (EPC) - CDPHP patient centered medical home (PCMH) model
- Monitoring plan use of data

The CDPHP board of directors, as the governing body, maintains overall accountability and responsibility of the Quality Management Program.

Specific clinical quality initiatives within the Quality Program and Annual Work Plan are categorized into one of the following groups based on the intensity and scope of the efforts in that area. These priorities may be subject to change during the year based on new information and/or changing regulatory, accreditation, and/or purchaser needs. For details on specific QM measures, please refer to the Quality Management Program Work Plan.

Evidence-Based Medicine

CDPHP adopts nationally recognized guidelines developed by experts and approved by professional organizations. Guidelines are reviewed and updated as needed to reflect current standards and scientific knowledge. Updates are disseminated to providers. Practice guideline implementation programs include clinical practice for both medical and behavioral health and preventive service guidelines, regular monitoring for performance issues and passive provider and member education (i.e., information available on the internet and in newsletters). CDPHP also participates in practice guideline development with Health Dialog, our NCQA-accredited disease management provider. The Quality Management Committee reviews and approves the clinical guidelines. Adopted guidelines are available to practitioners/providers and members.

Patient Safety

To proactively reduce errors and ensure patient safety, CDPHP uses an integrated and coordinated approach to review actual and potential risks. Health plans can encourage learning about what constitutes an error, promote internal reporting of findings and actions taken to reduce risk, and focus on process and system improvements that minimize blame to the individual. While CDPHP is not a direct provider of care, it does have a special role in improving patient safety that cultivates a supporting environment to assist practitioners/providers in improving safety in their practices.

CDPHP staff are responsible for identifying, reporting, and documenting potential quality concerns that impact the clinical safety of the patient. CDPHP reviews clinical quality complaints to ensure that the quality of care delivered is in accordance with professionally recognized standards of practice. In addition, CDPHP takes action on quality concerns to reduce risk to its members. Clinical quality review (CQR) is defined as an issue that relates to the quality of clinical treatment services provided by a practitioner/provider or facility. After the investigation of the CQR issue, corrective action and/or interventions are implemented as necessary. All CQR issues are assigned to a severity index level/grade 1–5. Levels 4 and 5 are reviewed by the Quality Management Committee (QMC). A practitioner/provider or facility that's being investigated may be asked to respond in writing to any identified deficiency.

At a minimum every six months, CDPHP staff will track and trend quality member complaints and will report to the Quality Management Committee (QMC) on a quarterly basis.

Patient safety issues are monitored to ensure:

- Complaints or concerns about quality or appropriateness of services are investigated and that appropriate corrective actions or interventions are implemented.
- Concerns about clinical quality are investigated and graded. Levels 4 and 5 require written corrective actions.
- Operations are compliant with local, state, and federal regulatory practices.

Other activities include:

- Monitoring medication safety through the following: Medicare Part D Medication Management Therapy Program (MTMP) and the expansion of MTM to the Medicaid and commercial high risk members; CMS 2016 Quality Improvement Project (QIP) on promoting effective management of chronic disease by providing safer care and reducing harm through improved medication adherence and transition of care in Medicare members with primary diagnosis of CHF; HEDIS measures impacting patient safety: DEA, medication reconciliation; Pharmacy & Therapeutics (P&T) Committee, and other pharmacy initiatives.

- Optimizing continuity and coordination of care across the continuum of care.
- Ensuring compliance with practice guidelines.
- Monitoring publicly available data sources, including NYS Hospital Profile, Hospital Compare, NCQA, and www.WhyNotTheBest.org .
- Ensuring safety and quality of our network are monitored during credentialing and recredentialing.

Quality Improvement

Quality Improvement (QI) is a systematic approach to measurement, analysis, and intervention based on the continuous quality improvement model of W. Edwards Deming's Plan-Do-Study-Act (PDSA) that defines a distinct area of opportunity, seeks to identify the causes of suboptimal performance/outcomes, and targets interventions to address the identified causes. Furthermore, departments such as resource coordination, member services, behavioral health, pharmacy, member complaints and appeals, regulatory compliance, provider services, claims operations, document management, and enrollment and billing have a number of quality and service indicators that are monitored and reported quarterly to QMC.

Key quality programs include:

A. Healthcare Effectiveness Data and Information Set/Quality Assurance Reporting Requirements - HEDIS/QARR

The Healthcare Effectiveness Data and Information Set (HEDIS)/Quality Assurance Reporting Requirements (QARR) are performance and accountability measures that span across five domains of care. These domains are:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resources Use
- Health Plan Descriptive Information

The plan uses HEDIS and QARR results to target specific opportunities for improvement. For example, if scores show that preventive health measures need improvement, educational articles are published in member newsletters to alert members to the importance of obtaining their preventive health visits and screening tests. Educational articles are also published in Network News, our practitioner newsletter, to stress the importance of ensuring members are seen for preventive health exams, prescribed the appropriate medications, and sent for screening tests. In addition, specific practitioner results are distributed in a scorecard format. Direct member outreach may also be performed.

Data is collected electronically via the claims system or through on-site medical record reviews, or a combination of the two. An NCQA certified auditor, Aqurate, verifies the accuracy of the data that is abstracted.

B. National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization committed to assessing, reporting, and improving the quality of care provided by organized delivery systems. Accredited health plans today face a rigorous set of 55 standards and 223 required elements in which plans must demonstrate compliance in the following five key reporting categories: access and service, qualified providers, staying healthy, getting better, and living with illness to earn NCQA's seal of approval.

CDPHP has consistently received high scores and consecutive “Excellent” health plan accreditation status. Standards are divided into six categories: Quality Improvement, Utilization Management, Network Management (new in 2016), Credentialing, Member Rights and Responsibilities, and Member Connections. NCQA requires health plans to undergo a triennial survey and annual re-accreditation scoring for all products based on triennial health plan standards score and annual HEDIS and CAHPS scores. A multi-disciplinary team ensures continuous survey readiness and is responsible for implementing compliance with new and updated standards and required elements.

C. Member Satisfaction Surveys

CDPHP will continue to monitor member satisfaction, with the assistance of DSS Research, an NCQA-certified survey vendor, who will conduct the following annual member satisfaction surveys. A mixed mail and telephone survey administration methodology is used. CDPHP continues to rank highly in New York state and is among the top in the country for member satisfaction.

CAHPS — Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted in the spring of each year (for the previous reporting year). A mixed mail and telephone survey administration methodology is used. The Commercial, Medicare, and Medicaid adult populations are surveyed. The results of this survey are a key part of the CDPHP NCQA rankings and Medicare Stars rating.

CG-CAHPS — Clinician Group Consumer Assessment of Healthcare Providers and Systems survey is conducted in the fall annually and asks patients to report on and rate their experience with a specific physician and that physician’s practice. CDPHP surveys both adult and child primary care. A mixed mail and telephone survey administration methodology is used. The results of this survey are shared with the physicians.

CMS QHP- Marketplace member survey will be conducted in calendar year 2016.

ECHO — Experience of Care and Health Outcomes survey is carried out in the fall of each year. A mail-only survey is administered to a random sample to measure member satisfaction with behavioral health services and plan administrative services.

New Member Survey — The purpose of this survey is to welcome new members and to assess their overall satisfaction and awareness and understanding of benefits, rights and responsibilities, and how to access the care or providers needed. Phase I takes place after the January enrollment period and Phase II is following the July enrollment period. Methodology consists of one wave of mail and telephone follow-up to non-respondents.

HOS — Health Outcomes Survey is administered to Medicare members. It is designed by the Centers for Medicare & Medicaid Services (CMS) and questions are phrased to provide information to CMS about the member’s state of health. HOS is a longitudinal study; therefore, the same member is contacted two years later and asked to complete the survey once again. Those two studies are compared to determine if the care received is keeping the member as healthy as possible. Results from this survey are captured in the health plan’s Medicare Stars rating.

Case Management — The Case Management Survey is designed to measure the member satisfaction and program experience with the CDPHP case management program. Participants of the CDPHP complex case management program will be surveyed to gain information about member perceptions, expectations, experiences, and satisfaction with their case manager and overall effectiveness of the program.

Survey methodology consists of at least three and up to six phone contact attempts using the Computer-Assisted Telephone Interviewing (CATI) methodology to achieve an optimal number of completed surveys.

Disease Management — Our national DM vendor conducts an annual survey of members to solicit feedback from their experience regarding the overall DM program, program staff, usefulness of the information disseminated, and the members' ability to adhere to health goals and plans determined with their physician and/or health coach.

DentaQuest Dental Service — Satisfaction with dental care and services will be conducted by DentaQuest, our dental vendor delegate for Child Health Plus and Medicaid.

In addition, member satisfaction regarding the CDPHP member call center will continue to be monitored monthly with the assistance of SPH Analytics, an NCQA-certified survey vendor.

D. Disease Management

CDPHP delegates selected disease management functions to Health Dialog, an NCQA-accredited disease management organization. The programs include the chronic conditions of diabetes and CAD. Members can contact a Health Coach for assistance at any time, without a physician referral. Disease management includes evidence-based guidelines; identification of a registry of patients; stratification into risk groups based on clinical needs and gaps in care; member interventions to promote patient self-management and empowerment; and evaluation, analysis, and reporting to assess effectiveness and enhance program design. Intervention by Health Dialog for disease management programs consists of outbound telephonic contact by Health Coaches, active member education, targeted member reminders, and clinical practice guidelines. Case managers also refer members to disease management as appropriate.

E. Complex Case Management

The CDPHP complex case management program is a multi-disciplinary model staffed by registered nurse case managers, certified case managers (CCM), a registered dietician, a certified diabetic educator and licensed master's social workers. CDPHP case managers provide information to members regarding disease process, clarify the available insurance benefits, locate and link members to community resources, provide emotional support, and help identify resources for services not covered by insurance. Case managers provide regular supportive phone calls, which can make it easier for members to live with a serious health problem by helping them understand and self-manage their condition. Case managers perform face-to-face case management in selected Enhanced Primary Care (EPC) practices and community partner locations, such as drop-in and homeless shelters. Embedded case management provides an opportunity for enhanced member and provider engagement throughout the case management episode of care. We collaborate on referral and meeting places with our community partners to ensure that people living in low-income neighborhoods can easily meet face-to-face with a case manager in an environment that is familiar to them.

It is the philosophy of CDPHP that when members obtain their optimal level of wellness, the members, their support systems, the health care delivery system, and the reimbursement sources all benefit. The CDPHP case management program also plays an integral role in ensuring appropriate, quality, cost-effective care delivery.

CDPHP medical and behavioral health case managers work collaboratively to assist members identified with complex medical and behavioral health conditions. A multi-disciplinary approach to care delivery is designed to optimize outcomes and provide continuity of care to members with complex needs. The CDPHP complex case management program is offered to members with complex medical and social needs.

The following conditions are examples of diagnoses that are commonly identified for case management:

- COPD
- CHF
- Oncology
- Diabetes
- HIV
- Complex neurologic conditions
- Trauma
- Organ transplant
- High-risk pregnancy
- Complex psychosocial issues
- Asthma

CDPHP meets the NYSDOH regulatory requirements for case management with annual data submission through the Case Management Annual Reporting Tool (CMART). We participate in calls and meetings with DOH, looking for opportunities and best practice examples to enhance our own care management programs. We review and evaluate our performance against statewide averages.

The 2016 objectives for case management in serving members with complex health needs are as follows:

- Timely identification of cases through multiple referrals sources.
- Comprehensive assessment of members' physical, psychological, social, environmental, linguistic and cultural preferences, financial and functional status as well as well as the family, community and institutional support systems required for optimal outcomes.
- Analysis of all available information to formulate an evidenced based plan of care reflecting statement of problem, barriers, interventions, short and long term goals.
- Facilitation and monitoring progress of member in self-care knowledge and management.
- Monitoring and modification of the plan of care through an interdisciplinary and collaborative team approach.
- Evaluation of the effectiveness of case management interventions.

F. High-Risk Maternity Case Management

CDPHP offers a case management program specifically tailored to the needs of a woman identified as having a high-risk pregnancy. The CDPHP case management and population health and wellness departments are working collaboratively with participating OB/GYN providers to identify high-risk pregnant women in the first trimester of pregnancy.

Pregnant women enrolled in the program receive regular supportive calls from a registered nurse case manager, printed materials and development of a self-management plan. Nurse case managers help pregnant women understand warning signs related to their high-risk condition and recognize when they need to contact their doctor. In addition, case managers focus on a variety of general pregnancy related topics including:

- Breast feeding
- Postpartum follow-up care
- Postpartum depression
- Well-baby care and immunization schedules

The CDPHP high-risk pregnancy program strives to identify and engage pregnant women with high-risk conditions, working collaboratively with their physician practices to increase the potential for a full-term, healthy pregnancy.

G. Population Health and Wellness

The CDPHP population health and wellness team ("the team") continues to focus on identifying population health needs and coordinating the delivery of population health and health promotion programs, campaigns, and targeted member outreach initiatives to improve health outcomes across all lines of business. The team is made up of health promotion specialists, population health and wellness specialists, a population health coordinator, and a health promotion coordinator who work collaboratively across multiple departments to engage members in their health. In 2016, CDPHP will continue current efforts with a special focus on engaging members where they live, work, and play through community and employer group initiatives focused on preventive health. Population health programs and activities in 2016 will include:

Enhanced Targeted Mail Campaigns - CDPHP runs a number of automated mail campaigns to engage members with specific health conditions and/or gaps in care. Campaigns target members in need of well visits, breast cancer screening, immunizations, smoking cessation, prenatal and postpartum care, and flu shots, among other important health care services. CDPHP will continue to run these campaigns in 2016 and will add one additional campaign, adult BMI. In 2015, reports were built for each campaign to determine the effectiveness of the campaigns and in 2016 the team will analyze results and implement additional outreach initiatives to engage members, if appropriate.

Targeted Community-Based and Workplace Wellness Programs - CDPHP outreaches members identified with certain health conditions to encourage them to either get the care they need and/or to participate in disease-specific community and workplace health promotion programs. Members are outreached via mailings, phone calls, and community events.

In 2016, the team will continue to identify and outreach members with appropriate health messages to engage them in programs and services. The team will also continue to collaborate with local community partners recognized as leaders in community outreach to engage hard to reach members. This will include focusing on CDPHP members who face challenges in transient housing, language barriers to care, and health risks secondary to daily social stressors. CDPHP plans to continue expanding its presence in the community through these types of partnerships with the goal of supporting improved outcomes in member engagement and health care.

Enhanced Primary Care Practice Outreach - As a part of our 2016 population health management strategy, the team will continue to partner with high-volume Medicaid enhanced primary care practices to engage members in recommended health care.

Using practice-specific gap lists and access to practice-specific electronic medical records, population health and wellness specialists will:

- Partner with practice staff to identify opportunities increase engagement in preventive health measures and address important health care needs.
- Coordinate outreach with embedded CDPHP case managers to improve health outcomes for members.
- Collaborate with other CDPHP departments, including performance management, to identify practice needs and empower practices with relevant tools to address HEDIS measures while simultaneously managing patient care.

CDPHP will continue to partner with provider practices to distribute co-branded mailings to engage members with gaps in annual well child and adolescent visits, mammograms, and diabetic eye exams.

Mom 2 Be Pregnancy Notification and Education Program - In 2016, population health staff will continue to communicate closely with OB/GYN providers and family practitioners to enroll members into the program as well as develop new and innovative ways to ensure that members are attending postpartum visits within the HEDIS timeframes. More wellness programs, like prenatal yoga at more accessible locations to our members, will be provided. The quality enhancement and population health and wellness departments will continue to work with OB/GYN providers to identify barriers specific to the practice's population in regards to postpartum attendance and develop plans to address these barriers. Additionally, new Mom 2 Be members, who self-enroll into the program, will receive a customizable pregnancy calendar with a welcome letter.

As a part of the Mom 2 Be program, women are identified through providers, Medicaid HRA forms, claims data, and through self-referral via the Mom 2 Be website. The Mom 2 Be program provides members with the support they need during and after pregnancy through:

- Tailored communications at 20 weeks, 30 weeks, and postpartum
- Access to text4baby
- Access to free wellness classes, including prenatal fitness and nutrition
- Access to a personal health coach through CDPHP Health Coach Connection program
- Case management services for high-risk pregnancies
- Postpartum resources

The Mom 2 Be program provides OB/GYN and family practitioner offices working with the health plan an opportunity to proactively engage members in important and timely prenatal and postpartum care. CDPHP partners with 33 OB/GYN offices that submit patient ACOG forms to CDPHP. This allows CDPHP to more actively support a member's engagement in appropriate prenatal care as early as possible and throughout her pregnancy. Site visits were conducted by population health staff to partnering practices to discuss the Mom 2 Be program. A communications toolkit was developed to show the importance of early identification and enrollment into the program. In 2016 population health staff will continue to communicate regularly with OB/GYN providers and family practitioners to ensure that program enrollment through provider identification continues to increase, leading to an ultimate goal of improving prenatal and postpartum care.

In 2016, the goal will be to continue to communicate closely with OB/GYN providers and family practitioners to enroll members into the program as well as develop new and innovative ways to ensure that members are attending postpartum visits within the HEDIS timeframes. Additionally, new Mom 2 Be members who self-refer will receive a customizable pregnancy calendar with a welcome letter. The quality enhancement and population health and wellness departments will continue to work with partnering OB/GYN providers to drive this agenda, with the ultimate goal of improving prenatal and postpartum care.

Postpartum Outreach - As a part of the Mom 2 Be program, the team conducts targeted outreach to new mothers in our Medicaid plan to facilitate timely access to postpartum care at three local hospitals post-delivery.

In 2016, the team will continue this outreach by calling members 5 to 7 days after delivery to offer assistance in scheduling postpartum appointments. Members will be offered a $50 incentive for completing their postpartum visit 21-56 days after delivery through a direct mail campaign. Establishing a connection to a medical home will help the member understand the importance of completing all necessary well-child visits and immunizations, and supports the provider and CDPHP in meeting the HEDIS requirements for postpartum visits.

Postpartum outreach activities focus on the following:

- Verifying that members have notified their local Department of Social Services of pregnancy or providing member guidance for notifying the Department of Social Services of newborn birth(s).
- Discussing what to expect during the postpartum visit and its importance to the mother's health
- Confirming and/or scheduling the postpartum visit.
- Offering information on community resources, including transportation assistance, as necessary.
- Obtaining current member contact information to streamline follow-up care.
- Coordinating referrals to CDPHP case management and/or behavioral health departments as appropriate.

Healthier Generation Benefit - CDPHP will continue to collaborate with the Alliance for a Healthier Generation to make the Healthier Generation Benefit available to children and adolescents diagnosed as overweight or obese. The Healthier Generation Benefit (the benefit) allows members aged 3 to 18 years to access exercise and nutritional counseling through their primary care provider or a registered dietitian. In 2016, promotion of the benefit will continue to engage primary care providers, registered dietitians, and members to increase awareness and utilization of the benefit.

H. Landmark

This program is a complexities, team-based model for managing the highest-acuity members. 24/7 medical care is delivered by an interdisciplinary team, in the member's home, over an extended period of time (possibly for the remainder of the member's life). The team delivering the care includes mental health providers, social workers, pharmacists, dieticians and case managers. The team is led by an MD/NP. The person maintains their own PCP, who maintains the ability to determine the extent of delegation of care in the home.

I. Health Homes for Medicaid Enrollees with Chronic Conditions

CDPHP currently serves more than 68,000 Medicaid managed care enrollees in counties served by a health home. While the majority of these members is relatively healthy and requires only access to primary care practitioners to obtain episodic and preventive health care, the Medicaid program also serves several population groups who have complex medical, behavioral, and long-term care needs that drive a high volume of high-cost services, including inpatient and long-term institutional care. A significant percentage of Medicaid expenditures are used by this subset of the Medicaid population. Counties currently served by a health home are Albany, Rensselaer, Schenectady, Fulton, Montgomery, Washington, and Northern Saratoga.

Navigating the current health care system can be difficult for these enrollees. Encouraging the appropriate utilization of services, through improved care coordination and service integration, is essential for controlling future health care costs and improving health outcomes for this population. These factors have resulted in the development of Medicaid health homes.

A health home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of the patient's needs are addressed in a comprehensive manner. This is done primarily through a care manager who oversees and provides access to the services an individual needs to stay healthy, out of the emergency room, and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. The services are provided through a network of providers, health plans, and community-based organizations, considered collectively as a virtual health home.

CDPHP has partnered with health homes to provide case management to vulnerable populations and maintains close delegation oversight, which is reported through its Joint Health Services Committee on a quarterly basis.

J. Behavioral Health Program

The CDPHP behavioral health services program is a comprehensive, NCQA-compliant program that offers triage and referral and performs prospective, concurrent, and retrospective review of services delivered to members. The program adheres to CDPHP health value strategy as the guiding principle. Behavioral health services reviewed include inpatient hospitalizations, medical hospitalizations with a co-morbid psychiatric/substance abuse diagnosis, prior authorizations of out-of-network services, specialized care management, selected behavioral health provider referrals, after-hours crisis services, and mental health and substance abuse rehabilitative services.

Members may access outpatient care either by going directly to a behavioral health provider or calling a toll-free number to get assistance in selecting a network behavioral health provider. All elective inpatient care must be preauthorized and reviewed for medical necessity. All care after the initial authorization requires medical necessity review for continued authorization.

To determine appropriateness of continued services, behavioral health staff refer to individual subscriber contractual benefits, individual clinical case data, assessments, and medical information in conjunction with CDPHP clinical review criteria, Milliman Care Guidelines, and consultations with the CDPHP behavioral health medical director. The care coordination reviewer takes into consideration the capacity and accessibility of the CDPHP provider and facility delivery system when making recommendations to members for services such as care in alternative settings. The behavioral health department works closely with other CDPHP departments to ensure optimal care coordination and total health management.

The behavioral health program provides personalized assistance to help CDPHP members access mental health and substance abuse care within the most efficient time frame, by the most appropriate practitioner, and in the most appropriate treatment setting.

In addition, CDPHP offers intensive case management for members identified as having co-morbid medical disorders or are high-risk for psychiatric/substance abuse relapse and hospital admission. This program partners with the medical case management program for both inpatient and outpatient care across all CDPHP lines of business.

Through health risk screening, predictive modeling, emergency department admission, and other mechanisms of referral, CDPHP identifies members who are at high risk for behavioral health issues. Member engagement occurs by means of letter, phone call, or hospital visit. The purpose of the contact is to address members' behavioral health needs and refer them to the most appropriate behavioral health provider. Members may also be referred to CDPHP wellness programs.

CDPHP has placed a high priority on continuity of care and improving rates of ambulatory follow-up post-hospitalization. A particular focus is assisting high-risk (multiple hospitalizations) and Medicaid members in making a successful transition from hospital to an outpatient level of therapeutic care. The CDPHP strategy includes coordinating two post-hospital appointments: one with the outpatient therapist and one for a home visit. Both are scheduled to occur within seven days of discharge. A clinical social worker performs the home visit, reviews the discharge instructions with the member, and ensures that the member understands his or her psychiatric condition. The social worker also performs a medication review and strengthens the member's motivation to attend the follow-up appointment with his or her mental health professional.

CDPHP has also embedded licensed mental health counselors and master's level social workers in several Enhanced Primary Care (EPC) practices to serve as case managers. These staff members assist primary care physicians with complex cases in which a patient is suffering from both physical and psychological issues, e.g., diabetes and depression or pregnancy and a bipolar disorder. The case manager works face-to-face with complex patients, referring them to appropriate behavioral health providers; helping them to understand their illness; motivating them to participate in treatment; recognize and overcome barriers to behavioral health care; follow the provider's recommended treatment plans; and navigate the health system. The goal is to improve overall health status and decrease emergency room visits, hospital admissions lengths of stay, and pharmaceutical needs.

In 2016, CDPHP will participate in the New York state Medicaid Redesign. Part of this program includes the new Health and Recovery Plan (HARP) for members with serious mental illness and co-existing medical conditions, chronic substance abuse and homelessness. CDPHP is contracting with Community Care Behavioral Health Organization (CCHB), an NCQA Managed Behavioral Health Organization (MBHO) Certified organization, to perform behavioral health case management for HARP members.

This contracted function will integrate seamlessly with all other CDPHP functions and personnel, as it will be performed onsite at CDPHP. CCBH will be responsible for oversight of the health homes care coordination services and directly provide case management for HARP enrollees where health home capacity is unavailable. CCBH will also help CDPHP develop provider profiles to gauge quality of care delivered by the CDPHP network, measure member satisfaction for HARP members, and develop and provide training for providers, including HCBS providers and health homes.

All behavioral health care is provided by an extensive network of behavioral health providers and facilities. This includes inpatient psychiatric and substance abuse units as well as free-standing psychiatric and substance abuse facilities. Outpatient care is provided by psychologists, psychiatrists, psychiatric nurse practitioners, social workers, and licensed mental health counselors.

Treatment is also provided in community mental health clinics and substance abuse programs. In addition to standard inpatient and outpatient behavioral health services, CDPHP has contracted with providers to develop both telephonic and mobile crisis intervention. All providers meet state requirements for licensure as well as CDPHP credentialing standards

CDPHP continuously looks for gaps in community behavioral health services. By partnering with local behavioral health providers and developing new programs these gaps can be addressed. One such example is the development of an intensive outpatient program for eating disorders. CDPHP has contracted with another provider to render in-home mental health treatment for members discharged from a psychiatric hospital and needing treatment prior to their scheduled outpatient appointment. Agencies are also available to provide telephonic and on-site stabilization for adolescents and adults.

K. Medication Therapy Management

The CDPHP Medication Therapy Management (MTM) program fulfills the Centers for Medicaid & Medicare Services' (CMS) requirements for Medicare beneficiaries. The program aims to identify an additional group of at-risk Medicare beneficiaries beyond the CMS minimum requirements, taking a multidisciplinary approach to MTM, coordinating engagement with beneficiaries with outreach and interventions by disease management and CDPHP case management as appropriate. The MTM program has expanded to our Medicaid and commercial lines of business. CDPHP pharmacists collaborate with our Enhanced Primary Care providers to promote MTM services to our members.

The goal of the MTM program is to improve the safety and effectiveness of pharmacotherapy for Medicare beneficiaries, leading to improved medical outcomes and efficiencies. Improvement will be achieved through pharmacist or pharmacist-directed interventions with beneficiaries, physicians, or provider pharmacies regarding the pharmacy co-therapeutic management of chronic disease states. A comprehensive medication review (CMR) is offered at least annually to all targeted members enrolled in the plan's MTM program.

L. Radiology Medical Necessity Program

As part of its efforts to provide members with access to high-quality, cost-effective care, CDPHP has partnered with MedSolutions, Inc., dba eviCore healthcare, an NCQA-UM certified radiology benefits manager, to provide a high-tech radiology medical necessity program for members in all lines of business.

All outpatient elective MR, CT, and PET studies performed will require a medical necessity review conducted by eviCore. The plan is to expand it to all modalities by mid-2016. The cases are reviewed for compliance with accepted clinical guidelines and results are provided to member and physician verbally and in writing.

The goal of the radiology medical necessity program is to improve the safety and quality of health care and radiology services for our members and ensure that physicians have access to the most current standards regarding radiology.

M. Health Equity: Member Race, Language, Culture and Linguistics

CDPHP will continue to dedicate internal and external resources in 2016 to promote cultural and linguistic competency within our organization as well as our provider network. In preparation for the addition of the Health and Recovery Plan (HARP), a new Medicaid product that will be launched in 2016 for members with serious mental health and chronic substance abuse issues, CDPHP will design and implement a training curriculum for behavioral and physical health providers focused on promoting health equity.

Education, language, culture, access to resources, and age are all factors that affect our members' health literacy skills, ability to access appropriate care and their experience of care. CDPHP will continue to engage in health literacy skill building with our members as health care consumers, and also continue to build cultural and linguistic competency among the health care professionals in our network, across all lines of business. This will be accomplished through a variety of activities, including trainings, interaction with case management, community based outreach, as well as print and web-based materials.

2016 Objectives for Serving a Culturally and Linguistically Diverse Membership:

- Transition the current internal health literacy workgroup into a broader cultural competency steering committee and increase representation of diversity and inclusion of affiliated community partners.
- Use and promote resources from the National Patient Safety Foundation, including Ask Me 3® materials and *Words to Watch* resources for provider/practitioners to continue to support health literacy awareness and skill-building.
- Continue to work with FDRs and community partners to coordinate care and resources for our members to promote greater health equity, with specific focus on the new Health and Recovery Plan (HARP) membership, which will include more members with serious mental illness, chronic substance abuse and homelessness.
- Implement a series of trainings focused on cultural and linguistic competency, health literacy and the impact of poverty on health outcomes to support the implementation of the new Health and Recovery Plan (HARP) for Medicaid members with high mental health and substance abuse needs. Training audience will include behavioral health and physical health providers, health homes and internal staff.

- Further expansion of the Community Health Project to increase culturally competent outreach to the Medicaid population, with the goal of addressing health disparities and gaps in care for preventive health services.
- Continue to assess all communications, including print and web-based materials to ensure clear communication and culturally competent messaging.
- Continue to identify and address provider/practitioner training needs around trauma-informed care and the impact of adverse childhood experiences on health outcomes. This effort will include sponsorship and promotion of a local symposium on trauma informed care for the health care community in April 2016
- Continue to identify in-service opportunities for care management and behavioral health staff to remain informed of relevant community resources across all lines of business.
- Expand access to community-based case management by embedding a nurse case manager at two additional community sites frequented by vulnerable Medicaid populations. Continue to analyze community based case management data to assist with resource allocation.
- Expand CDPHP Healthy Neighborhood events from two to four events during 2016, as a neighborhood-level opportunity for community engagement, offering access to health screenings and other resources to address the social determinants of health.
- Continue to monitor diversity of membership across all lines of business and identify any emerging needs or trends related to cultural and linguistic diversity.
- Continue to analyze and learn from member responses to CAHPS survey *Question: With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor who met your special cultural and/or language needs?*
- Explore additional community partnerships that will enhance our ability to be culturally and linguistically responsive to the needs of our membership

N. Medicare Stars Program

The Centers for Medicare & Medicaid Services (CMS) assigns a Stars rating (the highest being five) to health plans based on a number of factors, including the quality of their services, customer service, member satisfaction, and more. People in the market for Medicare coverage use the ratings to compare plans and identify those with the highest quality.

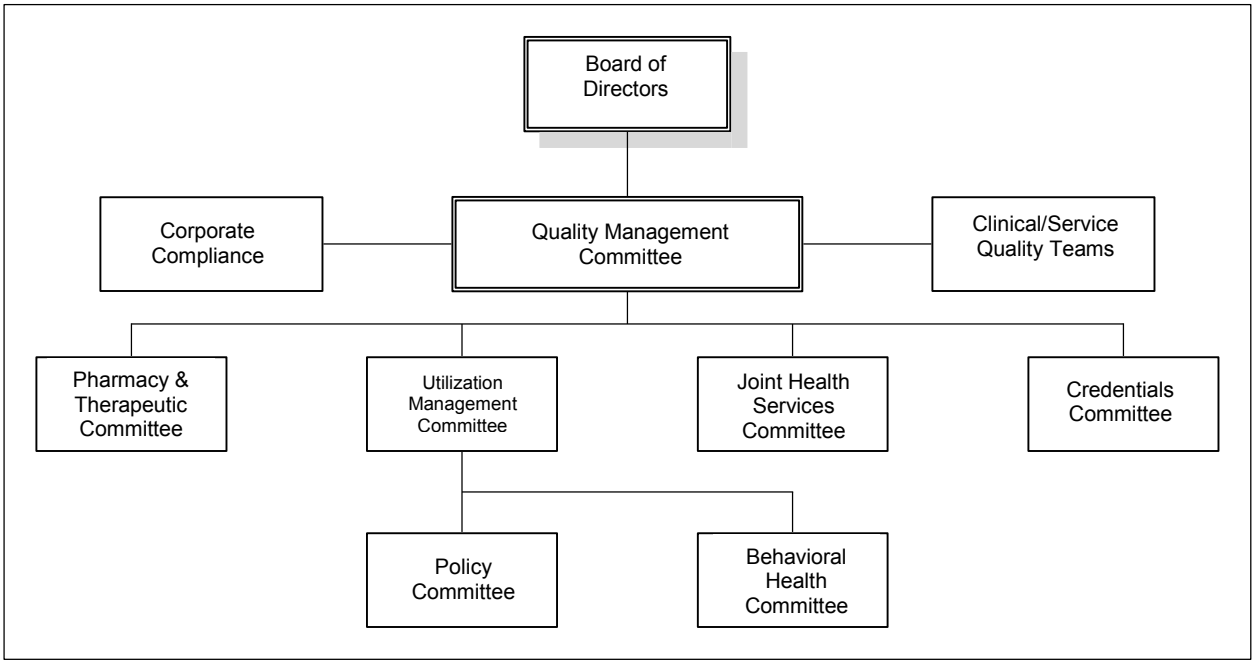
The Medicare Stars team develops outreach strategies based on past HEDIS and member satisfaction performance and current Star ratings. The team works within the quality department and consists of a Stars administrator, a Stars nurse, and a Stars clinical pharmacist. Together they work to identify members with gaps in care and reach out to them and/or their providers by phone, mail, or face-to-face.

Working collaboratively with the provider relations specialists, upon request a list of gaps in care is created for individual providers and is presented to their practice manager. The team also works cross-functionally with other departments, such as wellness, case management, and pharmacy. Together they take a team approach in engaging the members in their health care, working in concert with their physician and pharmacist, to ensure that members have the best possible health outcomes, in keeping with the Triple Aim.

O. Enhanced Primary Care (EPC)

Enhanced Primary Care (EPC) is the CDPHP patient centered medical home (PCMH) model. The EPC program began in 2008 as a patient centered medical home pilot targeted at transforming care delivery and compensation, a model that essentially abandons fee-for-service (FFS) and instead pays for the value derived from the PCP's influence on all care, advancing the principles of the Triple Aim, and thus providing comprehensive payment for comprehensive care. In 2012, the pilot moved into a sustainable program and is the predominant payment model for the CDPHP primary care network. In 2015, the EPC program included 101 provider practices and over 155,000 CDPHP members imputed to those 101 practices. Expansion will continue into 2016.

The EPC program uses a unique risk-based comprehensive global payment model, essentially replacing the FFS payment for attributed patients. The model compensates PCPs based on each patient's level of need – the sicker the patient, the greater the need, the higher the monthly compensation. PCPs are also eligible for bonus payments based on effectiveness and efficiency measures, providing for a combined opportunity (global payment + bonus) to increase earnings by an average of 40%. The EPC payment model is structured to encourage providers (through compensation incentives) to spend more time with the patients in most need of care, rather than focusing on the number of visits, which has economic incentive under the traditional FFS payment model.



CDPHP Board of Directors

The CDPHP board of directors, as the governing body, maintains overall accountability and responsibility for the Quality Management Program. The board delegates the responsibility and accountability for the day-to-day operation and administration of the program to the quality management committee (QMC) and to the chief medical officer (CMO). The CMO, who reports to the president, is responsible for:

- Implementing and operating the program.
- Ensuring responsible reporting and communication of plan progress.
- Ensuring an evaluation of the program from the QMC to the board of directors and back to the QMC.

Quality Management Committee (QMC)

The board of directors has designated the QMC as the responsible entity for the oversight and management of all quality-related activities. The QMC is chaired by a medical director and is comprised of fully credentialed physicians representing primary care and specialties. Representatives from CDPHP adjunct providers, network physicians, and the medical director of behavioral health also serve as committee members. The committee members are bound by a confidentiality and conflict of interest agreement, which is renewed at least annually.

The committee members are appointed by the vice president of medical affairs, subject to board approval, for a three-year term and may be re-appointed once. The vice president of health care quality, manager of quality review and measurement, manager of informatics, coordinator of audit, compliance, and communication, director of provider services, and supervisor of member services are CDPHP representatives on the committee.

Additional plan staff participate as ad hoc staff to the committee as needed. The QMC meets at least six times per year. Contemporaneous minutes are recorded for all committee activities. The QMC reports regularly to the board of directors, which has ultimate responsibility for the Quality Management Program. The QMC is accountable to and receives recommendations from the board.

Responsibilities of the Quality Management Committee include:

- Review, approve, and make recommendations for the QM program, including all pertinent quality related activities, the Annual Work Plan, and Annual Program Evaluation.
- Review, approve, analyze, and evaluate results, make recommendations and policy decisions, institute needed actions and ensure appropriate follow-up regarding pertinent quality activities, including but not limited to HEDIS, QARR, and all clinical and service initiatives. QI activities include but are not limited to the following:
    - Member satisfaction, including complaints/grievances monitoring and satisfaction survey results, practitioner availability
    - Appointment accessibility
    - Member accessibility to the plan
    - Clinical quality and safety measures
    - Utilization monitoring
    - Pharmaceutical management, including MTMP
    - Credentialing/recredentialing
    - Radiology High Tech Medical Necessity Program
    - Oversight of first tier downstream entities (FDRs) and other delegates delegated activities
    - Practitioner medical record and office site reviews
    - CMS Quality Improvement Project (QIP) and Chronic Care Improvement Projects (CCIP)
    - Preventive health and disease management program initiatives, including clinical practice guideline development
    - Establishment of clinical quality indicators and quality teams or subcommittees to address specific clinical issues
    - Making recommendations and monitoring continuity and coordination of care initiatives. Provider profiling and incentive programs
    - Accreditation, certification, and regulatory compliance
    - Development of initiatives to address health equity based on identified health literacy, cultural and linguistic needs of our membership
- The QMC submits regular reports of QM activities to the board of directors.

V. QUALITY MANAGEMENT PROGRAM COMMITTEES

The following committees have been established by CDPHP to develop, monitor, and analyze specific components of the Quality Management Program:

Credentials Committee

The Credentials Committee has the responsibility for the review and revision of the plan's credentialing and recredentialing criteria, standards, policies, and procedures. The committee reviews, approves, denies, or terminates participation of physicians, adjunct, and organizational providers. The committee members are bound by a confidentiality and conflict of interest agreement, which is renewed at least annually. The Credentials Committee reports to the Quality Management Committee (QMC). This committee also establishes and monitors practitioner access and availability standards. The credentialing and recredentialing process incorporates quality review information relative to each practitioner. The committee also oversees and monitors all delegated credentialing policies, procedures, and activities.

The Credentials Committee is chaired by a medical director as designated by the senior medical director. The committee membership is appointed by the senior medical director with approval of the CDPHP board of directors and includes both primary care and specialty physicians. The committee meets at least six times per year. Committee minutes are reported to the QMC and to the board. The manager of credentialing or his/her designee serves as staff to the committee. Additional plan staff participate ad hoc.

Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for the development, approval, and review/revision of resource coordination policies; new technology evaluation, including new uses of existing technology; recommending revisions to the member benefit package; monitoring of institutional, professional, and ancillary practitioner utilization trends; development or selection of industry-standard medical necessity/medical appropriateness screening criteria used for UM decision-making; monitoring of timely resolution of UM determinations and service indicators, including the inter-rater evaluation process for physician and non-physician reviewers; and evaluation for potential over- and under-utilization on a plan-wide, product-specific, and practitioner-site level, with recommendation of corrective action as appropriate. The Utilization Management Committee also serves as a liaison between participating practitioners and CDPHP on all clinical and utilization-related issues.

A medical director chairs the committee. The committee membership is appointed by the senior medical director, subject to CDPHP board of directors approval, and consists of participating board-certified physicians representing primary care and the high volume specialties. The committee meets at least six times per year and minutes are reported through the QMC to the board of directors. The senior vice president of medical affairs operations serves as staff to the Utilization Management Committee.

Behavioral Health Committee

Participating providers, representing the behavioral health specialties, are available to provide input to the CDPHP utilization management, care management, and quality improvement programs. The primary goal is to impact the behavioral health community by moving them toward the fulfillment of the CDPHP health value strategy. The committee meets three times a year, is chaired by the CDPHP behavioral health medical director, and includes representatives from psychiatry, psychology, social work, pediatrics, and substance abuse treatment. Minutes of the committee are reported to the UMC and to QMC, then finally to the board of directors.

Behavioral Health (BH) Committee members review and provide input on service or clinical quality monitors, preventive and clinical practice guidelines, and utilization management and case management processes. They review and recommend medical policies and procedures for benefit coverage by assessing technologies, medical intervention, or drugs in terms of efficacy and safety. They provide expert opinions on behavioral health issues, encourage and promote communication between CDPHP and the BH provider network, review and provide input into satisfaction surveys, share information relative to trends in the behavioral health care industry, and share ideas and recommendations on effecting better outcomes with specific populations.

Pharmacy and Therapeutics Committee

The role and function of the Pharmacy and Therapeutic (P&T) Committee is to ensure that the most clinically appropriate and cost-effective drugs will be available for the plan's members. The committee recommends the adoption of policies regarding evaluation, selection, and therapeutic use of drugs; recommends or assists in the formulation of programs to meet the pharmaceutical needs of practitioners; and recommends and maintains the plan's formularies in accordance with pharmacy policies and procedures.

The P&T committee consists of practicing physicians and pharmacists, appointed by the plan's board of directors, who represent a cross-section of primary care physicians and specialties from the plan's practitioner panel. The members of the P&T committee are bound by a confidentiality and conflict of interest agreement, which is renewed at least annually. A staff medical director from the plan chairs the committee. Up to five pharmacists from participating pharmacies may be invited to attend meetings as consultants to the committee. Other plan partners may also be invited to attend the committee meetings as consultants. The plan's medical affairs representatives, vice president, clinical integration/chief pharmacy officer, managed care pharmacists, and representatives from the plan's pharmacy benefits management company serve as presenters and consultants to the committee. The P&T committee meets every other month with a recess in August. Minutes from the committee are forwarded through the QMC to the board.

Policy Committee

The Policy Committee is charged with the development, review, revision and implementation of medical, behavioral health, pharmacy, utilization management, and reimbursement policies. Industry norms and clinical research are included in the evaluation of each clinical issue. The committee reviews and researches potential and actual coverage and contract issues, provides continuity in contract interpretations and ensures the implementation of associated policies (e.g., technology assessment and policy development). New billing practice patterns and member and provider requests for new services are evaluated to determine potential benefit and contract coverage and related policy changes.

The committee ensures consistency between member health programs and utilization policy.

The committee is an interdepartmental team consisting of a medical director and representatives from finance, government programs, configuration team, internal operations, medical affairs, healthcare network strategy, pharmacy services, business development, special investigation unit, application management, and resource coordination.

Minutes are reported to the UMC and upward through the QMC to the board of directors. The committee is supported by provider consultants and workgroups as needed to lend clinical or operational expertise to the review activities.

Joint Health Services Committee

CDPHP entrusts others to deliver specified services to its members and thus has entered into mutual agreements to perform precise activities. Separate documents clearly delineate the plan's oversight and responsibility for individual delegated activities. These include the functions and methodology used to evaluate and assess delegated activities on a regular basis in accordance with CDPHP policies and procedures. The CDPHP board of directors and Quality Management Committee have delegated to the Joint Health Services Committee the responsibility to monitor delegation oversight and coordination of delegated activities regarding first downstream entities (FDRs) and all other delegates.

The CDPHP Joint Health Services Committee consists of all CDPHP delegates: pharmacy vendor (CVS/Caremark); home bound complex care coordination vendor (Landmark); disease management of rare chronic condition vendor (Accordant); NYS DOH health homes; disease management vendor (Health Dialog); radiology medical necessity program (MedSolutions/eviCore); physician and hospital online directories vendor (Clarus Health Systems); Child Health Plus and Medicaid dental vendor (DentaQuest); and credentialing and recredentialing at specific sites. New delegate in 2016 to case manage our HARP enrollees will be Community Care Behavioral Health (CCBH). The vice president of health care quality and the accrediatition and quality program manager co-lead the joint health services meeting and other members include representatives from the delegated entities and the CDPHP delegation team, including a medical director, quality, behavioral health, resource coordination, credentialing, customer service, government programs, corporate compliance, IT security, and network services staff. CDPHP delegates develop agendas in consultation with and approval by the CDPHP delegation team.

Through approval of a delegate's activities, annual evaluation, and routine reporting, CDPHP will identify any deficiencies in the delegate's processes, clinical care, and services provided to the health plan's members. The health plan will work with the delegated agency in correcting deficiencies identified, and if the deficiencies are not corrected, the health plan may revoke the delegation arrangement. The committee meets quarterly and submits results of its activities to the Quality Management Committee (QMC) and the board of directors.

Joint Health Committee responsibilities include but are not limited to:

- Approve written delegation agreements, quality management evaluations, programs, and work plans
- Approve predelegation assessment evaluation audit
- Review quarterly reports containing results of delegated activities, including any corrective actions plans as indicated
- Conduct annual oversight of all delegates through annual reporting requirements
- Ensure delegates' adherence to CDPHP policies, procedures, and QI goals
- Pursue plan of correction for areas not meeting standards and consider delegate termination where applicable

Corporate Compliance and Privacy Committee

The Corporate Compliance and Privacy Committee is responsible for the oversight of the CDPHP corporate compliance and integrity program and privacy program. The CDPHP corporate compliance and integrity program is designed as a proactive and reactive approach to prevent, detect, and correct possible organizational and employee fraud or non-compliance.

V. QUALITY MANAGEMENT PROGRAM COMMITTEES

The major components of the CDPHP corporate compliance and integrity program are as follows:

- A compliance infrastructure and the appointment of a compliance officer and a corporate compliance committee
- Corporate standards of conduct for employees and policies related to compliance
- Education and training of employees and communication to members and providers
- A process to receive reports of suspected fraud and non-compliance
- A system to respond to those reports
- A system to investigate, document and when necessary implement corrective action
- Auditing and monitoring corporate compliance operations
- Reporting to the CDPHP board of directors and QMC

The CDPHP privacy program provides for ongoing activities related to the development, implementation, maintenance of, and adherence to CDPHP policies and procedures governing the privacy of, and access to, member health information in compliance with federal and state laws and regulations and CDPHP information privacy practices including the investigation, documentation, and response to member privacy inquiries and privacy complaints and responses to all HIPAA member rights matters.

The major components of the CDPHP privacy program are as follows:

- Provisions for HIPAA member rights including confidential communications, access to records, accounting of disclosures, privacy complaints, restriction, and amendment requests and privacy notices
- System of safeguards to protect member health information and guard against unauthorized and/or inappropriate uses/disclosures
- Education and training of employees
- Reports to privacy/corporate compliance committee

The Corporate Compliance and Privacy Committee is chaired by the CDPHP compliance officer and privacy official and is applicable to all lines of business. The committee's membership, appointed by the president, represents major business units within CDPHP. Each committee member's role is to actively assist and support the compliance officer and privacy official in the design, implementation and operation of the corporate compliance and integrity program and privacy program. Committee responsibilities include the following:

- Develop CDPHP standards of conduct and corporate-wide compliance and privacy policies
- Oversight of the implementation and operation of state, federal, and accrediting organization's privacy requirements, including:
    - privacy and security policies
    - mechanisms to oversee the application of the privacy and security policies
    - levels of user access
    - identification of unnecessary PHI collection
    - an appeals process for privacy issues
    - mechanisms to limit access to PHI
    - a process to review requests to use PHI
- Develop the company-wide employee compliance and privacy training curriculums and methods for continual reinforcement
- Establish the methods and documents necessary to communicate the principles of the standards of conduct to CDPHP business partners (e.g., members, providers, and employer groups)
- Identify corporate compliance risk areas for auditing and monitoring
- Champion the corporate compliance and integrity program and privacy program through ongoing employee interactions

Clinical/Service Quality Teams

Participating practitioners, representing the major medical and surgical specialties, are available to assist and support quality activities within the plan. These board-certified providers may function independently, in multidisciplinary clinical quality teams, or as a workgroup comprised of a particular specialty as needed. All other provider types are called on as needed for quality management activities. Current team includes the Radiology Quality Initative Workgroup. The providers actively assist the QMC and other quality-related committees in:

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

The following resources are dedicated to the Quality Management Program for 2016:

Job Title	Number of Staff	Number of FTEs Dedicated	Aggregate Years of Experience
MD—Senior Vice President, Chief Medical Office	1	0.30	33
MD—Vice President, Senior Medical Director-MPH	1	0.75	35
MD—Medical Directors	3	1.00	68
MD—Medical Director Behavioral Health—MD, MBA	1	0.35	18
Vice President, Behavioral Health—MBA	1	0.40	38
Director, Behavioral Health	1	0.75	26
Senior Vice President, Chief Pharmacy Officer/Quality—RPh, MBA	1	0.60	36
Vice President, Health Care Quality—MS, RN, NE-BC	1	1.00	30
Senior Vice President, Medical Affairs Operations—RN	1	0.40	37
Vice President, Healthcare Network Strategy	1	0.20	26
Senior Vice President, Corporate Analytics—MBA	1	0.25	28
Director, Clinical Informatics—MD, MA, MS	1	0.50	28
Managers, Informatics-MPH	2	0.75	38
Lead Pharmacy Analyst—PhD	1	0.25	10
Lead Health Informatics Analysts	2	1.50	55
Health Informatics Analysts	6	3.75	79
RN—Manager, Quality Review and Measurement—BSN	1	1.00	42
Director, Quality Medicaid Innovation	1	0.75	6
Medicare Stars Administrator	1	1.00	27
RN—Manager, Accreditation and Quality Program—MBA	1	1.00	31
RN—Medicare Stars Nurse	1	1.00	37
RN—Quality Review Nurses	3	3.00	84
RN—Clinical Quality Improvement Educators	1	2.00	36
Director, Credentialing and Appeals—BS	1	1.00	28
Coordinator, Member Complaints	1	1.00	5
RN—Clinical Appeals Specialists	3	3.00	104
Appeals Specialists	2	2.00	48
RN—Director Utilization Review and Ambulatory Coding—CPHQ	1	0.40	35
RN—Director Care Management—CCM	1	1.00	28
Administrators Care Management—RN, MBA (1); LPN (1)	2	2.00	46
Director Pharmacy/Quality—RPh	1	1.00	26
Medicare Stars Pharmacist	1	0.50	23
RPh—Managed Care Pharmacists	5	2.00	143
Manager, Formulary and Clinical Operations	1	0.30	27
Manager, Medicare Pharmacy Programs	1	0.75	25
Manager, Physician Engagement	1	0.50	25
Physician Engagement Specialists	3	0.75	70
Director, Ancillary Contracting, Healthcare Network Strategy	1	0.50	20
Director, Physician Contracting, Healthcare Network Strategy	1	0.50	20-

Job Title	Number of Staff	Number of FTEs Dedicated	Aggregate Years of Experience
Physician, Facility Contract Negotiators	4	0.15	40
Director, Performance Management	1	0.35	30
Performance Measurement Coordinators	6	3.00	90
Director, Provider Services	1	0.10	22
Manager, Provider Services	1	0.10	16
Manager, Provider Registry	1	0.75	16
Manager, Credentialing	1	0.75	29
Lead Credentialing Specialist	2	2.00	25
Credentialing Specialists	5	5.00	70
Provider Registry Specialists	6	6.00	51
Director, Population Health and Wellness—MS, CHES	1	0.50	21
Manager, Population Health and Wellness—MS	1	0.50	19
Health Promotion Team Lead—MS	1	0.25	9
Health Promotion Specialists—MS (2), CHES(3); MPH (1) CDE(1); MBA(1); BS(1) RD(2)	5	2.50	70
Health Promotion Coordinator—LPN	1	0.50	15
Population Health and Wellness Specialists—MPH	2	0.75	22
Population Health Assistant—MPH	1	1.0	5
Senior Editor—Communications	1	0.15	14

- Corporate Analytics incorporates clinical quality informatics and electronic data warehouse management. Team members have expertise in statistical analysis, regression analysis, and utilization of advanced statistical tools.
- Data resources available include claims, pharmacy claims, encounter data, CDPHP enrollment, NYSOH marketplace enrollment data, EPC metrics, complaints, appeals and grievances, utilization of services, HEDIS, QARR, medical record data elements, and member and practitioner survey data from CAHPS, CG-CAHPS, HOS and ECHO surveys.
- Through an established set of service indicators and quality process improvement teams, all departments participate in the ongoing process to improve service. The internal team structure forms the mechanism to link quality management activities with other management functions.
- Core asset management (CAM) provides project management leadership and software support through Clarity to process/service quality improvement teams. Clarity is a software program that tracks internal team/ workgroups activities, functions and annual objectives/milestones.
- Clinical Care Advance Enterprise (CAE) is an application that automates care management workflows and personalizes member communications (e.g., targeted campaign member mailings) in support of care management and population identification.
- Population health and wellness focuses on member-centric quality initiatives.
- Performance measurement focuses on practitioner/provider-centric quality initiatives.
- Pharmacy team supports Medicare Medication Therapy Management Program (MTMP) and drives pharmacy data analysis to improve quality and impact cost and utilization for all lines of business.
- Medicare Stars team works to engage Medicare members in their health care to achieve the best possible outcomes.

VII. ANNUAL QUALITY MANAGEMENT (QM) WORK PLAN

The annual QM Work Plan will be developed during the fourth quarter of each year with input from all internal departments, external regulatory agencies, QMC, and its subcommittees. The QM Work Plan will identify QM goals and objectives, areas for focus, and specific QM activities/initiatives and programs that are to occur. Action steps include target date for completion and responsible party. Activities include tracking of previously identified issues and planned evaluation of the QM Program on a quarterly basis throughout the year. The QM Work Plan will be submitted to the Quality Management Committee and board of directors for approval during the first quarter.

VIII. 2016 OBJECTIVES

The following table summarizes quality indicators to be measured during 2016. All data are reported to the Quality Management Committee (QMC) for review.

Indicator	Description	2016 Performance Goal
Enhanced Primary Care (EPC); Patient Centered Medical Home HEDIS CAHPS results	Compliance with improving Health Effectiveness Measures and Member Satisfaction	Meet or exceed goals
Member Service Abandonment Rate	Percentage of member who hang up before reaching a phone representative	<5% blended for all lines of business
Member Service Average Speed of Answer	Length of time caller waits before call is answered	<30 seconds blended for all lines of business
Member Services Call Answer Timeliness Percent	Percent of member calls answered in 30 seconds or less	80% blended for all lines of business
Member Services First Contact Resolution	Percentage of calls handled on initial contact with no re-contact within 30 calendar	88% Blended for all lines of business
Member Services Quality	Department quality percentage score	93-98%
Member Services Correspondence TAT	Days to complete correspondence requests from members	Resolve in 21 days or <
Secure email turnaround time/ average days to respond	Member secure emails are responded within goal	1 business day
Secure email TAT/Average days to complete	Member secure emails are completed within goal	1 business day
Secure email response meets 1 business day turnaround time	Percentage of secure emails responded to in 1 business day	100%
Claims Entry Turnaround Time	Length of time to enter claim in system	99% in 3 days 100% in 4 days
Claims Adjudication Turnaround Time	Length of time to adjudicate a claim in the	98% within 30 calendar days
Claims Adjudication Accuracy	Percentage of claims adjudicated without processing	98%
Provider Services Average Speed of Answer	Length of time caller waits before call is answered	4 or less minutes
Provider/Member Services Correspondence Turnaround Time	Receipt to completion	21 calendar days blended for all lines of business
Group Application Processing	Length of time to process	7.5 business days
Group Application Processing	Group Quality Score	95-99%

Indicator	Description	2016 Performance Goal
Member Application	Length of time to process	7.5 business days
Member Application	Member Quality Score	95-99%
Utilization Management Telephone Abandonment Rate	Percentage of callers who hang up prior to being connected to a phone representative	<5%
Utilization Management Speed of Answer	Percent of calls answered in 2 minutes or less	75% or >
Utilization Management Determination Turnaround Time	Percent of determinations made in 3 business days or less from date of complete information	96% or >
Utilization Management Monitoring of Over- and Under-Utilization	To measure use of services and identify incidences of higher or lower than expected utilization using the following key indicators: Measure Days/1,000 Discharges/1,000 Inpatient Length of Stay ER/1000 HEDIS 2015 data to evaluate 2016 results	Under-Utilization 2015HEDIS Data—less than 10th percentile Over-Utilization 2015 HEDIS Data—greater than 90th percentile Reduce LOS in acute hospital and SNF setting. Benchmark to be determined with year-end 2015 data. SNF readmission avoidance initiated with 2016 benchmark.
Behavioral Health Member Service Abandonment Rate	Percentage of members who hang up before reaching a phone representative	≤ 5%
Behavioral Health Member Services Call Answer Timeliness Percent	Percentage of member calls answered in 30 seconds or less	≥ 70% blended for all lines of business
Behavioral Health Member Services Determination Turnaround Time	Percent of determinations made in 3 business days or less from date of complete information	
Physician Satisfaction Survey	Survey performed annually to measure level of physician satisfaction with plan and identify opportunities for improvement	Maintain/improve previous levels of satisfaction
Member Satisfaction Survey	CAHPS conducted annually to measure member satisfaction and identify opportunities for improvement	Maintain/improve previous levels of satisfaction
Member Satisfaction with PCP	CG-CAHPS conducted monthly to measure member satisfaction with primary care providers; focused on EPC practices	Maintain/improve previous levels of satisfaction. Address areas for improvement.

Indicator	Description	2016 Performance Goal
Member Satisfaction with Behavioral Health Services	ECHO conducted annually to measure BH member satisfaction with BH services	Maintain/improve previous levels of satisfaction. Address areas for improvement.
Case Management Survey	Survey performed annually to measure level of member satisfaction with case management services	Maintain/improve previous levels of satisfaction. Address areas for improvement.
Disease Management (DM) Program Survey	National DM vendor conducts annul survey of members satisfaction with DM program	Maintain/improve previous levels of satisfaction.
New member survey	Measures new members understanding of benefits, rights and responsibilities, and how to access care needed	Maintain/improve previous levels of satisfaction. Address areas for improvement
Health Outcomes Survey (HOS)	CMS HOS is administered to our Medicare members to provide information on Medicare members state of health	Maintain/improve previous levels of satisfaction. Address areas for improvement through our Medicare Stars Team.
Marketplace Member Survey	CMS QHP survey to measure enrollees satisfaction of marketplace products (new in 2016)	Baseline data collected in 2016 of the level of satisfaction
Member survey of dental services provided by DentaQuest	Measures Medicaid and CHPs member satisfaction with DentaQuest	Maintain/improve previous levels of satisfaction. Address areas for improvement
Network Management GeoAccess Study	To ensure geographical availability of primary care and high volume specialty providers utilizing GeoAccess software.	85% combined average to meet access standards
Network Management After Hours Accessibility	To ensure that members contact a live voice.	85%
Network Management After Hours Accessibility	To ensure the practitioner responds within one hour.	100%
Network Management Appointment Availability	To ensure that plan's access standards are met. Site visits are conducted to identify appointments based on criteria.	100%

Indicator	Description	2016 Performance Goal
Medication Therapy Management (MTM) Program	The plan's MTM program for 2016 is designed to ensure that medications prescribed to targeted enrollees are appropriately used to optimize therapeutic outcomes through improved medication use, and aimed at reducing the risk of adverse drug events, including adverse drug interactions. The program will utilize plan and community pharmacists to provide this service to the targeted enrollees. The program will include an individual comprehensive medication review, quarterly targeted medication reviews, and additional targeted interventions as appropriate.	Avoidance of adverse hospital events as well as decreased emergency room utilization and inpatient admissions in these groups of targeted enrollees. Increased adherence of chronic medication in MTM enrollees as measured by the Medication Possession Ratio (MPR). Direct support to increase Medicare Stars measures and improvement of 2016 QIP on effective management of CHF with appropriate drug utilization management.
Continuity and Coordination of Care	Specialist to PCPs OB/GYN to PCPs Behavioral Health to PCPs CDPHP with Behavioral Health Between different settings of care Following transitions in care	90% 90% 82% 82% 90% 90%
Complaint and Appeal Analysis	Quarterly review by category of both complaints and appeals	Identify areas of member dissatisfaction and improve performance as per service indicators, department tracking and trending, and issues identified by the member/provider satisfaction team.
Member Complaint Resolution Turnaround Times	Length of time to resolve member complaints	<30 days
Radiology Program	High-tech radiology services medical necessity program on all outpatient elective MR, CT and PET studies for all lines of business	Improve member safety, quality of health care and radiology services and ensure physician access to most current radiology standards.

CDPHP entrusts others as first downstream entities (FDR) or delegates to deliver specified activities to its members and thus has entered into mutual agreements to perform precise activities. CDPHP has entered into contracted and delegated agreements for the following:

- Credentialing and recredentialing at selected sites
- Disease management
- Complex case management
- Physician and hospital online directories
- Health homes
- Pharmaceutical safety, benefit management and member connection activities
- Radiology high tech imaging medical necessity program
- Medicaid and Child Health Plus dental management
- Medicaid Health and Recovery Plan (HARP)

Separate documents clearly delineate the plan's oversight and responsibility for the delegated activities that include functions related to quality management, utilization management, credentialing, and complaint and appeal resolution. These documents include the methodology used to evaluate and assess the delegated activities on a regular basis in accordance with CDPHP delegation policies and procedures.

Strict adherence to accreditation and regulatory standards demonstrates the plan's commitment to the highest standards of member care and service. CDPHP performs a thorough assessment of external entities before delegating clinical, service, or credentialing activities to determine the ability of each entity to perform the activities. In addition, CDPHP maintains responsibility for assuring that each delegated function is performed appropriately through all of the above-defined mechanisms and conducts quarterly monitoring of the delegated function and annual evaluation of delegates' to ensure adherence to CDPHP policies, procedures, and QI goals. Delegates' report to the Joint Health Services Committee. Failure to meet CDPHP standards may result in termination of a delegated activity and agreement.

CDPHP has entered into mutual agreements with its FDRs or delegates' to perform specific activities as outlined on the following pages.

A. Bassett Hospital: Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Bassett Hospital, a PHO effective December 1, 1999. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Bassett's compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

A. Bassett Hospital: Credentialing Delegation Responsibilities *(continued)*

Activity/Function				Responsible Party	
				Delegate	CDPHP
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

B. Albany Medical Center (AMC): Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Albany Medical Center effective December 1, 2000. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule.

AMC has maintained NCQA CR Certification status through 1/28/2016. CDPHP will monitor in 2016 this NCQA Certification renewal status in accordance with NCQA. CDPHP conducts at a minimum an annual audit to ensure regulatory compliance. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

B. Albany Medical Center (AMC): Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

C. Slocum-Dickson Medical Network: Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Slocum-Dickson Medical Network, PLC effective October 1, 2002. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Slocum-Dickson's compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

C. Slocum-Dickson Medical Network: Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

D. Fletcher Allen Health Care (Vermont Managed Care, Inc.): Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Fletcher Allen Health Care (Vermont Managed Care, Inc.) effective December 1, 2002. Vermont Managed Care Inc. continues to maintain full NCQA CR Certification status effective through 1/02/2016. CDPHP will monitor in 2016 this NCQA Certification renewal status in accordance with NCQA. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Fletcher Allen Health Care's compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

D. Fletcher Allen Health Care (Vermont Managed Care, Inc.): Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

E. Health Alliance Physicians Organization, PLLC: Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Health Alliance Physicians Organization, PLLC effective February 13, 2007. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Health Alliance's compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

E. Health Alliance Physicians Organization, PLLC: Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

F. MagnaCare Administrative Services, LLC: Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to MagnaCare Administrative Services (MagnaCare), rental PPO network, effective, January 1, 2010. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to access MagnaCare's compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

F. MagnaCare Administrative Services, LLC: Credentialing Delegation Responsibilities
(continued)

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

G. Beech Street Corporation (Part of PHCS): Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Beech Street effective December 2008. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Beech Street's compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

G. Beech Street Corporation (Part of PHCS): Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

H. Private Health Care Services, Inc. (PHCS): Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Private Health care Services, Inc., (PHCS), as rental PPO network, effective January 2004, February 2009. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule.

PHCS continues to maintain full NCQA CR Certification, effective through 4/20//2017. PHCS transitioned the Beech Street Corporation network under the PHCS network. CDPHP will conduct an electronic or on-site review at a minimum annually to assess PHCS' compliance with standards. Results of annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

H. Private Health Care Services, Inc. (PHCS): Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

I. Hudson Headwaters: Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to Hudson Headwaters effective September 20, 2012. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess Hudson Headwaters' compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

I. Hudson Headwaters: Credentialing Delegation Responsibilities *(continued)*

Activity/Function				Responsible Party	
				Delegate	CDPHP
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

J. University Medical Associates of Syracuse (UMAS): Credentialing Delegation Responsibilities

CDPHP has delegated credentialing and recredentialing to the University Medical Associates at Syracuse (UMAS) effective September 11, 2013. A pre-delegation site visit was conducted to evaluate UMAS's ability to credential and recredential practitioners according to CDPHP standards. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess their compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

J. University Medical Associates of Syracuse (UMAS): Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

K. St. Elizabeth's Medical Center

CDPHP has delegated credentialing and recredentialing to St. Elizabeth's Medical Center, effective December 30, 2015. A pre-delegation site visit was conducted to evaluate the medical center's ability to credential and recredential practitioners according to CDPHP standards. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct an electronic or on-site review at a minimum annually to assess their compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only	X	
Recredentialing	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Medicare Opt-Out	X	
Request of information from NPDB / CMS	X	
Appointment availability (for PCPs and OB/GYN only)	X	
After Hours Access according to CDPHP policy		X

K. St. Elizabeth's Medical Center: Credentialing Delegation Responsibilities *(continued)*

Activity/Function				**Responsible Party**	
				Delegate	**CDPHP**
Recredentialing Performance Monitoring					
The following data will be incorporated in the decision-making process for PCPs and OB/GYN: member complaints; information from quality improvement activities				X	
Medicare Advantage (MA) Deeming Standards					
Adhere to Medicare Advantage (MA) regulations				X	
Delegate Reporting Requirements to CDPHP	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X Immediately	
Medicare and/or Medicaid sanction findings				X Immediately	
Credentialing/recredentialing policies and procedures(major) revisions must be reported immediately			X	X	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, OPMC, CMS)				X Immediately	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X
Review for revisions to NCQA Credentialing Policies and Procedures			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

L. DentaQuest: Credentialing Delegation Responsibilities

DentaQuest's delegation agreement, effective 3/31/2015, lists delegated responsibilities to provide dental services throughout the CDPHP service area and to comply with all CDPHP policies and procedures, applicable NCQA Health Plan Accreditation Standards and Guidelines related to the delegated functions described herein, New York State laws and regulations, and all other accrediting and regulatory agencies as appropriate. DentaQuest has earned NCQA Credentialing Certification, effective through 5/12/2016. CDPHP will monitor in 2016 this certification renewal status in accordance with NCQA. CDPHP did not delegate quality improvement to DentaQuest rather their role is provide assistance and support to CDPHP in furtherance of QI activities and requirements. DentaQuest will coordinate and/or manage credentialing, members' services, utilization management of medical necessity denials, member complaints and appeals, claims administration, and quality reporting activities through the CDPHP Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
Initial Credentialing (Dentist)	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards	X	
Request of information from NPDB / CMS	X	
Appointment availability (Dentist)	X	
Recredentialing (Dentist)	X	
Delegate Application (CAQH or state Mandated application, where applicable)	X	
Statement of Attestation	X	
Required Data Verification—appropriate NCQA standards and CDPHP requirements	X	
Request of information from NPDB / CMS	X	
Appointment availability (Dentist)	X	
Ongoing		
Credentialing decision	X	
Ongoing Medicaid sanction monitoring	X	
Office site evaluation of member comp	X	

L. DentaQuest: Credentialing Delegation Responsibilities *(continued)*

Delegate Reporting Requirements to CDPHP	Frequency				
	Monthly	Quarterly	Annually		
List of credentialed/recredentialed practitioners	X			X	
Newly credentialed practitioners	X			X	
Terminations or revisions to practitioner rosters				X w/in 48 hours via email	
Medicaid sanction findings		X		X w/in 48 hours via email	
Credentialing/recredentialing policies and procedures (major) revisions must be reported immediately			X	X Immediately	
Reporting practitioner sanctions/disciplinary actions to appropriate regulatory agencies (e.g., NPDB, NYS OPMC, CMS)				X w/in 48 hours via email	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Audit of policies. Audit credentialing/recredentialing files per NCQA delegation audit sample standards			X		X
Audit of office site visit process- site visit for cause only			X		X
Assess for Medicare Opt-Out			X		X
Recredentialing Performance Monitoring			X		X

CDPHP retains the right to approve and terminate delegated practitioners and providers.

L. DentaQuest: Member Rights and Responsibilities Complaints, Grievances and Appeals Delegation

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party Medicaid/CHP/FHP	
	Delegate	CDPHP
Medical Necessity		
1st Level of Dental Services Complaint and Appeal	X	
2nd Level of Dental Services Complaint and Appeal		X Member may choose to go to External Review
Administrative Denial		
1st Level Grievance	X	
2nd Level Appeal	X	
3rd Level Grievance Hearing		X Medicaid and FHP may choose Fair Hearing
Complaint		
1st Level Complaint	X	
2nd Level Appeal	X	
3rd Level Grievance		X Medicaid and FHP may choose Fair Hearing

Delegate Reporting Requirements	Frequency			Responsible Party	
	Monthly	Quarterly	An	Delegate	CDPHP
Medicaid Report Card	X	X	X	X	
Child Health plus Report Card	X	X	X	X	
Turn-Around-Time Complaints Report	X	X	X	X	
Turn-Around-Time appeals Report	X	X	X	X	
Issue Log	X	X	X	X	
Member Complaints/Appeals Statistics		X		X	
Number of Complaints/Appeals		X		X	
Types/Nature of Complaints/Appeals		X		X	
Disposition of Complaints/Appeals		X		X	
Number of Closed Complaints/Appeals		X		X	
Complaint/Appeals processing Time		X		X	

L. DentaQuest: Member Rights and Responsibilities Complaints, Grievances and Appeals Delegation *(continued)*

CDPHP Oversight/Monitoring and Evaluation	Frequency			Responsible Party	
	Monthly	Quarterly	Annually	Delegate	CDPHP
Review/Approval of Complaint and Appeal Policies/Procedures			X	X	X
Audit of Complaint and Appeal files	X	X	X	X	X

L. DentaQuest: Utilization Management Delegation Responsibilities

CDPHP retains responsibility for any NCQA 2016 accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Delegate	CDPHP
UM 1 Utilization Management Structure	X	
UM 2 Clinical Criteria for UM Decisions	X	
UM 3 Communication Services	X	
UM 4 Appropriate Professionals	X	
UM 5 Timeliness of UM Decisions	X	
UM 6 Clinical Information	X	
UM 7 Denial Notices	X	
UM 8 Policies for Appeals	X	
UM 9 Appropriate Handling of Appeals	X	
UM 10 Evaluation of New Technology		X
UM 11 Emergency Services *(Formerly UM 12 changed in 2016)*		X
UM 12 Procedures for Pharmaceutical Management *(Formerly UM 13 changed in 2016)*		X
QI 4G Satisfaction with the UM Process *(Formerly UM 11 changed in 2016)*	X	

Activity/Function	Responsible Party	
	Delegate	CDPHP

Delegate Reporting Requirements	Frequency				
	Monthly	Quarterly	Annually		
UM Committee Minutes	X	X		X	
UM Approvals/Denial/Appeals Statistics	X	X		X	
Utilization by Type of Service	X	X		X	
Quality Assurance Activity Outcomes	X	X		X	
Pre-Certification Turn-Around Time Report	X	X	X	X	
Pre-Service Appeals Report	X	X	X	X	

L. DentaQuest: Utilization Management Delegation Responsibilities *(continued)*

Activity/Function				Responsible Party	
				Delegate	CDPHP
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Pre-Service Requests Report	X	X	X	X	
Audit of UM Program			X		X
Review/Approval of UM Program Description			X		X
Review/Approval of UM Policies and Procedures			X		X
Review/Approval of Annual UM Work Plan			X		X
Review/Approval of Annual UM Program Evaluation			X		X

CDPHP reserves the right to conduct an on-site review to evaluate compliance with CDPHP standards at any time.

M. Health Dialog Services Corporation: Disease Management Delegation Responsibilities

CDPHP delegates disease management (DM) to Health Dialog Services Corporation effective 12/8/ 2005, amendments 7/2007, 01/2010, 6/2011 and 2014. Health Dialog holds NCQA DM Accreditation, effective through 11/19/2017. CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

	Delegated Activity/Function	Crosswalk to 2016 Standard	Responsible Party	
			Health Dialog	CDPHP
QI 8A	Identifying Chronic Conditions	QI 6A	X	
QI 8B	Program Content	QI 6A	X	
QI 8C	Identifying Members for DM Programs	QI 6B	X	
QI 8D	Frequency of member Identification	QI 6C	X	
QI 8E	Providing Members with Information	QI 6D	X	
QI 8F	Interventions Based on Assessment	QI 6E	X	
QI 8G	Eligible Member Active Participation	QI 6F	X	
QI 8H	Informing and Educating Practitioners	QI 6G	X	X
QI 8I	Integrating member Information	QI 6H		X
QI 8J	Satisfaction (Experience) with Disease Management	QI 6I	X	
QI 8K	Measuring Effectiveness	QI 6J	X	
QI 9A1-3	Adopting, Establishing Clinical Basis for, and Updating Clinical Guidelines for at Least Two Medical Conditions	QI 7A	X	
QI 9A4	Distributing the Guidelines to Appropriate Practitioners	QI 7A		X
QI 9B	Relation to DM Programs	QI 7C	X	
QI 9C	Performance Management	QI 7D	X	
MEM 1A	Health Appraisal Components	MEM 1A	X	
MEM 1B	Health Appraisal Disclosure	MEM 1B	X	
MEM 1C	Health Appraisal Scope	MEM 1C	X	
MEM 1D	Health Appraisal Results	MEM 1D	X	
MEM 1E	Health Appraisal Accessibility (Formats)	MEM 1E	X	
MEM 1F	Frequency of Health Appraisal Completion	MEM 1F	X	
MEM 1G	Review and Update Process	MEM 1G	X	
MEM 2A*	Topics of Tools	MEM 2A*	X	
MEM 2B*	Usability Testing	MEM 2B*	X	
MEM 2C*	Review and Update Process	MEM 2C*	X	
MEM 2D	Formats	MEM 2D	X	
*For elements MEM 2A, MEM 2B, and MEM 2C, Health Dialog relies on its vendor, Healthwise, Inc., to provide the Self-Management Tools to Health Dialog, to conduct usability testing for the tools, and to review and update the tools.				
MEM 7A	Access to Health Information Line	MEM 7A	X	
MEM 7B	Health Information Line Capabilities	MEM 7B	X	
MEM 7C	Monitoring the Health Information Line	MEM 7C	X	

M. Health Dialog Services Corporation: Disease Management Delegation Responsibilities *(continued)*

Health Dialog Delegated Reports				
QI 8	Activity reports and member return file - measure of participation	QI 6	X	
	Member satisfaction results		X	
MEM 7	Health Information Line summary	MEM 7	X	
	Member satisfaction results		X	
	Phone and web usage statistics by business and non-business hours		X	
	Health coach call listening report		X	

N. CVS Caremark: Pharmaceutical Management Delegation Responsibilities

CDPHP has delegated the following pharmaceutical management and patient safety activities effective 7/1/2005 to CVS Caremark. CDPHP has delegated member connection pharmacy related standards effective 7/1/ 2007. These delegated activities were revised effective 01/01/ 2013. CVS Caremark holds NCQA UM Certification status through 4/24/2016. CDPHP will monitor in 2016 this NCQA Certification renewal status in accordance with NCQA.

CDPHP retains responsibility for any NCQA accreditation requirement not listed as the responsibility of the delegate.

Activity/Function	Responsible Party	
	Caremark	CDPHP
MEM 4A Provision of pharmacy benefit information via secure member web site to meet all requirements in this element.	X	
MEM 4B Provision of pharmacy benefit information to members via telephone to meet all requirements in this element.	X	
MEM 4C Conduct monitoring of the quality and accuracy of information communicated via the website and customer call response for information entered into the system by Caremark.	X	
MEM 5D Respond to member email inquiries received via Caremark website within one business day of receipt. Have a process for evaluating the quality of email responses and analysis of the accuracy and value of information it provides.	X	
MEM 6A Provide electronic refill reminders to member or their physician when a refill is due to be refilled at the Caremark mail-service pharmacy but has not been refilled.	X	
UM12C NCQA patient and prescriber recall notices. Notify members and prescribers of Class I and II FDA recalls filled at any participating pharmacy within timeframes defined in Caremark's policy.	X	
CMS Adhere to Medicare Advantage (MA) requirements	X	
NCQA: Manager will be responsible for operating a toll-free customer TDD/TTY line as well as providing a foreign language line to its customer call center that provides customer telephone service for prescription benefit information.	X	

CDPHP reserves the right to conduct an on-site review to evaluate compliance with delegated requirements at any time.

N. CVS Caremark: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function				Responsible	
				Caremark	CDPHP
Oversight/Monitoring and Evaluation	Frequency				
	Quarterly	Semi-Annually	Annually		
Call monitor meetings with CDPHP and Caremark Call Center Customer Care	X			X	X
Review of Caremark's procedure for adopting or creating a system for point-of-dispensing communications to identify and classify drug to drug interactions by severity			X		X
Develop a formal procedure, criteria and data collection form to document CDPHP pharmacy staff review of the accuracy of Caremark's entry of formulary changes into the web application.			X		X
Review of Caremark's policy and procedure for monitoring timeliness and accuracy of mail-order requests			X		X
Review procedure or process for Caremark staff to respond to member email inquiries.			X		X

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Implement Point of Sale messaging to alert the dispensing pharmacy to the availability of a one time, cumulative 30 day override option for non-formulary drugs that would otherwise reject, formulary drugs that require prior authorization, step therapy or quantity limit. This will be available for new enrollees within the first 90 days of their enrollment or during the first 90 days of the contract year for members impacted by negative formulary changes across contract years. In the long term care setting the transition process will allow a 31 day supply with multiple refills as necessary up to a cumulative 98 day supply during the first 90 days of the member's enrollment in a plan or during the first 90 days of the contract year for members impacted by negative formulary changes across contract years.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.4.1-30.4.9
Send a CMS approved transition notice within 3 business days from the process date of the claim via U.S. First Class mail. Notices will be sent by Caremark Part D to both members and prescribers.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.4.10
Caremark Part D will have in place a process to extend a transition fill on a case by case basis if the member's exception request or appeal has not been processed by the end of the minimum transition period. Extension of transition fills will be determined by Caremark Part D Help Desk.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.4.4.3

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Caremark Part D must have in place a process to effectuate transition across contract years. These transition requirements apply to both drugs that are removed from the formulary from one contract year to the next, as well as to formulary drugs that remain on the formulary but to which a new prior authorization or step therapy restriction is added from one contract year to the next.		X		Medicare Prescription Drug Benefit manual, Chapter 6, 30.4.5
Caremark Part D will have a process in place to ensure that members with level of care changes have access to their medications. For non LTC residents, the pharmacy must call the CVS Caremark Part D Services, L.L.C. Pharmacy Help Desk in order to obtain an override to submit a Level of Care transition fill request. For LTC residents, automated reason for service codes are submitted by the pharmacy with transition fill eligible claim submission to allow transition supplies and override Refill Too Soon rejects for new admissions, and to allow at least a 31 day supply unless written for less (or greater based on plan set-up) with multiple fills, if needed, of medication that might be non-formulary, or formulary with prior authorization, step therapy, quantity limits or daily dose less than FDA maximum dose limits or age edits. If a dose change results in an “early refill” reject, the pharmacy may call the Pharmacy Help Desk to obtain an override.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.4.7

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Caremark will have a process in place that will allow an override on topical ophthalmic products when appropriate to prevent unintended interruptions in drug therapy.		X		HPMS Memo 06/02/2010
Caremark Part D will print, mail, and manage a CMS compliant EOB each month for participants with utilization during the reporting month as well as post EOBs to a secure website for customer service viewing. EOBs for each reporting month will be mailed by the end of the following month.			X	Medicare Marketing Guidelines for MAs, MA-PDs, PDPs and 1876 Cost Plans
Stand-alone negative formulary change notification mailings will be used in addition to standard EOBs for affected beneficiaries that did not receive an EOB during a specified time period (drug to be changed is found in prescription history) and for members who filled a prescription for the negatively changed medication within the last 120 days.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.3.3.3-30.3.4.4
Caremark Part D will submit negative formulary change requests via the HPMS interface, as necessary, on behalf of CDPHP.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.3.3.1-30.3.4
Negative formulary changes will be communicated to members within the CMS required timeframe of 60 days prior to the change via EOB or a separate mailing		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.3.4.1,30.3.4.3, 30.3.4.4
Negative formulary change notification will be provided to network pharmacies at least 60 days in advance of the effective date of the change.		X		Medicare Prescription Drug Benefit Manual, Chapter 6, 30.3.4.2

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Beginning on January 1, 2012, CVS Caremark will provide a standard message to the pharmacy to distribute the notice: MESSAGE 569—"Provide Beneficiary with CMS Notice of Appeal Rights". This notice must be distributed by the dispensing pharmacist whenever a prescription cannot be filled for an appealable reason and the issue cannot be resolved before the beneficiary leaves the pharmacy (Non-Formulary request, PA required, Plan limits exceeded or Step Therapy required)		X		Medicare Prescription Drug Benefit Manual, Chapter 18-Part D Enrollee Grievances, Coverage Determinations and Appeals
The Provider Pharmacy Network is notified of unilateral updates to the Provider Manual, Medicare Part D changes or existing plan changes/ additions that could potentially impact operations at the point of sale.		X		
Pharmaceutical Patient Safety Issues Provide a system at point of dispensing communications to identify and classify drug-drug interactions by severity and notify the dispensing providers at point-of-dispensing of specific interactions when they meet the organization's severity threshold		X		UM 13C
Caremark Part D will be responsible for operating a toll-free customer care center that provides customer telephone service regarding prescription medications and mail order in accordance with CMS requirements. CDPHP will be responsible to provide CMS with information related to the operations of this customer call center		X		Medicare Part D Reporting Requirements MR12

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Caremark Part D will be responsible for operating a toll-free customer TDD/TTY line as well as providing a foreign language line to its customer care call center that provides customer telephone service regarding prescription medications and mail order in accordance with CMS requirements. CDPHP will be responsible to provide CMS with information related to the operations of this customer call center as well as to share relative performance.		X		Medicare Part D Reporting Requirements (Star Ratings)
Caremark Part D will measure the satisfaction of CDPHP members that call into Caremark regarding the service they received on monthly surveys. Caremark will report results to CDPHP on a monthly, quarterly and annual basis.		X		NCQA
Caremark Part D will be responsible to report if their customer care call center blocks calls during peak call periods (or regular business hours) by immediately giving members a busy signal and keeping the calls from reaching the call queue, the percentage of blocked calls should be reported to CDPHP.		X		HEDIS Data Element
Caremark Part D will be responsible to maintain a reasonable and appropriate Drug Utilization Management Program that maintains policies and systems to assist in preventing over and underutilization of prescription medications and establishes incentives to reduce costs when medically appropriate.		X		Medicare Prescription Drug Benefit Manual, Chapter 7—Medication Therapy Management and Quality Improvement Program—Section 60-DM01 and DM02

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Concurrent Drug Utilization Review—Caremark Part D must have concurrent drug utilization review (DUR) systems, policies and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee at the point of sale or distribution. For 2013, Caremark Part D is implementing the CMS required overutilization management program as outlined in the 2013 Final Call letter and subsequent guidance, including enhanced POS overutilization edits, quantity limits as appropriate. Member specific utilization management edits may be implemented as part of the retrospective program with the approval of CDPHP. Enhanced Point of Sale Drug Utilization Review Edits. For the fees set forth on Exhibit B to the PBM Agreement, Caremark Part D has added additional SOFT edits in order to be in compliance with CMS requirements. Such edits shall include edits for multiple doctors, multiple pharmacies, cumulative APAP dose and excessive controlled substances. The edits will stop at the pharmacy, the pharmacist will enter a code and the claim will process. Caremark Part D, in its discretion, may modify the edits described in this paragraph. Formulary Edits. For 2013, Caremark has added 500 plus edits to the Caremark Part D template formulary for the fees set forth on Exhibit B to the PBM Agreement. Such edits include QL, daily dose and dose opt edits. Caremark Part D, in its discretion, may modify the formulary edits.		X		Medicare Prescription Drug Benefit Manual, Chapter 7—Medication Therapy Management and Quality Improvement Program—Section 20.2, QA02, 2013 Call Letter pages 134-135

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Retrospective Drug Utilization Review—Caremark Part D must have retrospective drug utilization review (DUR) systems, policies and procedures designed to ensure ongoing periodic examination of claims data and other records, through computerized drug claims processing and information retrieval systems, in order to identify patterns of inappropriate or medically unnecessary care among enrollees in the Part D plan, or associated with specific drugs or groups of drugs. For 2013—CVS Caremark will implement the CMS required retrospective overutilization management program as outlined in the 2013 Final Call letter and subsequent guidance, retrospective DUR for controlled substances. Member specific utilization management edits may be implemented as part of the retrospective program with the approval of CDPHP. The Caremark Part D Core and Enhanced Safety and Monitoring Solutions program supports this requirement and is available to CDPHP for the fees set forth on Exhibit B to the PBM Agreement. The CORE program consists of a queue of edits that is managed by a Caremark Part D pharmacist on a daily basis. The pharmacist is looking for alerts that would potentially flag FWA (excessive controlled substances, multiple doctors for controls, multiple pharmacies, high cost etc.). If upon review by the pharmacist it is deter- mined that the case warrants more information a letter is sent to the physician and Caremark Part D follows the case for a period of time (9 months). Caremark Part D, in its discretion, may modify the CORE program.		X		Medicare Prescription Drug Benefit Manual, Chapter 7— Medication Therapy Management and Quality Improvement Program—Section 20.3 QA03, 2013 Call Letter pages 136-140

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Retrospective Drug Utilization (continued) The next level of Drug Utilization Review involves members who are referred by a pharmacist from the CORE program and involves more extensive follow up and member/ provider coordination. The Caremark Part D program consists of the following components: 1. Notification and Coordination of Care letters to prescribers and member 2. Coordination of Care reminder letter to prescriber 3. Final member /provider/pharmacy notification letter with actions taken (drug restricted, dose restricted etc.) 4. Positive Reinforcement Letter to member 5. Pharmacy Follow up 6. Prescriber follow up includes Opioid Prescriber Tool Kit The Drug Utilization Review services described above are available to CDPHP for the fee set forth on Exhibit B to the PBM Agreement and may be modified by Caremark Part D in its discretion. Additional services can be performed for an additional fee (Medication Therapy Counseling, Peer to Peer telephonic consultation, Special Investigations Unit) All cases that are referred to the next level will require signoff from CDPHP with suggested actions from Caremark Part D provided		X		See prior page.

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Internal Medication Error Identification and Reduction Systems—Caremark Part D must have internal medication error identification and reduction measures and systems that address ways to reduce medication errors and improve medication use.		X		Medicare Prescription Drug Benefit Manual, Chapter 7—Medication Therapy Management and Quality Improvement Program—Section 20.4 QA04
Caremark Part D must establish and maintain an electronic prescription drug claim processing systems program that complies with Transaction Standards		X		Medicare Prescription Drug Benefit Manual, Chapter 7—Medication Therapy Management and Quality Improvement Program—Section 50.3
Caremark Part D must meet CMS standards for convenient access to Part D drugs via contracted retail, home infusion, long term care and Indian Health Service, Indian Tribe and tribal Organization and Urban Indian Organization (I/T/U) pharmacies.		X		Medicare Prescription Drug Benefit Manual, Chapter 5—Benefits and Beneficiary Protection, Sections 50, 50.1, 50.4-50.7 PH01–PH04
Caremark Part D must contract with any pharmacy that meets the plan's standard contracting terms and conditions (the "any willing pharmacy requirement") or meet CMS criteria for a waiver of the any willing pharmacy requirement		X		Medicare Prescription Drug Benefit Manual, Chapter 5—Benefits and Beneficiary Protection, Section 50.8.1 PH05
CDPHP must ensure that at the point of sale network pharmacies apply accurate cost-sharing as established in the enrollee benefit design and for LIS beneficiaries, statutory copayment amounts	X			FM04
Caremark will effectuate transition supplies for affected Part D members when there is a federal declared disaster or public health emergency as and to the extent required by CMS.		X		Medicare Prescription Drug Benefit Manual Chapter 5, Medicare Managed Care manual, Chapter 4, Sec. 30.9, HPMS memos 6/16/2008 and 7/20/2009

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Submission of Prescription Drug Event (PDE) Data and Direct and Indirect Remuneration (DIR) data—By May 31 following the end of a coverage year, Caremark Part D must provide to CMS PDE data on behalf of CDPHP that will be used to reconcile the reinsurance subsidy, low income cost- sharing subsidies and risk corridors. By June 30 following the end of a coverage year Caremark Part D must provide DIR data to CDPHP. CDPHP will supplement the DIR data as appropriate and will submit their final DIR files to CMS. (These dates may be altered for any given year) Detailed DIR Report data will also be included pursuant to CMS requirements.		X		Medicare Part D DIR Reporting Requirements for Payment Reconciliation PA02
Caremark Part D will adjudicate claims for Part D prescriptions using valid NPI numbers, and only in order to avoid service interruptions, allow valid alternative prescriber identifiers such as DEA numbers or state license numbers.		X		http://questions.cms.hhs.gov/app/answers/detail/aid/2623/session/L3NpZC9jeUQydDE3as%3D%3D HPMS Member 08/13/2010
PDE Investigation/resolution—Caremark Part D will handle investi- gation of potential discrepant PDE's when identified by CMS or its designee. Caremark Part D will provide response/ detail to CDPHP with sufficient detail for CDPHP to provide the required response to CMS' vendor.		X		

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Caremark Part D must provide the beneficiary's gross covered drug spend and true out-of-pocket (TrOOP) balance to the beneficiary as of the effective date of disenrollment. If enrollment changes occur during the coverage year, the disenrolling sponsor provides a report of these beneficiary data to the new plan of record and the new plan sponsor uses the data to position the beneficiary in the benefit.		X		Medicare Prescription Drug Benefit Manual, Chapter 14—Coordination of Benefits Section 50.9.1 CB03
Caremark Part D/CDPHP must provide CMS with information related to pharmaceutical manufacturer rebates, discounts and other price concessions according to the guidelines specified by CMS.	X			Medicare Part D Reporting Requirements PA04
Coverage Gap Discount Program— Caremark must assist with investiga- tion/resolution of potential duplicate/ discrepant PDE records impacting CGDP payments from manufacturer quarterly basis (or as otherwise identified by CMS or their designee— such as Acumen).	X	X		HPMS Memos re: CDGP
CDPHP must adhere to CMS guidance for adopting and maintaining current, written policies and procedures that address all applicable Part D statutes, regulations and program requirements. These policies and procedures must articulate the specific procedures personnel should follow when per- forming their duties. In addition, Caremark Part D must maintain written policies and procedures for all delegated functions that will be monitored and reviewed by CDPHP.	X	X		PP01

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
Excluded Provider Complaints— Caremark provides file with detail of excluded providers who've written scripts for our members. CDPHP Pharmacy sends letters to impacted members. Per 6/29/11 memo from CMS, if erroneously excluded, Caremark must reprocess impacted claims within 24 hours of notification that provider was excluded in error. CDPHP will handle letter that must be sent to impacted member/provider that issue has been corrected and notification to CMS.	X	X		6/29/2011 HPMS memo and further clarifying guidance from CMS.
Hospice members are identified by CMS and transmitted to CDPHP on the TRR file. CDPHP will transmit hospice status to Caremark on the eligibility file beginning on 1/1/2014. Caremark Part D will provide payment determinations for four categories of drugs (i.e. analgesics, antiemetics, laxatives and antianxiety drugs) via the Pharmacy Help Desk. The list of drug categories for payment determinations will be expanded as of March 3, 2014 to require payment determination for ALL drugs for hospice beneficiaries. If the member's eligibility includes the hospice indicator and the claim is for a hospice drug, the claim will reject with messaging directing the pharmacy to call the pharmacy help desk. If the patient is not in hospice, the pharmacy help desk will enter an override so the claim will be payable under the Part D benefit. For claims processed prior to March 3, the pharmacy help desk will ask additional questions and if the drug is determined to be covered under Part D, an override will be entered by the pharmacy help desk; if the drug is not payable under Part D, no override is entered.	X	X		Medicare Part D Call Letter pages 134-138; CMS Memo PART D PAYMENT FOR DRUGS FOR BENEFICIARIES ENROLLED IN HOSPICE 12/6/2013

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
For claims processed after March 3, once the patient is confirmed as being in hospice, the pharmacy will be instructed to bill the hospice provider. If the hospice provider feels the Part D plan should pay for the claim, the hospice provider must provide written documentation to the CVS Caremark Coverage Determinations and Appeals department or CDPHP Pharmacy Department, who will review the documentation for completeness. If the documentation is received and is complete, an override will be entered and the pharmacy will be contacted to resubmit the claim. If the documentation is not received or is incomplete, no override will be entered. CDPHP may review paid hospice claims to submit them to an Independent Review Entity (IRE) if CDPHP feels they paid for the claims in error. Should the IRE determine the claim was paid by CDPHP in error, CDPHP can provide that claim detail to CVS Caremark for deleting the associated PDE records.	X	X		Medicare Part D Call Letter pages 134-138; CMS Memo PART D PAYMENT FOR DRUGS FOR BENEFICIARIES ENROLLED IN HOSPICE 12/6/2013

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function	Responsible Party			Source for Deliverable, Accreditation Standard, Contract Provision, or CMS Reference
	CDPHP	Caremark Part D	Other	
ESRD members are identified by CMS and transmitted periodically to CDPHP. CDPHP will transmit ESRD status to Caremark on the eligibility file beginning 1/1/2014. Caremark Part D will identify members with ESRD flag and electronically prompt messaging to facilitate correct payment of ESRD "always" and ESRD "maybe" drugs. At the POS the pharmacy will receive a message depending upon the drug category and pharmacies will be directed to CDPHP to make payment determinations.	X	X		2014 Medicare Part D Call Letter pages 138-139
Caremark Part D Services will, after receiving information that necessitates a retroactive claims adjustment, process the adjustment and issue refunds or advice CDPHP of recovery amounts within 45 days of the sponsor's receipt of complete information regarding the claims adjustment.		X		42 C.F.R.§ 423.466(a)
Member submitted paper claims processing—Caremark Part D will process member submitted Part D claims and process payment within 14 days of receipt of the claim; in the case of a claim that is not paid, the appropriate coverage determination and appeal language is provided to the member within the CMS mandated timeframes.		X		http://www.cms.hhs.gov/PrescriptionDrugCovContra

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Activity/Function				Responsible	
				Caremark	CDPHP
Oversight/Monitoring and Evaluation	Frequenc				
	Monthly	Quarterly	Annually		
Medicare D performance monitoring meeting with Caremark Part D	X				X
Review and evaluation of Caremark Part D transition policy and procedure			X		X
Review and evaluation of Caremark Part D EOB policy and procedure			X		X
Monitoring of external EOB vendor for accuracy and timeliness			X	X	
Review and evaluation of Caremark Part D formulary management policy and procedure			X		X
Review Medicare CIF and update with most current policies and procedures		X (Semi-Annually)		X	X
Call monitor meetings with CDPHP and Caremark Part D Call Center Customer Care		X		X	X
Review of Caremark Part D's procedure for adopting or creating a system for point-of-dispensing communications to identify and classify drug to drug interactions by severity			X		X
Develop a formal procedure, criteria and data collection form to document CDPHP pharmacy staff review of the accuracy of Caremark Part D's entry of formulary changes into the web application.			X		X
Review of Caremark Part D's policy and procedure for monitoring timeliness and accuracy of mail-order requests			X		X
Review procedure or process for Caremark Part D staff to respond to member email inquiries.			X		X
Fraud Waste and Abuse Training shall be provided to CVS Caremark employees and Network Pharmacies			X	X	

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
1.0	PDE	Weekly-PDE Submission and Response Files	PDE submission and responses files are housed on secure transport weekly for 90 days.		Caremark Part D sends files directly to CMS on behalf of CDPHP and the files are also posted to Caremark Part D's secure web portal (Webtransport) dedicated to CDPHP. These files are then put into a database to recycle eligibility errors. PDE eligibility errors are pulled from this file by CDPHP and worked internally by Membership and Billing. Caremark Part D works all non-eligibility errors.	Government Programs
2.0	PDE	Weekly-PDE Error Reports	PDE error reports are sent weekly.		Caremark Part D sends files directly to CMS on behalf of CDPHP and are also posted to Caremark Part D's secure web portal (Webtransport) dedicated to CDPHP. These files are then put into a database to recycle eligibility errors. PDE eligibility errors are pulled from this file by CDPHP and worked internally by Membership and Billing. Caremark Part D works all non-eligibility errors.	Membership and Billing
3.0	EOB	Annually-Audit of EOB file	Summary of EOB recipients and list of members who received an EOB and the date it was mailed is sent to CDPHP on a monthly basis (see Section 5.0). A select sample of EOBs will be pulled to audit		A random sample is pulled for each contract number and a hard copy of the Part D EOB is viewed via Caremark Part D provided secure website. EOB is reviewed to determine all applicable medications are indicated, appropriate member cost that the EOB issued is the CMS-approved version and that all information populated is complete and accurate.	Government Programs/ Pharmacy
4.0	EOB	Monthly-URL to view EOBs and email notification (Caremark Part D provided URL)	The EOB URL is static and EOBs are viewable within 24 hrs. of the EOB mailing deadline (i.e. Jan 31st deadline, EOB viewable Feb 1st at the latest).		EOBs are mailed the last day of the month following the month of service and viewable on URL within 24 hours. (i.e. December EOB mailed by January 31st and EOB viewable by February 1st)	Government Programs/ Pharmacy
5.0	EOB	Monthly-EOB report	Report of EOB recipients and list of members who received an EOB and the date it was mailed.		Report will include Contract ID, Member ID, Member Name, Mail Date, EOB Month Data, Address info (not complete)	Pharmacy

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
6.0	Account Team	Monthly Meeting	Medicare D performance monitoring meeting with Caremark Part D		Meeting trackers from monthly meeting are kept on file for documentation of issues	Government Programs
7.0	Custom er care	Monthly- Calls for CDPHP Call Monitoring - Medicare D	20 Medicare Customer Care calls sent via encryption by the 20th of the following month CDPHP will review calls and provide QA assessment to Caremark Part D Customer Care for review and follow-up Caremark Part D Customer Care is required to respond to QA assessment no later than 10 business days after receipt of report from CDPHP	NA	CDPHP reviews and provides a "Meets" or "Not Meets" score for each call. Information is sent back to Caremark Part D for action for all calls receiving a "Not Meet"	Member Services
8.0	EOB	Audit of EOB file	Summary of EOB recipients and list of members who received an EOB and the date it was mailed is sent to CDPHP on a monthly basis (see Section 5.0). A select sample of EOBs will be pulled to audit		A random sample is pulled for each contract number and a hard copy of the Part D EOB is viewed via Caremark Part D provided secure website. EOB is reviewed to determine all applicable medications are indicated, appropriate member cost that the EOB issued is the CMS-approved version and that all information populated is complete and accurate.	Government Programs/ Pharmacy

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
8.0(a)	Customer Care	Monthly Meeting	Call Type Summary with percentages Recommendations: Quality performance for phone staff (what are the issues/barriers /actions identified through tracking and trending) First Call Resolution without recontact in 30 days Breakdown (weekly, monthly, quarterly and year to date) Total number of calls received (CCR NCO) Total number of calls answered (NCA) Total number of calls abandoned (ABN>0) Abandonment Rate (%ABN>0) Average Talk Time (ATT) Average Call Work (ACW) Average Hold Time (HOLD) Average length of calls (AHT) Average Speed of Answer (ASA) Total # of Calls answered in 30 seconds or less (%TSF30) Weekly summary definition Report Acronym Legend Measurement Goals as stated in contract Abandonment measure description Additional Measurements % of calls received per eligible member % of calls received per using member % of calls received per total claims	Average Speed of Answer: 30 seconds or less Abandonment: 4% Percentage of Calls Answered in 30 seconds or less: 80% First Call Resolution without recontact: 83%	Report monthly and quarterly **CCR NCO** - Calls offered to a representative **NCA** - Calls answered by a representative **ABN>0** - Total number of calls abandoned **%ABN>0** - Percentage of calls abandoned (ABN>0 divided by CCR NCO) no calls excluded In addition, if an organization's phone system tracks a member's wait time and the system has the capability to call the member back when it is his/her turn in the queue, the organization may count the call as compliant (i.e., not abandoned) only if the member answers the call-back and the vendor reports clearly show this activity. **ATT** - Average talk time - time engaged in conversation, excludes hold and after call work, in seconds (Total Talk Time divided by NCA) **ACW** - Average after call work, in seconds (Total After Call Work divided by NCA) **HOLD** - Average time spent on hold, in seconds (Total HOLD Time divided by NCA) **AHT** - Average Handle Time, includes ATT, ACW and HOLD (ATT+ACW+HOLD) **ASA** - Average Speed of Answer (Total Answer Time divided by NCA) **NCA30 -** Number of calls answered at 30 seconds or less (no calls excluded)	

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
8.0(a)	Custom er Care	Monthly Meeting	Weekly summary definition Report Acronym Legend Measurement Goals as stated in contract Abandonment measure description Additional Measurements % of calls received per eligible member % of calls received per using member % of calls received per total claims		(no calls excluded) **%TSF30** - Percentage of calls answered at 30 seconds or less (NCA30 divided by CCR NCO) no calls excluded **% Of Blocked Calls**	
8.0(b)	Custom er Care	Monthly-Customer Care Medicare D Call Center Phone Statistics Reporting	Caremark Part D will be responsible to report if their customer care call center blocks calls during peak call periods (or regular business hours) by immediately giving members a busy signal and keeping the calls from reaching the call queue, the percentage of blocked calls should be reported to CDPHP.	The outcome of this measure is determine d by the HEDIS auditor.	Reported monthly and quarterly	HEDIS Data Element

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
8.0(c)	Customer Care	Quarterly-Customer Satisfaction Surveys for Customer Care Call Centers	Caremark Part D will measure the satisfaction of CDPHP members who call into Caremark Part D regarding the service they received on quarterly surveys. Caremark Part D will report CDPHP-specific results to CDPHP on a quarterly basis broken out by product (Commercial, Medicare Part D, and Medicaid).	Caremark Part D Services Customer Satisfaction Surveys: • 95% of those surveyed will respond "Yes" to "Was the Customer representative courteous, professional and concerned for your needs." • 95% of those surveyed will respond "Yes" to "Did the Customer Care representative effectively respond to your inquiry in one call?" • 95% of those surveyed will rate Caremark Part D Services as 3 or above on a 5 point scale for "Satisfaction with CVS Caremark's Customer Care Representatives." Caremark Part D Services and CDPHP acknowledge and agree that the questions set forth above are based on the Caremark Part D Services' 2013 Customer Satisfaction Survey. If these questions change in a future Customer Satisfaction Survey, Caremark	Reported quarterly and broken out by product (Commercial, Medicare Part D, Medicaid). CDPHP should also receive the Executive Summary, customer comments, and scoring broken down by question. Caremark Part D Services or its affiliate will ensure there are 250 completed surveys for Commercial and 250 completed surveys for Medicare Part D that are specific to CDPHP. Caremark Part D Services or its affiliate will survey 500 per quarter for the Medicaid product using a paper survey. Caremark Part D Services will work directly with CDPHP prior to implementing any revisions to the Customer Satisfaction Survey and the parties will mutually agree on any revisions prior to implementing.	

				Part D Services and CDPHP will mutually agree on the questions and standards that will apply.		

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
9.0	Customer Care	Monthly-Pharmacy Help Desk Reporting (Medicare)*Caremark Part D BOB numbers	Total number of calls received (NCO)Total number of calls answered (NCA)Total number of calls abandoned (NC ABN)Abandonment Rate (%ABN)Average Talk Time (ATT)Average Call Work (ACW)Average Hold Time (HOLD)Average length of calls (AHT)Average Speed of Answer (ASA)Total # of Calls answered in 30 seconds or less (%TSF30)	**Average Speed of Answer:** 30 seconds or less **Abandonment: 5%** Percentage of Calls **Answered in 30 seconds or less:** 80%	Reported monthly and quarterly **NCO** - Calls offered to a representative **NCA** - Calls answered by a representative **ABN** - Total number of calls abandoned **%ABN>0** - Percentage of calls abandoned 0 (zero) seconds or greater (ABN divided by NCO) no calls to be excluded **ATT** - Average talk time - time engaged in conversation, excludes hold and after call work, in seconds (Total Talk Time divided by NCA) **ACW** - Average after call work, in seconds (Total After Call Work divided by NCA) **HOLD** - Average time spent on hold, in seconds (Total HOLD Time divided by NCA) **AHT** - Average Handle Time, includes ATT, ACW and HOLD (ATT+ACW+HOLD) **ASA** - Average Speed of Answer (Total Answer Time divided by NCA) **NCA30** - Number of calls answered at 30 seconds or less no calls excluded **%TSF30** - Percentage of calls answered at 30 seconds or less (NCA30 or less divided by NCO) no calls excluded **% Of Blocked Calls**	Member Services

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
10.0	Mail	Monthly-Mail Turn Around Time Report - Medicare	Caremark Part D report that documents turnaround times for the CDPHP commercial and Medicare mail facilities avail monthly	Provided via email to CDPHP at least once quarterly		Pharmacy
11.0	Account Team	Monthly-Utilization Reports	Plan Performance information on MAPD business. Med D utilization numbers and estimated rebate information. The Med D lines of business are broken down and provided as follows: Med D IND, Med D Group, Med D combined, Med D HMO, Med D PPO.	N/A	Sent to CDPHP by the last day of the following month (i.e. reports for July sent by August 31st)	Pharmacy
12.0	Account Team	Monthly-Medicare D Formulary Update Kits	Medicare Operations provides CDPHP with monthly Medicare Part D Formulary Update Kits that contain updated formulary files created from Zynchros, our formulary management tool. The updated formulary files are provided to CDPHP according to the CMS submission calendar.		Received by the last day of the month prior to submission via web transport	Pharmacy
13.0	EOB	Annual-Oversight Document-ation for EOB vendor	Caremark Part D will provide appropriate oversight of its vendors and will provide documentation to CDPHP of this oversight			Government Programs will house the document-ation from Caremark Part D

14.0	All	Annual-Policies and Procedures	Caremark Part D to provide supporting policy and procedures associated with areas delegated to Caremark Part D: EOB Formulary management Concurrent DUR Retrospective DUR Medication Error Identification and Reduction (MEIR) Revised Standard Audit Procedure Transition Fill			

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
15.0	Customer Care	Quarterly-Calibration Review - Medicare D	Calibration Review between Caremark Part D and CDPHP representatives - CDPHP Customer Care Representative - Caremark Part D Customer Care Representative - Account Manager - CDPHP Quality Representative - Caremark Part D Quality Representative	N/A	Review a minimum of 3 but no more than 5 Med D Calls for: - Hassle Free Experience - First Contact Resolution - Proactive Education - Courtesy, Professional, Empathy - Accuracy - Authentication	Member Services
16.0	Mail Customer Care	Quarterly-Member Experience Reporting Review	Review of issue/complaint received into Service Recovery from CDPHP members and discuss trends, improvements	Tracks and trends changes for year.	Raw number list of issues/complaints received by Caremark Part D regarding CDPHP members by month / by quarter by main category and sub-category per the Caremark Part D Service Recovery database	Pharmacy/ Member Services
17.0	Mail Customer Care, Pharmacy	Quarterly Member Experience Reporting	List of issues/complaints received by Account Management, Service Recovery Unit, and Network Compliance for CDPHP members.	CDPHP requirement is that 95% of issues will be resolved within 30 calendar days	Current deliverable: Raw number list of issues/complaints received by Caremark Part D regarding CDPHP members by month, by quarter, by main category and sub-category per the Caremark Part D Service Recovery database. Data Elements required: Participant Name, Line of Business, Date Received, Date Resolved , Main Category, Sub-category, and Detail Summary	Pharmacy/ Member Services

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
18.0	Account Team	Quarterly-Point-of-dispensing interaction alert reports.	Quantum alerts- these are POS interactions such as Drug-Age, Drug-Drug, Drug- Disease broken down by Carrier Group NOTE this will no longer be an NCQA requirement after 7/1/2013	None	To ensure these alerts are occurring at POS and that CDPHP is notified of the interactions. Sent quarterly as a zip file for all CDPHP BOB	Pharmacy
19.0	Medicare Reporting	Quarterly-Exceptions info	Exceptions info is provided in quarterly workbook. This includes RXs denied at the POS such as PA/Step Therapy meds.	Received 60 days after the close of the quarter		Pharmacy and Government Programs
20.0	Medicare Reporting	Quarterly Annually Rebate reports	Caremark Part D compiles quarterly and annual reports for CDPHP per CMS schedule			Pharmacy and Government Programs
21.0	Customer care	Semi-annually CIF review	Review Medicare CIF (Customer Information Form) and update with most current policies and procedures. These forms are used by Caremark Part D Customer Care to answer calls from CDPHP members.		Current CIF are reviewed twice a year and updated with most current information	Pharmacy
22.0	Negative formulary Changes	Semi-annual Copy of Fax Blast to pharmacies	Copy of fax blast with negative formulary changes and date sent to all network pharmacies within 60 days of the change	Send in March for June changes and August for October changes per CMS schedule		Pharmacy and Government Programs

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
23.0	Mail	Annually-Mail Performance Guarantee reporting	Reports monitoring timeliness of mail order requests for Medicare Part D. Reports must include a comparison of performance to a goal, identification of barriers and improvement actions when performance does not meet goal.	**Mail Turnaround Time - All Prescriptions**. Within an average of five (5) business days of receipt, Caremark Part D shall dispense and ship 100% of all mail service pharmacy Prescriptions, as measured on a contract year basis. **Mail Turnaround Time - Clean Prescriptions.** Within an average of three (3) business days of receipt, Caremark Part D shall dispense and ship 100% of all clean (not requiring intervention or clarification) mail service pharmacy Prescriptions, as measured on a contract year basis.	**Mail TAT - All:** The average calculation is determined by taking the total number of prescriptions shipped (as recorded by Caremark Part D's systems) multiplied by the number of days these prescriptions took to ship divided by the total number of shipped prescriptions as measured on Caremark Part D book of-business basis. **Mail TAT - Clean:** The average calculation is determined by taking the total number of prescriptions shipped (as recorded by Caremark Part D's systems) multiplied by the number of days these prescriptions took to ship divided by the total number of shipped prescriptions as measured on Caremark Part D book-of-business basis.	Pharmacy
24.0	Audit	Annually-Results of Pharmacy Audit	Results of network pharmacy audits and the number/percent of pharmacies that have undergone audit.		Over the course of one year, CDPHP can review the monthly audit reports and request 15 audit examples. Once requested, Caremark Part D will need approximately 30 days to provide information.	Pharmacy and Government Programs

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
25.0	Transition Fill Letter Sample	Annually- Sample of 25 Transition Fill Letters	Annually CDPHP may elect to do the following:(i) via RxNavigator report, identify a sample of up to 25 transition fill letters (total between both contracts) that have been mailed to Members by Caremark Part D during the previous twelve months; and (ii) request in writing that Caremark Part D produce copies of such sample of transition fill letters. Caremark Part D will then have 45 days to provide to CDPHP copies of the letters.		Run RX Navigator report to pull transition fill letters to review for timeliness and completeness	Government Programs/ Medicare Compliance
26.0	Account Team	As needed- Formulary Change reports	Formulary Change reports	Caremark Part D sends a Formulary Update Form to CDPHP advising of any template formulary changes that will affect their formulary. Formulary tiering is based off this form and is used to assist with utilization management updates by CDPHP and Caremark Part D. This form is provided weekly. If there are no changes, a form is not created for that week.		
27.0	Formulary	As needed- Formulary Change mailing	List of members that received a standalone formulary change mailing with details of the name of the affected drug and date of mailing for purposes of CMS regulation of 60 day advance notice			

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
28.0	Negative Formulary Changes	As needed-Email for negative formulary changes	Email notification that negative formulary changes have been submitted through HPMS on behalf of CDPHP			Pharmacy
29.0	Fraud, Waste and Abuse Training	Annually-Results of Training	Caremark Part D will conduct annual Fraud Waste and Abuse training for Caremark Part D affiliated network pharmacies and employees, and will require all network pharmacies to conduct training for employees involved in providing services under Medicare Part D			Government Programs/ Corporate Compliance
30.0	Customer Care, Mail, Account Team	As needed-Drug recall letters	NCQA patient and prescriber level recall notices		Caremark Part D will send to Members that have filled a prescription for the affected product within six months of the recall, and their prescribers, an NCQA Notification Letter.	
31.0	Formulary	Daily, Weekly-Daily reject reports	Caremark Part D will send CDPHP daily reject reports for review		Caremark Part D will send reports for daily prescription claim rejects for review by CDPHP as a check for compliance, safety, and accuracy of formulary adjudication.	Government Programs, Pharmacy Compliance

O. CVS Caremark PART D: Pharmaceutical Management Delegation Responsibilities *(continued)*

Section	Area	Frequency and Deliverable	Description	Goal	Methodology	CDPHP Responsible Area
32.0	Vendor Oversight	As needed-Status Updates	Caremark Part D will conduct an audit, at least annually or as otherwise required by CMS, of all offshore vendors to ensure they are in compliance with all CMS requirements. Caremark Part D Services shall inform Client regarding any issues that arise as a result of any audit that will impact Client or its Members on an annual basis. Caremark Part D Services will provide to CDPHP (1) notice of new offshore vendors and termination of existing offshore vendors and (2) a summary of current offshore vendor attestations in the fourth quarter of each year.		Caremark Part D agrees to provide to CDPHP the information necessary for CDPHP to submit or to modify the applicable offshore vendor attestation(s) filed with CMS. Caremark Part D agrees to provide to CMS, upon request, offshore vendor audit information.	Government Programs, Pharmacy Compliance

P. MedSolutions, Inc., dba eviCore Health Care: Utilization Management Delegation Responsibilities

CDPHP delegates high-tech radiology Medical Necessity Program to MedSolutions, Inc., dba eviCore health care, a radiology management organization, effective, 04/01/2015. eviCore was formed from CareCore and MedSolutions, currently named as MedSolutions, Inc., dba eviCore health care and holds NCQA Utilization Management Certification status effective through 9/23/2016. CDPHP will monitor in 2016 this NCQA Certification renewal status in accordance with NCQA.

CDPHP retains responsibility for any NCQA accreditation requirement not listed below as the responsibility of MedSolutions, Inc. dba eviCore health care.

Activity/Function	Responsible Party	
	eviCore	CDPHP
UM 1 Utilization Management Structure	X	
UM 2 Clinical Criteria for Utilization Management Decisions	X	
UM 3 Communication Services	X	
UM 4 Appropriate Professionals	X	
UM 5 Timeliness of Utilization Management Decisions	X	
UM 6 Clinical Information	X	
UM 7 Denial Notices	X	
UM 8 Policies for Appeals	X	
UM 9 Appropriate Handling of Appeals (First Level Appeal Only for all product lines except Medicare)	X	
UM 10 Evaluation of New Technology		X
QI 4G Assessing Experience with the Utilization Management Process		X
UM 11 Emergency Services		X
UM 12 Procedures for Pharmaceutical Management		X

Delegate eviCore will review clinical information submitted by plan network practitioners and providers for requested radiology services and make a decision regarding whether a service meets national radiology UM clinical criteria. Determination of medical necessity, denial of service or other utilization management processes within the meaning of Articles 49 of the Insurance Law or Public Health Law of the State of New York.

P. MedSolutions, Inc. dba eviCore Health Care: Utilization Management Delegation Responsibilities *(continued)*

Activity/Function				Responsible Party	
				eviCore	CDPHP
Delegate Reporting Requirements	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Call Statistics Report	X	X	X	X	
Turn Around Time Report	X	X	X	X	
Requesting Physician Report	X	X	X	X	
Performing Sites Report	X	X	X	X	
Provider Issues Summary Report	X	X	X	X	
Provider Satisfaction Survey Report			X	X	
Case Summary Report upon request			X	X	
Top Procedures Report	X	X	X	X	
Radiology Utilization and Cost Trend Report		X	X	X	
Approval/Denial Reports	X	X	X	X	
Oversight/Monitoring and Evaluation	**Frequency**			**eviCore**	**CDPHP**
	Monthly	**Quarterly**	**Annually**		
Audit of UM Program			X		X
Review/Approval of UM Program Description			X		X
Review/Approval of UM Policies and Procedures			X		X
Review/Approval of Annual UM Work Plan			X		X
Review/Approval of Annual UM Program Evaluation			X		X
Review of Security Program			X		X
Review of Disaster Planning Program			X		X
Review of eviCore health care Clinical Criteria			X		X

CDPHP reserves the right to conduct an on-site review to evaluate compliance with CDPHP standards at any time.

Q. Landmark Health, LLC: Delegation Responsibilities

CDPHP delegates complex case management of chronically ill home bound members, who have six or more chronic diseases, effective 12/31/2014, to Landmark Health LLC; however, CDPHP reserves the right to review the quality program description, evaluation and work plan of Landmark on an annual basis. Landmark's role is to provide assistance and support to CDPHP in furtherance of CDPHP quality improvement activities, including through the regular reporting obligations and the delegated activities and the responsibilities of CDPHP and Landmark identified below. CDPHP will conduct monthly meetings and review at least annually to assess their compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP retains responsibility for any NCQA accreditation requirement not listed below as the responsibility of Landmark.

Activity/Function	Responsible Party	
	Landmark	CDPHP
QI 1 Program Structure		X
QI 2 Program Operations		X
QI 5 Complex Case Management	X	X
QI 5A Population Assessment		X
QI 5B Complex Case Management Program description		X
QI 5C Identifying Members for Case Management	X	X
QI 5D Access to Case Management		X
QI 5E Case Management Systems	X	
QI 5F Case Management Process		X
QI 5G Initial Assessment	X	
QI 5H Case Management-Ongoing Management	X	
QI 5I Experience with Case Management-Annually Measured	X	X
QI 5J Measuring Effectiveness-Annually Measured		X
QI 5K Action and Re-measurement		X
QI 7 Clinical Practice Guidelines		X
QI 8 Continuity and Coordination of Medical Care		X
QI 9 Continuity and Coordination of Medical Care and Behavioral Health care		X
QI 10 Delegation Oversight of QI Function		X
Adherence to CMS MA Regulations	X	X

Q. Landmark Health, LLC: Delegation Responsibilities *(continued)*

Monitoring Activity/Function				**Responsible Party**	
				Landmark	**CDPHP**
Delegate Reporting Requirements	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
QI Committee Minutes		X		X	X
HEDIS/ Star Measures			X		X
Member Satisfaction (after 1 year of services rendered)			X	X	
Complex Case Management Enrollment File	X			X	
QI 5C Member Identification Report	X			X	
QI 5H Monthly Activity Report with Participation Rate	X			X	
Case Management Medical record documentation accuracy as required by QI 5 F-H	X			X	
Continuity of care related to Behavioral Health referrals		X		X	
QI 5I Member Experience with CM Program; including complaints/inquiry report and annual member satisfaction survey		X	X	X	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Evaluation of landmark' s CM Program	X	X	X		X
Audit of QI Program		X	X		X
Review/Approval of QI Program Description			X		X
Review/Approval of QI Policies and Complex Case Management Policies and Procedures			X		X
Review/Approval of Annual QI and Complex Case Management Program/Work Plan			X		X
Review/Approval of QI and Complex Case Management Program Evaluation			X		X

CDPHP reserves the right to conduct an on-site review to evaluate compliance with CDPHP delegation requirements at any time.

R. Accordant Health Services: Disease Management Delegation Responsibilities

CDPHP delegates rare chronic disease management to Accordant Health Services, effective October 2014. Accordant holds NCQA Patient and Practitioner Oriented DM Accreditation, effective through 8/04/2017. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct monthly meetings and review at least annually to assess their compliance with standards. Results of the quarterly and annual review will be reported at the Joint Health Services Committee and reported through the CDPHP Quality Management Committee to the CDPHP board. CDPHP retains responsibility for any NCQA accreditation requirement not listed below as the responsibility of Accordant. CDPHP reserves the right to conduct an on-site review to evaluate compliance with delegation requirements at any time.

Delegated Activity/Function				Responsible Party	
				Accordan	CDPH
QI 1 Program Structure					X
QI 2 Program Operations					X
QI 6A Disease Management Program Content for Chronic Conditions				X	
QI 6 B Identifying Members for Disease Management Programs				X	
QI 6 C Frequency of Member Identification				X	
QI 6 D Providing Members with Information				X	
QI 6 E Interventions Based on Assessment				X	
QI 6 F Eligible Member Active Participation				X	
QI 6 G Informing and Education Practitioners				X	X
QI 8 H Integrating Member Information					X
QI 6 I Experience with Disease Management				X	X
QI 6 J Measuring Effectiveness				X	
QI 10 Delegation Oversight of QI Function					X
CMS Adherence to MA Regulations				X	X
Monitoring Activity/Function					
Reporting Requirements	**Frequency**				
	Monthl	**Quarterly**	**Annually**		
QI 6 B and C Member Identification Report	X			X	
QI 6 F Monthly Activity Report with	X			X	
QI 6 I- Member Experience with DM Program; including complaints/inquiry report and annual member satisfaction survey		X	X	X	X
QI 6J Effectiveness Measure Analysis			X	X	

Formerly NCQA DM Standards were under QI 8 in 2016 NCQA changed to QI 6

R. Accordant Health Services: Disease Management Delegation Responsibilities *(continued)*

Delegated Activity/Function				Responsible Party	
				Accordan	CDPH
Oversight/Monitoring and Evaluation	**Monthl**	**Quarterly**	**Annually**		
Evaluation of Accordant DM Program			X	X	X
Audit of QI Program			X		X
Review/Approval of QI Program Description			X	X	X
Review/Approval of QI Policies and			X	X	X
Review/Approval of Annual QI Program			X	X	X
Review/Approval of Annual QI Work Plan			X	X	X

CDPHP reserves the right to conduct an on-site review to evaluate compliance with delegated requirements at any time.

S. Clarus Health Systems: Delegation Responsibilities

CDPHP delegates the following activities related to the physician and hospital online directories to Clarus Health Systems, formerly Prism Services Group, Inc., effective, 12/2008. Clarus was acquired in 1/2014 by wholly owned subsidiary Healthsparq, Inc. Cambia Health Solutions is the parent company to HealthSparq. Clarus is NCQA Certified in Health Product Information HIP 4: Physician and Hospital Directory effective through 12/1/2016. The grid below outlines the delegates' and CDPHP roles and responsibilities and reporting schedule. CDPHP will conduct monthly meetings and review at least annually to assess their compliance with standards. Results of the annual review will be reported at the Joint Health Services Committee, which meets quarterly. The CDPHP Joint Health Services Committee minutes are reported through the CDPHP Quality Management Committee to the CDPHP board.

CDPHP reserves the right to conduct an on-site review to evaluate compliance with delegated requirements at any time. CDPHP retains responsibility for any NCQA accreditation requirement not listed below as the responsibility of Clarus.

Activity/Function	Responsible Party	
	Clarus	CDPHP
NET 6A Physician Directory Data	X	X
NET 6C Assessment of Physician Directory Accuracy	X	X
NET 6F Searchable Physician Web-Based Directory	X	
NET 6G Hospital Directory Data	X	X
NET 6H Hospital Information Validation	X	X
NET 6J Searchable Hospital Web-Based	X	
NET 6K Usability Testing	X	
NET 6L Availability of Directories	X	X
CMS Delegate adheres to Medicare Advantage (MA) regulations	X	

Activity/Function				Responsible Party	
				Clarus	CDPHP
Delegate Reporting Requirements	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Results of usability testing of online directory			*No less than every 3 years or any time user inter-face	X	X
Reporting as identified in the service agreement		X		X	
Oversight/Monitoring and Evaluation	**Frequency**				
	Monthly	**Quarterly**	**Annually**		
Contingent upon Clarus parent Healthsparq maintaining current NCQA HIP -WHIP Certification			X	X	X

Formerly NCQA Physician and Hospital directories Standards were under RR 4 in 2016 NCQA changed to Network Management NET 6

X. CONFIDENTIALITY AND CORPORATE COMPLIANCE INITIATIVES

Activities of the CDPHP Quality Management Program are privileged, confidential, and conducted in a manner that ensures the confidentiality of member and provider information. Employees and committee members are required to handle data responsibly and take the necessary steps to protect the privacy of the involved individuals in compliance with HIPAA regulations and applicable New York state privacy laws and regulations. Member and provider identities are anonymous in presentations, quality data reports, and committee minutes. In addition, each employee receives detailed privacy and security training upon hire and annual primers thereafter. Further, all CDPHP employees are subject to a confidentiality agreement as a condition of employment with CDPHP. Any breach in confidentiality will result in disciplinary action as described in the employee handbook. The corporate compliance officer, at a minimum, annually reviews the standards of conduct and confidentiality policies.

CDPHP Debarred Process Checks

CDPHP is prohibited from contracting with individuals or entities or employing individuals who have been excluded from Medicare, Medicaid or other federal or state sponsored health care programs. CDPHP has a monthly obligation to check the appropriate government lists to determine the participation/exclusion status of providers, employees, board members and vendors and terminate contacts, as appropriate. The corporate compliance department and SIU will implement an enhanced oversight process of debarred checks. A corporate team has also been established to explore outsourcing this process. Model contract language regarding the debarred requirements will be reviewed and enhanced as needed.

Training Enhancements

Fraud, Waste and Abuse (FWA) employee and delegate training will be modified to comply with new CMS guidance. A combined Compliance, FWA, Privacy and Security attestation will be designed and implemented. Halogen will be used as a corporate-wide method to annually distribute and document employee sign-off of the CDPHP Standards of Conduct. Temporary and consultant compliance training will be redesigned and enhanced.

SIU Enhanced Proactive Data Analysis

Continue advanced training and use of SAS software to enhance proactive FWA data analysis in coordination with the Data Science and Statistics Unit.

SIU Process Improvement

Explore the potential to develop SIU process improvements by using existing corporate compliance department resources to assist with less complex SIU investigative processes.

Waste and Abuse Prevention

Continue collaboration efforts with the chief operating officer, chief financial officer, vice president of informatics and vice president of medical affairs operations and others to coordinate and identify improvements and proactive procedures to prevent waste and abuse.

CDPHP NCQA Team

In an effort to further ensure accurate and complete information for NCQA accreditation review, the CDPHP privacy official will work directly with the CDPHP NCQA team for review and completion of related NCQA defined standards, elements and factors.

Confidentiality Requirements

Work with the internal operations quality team to ensure appropriate resources detailing guidelines for routine uses/disclosures of member PHI are available and updated periodically to ensure accuracy, concision and ease of use.

HIPAA/ HITECH

The corporate compliance department will continue to monitor the still pending release of final regulations concerning the proposed rulemaking for the HIPAA Privacy Rule Accounting of Disclosures and “minimum necessary” guidance under HITECH, in addition to the “Phase 2” Office for Civil Rights (OCR) HIPAA Audit program protocols to be conducted under the HITECH Act. Changes to policy, process and procedures will be implemented as required.

Electronic Release of Health Information Authorization (EROI)

In an effort to further minimize errors and streamline processes involved in the completion of individual ROIs, the corporate compliance department will work with internal operations to implement functionality to allow completion of the ROI via the electronic member portal.

XI. ANNUAL QUALITY PROGRAM EVALUATION

As part of its annual Quality Improvement (QI) program evaluation, CDPHP determines the overall effectiveness of its practices including patient safety activities. This includes trending of measures to assess performance in quality and safety of clinical care and quality of service and evaluation of overall effectiveness of the QI program, including progress toward influencing safe clinical practices throughout the network.

The evaluation provides evidence of effectiveness of practices, determines if opportunities for improvement exist, notes the degree of improvement where the process of care was found to improve, and identifies any policies and procedures that require enhancement or development.

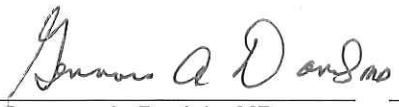
In carrying out the annual evaluation, CDPHP strives to:

- Evaluate and trend ongoing QI activities that address quality and safety of clinical care and quality service
- Document any barriers and/or limitations in current practice and develop a mitigation plan
- Communicate the results and analysis in an organized format and in a manner that is easily understood by all stakeholders including: CDPHP staff, network providers, and members
- Focus on the structure, processes, and outcomes of care with a focus on the quality and safety of clinical care and quality of service
- Respond to opportunities identified on the annual quality performance matrix
- Determine program effectiveness

The evaluation will be presented to the QMC and the board of directors for approval. Programs/initiatives still in progress or requiring ongoing monitoring will be incorporated into the Quality Management Work Plan for the upcoming year.

XII. ANNUAL REVIEW AND REVISION OF THE QUALITY MANAGEMENT PROGRAM DESCRIPTION

The Quality Management Program Description is reviewed at least annually and updated more frequently as appropriate. The Quality Management Committee is accountable for approving the Quality Management Program Description during the first quarter of each calendar year. The medical director presents the program description to the board of directors for review and approval.

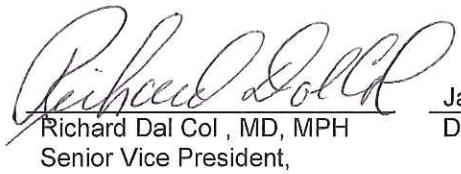


Gennaro A. Daniels, MD
Chairman, Board of Directors

January 20, 2016
Date

John D. Bennett, MD
President and Chief
Executive Officer

January 20, 2016
Date



Richard Dal Col , MD, MPH
Senior Vice President,
Medical Affairs
and Senior Medical Director

January 20, 2016
Date

Initial Program	4/96
Review and Revision	12/96, 12/97, 12/98, 9/99, 2/00, 3/01, 12/01, 12/02, 12/03, 12/04, 12/05, 12/06, 1/08, 1/09, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15. 1/16

Quality Management Program Description 2016

Appendix I

Quality Management (QM) Work Plan 2016

APPENDIX I – 2016 QM PROGRAM DESCRIPTION

- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Core Documents						
	QM Program Description and Work Plan (NCQA: QI 1,2; UM 1)	Annual QM Program's goals, objectives, structure and work plan for 2016 reviewed, approved by QMC and board by January 2016	A.O'Donnell Contributors: Applicable Business Owners	10/1/2015	Progress report towards goal submitted quarterly to QMC	1/19/2016
	QM Program Evaluation (NCQA QI1,2; UM 1)	Annual QM evaluation reporting the program's progress in meeting established goals and objectives for 2015. Plan for 2016 program activities based on the results from QM 2015 evaluation. Reviewed and approved by January 2016.	A.O'Donnell Contributors; Applicable Business Owners	9/15/2015	Progress report towards goal submitted quarterly to QMC	1/19/2016
	Patient Safety Plan *(Refer to Appendix II)* Safety Plan 2016 (NCQA: QI 1,2)	Annual plan on how CDPHP addresses patient safety improvement (NCQA QI 1,2) – approved by QMC and board	R. Golderman Contributors: A.O'Donnell	10/1/2015	Progress report towards goal submitted quarterly to QMC	1/19/2016
	Resource Coordination Program Description Workplan 2016 *(Refer to full RC Program Description)* (NCQA: UM 1ABC)	Annual Resource Coordination 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– approved by UMC, QMC and board	T. Langlais Contributors: B. Holtz	1/1/2016	Submit to UMC in 1st Q 2015, then reported up to QMC	3/31/2016
	Resource Coordination Program Evaluation 2015 *(Refer to separate RC Program Evaluation)* (NCQA: UM 1D	Annually review and document the effectiveness of the RC program and progress towards goals. Plan for 2016 program activities based on the results from RC 2015 Evaluation. Approved by UMC, QMC and board	T. Langlais Contributors: B. Holtz	10/1/2015	Submit to UMC in 1st Q 2016, then reported up to QMC	3/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Core Documents						
	Annual Resource Coordination Program Policies Procedure Review 2016 (NCQA: UM 1-4)	Annually review/revise the RC policy and procedures for the upcoming year. Develop RC policies/procedures in collaboration with our strategic alliance partner, Independent Health.	T. Langlais Contributors: B. Holtz D. Stewart	1/1/2016	Submit to UMC on staggered schedule to assure annual review. UMC Policy Approvals and Updates Reported quarterly up to QMC.	12/31/2016
	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 (US Census, enrollment, CMS, HEDIS, CAHPS, 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 2016 focus on LOB member health literacy and practitioner office practice on cultural competency.	D. Felitti Contributors: HNS K. Leyden Informatics Quality Review Nurses	1/1/2016	Progress report towards goal submitted at least annually to QMC	12/31/2016
	HEDIS® 2016 HEDIS/QARR Submission HEDIS Medicare Submission	Completion of HEDIS® 2016 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 MMRV requirements • Full Compliance with NCQA Onsite HEDIS Audit • Complete HEDIS 2016 Data Submission by 6/15/2016 Meet or exceed the national of state 75th percentile for not less than 5 measures in HEDIS 2016	R. Golderman Contributors: C. Roullier S. Beck Informatics Quality Review HEDIS RNs	10/1/2015	Progress report towards goal submitted quarterly to QMC	6/15/2016
	National Committee for Quality Assurance (NCQA) Health Plan	Successful Completion of *NCQA Preparatory File Review Audits*; UM, BH, Pharmacy, Appeals and Complex Case Management by June 30, 2016.	A.O'Donnell Contributors:	7/01/2015 Ongoing	Progress report towards goal submitted quarterly to QMC	7/01/2016

APPENDIX I – 2016 QM PROGRAM DESCRIPTION

- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Core Documents						
★★★★★	Accreditation (HPA) Renewal Survey 2018	CDPHP's legal entities: CDPHP, Inc., CDPHP Universal Benefits, Inc., and CDPHN, Inc. documents fully meet 2015 standards by 2/20/16 (start of survey 24 month look back period) and fully meets NCQA HPA 2016 requirements for structure, process and outcome by July 1, 2016. Conduct NCQA Preparatory File Reviews of the following areas in Q2-2016: CM, UM, BH, Pharmacy, and Credentialing and Appeals. Close all gaps identified through file audit prior to close of Q4-2016. Goal: Achieve full 50 points out of possible 50 overall accreditation score for all accredited products.	NCQA Survey Team R. Golderman			12/31/16
★★★★★	Implement New NCQA HPA Accreditation Standards for 2016	Maintain a constant state of survey readiness by implementing the new 2016 requirements, updates, corrections and policy clarifications as distributed by NCQA regarding QI, UM, NET, CR, RR and MEM standards/elements/factors. Address any gaps in meeting the requirements and close the gaps by 7/1/16.	A.O'Donnell <u>Contributors:</u> NCQA Survey Team R. Golderman	7/1/2015	Progress report towards goal submitted quarterly to QMC	12/31/2016
★★★★★	Delegation Oversight *(Refer to Delegation Section XI)*	Maintain Oversight of 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.	A.O'Donnell <u>Contributors:</u> JHSC R. Golderman	1/01/2016	Oversight monitoring of delegates is reported quarterly to QMC and to the board.	12/31/2016

APPENDIX I – 2016 QM PROGRAM DESCRIPTION

- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Core Documents						
	Clinical Practice Guidelines and Preventive Health Guidelines Management	Annual review for Preventive Care Guidelines, all others Biennial review. Chronic disease practice guidelines are reviewed and updated (per QMC schedule) by a Medical Director. All Guidelines are reviewed, revised and submitted according to schedule. The start date reflects the next date guidelines are reviewed, unless new national guidelines are released prior. Completion date reflects the date the guidelines are presented (with expected approval) at QMC. ***Preventive Guidelines- Annual Review*** ***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier Contributors: R. Dal Col, MD QMC Med Directors	1/1/2016	Progress report towards goal submitted quarterly to QMC	12/31/2016
	CHF	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	11/2015		**1/1/2016**
	Perinatal	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	09/2015		11/2015
	Asthma	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	06/2017		07/2017
	Hypertension	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	07/2016		**09/2016**
	Diabetes Mellitus	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	03/2017		05/2017
	Diagnosis of Diabetes: *Criteria and Testing*	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	03/2017		05/2017
	Obesity	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	11/2015		01/2017
	Preventive Health Guidelines	Preventive Health: *Children 0-12 years* *Adolescents 13-20 years* *Women and Men –Use of pneumococcal conjugate vaccine*	C. Roullier	01/2016		**03/2016**
	Influenza Prevention Control and Reporting	***Preventive Guidelines- Annual Review***	C. Roullier	01/2016		**03/2016**

APPENDIX I – 2016 QM PROGRAM DESCRIPTION

- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Core Documents						
	Pneumonia	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	05/2016		**07/2016**
	COPD	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	03/2017		05/2017
	Obesity	***Child and Adolescent Overweight and Obesity Guidelines***	C. Roullier	11/2016		01/2017
	STI Screening Guidelines for sexually active patients	***Preventive Guidelines- Annual Review***	C.Rouiller	03/2016	Progress report towards goal submitted Quarterly to QMC	**05/2016**
	HIV Guidelines	***Preventive Guidelines- Annual Review***	C. Roullier	01/2016	Progress report towards goal submitted Quarterly to QMC	**03/2016**
	ADHD	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	01/2016		**03/2016**
	ADHD for Primary Care	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	01/2016		**03/2016**
	Depression	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	01/2016		**03/2016**
	Bipolar	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	01/2017		03/2017
	Schizophrenia	***Chronic Disease Practice Guidelines- Biennial Review***	C. Roullier	01/2016		**03/2016**
	Health Dialog Chronic Condition Guidelines	Nationally recognized standards of care by nationally recognized organizations. Chronic Condition Guidelines in conjunction with our NCQA Disease Management Accredited delegate Health Dialog	C. Roullier	05/2016		**07/2016**
	Radiology Management Guidelines	In conjunction with our NCQA UM Certified **eviCore-** MedSolutions Delegate	R Dal Col,MD	01/2016		12/2016
	Compliance with the Plan's Preventive Health Guidelines	2 Standard Deviations below physician peer group mean	R Dal Col,MD	08/2016 01/2017		10/2016 12/2017

APPENDIX I – 2016 QM PROGRAM DESCRIPTION

- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
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*	C. Roullier	06/2016	Progress report towards goal Submitted annually to QMC	10/2016
	Facility to PCP	From a facility to practitioner	C. Roullier	06/2016	Progress report towards goal Submitted annually to QMC	10/2016
	OB/GYN to PCP	Specialist to PCP	C. Roullier	06/2015	Progress report towards goal Submitted annually to QMC	10/2016
	Advance Care Planning	Formal Chart review is no longer required as compliance is demonstrated by the amended executed Physician Contracts which have a clause addressing compliance with Advance Directives, effective 2012. *Charts are reviewed for the execution of Health Care proxy and or MOLST*	C. Roullier	06/2015	Progress report towards goal Submitted annually to QMC	10/2016
	Medical record Documentation for Medical and BH records	Compliance with CDPHP's standards for acceptable medical record documentation @ 90%; NCQA requirement for Continuity and Coordination of Care	C. Roullier	06/2015	Progress report towards goal Submitted annually to QMC	10/2016
	AD Hoc Regulatory Audits/ Quality of Care Studies	Ad Hoc quality studies as requested by regulatory agencies as NYSDOH, CMS, HEDIS 2015 and 2015 Interim HEDIS Measures.	C. Roullier	01/02/16	Progress report towards goal Submitted annually to QMC	12/31/2016
	Perinatal Study/Hysterectomy/ Sterilization Consents for Medicaid	NYSDOH Article 44	C. Roullier	07/2016	Progress report towards goal Submitted annually to QMC	9/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Continuity and Coordination of Care Monitoring – Behavioral Health						
	Behavioral Health to Medical Providers Behavioral Health to Medical Providers *(continued)*	To improve continuity and coordination of care between medical and behavioral health practitioners within the CDPHP community BH is focused on **6 Critical Areas** to Monitor and Evaluate annually: **1. Exchange of Information** – monitored via Provider Satisfaction Survey 2. **Appropriate Diagnosis, Treatment and Referral** HEDIS Measure: Antidepressant Medication Management (AMM) **3. Psychopharmacological Medications** HEDIS Measure: Follow-up Care for Children Prescribed ADHD Medication (ADD) 4. **Screening and Management of Coexisting Disorders** HEDIS Measure: Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) 5. **Preventive Behavioral Program** Postpartum Depression Screening 6. **Needs of Individuals with SPMI** HEDIS Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	C. Rorie-Alexandrov T. Doherty	01/1201 6	Progress report towards goal submitted quarterly to QMC	12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality						
	Enhanced Primary Care (EPC) NCQA: PCMH Level III	**Meet or exceed EPC Effectiveness Measures:** **Population Health:** Breast Cancer Screening BCS Cervical Cancer Screening CCS Childhood and Adolescent Immunizations CIS + IMA + HPV Chlamydia Screening CHL Colorectal Cancer Screening COL Lead Testing in Children LSC **Managing Chronic Conditions and Medications** Asthma Medication Ratio AMR Pharmacotherapy management of COPD Exacerbation (bronchodilators and corticosteroids) PCE Composite of 3 Diabetes measures (Eye, A1C, Nephropathy) CDC Persistent Medication Management MPM (ACE/ARB + Digoxin + Diuretics) **Antibiotic Use In Adults and Children** Three antibiotic use measures (adult bronchitis, children with Pharyngitis, children with URI) AAB+CWP+URI **Behavioral Health** Antidepressant Medication Management – Continuation phase AMM Follow-up Care for Children Prescribed ADHD Medication – Continuation phase ADD Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (30 day) IET	J. Heath Contributors: E. Martin C. Schlude J. Wilson T. Doherty M. Courtney J. Keohan	1/1/2016	EPC practices receive monthly practitioner gap lists on measures they can impact. Performance Improvement reports on EPC Progress towards goal quarterly to QMC	12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality						
🗝	Enhanced Primary Care (EPC) NCQA: PCMH Level III *(continued)*	**Meet or exceed EPC Effectiveness Measures:** *(continued)* **Member Experience of Care Summary** CG-CAHPS Measures (Summary score of 10 questions) **Managing Chronic Conditions/Comprehensive Coding** Comprehensive HCC Coding for chronic conditions 3X				
🗝	Enhanced Primary Care (EPC) NCQA: PCMH Level III *(continued)*	**REPORTING ONLY the Following:** **Population Health Immunizations** Childhood Immunization Status CIS Immunizations for Adolescents IMA Human Papillomavirus (HPV) for female adolescents HPV **Managing Chronic Conditions and Medications** Pharmacotherapy management of COPD Exacerbation (bronchodilators) PCE Pharmacotherapy management of COPD Exacerbation (corticosteroids) PCE Eye Exam – Diabetes CDC HgbA1c Testing – Diabetes CDC Nephropathy Attention – Diabetes (reporting only) CDC Persistent Medication Management – ACE/ARB (K+ and Creat) MPM Persistent Medication Management – Digoxin level and K+ and Creat MPM Persistent Medication Management – Diuretics (K+ and Creat) MPM				

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality						
	Enhanced Primary Care (EPC) NCQA: PCMH Level III *(continued)*	**REPORTING ONLY the Following:** *(continued)* **Antibiotic Use In Adults and Children Composite** Appropriate Antibiotic Use for Acute Bronchitis AAB Appropriate Treatment for Children with Pharyngitis CWP Appropriate Treatment for Children with URI **Behavioral Health** Antidepressant Medication Management – Acute phase AMM Follow-up Care for Children Prescribed ADHD Medication – Initiation phase ADD Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation) IET **CG-CAHPS Experience of Care - 10 question composite** 1. Did you get an appointment with your doctor as quickly as you thought you needed to? 2. Wait time to see provider in relation to actual appt time 3. Did the provider give you easy to understand information about your health concerns? 4. Did the provider seem to know important information about your medical history 5. Did someone from the office follow up to give you test results? 6. Were clerks and receptionists helpful 7. How long did it take for the doctor's office staff to return your call? 8. How often did this doctor seem informed about your care with specialists?				

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target			Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality								
		9. Did the office give you information about what to do if you needed care during evenings, weekends, or holidays? 10. In the last 12 months, how often were you able to obtain care you needed during evenings, weekends, or holidays?						
*****	2016 CMS Medicare Star Ratings Measures and Weights	**Part C**: (33 Measures) Medicare HMO and PPO Members	**STAR Goal HMO/PPO**		C. Aguglia <u>Contributors:</u> T. Scotti T. Baker T. Nasadoski Informatics Medicare Stars Call Center	1/1/2016	Medicare Stars Team monitor monthly GAP lists on measures they can impact. Progress towards goal to be reported quarterly to QMC	12/31/2016
		Staying Healthy *Process Measures*:						
		• C01- Breast Cancer Screening-BCS	81	81				
		• C02-HEDIS Colorectal Cancer Screening	78	78				
		• C03- CAHPS Annual Flu Vaccine^						
		• C06- HEDIS/HOS Monitoring Physical Activity^	81 60	81 60				
		• C07- HEDIS Adult BMI Assessment^						
		Staying Healthy *OUTCOME Measures:*	95	95				
		• C04- HOS Improving or Maintaining Physical Health (3X)	72	72				
		• C05- HOS Improving or Maintaining Mental Health (3X)	82	82				
		Managing Chronic Long Term Conditions *Process Measures:*						
		• C12- HEDIS Osteoporosis Management	26	26				
		• C13- HEDIS Diabetes Care- Eye Exam	82	82				

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target			Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality								
		• C14- HEDIS Diabetes Care- Kidney Disease Monitoring	94	92				
		• C17- HEDIS Rheumatoid Arthritis Management	86	86				
		• (Display)- HEDIS/HOS Improving Bladder Control	41	41				
		• C18- HEDIS/HOS Reducing the Risk of Falling ^	60	60				
		Managing Chronic Long Term Conditions *Intermediate Measures:*	87	87				
		• C15- HEDIS Diabetes Care –Blood Sugar Controlled	73	74				
		• C16- HEDIS Controlling Blood Pressure						
		Managing Chronic Long Term Conditions Outcome *Measures:*	9	8				
		• C19- HEDIS Plan All-Cause Readmissions						
		CAHPS - Member Experience with Health Plan	86	86				
		Experience/Complaint:	81	82				
		• C20-CAHPS Getting Needed Care	94	94				
		• C21- CAHPS Getting Appointments and Care Quickly	89	89				
		• C22- CAHPS Customer Service	93	92				
		• C23- CAHPS Overall Rating of Health Care Quality	86	86				
		• C24- CAHPS Overall Rating of Plan						

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target			Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality								
		• C25-CAHPS Care Coordination **<u>Member Complaints and Improvements in Plan's Performance</u>** *<u>Experience/Complaints:</u>* • C26- CTM -Complaints about the Health Plan • C27- Beneficiary -Members Choosing to Leave the Plan^ **<u>Member Complaints and Improvements in Plan's Performance</u>** *<u>Outcome Measure:</u>* • C3129- Plan Ratings -Quality Improvement (5X) **<u>Customer Service</u>** *<u>Access Measures:</u>* • C30- IRE- Plan Makes Timely Decisions about Appeals • C31- IRE- Reviewing Appeals Decisions • C32- Call Center Foreign Language Interpreters	.06 2 0.2 92 87 95	.06 7 0.2 88 88 95				
	2016 CMS Medicare Star Ratings Measures and Weights	**Part D**: (13 Measures) Medicare HMO and PPO Members	**Star Goal HMO/PPO**		C. Aguglia <u>Contributors:</u>	1/1/2016	Medicare Stars Team monitor monthly GAP lists on measures they can impact. Progress	12/31/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target			Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality								
		Drug Plan Customer Service *Access Measures*: • D01-Foreign Language Interpreter and TTY • D02-IRE- Appeals Auto-Forward • D03- IRE- Appeals Upheld	94 1.0 75	94 1.0 75	T. Scotti T. Baker T. Nasadoski Informatics		towards goal to be reported quarterly to QMC	
		Member Complaints and Improvements in Plan's Performance *Experience/Complaints:* • D04- CTM- Complaints about the Drug Plan (Part C and D) • D06-Beneficiary- Members Choosing to Leave Plan (Part C and D)	.06 10	.06 10				
		Member Complaints and Improvements in Plan's Performance *Outcome Measure:* • D07- Plan Ratings -Quality Improvement	.65	.70				
		Member Experience with Drug Plan *Experience/Complaints:* • D08- CAHPS- Rating of Drug Plan^ • D09- CAHPS- Getting Needed Prescription Drugs^	86 92	86 92				
		Patient Safety and Drug Pricing Accuracy *Process Measure*: • D10- Multiple - Medicare Plan Finder Price Accuracy	99	99				

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target			Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality								
		Patient Safety and Drug Pricing Accuracy Intermediate *Measure*: • Display PDE- High Risk Medication • D12-PDE- Part D Medication Adherence for Oral Diabetes • D13- PDE- Part D Medication Adherence for Hypertension • D14- PDE- Part D Medication Adherence for Cholesterol	6 82 87 82	6 82 87 82				
	Medicaid Quality Incentive	**Medicaid Quality Incentive** (based on MY 2014 performance) **Effectiveness of Care:** • *Adherence to Antipsychotics Medications for Individuals with Schizophrenia* • Adolescent Preventive Care • Adult BMI Assessment • Antidepressant Medication Management • Appropriate Testing for Pharyngitis • *Asthma Medication Ratio* • Avoidance of Antibiotics for Adults with Acute Bronchitis • *Breast Cancer Screening* • *Chlamydia Testing for Sexually Active Women* • Childhood Immunization • Cholesterol Management for Patients with Cardiovascular Event	**Goal**		R. Golderman Contributors: S. Nelson S. Banardo BH Team Informatics	1/1/2016	Progress report towards goal submitted annually to QMC	4/30/2016 12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target		Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality							
		• Comprehensive Diabetes Care • Comprehensive Diabetes Control • Diabetes Screening for People with Schizophrenia or Bipolar Disorder • Disease-Modifying Anti-Rheumatic Drugs for Rheum. Arthritis • Flu Shots for Adults (CAHPS) Ages 50-64 • Follow Up After Hospitalization for Mental Illness • *Follow Up for Children Newly Prescribed ADHD Medication – Initial* • Comprehensive Care for People Living with HIV/AIDS • Immunizations for Adolescents • Medical Assistance with Tobacco Cessation (CAHPS) • *Medication Management for People with Asthma* • Persistence of Beta-Blocker Treatment After a Heart Attack • Pharmacotherapy for COPD Exacerbation • *Postpartum Care* • *Use of Imaging Studies for Low Back Pain* • *Use of Spirometry Testing in the Assessment of COPD*					

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target		Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality							
		• Weight Assessment and Counseling for Children and Adolescents **Access and Availability** • Annual Dental Visits Ages 2 -18 **Use of Services** • Well Child Visits in the First 15 Months – Five or more visits • *Well Child Visits in the 3rd, 4th, 5th and 6th Year* • Well Care Visits for Adolescents Ages 12-21 **CAHPS Satisfaction Survey Measure: (30 points)** • Rating of Health Plan • Getting Care Needed • Customer Service and Information **Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) (20 points):** • Adult Composite (all PQIs except respiratory) • Adult Respiratory (PQI #5 and #15) • Pediatric Composite (all PDIs except Asthma) • Pediatric Asthma (PDI #14) Goal: The Plan's Quality Performance trend moves in a positive direction towards improvement when compared to plans past MY					

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality						
		performance the current MY x 20% improvement from NYS Goal of 100%.				
Programs to Improve Quality						
	Comprehensive Primary Care (CPCi) Initiative	Comprehensive Primary Care (CPCi) Initiative is a four year (2013-2016) multi-payer initiative fostering collaboration between CMS and private health care payers to strengthen primary care in the Capital District/Hudson Valley health care market. Goal: Monitor and focus on improving quality of care and controlling costs through provision of data and joint activities.	E. Wood Contributors: Performance Management	11/1/2012	Progress report towards goal submitted at least annually to QMC.	12/31/2016
	Radiology Management	Medical Necessity Review Program for high tech imaging in collaboration with our delegate eviCore/ healthcare (formerly MedSolutions). This program will expand to all product lines including Medicare on 1/1/2016. *Quality Performance Matrix 2015 for Medicaid CHPS* will focus on the HEDIS/QARR measure Re: Use of Imaging for low back pain. (*Refer to Section on Quality Performance Quality Matrix 2015 , pg. 63 of 2016 Workplan)*	M. Elliott R. Dal Col Contributors: eviCore/ MedSolutions Medical Necessity	1/01/2016	Progress report towards goal reported monthly through practitioner and practice performance reports on Imaging approvals from eviCore and reviewed by the medical director and director of RC.	12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Programs To Improve Quality						
		Goal: Reduce the use of high tech imaging and increase the use of conservative therapies by our PCPs and specialist.	Review Program Team		Monitor monthly Interim HEDIS 2016 for the Use of Imaging for Low Back Pain. Quarterly reporting to Joint Health Services Committee (JHSC) and up to QMC.	
	Pharmacy: Medication Therapy Management (MTM) Program	CDPHP's MTM program for 2016 is designed to ensure that medications prescribed to targeted enrollees are appropriately used to optimize therapeutic outcomes through improved medication use, and aimed at reducing the risk of adverse drug events, including adverse drug interactions. The program will utilize community pharmacists to provide this service to the targeted enrollees. The program will include an individual comprehensive medication reviews (CMR), and additional targeted interventions as appropriate with our members and prescribing providers. Goal: Avoidance of adverse hospital events as well as decreased ER utilization and inpatient admissions in these groups of targeted enrollees. Increased adherence of chronic medication in MTM enrollees as measured by the Medication Possession Ratio (MPR). Direct support to increase Medicare Stars measures with appropriate drug utilization management.	L. Reed Contributors: L. Lincoln Pharmacy and Therapeutics Committee Medicare Stars Team	Ongoing	Progress report towards goal submitted semi-annually to QMC through Pharmacy and Therapeutics Committee (PandT) reports.	Ongoing

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
CAHPS- Annual Satisfaction Surveys						
	Medicaid CAHPS Survey Results	Multiple linear regression analyses were run on the SPH Analytics 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: (survey *in field 2/2016-5/2016):* • Customer Service • How well doctors communicate • How well doctors communicate coordination of care • Goal: Improvement that is statistically significant.	R. Golderman Informatics S. Beck Contributors Medicaid Team	1/1/2016	Progress report towards goal submitted annually to QMC	5/20/2016
	Commercial HMO and PPO Products CAHPS Survey	**Improve CAHPS Survey results specific to Areas Identified as " Monitor" or "Opportunity" as compared to SPH Analytics CAHPS Book of Business** (survey *in field 2/2016-5/2016):* • Customer Service • How well doctors communicate • Coordination of Care Goal: Improvement that is statistically significant.	R. Golderman Informatics S. Beck Member Provider Satisfaction Team Contributors: C. Schlude	1/1/2016	Progress report towards goal submitted annually to QMC	5/20/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target		Owner(s)	Start Date	Progress Towards Goal	End Date
CAHPS- Annual Satisfaction Surveys							
	Medicare HMO and PPO Products CAHPS Survey	**Improve CAHPS Survey results specific to Areas Identified as " Monitor" or "Opportunity" as compared to SPH Analytics CAHPS Book of Business** (survey *in field 2/2016-5/2016):* • **Member Experience with Health Plan**: *Coordination of Care* • **Getting Care Quickly (PPO)** • **Getting Needed Rx Drugs (HMO and PPO)** • **Getting Info about x Drug Coverage/Cost**	**Goal** **86**	R. Golderman Informatics S. Beck Contributors: C. Aguglia	1/1/2016	Progress report towards goal submitted annually to QMC	5/20/2016
	New Member Survey	Measure new member understanding of benefits and address opportunities for improvement as identified through the survey 2016 results.		R. Geurtze Contributors: Informatics R. Golderman	01/2016	Progress report towards goal submitted annually to QMC	12/2016
	Member Satisfaction with PCP	CG CAHPS survey performed to measure level of member satisfaction with care provided by imputed physician during the survey period.		B. Freer Contributors: R. Golderman Informatics	10/2015	Progress report towards goal submitted annually to QMC	03/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
CAHPS- Annual Satisfaction Surveys						
	Case Management Member Satisfaction	Survey performed to determine how well case management programs are meeting member's needs, specifically related to positive impact on members' recovery. Maintain/improve previous levels of satisfaction	C. Schlude	1/2016	Progress report towards goal submitted annually to QMC	12/2016
	Physician Satisfaction Survey	Survey performed to measure level of physician satisfaction with the Plan Maintain/improve previous levels of satisfaction	B. Freer Contributors: Provider Services Informatics	1/2016	Progress report towards goal submitted annually to QMC	5/2016
	Qualified Health Plan Enrollee Experience Survey	**New enrollee survey** in 2016 to measure satisfaction of our Marketplace members in HMO and EPO product in 2016. Vendor to conduct survey is DSS Research. Spring 2016 survey in field. Baseline Year	M. Cassidy Contributors: R. Golderman Informatics	1/2016	Progress report towards goal submitted annually to QMC	12/2016
	Call Center Satisfaction Survey	Call Center Satisfaction Survey will be conducted monthly throughout 2016 by the survey vendor, SPH Analytics Maintain/improve previous levels of satisfaction	L. Kordas Contributors: R. Golderman Informatics	1/2016	Progress report towards goal submitted quarterly to QMC	12/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Childhood Immunizations (CIS)	The percentage of 2 year olds who are appropriately immunized on or before the 2nd birthday	C. Roullier E. Martin Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/15/2016
	Combo 3: 4 DTaP, 3 IPV, 1 MMR, 3HIB, 3 HEP B, 1 VZV, 4PCV	HMO/POS: 81% Medicaid/CHPs: 77% PPO: 83%	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Well Child Visits in the 1st 15 months of Life (W15)	The percentage of members who receive the appropriate number of well child visits with their PCP during the first 15 months of life. **HMO/POS: 94%** **Medicaid/ CHPs: 81%** **PPO: 90%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Well Child Visits Age 3–6 (W34)	The percentage of members aged 3-6 who received an annual appropriate well child visits with their PCP in the calendar year **HMO/POS: 90%** **Medicaid/ CHPs: 79%** **PPO: 89%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Lead Screening (LSC)	The percentage of members who receive lead screening on or before 2 years of age. **HMO/POS: 89%** **Medicaid/ CHPs: 83%** **PPO: 87%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Immunizations for Adolescents (IMA) (Score Card)	The percentage of adolescents 13 years of age who had: 1 does 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 ember's 10th and 13th birthdays. **HMO/POS: 75%** **Medicaid/ CHPs:69%** **PPO:74%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Human Papilloma Virus (HPV) for female Adolescents	The percentage of female adolescents 13 years of age who had 3 does of the HPV vaccine by their 13th birthday. **HMO/POS: 15%** **Medicaid/ CHPs:15%** **PPO:19%**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Adolescents Well Care Visits (AWC)	The percentage of members aged 12-2 who receive an annual well care visit with a PCP or OB/GYN in calendar year **HMO/POS: 69%** **Medicaid/ CHPs:61%** **PPO:66%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Breast Cancer Screening (BCS)	The percentage of women members 50-74 years of age when had a mammogram to screen for breast cancer on or between October 1 two years prior to the measurement year, and December 31st of the measurement year. **HMO/POS: 50-74: 80%** **Medicaid: 50-74: 61%** **PPO: 50-74: 75%** **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Roullier Contributors: C. Aguglia Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	The percentage of children 3 months to 18 years who were given a diagnosis of URI., and who were not dispensed an antibiotic prescription **HMO/POS: 92%** **Medicaid/ CHPs:92%** **PPO: 92%**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Appropriate Testing for Children with Pharyngitis (CWP)	The percentage of children 2-18 years, who were given a diagnosis Pharyngitis, dispensed an antibiotic and who received a group A Strep test for the episode. **HMO/POS: 93% PPO: 90%** **Medicaid/ CHPs:88%**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	The percentage of adults 18-64 years diagnosed with acute bronchitis who were not dispensed an antibiotic prescription **HMO/POS: 16%** **Medicaid/CHPs:25%** **PPO: 23%**	C. Roullier Contributors: Performance Management	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	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 6 months after the date of the fracture **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Aguglia Contributors: T. Scotti Medicare STARS Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who have had a cervical cytology within the past 3 years or those aged 30-64 who had cervical cytology/human papilloma virus (HPV) co-testing every 5 years. **HMO/POS: 80%** **Medicaid: 74%** **PPO: 82%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	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: 4%** **Medicaid: 4%** **PPO: 4%**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	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: 98%** **Medicaid: 92%** **PPO: 98%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	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 1 test for Chlamydia in the calendar year. **HMO/POS: 65%** **Medicaid/CHPs: 64%** **PPO: 63%**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Colorectal Cancer Screening (COL)	The percentage of adults aged 50-75 who had appropriate screening for colorectal cancer **HMO/POS: 76%** **Medicaid: 43%** **PPO: 76%** **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Persistence of Beta Blocker Treatment After a Heart Attack (PBH)	The percentage of members age 18+ discharged from July 1, 2013-June 3, 2014 with a diagnosis of AMI who received persistent beta blocker treatment for 6 Months after discharge **HMO/POS: 97%** **Medicaid: 95%** **PPO: 93%** **Medicare HMO : 97%** **Medicare PPO: small n**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Comprehensive Diabetes Care (CDC)	**The percentage of members age 18-75 with diabetes who have evidence of appropriate diabetes care as measured by the following indicators:**	C. Roullier Contributors: Case Management	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
			Population Health and Wellness			
	Comprehensive Diabetes Care (CDC) 1. HbA1c Testing	**HMO/POS: 92%** **Medicaid: 88%** **PPO: 90%** **Medicare HMO 93%** **Medicare PPO: 92%**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Comprehensive Diabetes Care (CDC) 2. Poor HbA1c Control (>9%)	**HMO/POS: 22%** **Medicaid: 39%** **PPO: 25%** **Medicare HMO 17%** **Medicare PPO: 17%**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Comprehensive Diabetes Care (CDC) 3. Adequate HbA1c	**HMO/POS: 69%** **Medicaid: 54%** **PPO: 70%** **Medicare HMO 76%** **Medicare PPO: 78%**	C. Roullier Contributors:	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Control (<8%)		Case Management Population Health and Wellness			
	Comprehensive Diabetes Care (CDC) 4. Good HbA1c Control (<7%)	**HMO/POS: 45%** **Medicaid: 36%** **PPO: 44%**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Comprehensive Diabetes Care (CDC) 5. Retinal Eye Exam Performed	**HMO/POS:63%** **Medicaid: 60%** **PPO: 66%** **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Comprehensive Diabetes Care (CDC) 6. Medical Attention for Nephropathy	**HMO/POS:84%** **Medicaid: 78%** **PPO: 84%** **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Comprehensive Diabetes Care (CDC) 7. Blood Pressure control (<140/90 mm/hg)	**HMO/POS: 76%** **Medicaid: 73%** **PPO: 70%** **Medicare HMO: 76%** **Medicare PPO: 69%**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Diabetes Screening for People with Schizophrenia or bipolar Disorder Who Are using Antipsychotic Medications (SSD)	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: 83%**	C. Roullier Contributors: BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	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: 77%**	C. Roullier Contributors: BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	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**	C. Roullier Contributors: BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Antidepressant Medication Management (AMM)	The percentage of members age 18+- with a Dx of major depression who receive appropriate pharmacological management for the treatment of depression.	C. Roullier Contributors: BH Team Performance Management	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Antidepressant Medication Management (AMM) *Effective Acute Phase Treatment*	The percentage of members who remained on treatment for at least 12 weeks. **HMO/POS:70%** **Medicaid: 53%** **PPO: 70%**	C. Roullier Contributors: BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
		Medicare HMO 83% **Medicare PPO: 86%**	Performance Management			
	Antidepressant Medication Management (AMM) *Effective Continuation Phase Treatment*	The percentage of members who remained on treatment for at least 6 weeks. **HMO/POS:58%** **Medicaid: 34%** **PPO: 57%** **Medicare HMO 73%** **Medicare PPO: 83%**	C. Roullier Contributors: BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Controlling High Blood Pressure (CBP)	Member percentage with hypertension, ages 18-85, whose blood pressure is adequately controlled (<140/90) during the measurement year. **HMO/POS: 71%** **Medicaid: 65%** **PPO: 69%** **Medicare HMO: see stars goals above** **Medicare PPO: see stars goals above**	C. Roullier Contributors: Medicare STARS Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Use of Appropriate Medication for People with Asthma (ASM)	The percentage of members age 5-64 identified as having persistent asthma and were appropriately prescribed medications during the measurement year.	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Asthma *Ages 5-11 years* *Ages 12-18 years* *Ages 19-50 years* *Ages 51-64 years* Total	**HMO/POS:** **5-11: 95%** **12-18: 95%** **19-50: 93%** **51-64: 95%** **Medicaid/CHPs:** **5-11: 90%** **12-18: 83%** **19-50: 80%** **51-64: 87%** **PPO:** **5-11: 100%** **12-18: 94%** **19-50: 92%** **51-64: 95%**	Contributors: C. Roullier J. Wilson		progress towards goal submitted to QMC	
	Medication Management for People with Asthma (MMA)	The percentage of members age 5-64 during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1.) The percent of members who remained on an asthma controller medication for at least 50% of the treatment period. 2.) The percent of members who remained on an asthma controller medication for at least 75% of the treatment period. **HMO/POS:** **5-11: 50% , 70%** **75%, 40%** **12-18: 50%, 68%** **75%, 43%** **19-50: 50%, 80%** **75%, 55%** **51-64: 50%, 85%** **75%, 65%** **Total: 50%, 79%** **75%, 56%** **Medicaid/CHPs:** **5-11: 50% , 55%** **75%, 30%** **12-18: 50%, 60%** **75%, 34%** **19-50: 50%, 58%** **75%, 30%** **51-64: 50%, 64%** **75%, 35%** **Total: 50%, 55%** **PPO:** **5-11: 50% , 60%** **75%, 36%** **12-18: 50%, 70%** **75%, 54%** **19-50: 50%, 73%** **75%, 47%** **51-64: 50%, 84%** **75%, 57%** **Total: 50%,75%** **75%,48%**	C. Roullier Contributors: J. Wilson	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
		75%, 31%				
	Asthma Medication Ratio (AMR)	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: 83%** **Medicaid/CHPs: 66%** **PPO: 82%**	C. Roullier Contributors: J. Wilson	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Prenatal and Postpartum care (PPC) *1.) Timeliness of prenatal care* *2.) Postpartum Care*	The percentage of members who gave birth that received appropriate prenatal and postpartum care. 1.) The percentage of members who gave birth that received a prenatal care visit in the 1st trimester: **HMO/POS: 91%** **Medicaid: 88%** **PPO: 93%** 2.) The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. **HMO/POS: 82%** **Medicaid: 70%** **PPO: 86%**	C. Roullier Contributors: Case Management Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Use of Spirometry Testing in the Assessment and	The percentage of members age 40+ with new diagnosis or newly acquired COPD who received appropriate spirometry testing to confirm the diagnosis.	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on	6/16/2016

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HEDIS Effectiveness Quality Measures						
	diagnosis of COPD (SPR)	**HMO/POS:45%** **Medicaid: 40%** **PPO: 42%** **Medicare HMO: 42%** **Medicare PPO: 41%**	Contributors: Case Management Population Health and Wellness		progress towards goal submitted to QMC	
	Pharmacotherapy Management of COPD Exacerbation (PCE) 2 Rates: *1.) Dispensed a bronchodilator within 30 days of the event.* *2.) Dispensed systemic corticosteroid within 14 days of the event.*	The percentage of COPD Exacerbations for members 40+ of age who had an acute inpatient discharge or ED visit between January 1- November 30 of the measurement year and were dispensed appropriate medications. Two rates are reported. **HMO/POS: 81%, 81%** **Medicaid: 85%, 78%** **PPO: 83%, 75%** **Medicare HMO 85%, 80%** **Medicare PPO: 73%, 85%**	C. Roullier Contributors: Performance Management- EPC Metrics	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Potentially Harmful drug-Disease Interactions in the Elderly (DDE) 4 Rates: *1.)Hx of falls and Rx for tricyclic antidepressants,*	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	C. Roullier Contributors: Performance Managemen	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	antipsychotics or sleep agents 2.) Dementia and an Rx for tricyclic antidepressants' or anticholinergic agents. 3.) CRF and Rx for nonaspirin NSAIDS or COX-2 NSAIDS. 4.) Total rate.	1. 42%, 2. 43% 3. 6% 4. 36% Medicare PPO 1. 44%, 2. 43% 3. 8% 4. 39%	t- EPC Metrics			
	Follow-up Care for Children Prescribed ADHD Meds (ADD) Initiation Phase: *1 follow-up visit in first 30 days* Continuation and Maintenance: *on medication for 2010 days and had at least 2 follow up visits within 9 months after the initiation phase ended*	The percentage of children age 6-12 who receive appropriate pharmacological management for the treatment of ADHD. **Initiation Phase:** HMO/POS: 40% Medicaid/CHPs: 45% PPO: 47% **Continuation and Maintenance:** HMO/POS: 48% Medicaid/CHPs: 51% PPO: 40%	C. Roullier Contributors: BH Team Performance Management	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Adherence to Antipsychotic Medications for	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.	C. Roullier Contributors:	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Individuals With Schizophrenia (SAA)	**Medicaid: 63%**	BH Team		progress towards goal submitted to QMC	
	Use of Imaging Studies for Low Back Pain (LBP)	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% Medicaid: 75% PPO: 78% Improvement for all products lines by 0.50% as short term goal ; long term goal 1.0% or higher to exceed plans performance	C. Roullier Contributors : Dal Col, MD M. Elliott eviCore Medical Necessity Program	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC and the NYS DOH as part of Quality Performance Matrix 2015	6/16/2016 and 12/31/16
	Disease Modifying Anti-Rheumatoid Arthritis (ART)	The percentage of members ages 18+ diagnosed with RA and who were dispensed at least one ambulatory Rx for a DMARD. **HMO/POS 90%** **Medicaid: 83%** **PPO: 89%** **Medicare HMO 89%** **Medicare PPO: 79%**	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Annual Monitoring for Patients on Persistent Medications (MPM) 5 Rates: *1.)ACE or ARBs* *2.)Digoxin* *3.)Diuretics* *4.) Total Rate*	The percentage of members age 18+- taking selected therapeutic agents (ACE,ARB, Dioxin, Diuretics) for at least 180 treatment days who have at least one serum potassium and either a serum creatinine or BUN and those taking anticonvulsants at least one serum concentration level monitoring ***1.)ACE or ARBs***: HMO/POS 85% Medicaid: 89% PPO: 89% Medicare HMO 95% Medicare PPO: 93% ***2.)Digoxin*** HMO/POS 90% Medicaid: 95% PPO: 87% Medicare HMO 97% Medicare PPO: 94% ***3.)Diuretics*** HMO/POS 88% Medicaid: 89% PPO: 84% Medicare HMO 95% Medicare PPO: 94% ***4.) Total Rate*** HMO/POS 87% Medicaid: 87% PPO: 85% Medicare HMO 95% Medicare PPO: 93%	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Use of High Risk Medications in the Elderly (DAE) *1.) At least one high risk medication* 2.) *At least two high risk medications*	The percentage of Medicare members age 66 and older who received 1 high risk medication or received at least 2 different high medications. **1.) <u>One High Risk Medication</u>** Medicare HMO 12% Medicare PPO: 12%, 2.) **<u>At least two High Risk Medications</u>** Medicare HMO 1% Medicare PPO: 1%	C. Roullier <u>Contributors:</u> Medicare STARS Team MTMP	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Follow Up After Hospitalization for Mental Illness (FUH) 2 Rates: *1.) Follow up within 30 days of discharge* *2.) Follow up within 7 days of discharge*	The percentage of members age 6 and older who were followed up as an outpatient following hospitalization for mental illness. **1.) <u>Follow up within 30 days of discharge</u>** HMO/POS 83% Medicaid/CHPS: 73% PPO: 83% Medicare HMO 84% Medicare PPO: Small n **2.) <u>Follow up within 7 days of discharge</u>** HMO/POS 73% Medicaid/CHPS: 61% PPO: 67% Medicare HMO 65% Medicare PPO: Small n	C. Roullier <u>Contributors:</u> BH Team	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
	Frequency of On-Going Prenatal Care (FPC)	The percentage of pregnant women who received the appropriate number of prenatal visits. Medicaid: 75% with > 81% of expected visits	C. Roullier Contributors: E. Martin	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had outpatient visit and who had their Body Mass Index (BMI) documented during the measurement year or the year prior to the measurement year. HMO/POS 93% Medicaid: 84% PPO: 86% Medicare HMO see stars goals above Medicare PPO: see stars goals above	C. Roullier	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016
	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.) BMI Percentile** HMO/POS 87% Medicaid/CHPS: 78% PPO: 87% **2.) Counseling for Nutrition** HMO/POS 85% Medicaid/CHPS: 78% PPO: 81%	C. Roullier Contributors: Population Health and Wellness	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
		3.) <u>Counseling for Physical Activity</u> HMO/POS 76% Medicaid/CHPS: 65% PPO: 76%				
	HIV/AIDS Comprehensive Care *1.)Engaged in Care* *2.)Viral Load Monitoring* *3.)Syphilis Screening*	The percentage of members who qualified through at least one method as living with HIV/AIDS during the year prior to the measurement year, and received: two outpatient visits for primary care or HIV related care during the measurement year and at least one visit in the second half of the measurement year, two viral load tests conducted during the measurement year with at least one viral load test in the first half and one in the second half of the year, and one syphilis test conducted during the measurement year. **<u>Medicaid:</u>** 1.) Engaged in care: 93% (QARR Measure) 2.) *Viral Load Monitoring: 77%* 3.) *Syphilis Screening: 66%*	C. Roullier <u>Contributors</u> : C.Schlude	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC and the NYS DOH as part of Quality Performance Matrix 2015 for HIV-Engaged in Care	6/16/2016 and 12/31/16
	Adolescent Preventive Care Measures (APC)	The percentage of members age 12-17 screened for sexual activity, depression, tobacco use and substance abuse during the measurement year. **<u>Sexual Activity</u>** **<u>Substance Abuse</u>**	C. Roullier <u>Contributors</u> :	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on	6/16/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
HEDIS Effectiveness Quality Measures						
		HMO/POS 66% Medicaid/CHPS: 58% Medicaid/CHPS: 60% PPO: 71% PPO: 65% **Depression** HMO/POS 58% Medicaid/CHPS: 48% PPO: 50% **Tobacco Use** HMO/POS 80% Medicaid/CHPS: 65% PPO: 75% **Substance Abuse** HMO/POS 75%	Population Health and Wellness		progress towards goal submitted to QMC	
	Statin Therapy for Patients with Cardiovascular Disease (SPC) – **New Measure 2016**	Percentages of males 21-75 years of age and females 40-75 years of age during measurement year, who were Id 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. 2. Statin Adherence 80%. Members who remained on a high or moderate intensity statin med for at least 80% of the treatment period. Goal: Baseline year for data	C. Roullier Contributors: S. Beck	1/1/2016	Progress on Monthly Interim HEDIS report and quarterly reports on progress towards goal submitted to QMC	6/15/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Complaints and Appeals						
	Complaints and Appeals	Members who express any level of dissatisfaction and who request that a provider or service e reviewed. Acknowledge, review and respond per Policy and Procedure	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	Member Complaint Turnaround Time	Length of time to resolve member complaints < 30 calendar days	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	Complaint and Appeal Analysis	Identify areas of member dissatisfaction and improve performance, and member education of policies, contracts and benefits. Conduct 1st, 2nd and 3rd level appeals according to regulatory requirements.	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	External Appeals	Monitor external appeals volume, upheld and overturn rates monthly. Monitor for any trends. Goal: Upheld rate of External Appeals 100%	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	Grievance Hearings	Monitor member grievance hearings results monthly. Monitor for trends. Goal: Overturn rate of Grievance Hearings 0%	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	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%	J. Keohan	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
	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	J. Keohan Contributors:	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Complaints and Appeals						
			Quality Review Nurses			
	Regulatory Agency Closed Complaints	Monitor the investigation of regulatory agency i.e. DOI, DOH, etc. complaints: type, volume closed and upheld monthly Goal: Regulatory Agency Upheld rate 84%	R. Rothstein Contributor: Corporate Compliance	Ongoing	Progress towards goal submitted quarterly to QMC	Ongoing
Disease Management						
	Coronary Artery Disease (CAD) Diabetes Mellitus	Chronic disease programs delegated to Health Dialog, Monthly reports are received from HD. Goal: Increase focus on gaps in care, particularly related to diabetes measures.	C. Schlude Contributors: Health Dialog	1/1/2011	Progress towards goal submitted semi-annually to QMC	12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Case Management						
	Community Based Case management	Continue to evaluate current case management community assignments to ensure maximum engagement with vulnerable, low-income populations. When appropriate, re-allocate resources to increase case management exposure in existing community exposure or for case management penetration in a new community.	C. Schlude Contributors: J. Wilson C. Zeppieri	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Case Management Enrollment	Monitor CM enrollment with goal of 2% total member engagement in CDPHP case management program.	C. Schlude Contributors: J. Wilson C. Zeppieri	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	CM Targeted HEDIS Initiative	Case Management will have two separate targeted initiatives to address Diabetes and Asthma quality measures.	C. Schlude Contributors: J. Wilson C. Zeppieri	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
Resource Coordination : 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	T. Langlais Contributors . D. Stewart	1/1/2016	Submit to UMC ad hoc; report quarterly to QMC	12/31/2016

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Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Resource Coordination : Service Indicators						
	Receipt /Determination Turnaround	Percent of determinations made in 3 business days or less from date of when complete information is received. Goal: TAT => 96%	M. Elliot	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Telephone Abandonment Rate	Percentage of callers who hang up prior to being connected to a phone representative Goal: <= 5%	M. Elliot	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Average Rate of Speed (ASA)	Percentage of calls answered in 120 seconds or less Goal: => 75%	M. Elliot	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	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 HEDIS 2015 data to evaluate 2014 results **GOAL:** Under Utilization- 2015 HEDIS Data- less than 10th percentile Over- Utilization- 2015 HEDIS Data- greater than 90th percentile	H. Hebert	1/1/2016	Utilization data will be reported at quarterly UM meetings in 2016 o SNF LOS and readmissions benchmarks to be determined 1/31/16 o Inpatient acute readmissions benchmark to be determined 1/31/2016 o Readmission Avoidance Program with Eddy VNA	12/31/2016

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
					benchmarks to determine outcomes for readmissions with specific dx (CHF, COPD, pneumonia, MI,CAD, UTI, diabetes) 1/31/16	
Behavioral Health : Service Indicators						
	Behavioral Health Member Services Telephone Abandonment Rate	Percentage of callers who hang up prior to being connected to a phone representative Goal: <= 5%	C. Rorie-Alexandrov	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Behavioral Health Member Services Average Speed of Answer	Length of time BH caller waits before call is answered Goal: ASA < 30 seconds	C. Rorie-Alexandrov	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Behavioral Health Member Services Call Answer Timeliness Percent	Percentage of member calls answered in 30 seconds or less Goal: > 70%	C. Rorie-Alexandrov	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Behavioral Health Turnaround Time for determinations	Percent of determinations made in 3 business days or less from date of complete information Goal: TAT >= 96%	C. Rorie-Alexandrov	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Inter-rater Reliability						
	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/Pharmacy Technical Benefits Specialists 90% Referral Services (Case Managers/OOA and Specialists 90% Quality review Specialists 90% Member Complaints andQuality Committees Coordinator 90% Disease Management 90% Behavioral Health Services 90%	L. Swett Contributors: M. Elliott C. Roullier Pharmacy RC	1/1/2016	Progress towards goal submitted annually to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Population Health and Wellness						
	Community Calendar	Community-based programs that help our healthy members stay healthy and assist those with existing medical conditions to optimize their health and functional capacity. **Goal:** Increase number of members who participate in condition-specific free wellness programs throughout the service area for LOB	E. Martin	1/1/2016	Progress towards goal submitted semi-annually to QMC	12/31/2016
	Healthier Generation Benefit	Comprehensive health benefits for eligible children ages 3 to 18 to prevent, access and treat childhood obesity. **Goal:** 1.) Increase utilization of the childhood overweight and obesity diagnoses codes by PCPs and RDs	E. Martin	1/1/2016	Progress towards goal submitted semi-annually to QMC	12/31/2016
	Workplace Wellness	Workplace wellness program provides employer groups health promotion activities and support to help improve employee health and manage health care costs. Groups participating in the Shared Health program receive additional clinical data management support in combination with financial strategies aimed to reduce their health care spending. **Goal:** Engage interested employer groups to develop and implement customized workplace wellness plans.	E. Martin	1/1/2016	Progress towards goal submitted semi-annually to QMC	12/31/2016
	Targeted Member Outreach	Targeted member communication campaigns designed to increase member awareness and knowledge around various preventive health measures or identified gaps in care are delivered to improve member health outcomes.	E. Martin	1/1/2016	Progress on Monthly Interim HEDIS 2016 report and quarterly reports on progress towards goal submitted to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key 	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Population Health and Wellness						
		Goal: Improve member health outcomes as measured through interim HEDIS 2016.				

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Internal Operations Service Indicators						
Document Management						
	Document Management: Claims Entry Turnaround	Monthly Claims entry Turnaround time (TAT): Weekly monitoring and Evaluation of the Number of days from receipt to entry on the system Goal: 99% in 3 business days 100% in 4 business days	K. Moffre	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
Claims Department						
	Claims Adjudication Turnaround TAT	Monthly monitoring of length of time to adjudicate a claim in the system Goal: 98% within 30 days	A Guidi	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Claims Adjudication Accuracy	Percentage of claims adjudicated without processing errors Goal: 98%	A Guidi	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
Membership and Billing: Enrollment						
	Group Application	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: 7.5 business days Accuracy Goal: 95-99% Group Quality Score	C. Salzer and K. Keller	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
	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: 7.5 business days Accuracy Goal: 95-99% Member Quality Score	C. Salzer and K. Keller	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Member ID Card Turnaround Time	Weekly monitoring of Time Standards by Manager. Length of time to generate new ID cards. Goal: TAT for Member ID cards within 9 business days	C. Salzer and K. Keller	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
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 5:00 minutes	J. DiDonna	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Quality Score - Phone Unit	Identify opportunities and trends. Goal: Quality Score of 93-98%	J. DiDonna	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Correspondence Turnaround Time	Length of time from receipt to completion. Measure and monitor data monthly. Goal: TAT within 21 days	J. DiDonna	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Quality Score- Inventory Unit	Identify opportunities and trends. Goal: Quality Score of 94-98%	J. DiDonna	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Member Services						
	Abandonment Rates	Monitor and measures data weekly of the percentage of callers who hang up prior to being connected to a phone representative Goal: <= 5%	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Average Speed to Answer	Monitor and measures data weekly LOB call center metrics regarding the percentage of calls answered in Goal: < 30 seconds	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	% of Calls Answered	Monitor and measures data weekly on LOB call center metrics regarding percent of calls answered in 30 seconds or less Goal: 80%	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Quality Scores	Monitor and measures data weekly 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%	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Correspondence Turnaround time	Monitor and measures data weekly on LOB call center metrics regarding correspondence TAT Goal: resolve <= 21 days	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Member Services						
	Secure E-mail/Average days to respond	Monitor and measures data weekly on LOB call center metrics regarding secure email average days to respond Goal: 1 business day	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Secure E-mail/Average days to complete	Monitor and measures data weekly on LOB call center metrics regarding secure email average days to complete Goal: 1 business day	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	Secure E-mail/Responded within 1 business day	Percent of secure emails responded to within 1 business day Goal: 100%	C. Gates Contributors: All LOB MS Call Center Supervisors	1/1/2016	Progress towards goal submitted quarterly to QMC	12/31/2016
	New Member Outbound – Orientation Program Calls	Outbound educational telephone calls to new members-monitored monthly Goal: Weekly outbound calls are made	B. Geurtze	1/1/2016	Progress towards goal submitted annually to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Credentialing						
Monthly Credentialing						
	Monitor Time to process initial Credentialing application	To ensure that all initial applications are completed and approved within 60-90 days of receipt of a completed application. Goal: 90% are completed in 90 days	D. Felitti	Ongoing	Submit findings to Credentials Committee monthly for approval and report up to QMC quarterly	Ongoing
	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.	D. Felitti	Ongoing	Submit findings to Credentials Committee monthly for approval and report up to both Joint Health Services Committee and QMC quarterly	Ongoing
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	D. Felitti	Ongoing	Submit findings to Credentials Committee monthly for approval and report up to QMC quarterly	Ongoing
Credentialing Policy and Procedures						
	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	D. Felitti	1/1/2016	Submit to Credentials Committee on staggered schedule to assure annual review of all policies. Approvals and updates reported to quarterly to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Member Complaint Data- Credentialing						
	Member provider/practitioner complaints	Credentialing monitors members who express dissatisfaction with providers and practitioners and reports biannually to Credentials Committee	D. Felitti	1/1/2016	Report to Credentials Committee biannually and up to QMC	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Accessibility and Access						
	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%	D. Felitti	1/1/2016	Submit findings to Credentials Committee for review/approval and report up to QMC annually, or more frequent if needed.	12/31/2016
	Practice Site Assessment for Appointment Access	To ensure that the plan's access standards are met. Site visits are conducted to identify appointments based on criteria Goal: 100% Appointment Access Standards: Urgent care within 48 hours Sick care visits within 24 hours Emergency care immediately Routine primary care within 4 weeks Initial prenatal (in 1st trimester) within 3 weeks Initial prenatal (in 2nd or 3rd trimester) within a week Initial family planning within 2 weeks Initial newborn visit within 2 weeks of hospital discharge Behavioral Health Appointment Access Standards: Emergency care immediately Non-life threatening emergency care within 6 hours Chemical dependency/urgent care within 48 hours Routine care within 10 business days	D. Felitti Contributors : B. Freer B. Cocozza Provider Relations BH Quality	1/1/2016	Submit findings to Credentials Committee for review/approval and report up to QMC quarterly	12/31/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Accessibility and Access						
	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 30 miles/30 min 2 Specialist from each of the types designated as high –volume 30 miles/30 min 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	D. Felitti Contributors: Informatics	7/1/2015	Corporate Analytics/ Informatics to complete year analysis report 7/1/2015-6/30/16 Submit findings annually to Credentials Committee for review/approval and report up to QMC	6/30/2016 10/4/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Accessibility and Access						
		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 30 miles/30 min psychiatric, inpatient med rehab, skilled nursing facility, SNF, Home health agency, and ambulatory surgery clinic 1 Laboratory- urban 20 miles/30 min 1 Laboratory- rural/suburban 40 miles/60 min 1 Cardiac Catherization, kidney transplant, major 60 miles/90 min treatment, neonatal intensive care and open heart surgery				
	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. **Ratio Standard:** NYS DOH Practitioner to Member Ratio: 1:1500 I FTE 1:2400 1 FTE with a mid-level practitioner support	D. Felitti Contributors: Informatics HNS	7/1/2015	Corporate Analytics/ Informatics to complete year analysis report 7/1/2015-6/30/16 Submit findings annually to Credentials Committee for review/approval and report up to QMC	6/30/2016 10/4/2016

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Accessibility and Access						
	Specialty Capacity	Annually reviewed based on Bureau of Managed Care Certification and Surveillance Standards compared to number of people in community: **Specialty — Population per Professional** OB/GYN 10,400 Allergy/Immunology 121,780 Cardiology 32,210 Dermatology 35,420 Endocrinology 121,780 Gastroenterology 38,410 Hematology 27,740 Oncology 27,740 Infectious Disease 110,960 Nephrology 90.780 Neurology 94,210 Ophthalmology 21,520 Orthopedic Surgery 16,530 Otolaryngology 31,210 Plastic Surgery 92,470	D. Felitti Contributors: Informatics	7/1/2015	Corporate Analytics/ Informatics to complete year analysis report 7/1/2015-6/30/16. Submit findings annually to Credentials Committee for review/approval and report up to QMC	6/30/2016 10/04/2016
	Panel Status	Monitor the open and closed panel status of our network to assure member adequate access to practitioners	D. Felitti Contributors: Informatics	Ongoing	Submit findings annually to Credentials Committee for review/approval and report up to QMC	Ongoing

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
QARR- Quality Performance MATRIX 2015 (2014 Measurement Year (MY)) Compared to State Wide Averages (SWA)						
	QARR	QARR/HEDIS Measures (MY 2014) involved (in D cell): 1. **Use of Imaging for low Back Pain-** 2104 MY-72.89 (SWA 76.56) 2. **HIV-Engaged in Care** (QARR measure) 2014 MY 89.01 (SWA-81.34) 3. **Chlamydia Screening** 2104 MY -66.13 (SWA-72.15) <u>Activity:</u> • Conduct Root cause Analysis for each measure • Develop and implement Plans of Correction (POC) (i.e. Action Plans) for the Quality Performance Matrix 2015 (*refer to separate POCs 2015 for action plan details)* • Work with eviCore healthcare, radiology management vendor, to improve use of imaging for low back pain • Monitor progress towards goal via interim HEDIS 2016 (MY 2015) • POC Teams meet monthly to discuss progress towards goal and to update actions, if needed to better move the measures.	Dal Col, MD K. Leyden, C. Schlude <u>Contributors:</u> P. Vellis, MD S. Nelson M. Elliott L. Kodela J. Westcott B. Madej S. Huwe Informatics: S. Beck	1/8/2016	Plan of Correction which includes: Root Cause Analysis and Action Plans due to NYS DOH by January 15, 2016. Progress towards goal submitted via quarterly reports to QMC and up to the Board of Directors.	12/31/2016 Quarterly

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- **QUALITY MANAGEMENT (QM) WORK PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
NYS Performance Improvement Project PIP 2015-2016						
	Improving Member Identification and Maximizing Appropriate Utilization of Smoking Cessation Benefits	The following objectives will be accomplished in year one of the project at selected EPC practices, which have a high volume of Medicaid members. Baseline measurements will be determined using 2014 data. **Objectives/Goals:** **1.** Increase the number of Medicaid members assessed for tobacco use by case management by 10%. **2.** Develop and implement a standard of care of tobacco use identification and treatment in targeted provider settings, including follow-up and relapse prevention, among adult Medicaid members, and where applicable, pregnant women and pregnant teens. **3.** Increase the utilization of tobacco cessation counseling or services benefits by 10% in targeted provider settings. **4.** Increase the utilization of tobacco cessation counseling or services benefits by 10% among those members already utilizing a cessation pharmacotherapy agent **5.** Refer at least 10 members to alternative tobacco cessation support programs.	**C. Roullier** Contributors: Medical Director Pharmacy Population Health	1/4/2016	Progress towards goal submitted quarterly to QMC	12/31/2016

Quality Management Program Description 2016

Appendix II

Quality Management (QM) Safety Plan 2016

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- **QUALITY MANAGEMENT (QM) SAFETY PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Safety Plan - Providers						
	Organizational Providers (includes hospitals, home health agencies, skilled nursing facilities, behavioral health facilities, and freestanding surgical centers)	All network practitioners/providers at initial credentialing and during recredentialing: • Verify good standing with state and federal regulatory agencies. • Verify that provider has been reviewed and approved by an accrediting body. • Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints. • Monitor potential quality of clinical care review (CQR) concerns related to patient safety as identified throughout the delivery care system	D. Felitti C. Roullier J. Keohan Contributors: Credentialing Committee Medical Directors Quality SIU	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing
	Skilled Nursing Facilities	Monitor publicly available data (e.g., www.medicare.gov) to detect existing patterns of poor quality or safety. • Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints. Inpatient care specialists and discharge planners to assist in identifying potential safety concerns regarding a skilled nursing facility.	H. Hebert C. Roullier Contributors; Applicable Business Owners	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing
	Behavioral Health Facilities	Behavioral health (BH) monitors follow-up after hospitalization within 7 and 30 days: readmission reasons, and maintains communication across the BH care continuum to identify safety concerns. Quality, BH ongoing facilities	B. Holtz C. Rorie-Alexandrov Contributors: mental health clinics, Four Winds	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Safety Plan - Providers						
			hospitals and outpatient services			
	Hospitals	Include contract language requiring hospitals to submit national quality of care standards relating to patient safety. Include links on the plan website to publicly reported comparisons of safety and quality (CMS Hospital Compare, NYS DOH, and Why Not The Best).	L. Kabay D.Felitti Medical Director <u>Contributors:</u> Healthcare Network Strategy and Contracting NS Credentials Committee Quality Corporate Communicat-ions	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing

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- **QUALITY MANAGEMENT (QM) SAFETY PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Safety Plan - Practitioners						
	All Practitioners	At initial credentialing and during recredentialing: • Verify licensure, education and training, board certification status, history of malpractice or actions on license. • Receive signed attestation to lack of present illegal drug use, history of loss of license and felony convictions, and history of loss or limitation of privileges or disciplinary activity. • Conduct site visit during any study conducted during calendar year. • Assess handicapped accessibility, proper containment and storage of prescription drugs, appropriate maintenance of refrigerators used to store biologicals, storage of sharps and biohazards, and confidentiality of medical records. • Conduct additional site visit in response to any complaints received by the plan. • Monitor all sanctions and limitations on licensure, any complaints, adverse events, or instances of poor quality through clinical quality review (CQR) process. • Perform pharmacy reviews, including systematic checks for potential drug interactions, drug utilization reviews, and poly-pharmacy reports. • Performance is monitored for measurements of quality, efficiency, safety, and member satisfaction. • Identify physicians meeting NCQA physician recognition standards in provider directory, including Find-A-Doc	D. Felitti <u>Contributors:</u> Credentialing Committee Medical Director Quality SIU Pharmacy-MTMP	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing

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- **QUALITY MANAGEMENT (QM) SAFETY PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Safety Plan - Practitioners						
		• Monitor any potential quality of care and safety issues that are identified by plan staff or through member complaints. • Monitor to ensure members receive persistent medications; high-risk medications in elderly; or known contraindicated medications, or medications that could interact with their data collection and augmented particular disease state are being tested appropriately to prevent adverse outcomes and referred, when applicable to medication management therapy program (MTMP) for CMR or TMR. • Monitor use of high-tech imaging studies to reduce members' radiation risks.				
	Primary Care Practitioners	• Enhanced Primary Care (EPC) patient centered-medical home (PCMH) payment model and bonus potential is based measurements of quality, efficiency, safety, and member satisfaction. • Monitor compliance with CDPHP preventive health and clinical guidelines. • Practitioners clinical practice guidelines based on evidence-based medicine via the secure practitioner portal on www.cdphp.com • Measure continuity of care between PCPs and specialty care practitioners. • Distribute physician reports that include quality, safety, efficiency, and member satisfaction via CG-CAHPS results from monthly surveys to imputed EPC members.	J. Heath Contributors: Performance Management Pharmacy Medical Director Quality Informatics	Ongoing	Progress report toward goal submitted quarterly to QMC Measured as part of various medical record studies throughout the year	Ongoing

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- **QUALITY MANAGEMENT (QM) SAFETY PLAN 2016**

Key	Quality Indicator/ Initiative or Regulatory Agency/Standard	Goal Baseline/Target	Owner(s)	Start Date	Progress Towards Goal	End Date
Safety Plan - Practitioners						
	OB/GYN Practitioners	Monitor compliance with CDPHP clinical practice guidelines, measured annually as part of the ensure continuity of care with primary care practitioners.	C. Roullier Contributors: Medical Director Quality Informatics	Ongoing	Measured annually through the perinatal study, which is reported up to QMC	12/31/2016
	Other Specialty Care	Develop measurements of compliance with CDPHP clinical practitioner practice guidelines. Develop CAVE reports on quality metrics, efficiency, safety, and member satisfaction for the following specialists: cardiology, gastroenterology and oncology	R.DalCol, MD Contributors: Performance Management Quality Informatics	Ongoing	Measured annually through HEDIS data collection. Report to QMC quarterly on the progress with CAVE	Ongoing
	Behavioral Health Practitioners	Measure continuity of care among behavioral health practitioners. Measure continuity of care between behavioral health practitioners, primary care practitioners, and specialists.	C .Rorie-Alexandrov Contributors: Quality Behavioral Health Medical Director BH Committee	Ongoing	Progress report toward goal submitted quarterly to QMC	Ongoing