14. Clinical Performance Management

14.1 Overview and Philosophy

The Clinical Performance Management Program and Integrated Quality Plan is an organization-wide commitment that supports processes designed to improve the quality and safety of clinical care and the quality of service provided to our members. The Program utilizes clinical and service indicators to plan, implement, monitor, and improve the organization's commitment to improve quality, maximize safe clinical practices, and enhance service delivery to our members.

Key Objectives of the Healthfirst Clinical Performance Management:
1. To establish and maintain a Clinical Performance Management Program and Integrated Quality Plan that demonstrates a commitment from the highest governing body of Healthfirst to every employee of the organization and to provide the highest possible quality in clinical care and service delivery to our members.
2. To share with its participating providers clinical and service performance indicators by which care and member satisfaction are measured and to hold those accountable in the implementation of actions designed to improve performance.
3. To establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring, and evaluating performance to improve desired outcomes.
4. To demonstrate a quality process that ensures compliance with all rules and regulations set forth by local and federal regulatory agencies that affect all aspects of the organization's business, service, and clinical operations.
5. To implement and monitor educational materials and programs designed to empower members to take better care of themselves.

Scope of the Integrated Quality Plan/CPM Program

The Integrated Quality Plan/CPM Program is applicable to all Healthfirst products. All aspects of the organization participate in every facet of the Plan's overall quality improvement efforts. The overall goal of this program is to include both administrative and clinical initiatives that are monitored regularly and evaluated annually. All clinical performance activities, when applicable, shall be conducted in accordance with the National Committee for Quality Assurance (NCQA) Standards for the Accreditation of Managed Care Organizations and/or other reporting requirements as promulgated by the different regulatory agencies that oversee the organization, such as the New York State Department of Health (NYSDOH), New York City Department of Health and Mental Hygiene (NYC DOHMH), and the Centers for Medicare & Medicaid Services (CMS). Activities fall into two (2) major categories: activities that improve the quality and safety of clinical care, and activities that improve the quality of service provided to its membership.

14.2 Reporting Requirements and Quality Programs

Healthfirst is required to report to federal, New York State, and New York City regulatory authorities on a variety of data elements, including clinical studies and quality-related indicators. In order to maintain compliance with these requirements, Healthfirst relies upon its provider network to supply it with comprehensive, accurate, and timely information. Healthfirst also expects its participating providers to follow all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents (e.g., sterilization/hysterectomy), child abuse and domestic violence, and any other required data sets.

This section of the Provider Manual describes the range of regulatory reporting requirements and provider data requirements mandated by CMS, the NYSDOH, the NYC DOHMH, and Healthfirst. It also describes the

Quality Program's tools, support, and educational initiatives that Healthfirst has implemented to help providers meet and satisfy these regulatory requirements.

Risk Adjustment: Member Diagnosis Information and Coding Requirements

Medicare, NYS-Medicaid, and Health Exchange Programs utilize ICD-9-CM as the official diagnosis code set for each respective risk-adjustment model. Accordingly, ICD-9 diagnosis codes are required in the determination of risk-adjustment factors. Accurate and appropriate ICD-9 codes must be submitted for each beneficiary. As of 10/1/2015, ICD-9 codes will no longer be accepted by Healthfirst and will be replaced with the ICD-10 code set.

Coding and Medical Record Documentation:

- As a standard policy, Medicare, Health Exchange, and NYS-Medicaid programs require accuracy and specificity in diagnostic coding
- Use current ICD-9-CM diagnostic coding conventions through 9/30/2015 and ICD-10 coding conventions beginning 10/1/2015
- Ensure office staff is up to date on the basics of ICD-9-CM and ICD-10 coding
- Code in the highest level of specificity known
- Clinical specificity of a disease/condition can be expressed through the fourth (4th) and/or fifth (5th) digit of some ICD-9CM diagnostic codes (ending 9/30/2015)
- Clinical specificity of a disease/condition can be expressed through the fourth (4th), fifth (5th), sixth (6th), and/or 7th (seventh) digit of some ICD-10CM diagnostic codes(beginning 10/1/2015)
- Specificity of coding is based on the accuracy of information written in the medical records
- Medical records are the source of all codes
- Verify that codes are supported by the medical record
- All claims submitted that do not have the appropriate fourth (4th) and/or fifth (5th) digit in the ICD-9CM diagnostic codes will be denied by Healthfirst

Guidelines when managing medical records:

- As per provider and member agreement with Healthfirst, access to medical records must be available for verification of diagnosis (please refer to your agreement)
- Include the member's identification on each page of the medical record and date of service. Include the signature of the person(s) doing the treatment, reason for the visit, care rendered, conclusion and diagnosis, and follow-up care plan in all medical records
- Documentation in the medical record of encounters with members must include all conditions and comorbidities being treated and managed
- Include the provider's credentials on the medical record, either next to his/her signature or preprinted with the provider's name on the practice's letterhead
- Report and submit all diagnoses that impact the member's evaluation, care and treatment; reason for the visit; co-existing acute conditions; chronic conditions or relevant past conditions
- Medical records must reflect the codes submitted
- For more information on Medicare program: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/

- For more information on Medicaid program: www.health.state.ny.us
- For more information on the Health Exchange program: www.hhs.gov/
- For more information on ICD-9-CM: www.cdc.gov/nchs/icd.htm
- For more information on ICD-10-CM: www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10

Quality Assurance Reporting Requirements (QARR)

QARR are a series of measures designed to examine managed care plan performance in several key areas. These measures are largely adopted from the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®), with additional New York State–specific measures added to address public health issues of particular significance in New York.

HEDIS consists of eighty-three (83) measures and QARR has three (3) NYS-specific measures across five (5) domains of care. Highlights of the four (4) domains from HEDIS/QARR that are greatly impacted by the performance of a Plan's participating providers are presented here.

DOMAIN	MEASURES
Effectiveness of Care	■ Adult BMI Assessment ■ Weight Assessment & Counseling for Nutrition & Physical Activity for Children /Adolescents ■ Childhood Immunization Status ■ Immunizations for Adolescents ■ Human Papilloma Vaccine for Female Adolescents ■ Lead Screening in Children ■ Adolescent Preventive Care ■ Breast Cancer Screening ■ Cervical Cancer Screening ■ Non-Recommended Cervical Cancer Screening in Adolescent Females ■ Chlamydia Screening in Women ■ Colorectal Cancer Screening ■ Non-Recommended PSA-Based Screening in Older Men ■ Care for Older Adults ■ Appropriate Testing for Children with Pharyngitis ■ Appropriate Testing for Children with Upper Respiratory Infection ■ Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ■ Use of Spirometry Testing in the Assessment & Diagnosis of COPD ■ Pharmacotherapy Management of COPD Exacerbation ■ Use of Appropriate Medications for People with Asthma ■ Medication Management for People with Asthma ■ Asthma Medication Ratio ■ Cholesterol Management for Members with Cardiovascular Conditions ■ Controlling High Blood Pressure ■ Persistence of Beta-Blocker Treatment After a Heart Attack ■ Comprehensive Diabetes Care ■ HIV/AIDS Comprehensive Care ■ Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ■ Osteoporosis Management in Women who had a Fracture ■ Use of Imaging Studies for Low Back Pain ■ Antidepressant Medication Management ■ Follow-up Care for Children Prescribed ADHD Medication ■ Follow-Up After Hospitalization for Mental Illness ■ Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications

	■ Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia ■ Use of Multiple Concurrent Antipsychotics in Children and Adolescents ■ Metabolic Monitoring for Children and Adolescents on Antipsychotics ■ Medication Reconciliation Post-Discharge ■ Potentially Harmful Drug-Disease Interactions in the Elderly ■ Use of High-Risk Medications in the Elderly
Access & Availability of Care	■ Adults' Access to Preventive/Ambulatory Health Services ■ Children and Adolescents' Access to Primary Care Practitioners ■ Prenatal and Postpartum Care ■ Annual Dental Visit ■ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ■ Call Answer Timeliness ■ Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Experience of Care	■ CAHPS Health Plan Survey 5.0H, Adult Version ■ CAHPS Health Plan Survey 5.0H, Child Version ■ Children with Chronic Conditions
Utilization & Relative Resource Use	■ Frequency of Ongoing Prenatal Care ■ Well-Child Visits in the First 15 Months of Life ■ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ■ Adolescent Well-Care Visits ■ Frequency of Selected Procedures ■ Ambulatory Care ■ Inpatient Utilization – General Hospital/Acute Care ■ Identification of Alcohol and Other Drug Services ■ Mental Health Utilization ■ Plan All-Cause Readmissions ■ Antibiotic Utilization ■ Relative Resource Use for People with Diabetes ■ Relative Resource Use for People with Cardiovascular Conditions ■ Relative Resource Use for People with Hypertension ■ Relative Resource Use for People with COPD ■ Relative Resource Use for People with Asthma

Performance in the HEDIS/QARR data sets is one (1) of the core indicators on which Healthfirst plan-wide quality improvement efforts have been focused. It is extremely important to note the following:

HEDIS/QARR measures are primarily based on preventive health standards and clinical practice guidelines issued by expert panels and community respected organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), American Diabetes Association (ADA), American College of Obstetrics and Gynecology (ACOG), and the American College of Cardiology (ACC).

HEDIS/QARR requires specific technical specifications on how data is reported for each measure (see Appendix XVI).

Documentation is key – starting from the medical records (members' charts) to the business office submission of encounter and claims data. There are measures such as well-child visits in the Medicaid product that can only be reported through claims and encounter data, but only if the appropriate coding and timing of service was submitted to the plan.

To assist providers, the Clinical Performance Management department will periodically prepare and forward listings of members to the appropriate providers indicating services that were not reflected on the encounter and claims data submitted. Providers are asked to review their records to see whether these services were rendered but not reported to Healthfirst. If the services were rendered, providers are asked to submit the claims/encounter data to Healthfirst as soon as they are identified. If they were not but would be beneficial to

the member, the provider is asked to reach out to the member to offer the service. Staff from the Clinical Performance Management department will work with providers closely to monitor provider specific initiatives and performance rates.

Provider Network Reports

On a quarterly basis, Healthfirst submits its Health Provider Network (HPN) report to the State, listing all participating providers. This submission includes provider license numbers, Medicaid provider numbers, office locations and hours, provider types and specialties, etc. Healthfirst must attest to the accuracy of this provider information with a notarized affidavit. It is imperative that the information you give us about your practice—such as office address and office hours, your credentials and license/provider numbers—be accurate at the time and be updated promptly whenever there is a change. To submit any change in your information, fill out the Demographic Change Form on our website at www.healthfirst.org or call Provider Services at **1-888-801-1660.**

Reporting Requirements for the New York State Cancer Registry (NYSCR)

The Cancer Research Improvement Act of 1997 amended section 2401 of the Public Health Law. Under this law, all managed care organizations certified pursuant to Article 44 are required to report cancer cases to the NYSCR. A prescribed list of data elements to track cancer incidence has been developed. Data is collected from the encounter forms submitted to Healthfirst by providers. Healthfirst providers must submit encounter forms to document services rendered and may be requested to forward additional information to support the reporting requirements of the NYSCR.

Public Health and Communicable Disease Reporting

Public health law requires that confirmed diagnoses of specific communicable diseases must be reported to the NYSDOH. Diseases relating to the potential for bioterrorism attacks are included on the mandatory reporting list. For a copy of the complete set of mandatory reporting lists, please refer to Appendix XV, check the NYSDOH website at www.health.ny.gov/professionals/diseases/reporting/communicable, or call the NYSDOH at **1-518-474-0548**.

In addition to providers, all laboratories must submit a report to the NYSDOH when a communicable disease is identified. However, even though a laboratory may report the disease, providers are also required to submit a report once the diagnosis is confirmed.

Reports may be submitted by mail, fax, or telephone, and specific forms must be used in certain cases. If you file a report by telephone, please remember to document this in the member's medical record, being sure to include the date reported, the telephone number, and the name of the person taking the report. The following telephone list contains important numbers for you to have available to report communicable and other reportable diseases.

Telephone Guide for Communicable and Reportable Diseases	
New York City	
NYC AIDS Reporting	1-212-442-3388
NYC Communicable Disease Bureau	1-212-788-9830
Lead Poisoning	1-212-676-6158
Sexually Transmitted Diseases	1-212-788-4444
Tuberculosis	1-212-788-4162
Nassau County	
Communicable Disease Control	1-516-227-9496
Suffolk County	
Bureau of Epidemiology & Disease Control	1-631-787-2200

Additional Information Regarding Public Health Reporting

Providers must cooperate with local department of health efforts to address and identify community health problems and gaps in service.

HIV/AIDS Comprehensive Care

Report new cases of HIV infection and HIV illnesses, along with AIDS cases, to the NYC DOHMH on a timely basis. Cases of HIV infection, HIV-related illness, and AIDS are reportable by telephone to **1-212-442-3388.**

Please ensure that HIV-positive Healthfirst members receive necessary preventive care services and that appropriate documentation is found in the member's medical records

Encounter data/claims should contain the following appropriate coding:

Two outpatient visits for primary care or HIV related care - 1 in the first 6 months of the year; 1 in the second 6 months of the year (ages 2 years and older)	
CPT-4: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	ICD-9 Diagnosis: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Two viral load tests - 1 in the first 6 months of the year; 1 in the second 6 months of the year (ages 2 years and older)	
CPT-4: 87534-87536, 87537-87539	
One syphilis test (age 19 and older only)	
CPT-4: 86592-86593, 86780	

If your patient does not have private health insurance or Medicaid, he/she can get HIV care and medication from the AIDS Drug Assistance Program (ADAP) at no cost. For more information, call **1-800-542-2437**

The HIV/AIDS practice guidelines are downloadable at www.hivguidelines.org/clinical-guidelines/. For additional information, visit www.health.state.ny.us/diseases/aids/index.htm

Encourage members to get tested for HIV infection, especially populations at risk, such as drug users, homosexual males, bisexual males/females, sexually active teenagers, etc.

Provide members with the toll-free numbers **1-800-541-AIDS (1-800-541-2437)** and **1-800-233-SIDA** (Spanish) for HIV testing and counseling

Today's test technologies afford individuals the ability to receive an HIV test result in a single visit. If your office or organization offers HIV counseling and testing and has not yet adopted rapid testing, you should consider doing so.

Detailed guidance for implementing rapid testing for HIV is available at www.health.ny.gov/diseases/aids/testing/#rapid.

Sexually Transmitted Diseases (STDs)

Disease surveillance indicates that over fifty (50) percent of all infections reported on a national level are sexually transmitted. STDs represent the most commonly reported infectious diseases among sexually active adolescents. It is extremely important that both the healthcare provider and the health plan from which a young person may seek help and advice regarding these diseases are sensitive to the issues and challenges

that face this population. Suggestions to improve performance:

- Be sure encounter data/claims contain appropriate coding
- Encourage members to get tested for STDs, especially members of high-risk populations and populations at risk, such as drug users, homosexual males, bisexual males/females, sexually active teenagers, etc. For additional information, visit www.health.state.ny.us/diseases/communicable/std/index.htm
- Provide members with the following STD hotlines for information and testing sites:
    - CDC National STD Hotline: **1-800-227-8922**
    - NYS Department of Health STD Education Office: **1-212-427-5120**
    - NYS HIV/AIDS Hotline: **1-800-541-AIDS (1-800-541-2437)**
- Remind Healthfirst members that confidential STD services are available at the NYCDOH clinics for non-Healthfirst sexual and needle sharing partners for no charge
- Document all care and services rendered in the member's chart and submit claims and encounter forms using the above appropriate codes

Tuberculosis (TB) Control

Healthfirst has adopted the clinical practice guidelines for the diagnosis and treatment of tuberculosis from the Clinical Policies and Protocols Manual, Bureau of Tuberculosis Control, New York City Department of Health, Third Edition, June 1999; Updated Fall, 2006. All Healthfirst providers should use these guidelines in the care and treatment of Healthfirst members with TB. These guidelines contain important information about counseling TB members and their families and about household precautions that are necessary to avoid spreading the disease.

A copy of these guidelines can be ordered from the NYC DOHMH Bureau of Tuberculosis Control by calling **1-212-788-4162**. Directly Observed Treatment (DOT) programs are available at various locations throughout New York City, and referrals can be made for members who are not compliant with their medication regimen or do not keep follow-up visits. To enroll/refer a Healthfirst member to the DOT program, call **311.**

The New York City health code mandates the reporting of children aged younger than five (5) years with a positive tuberculin skin test (TST) to the Department of Health and Mental Hygiene. Medical providers and infection control practitioners are now required to report on these children, in accordance with Article 11. Treatment for latent TB infection is recommended in all children as soon as active TB is ruled out. For all DOH-reported cases, children younger than five (5) years are assigned a Case Manager to follow up on their evaluation and treatment.

Child Abuse and Domestic Violence

It is important that providers and their staff be alert to potential cases of child abuse, domestic violence, and adult and elder abuse. An assessment screening is recommended for all new members during annual follow-ups and when child abuse/domestic violence is suspected (including in same-sex relationships). Reporting of child abuse or maltreatment is mandatory for all healthcare professionals. The Injury Prevention Program (TIPP) can be used as a reference guide to help prevent/minimize injury and violence. Your local department of health is also a resource for additional information and referral resources for domestic violence and abuse. The telephone numbers listed below provide resources for information and reporting of child abuse and domestic violence:

- New York State Child Abuse or Maltreatment Registry: **1-800-635-1522**
- General Information on Child Abuse: **1-877-543-7692**
- General Information on Domestic Violence: **1-800-942-6906**

- General Information on Social Services: **1-800-342-3009**

Hepatitis B Screening

All pregnant women must be screened for Hepatitis B, with a follow-up vaccination when indicated. If applicable, infants and close contacts of the women must also be tested. Members with positive Hepatitis B findings must be reported to the local department of health.

Smoking Cessation

Tobacco has been linked to lung cancer and other deadly chronic diseases. We urge providers to help your members fight tobacco addiction as part of your standard of care rendered to your members. For every member at every clinic visit, the healthcare provider should:

- Identify whether a member is a smoker
- Document smoker status in the member's chart as a vital sign
- Provide smoking cessation resources, such as:
    - NY State Smoker's Quitline – **1-866-NY-QUITS or 1-866-697-8487**
    - Smoking Cessation Centers – for a list of smoking cessation centers in NYC and Long Island, visit www.healthfirst.org, www.nysmokefree.com, https://a816-nycquits.nyc.gov/pages/homepage.aspx, and www.cdc.gov/tobacco/how2quit.htm
- Treat by introducing pharmacological counseling therapies

Healthfirst Medicaid programs provide smoking cessation counseling coverage for eligible members. Nonprescription medications must have "over the counter" written on the order. Healthcare providers can call the NY State Quitline to obtain concise, up-to-date information on stop-smoking techniques and medications, or to order office materials that can be shared with their members

Member Incentive Program

Through Healthfirst's Health Promotion Programs, members may be entitled to the following incentives:

The **Healthfirst Wellness Reward Card Program** is a way for Healthfirst members to earn rewards for taking care of themselves:

The program is available to Healthfirst Medicaid, Child Health Plus and Medicare members. Members can qualify for reward cards by completing selected preventive screenings and health initiatives, such as well child visits, completion of health risk assessments, mammograms, medication adherence and colorectal screenings. Reward card forms can be found on the Provider Portal, at http://healthfirst.org/providers/. Members can fill out a form and mail or fax the form back to Healthfirst. Providers must submit the correct claims in order for the members to be approved for a reward card.

Free car service – Available to qualified Medicaid members who need prenatal and/or post-partum visits, well-child visits, and immunizations within the required time frames. Members should contact **Member Services** at **1-866-463-6743** to arrange for their free transportation

14.3 Clinical Practice Guidelines

Clinical practice guidelines (Appendix XII) are systematically developed standards that help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. The use of clinical practice guidelines gives Healthfirst the ability to measure the impact of guidelines on outcomes of care and may reduce practice variations in diagnosis and treatment. In addition to guidelines and recommendations required by CMS, the NYSDOH, and the local departments of health, participating providers are expected to comply with the guidelines adopted by Healthfirst.

Healthfirst has adopted preventive care and practice guidelines that are based on nationally accepted guidelines that are reviewed and updated every two (2) years unless otherwise specified. Healthfirst adopts guidelines upon the recommendation and approval of the Healthfirst Quality Improvement Committee (QIC). They are communicated to providers—including performance indicators chosen by the clinical members of the Committee—through the Provider Manual, annual mailings, newsletters, and the Healthfirst website. Performance against chosen indicators is measured annually—preventive guidelines are measured utilizing HEDIS/QARR measurement tools and clinical guidelines are measured using focused studies methodologies.

Please note: Healthfirst disclaims any endorsement or approval of these guidelines for use as substitutes for the individualized clinical judgment and decision making that is required in the treatment and management of our members. These guidelines provide a tool for objective comparison of clinical practices among network providers and ensure appropriateness of care to our members. These guidelines are readily available by virtue of their already broad publication and distribution.

To obtain a copy of the list of guidelines required by the NYSDOH and the list of guidelines adopted by Healthfirst, visit http://healthfirst.org/providers/provider-resources/

14.4 Studies, Surveys, and Investigations

Studies - Medicaid and Managed Long Term Care (MLTC)

Every two years, the Managed Care Organizations (MCOs) participating with Medicaid and Managed Long Term Care (MLTC) programs are required by the NYSDOH to conduct a Performance Improvement Project (PIP) in a priority topic area or a topic relevant to the MCO's population demographics. A PIP, as defined by the NYSDOH, is a methodology for facilitating MCO and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through the PIPs MCOs and providers determine what processes need to be improved and how they should be improved. Providers are strongly encouraged to participate in the conduct of these studies, as well as in the implementation of action plans to improve performance. Participation can be accomplished by becoming a member of Healthfirst's quality improvement committees.

We are also mandated to participate in the NYSDOH's focused clinical studies on an annual basis. The NYSDOH determines the topic of focus. Participating providers are expected to cooperate with medical record reviews necessary to conduct these studies, comply with medical records standards, and meet required performance thresholds established for the project. The projects, their results, and updates are published in The Source, our provider newsletter, and/or on the Healthfirst website, at www.healthfirst.org as well as reported quarterly at the Quality Improvement Committee and the Board Meetings. For information on how to become a member of Healthfirst's Quality Committee, or to obtain copies of the projects, please contact the Clinical Performance Management department.

Contract Period	Study Topic
2015	Improving the Identification of Smokers in the Adult 18-64 y.o. Medicaid Populatic and Increasing the Utilization of Smoking Cessation Benefits (PIP)
2015	NY Depression Screening Validation Study (Focused Clinical Study)
2015	Reduce the number of falls requiring medical intervention (MLTC PIP)

Studies – Medicare, Special Needs Plans (SNP), and Fully Integrated Duals Advantage (FIDA)

Each year, Managed Care Organizations (MCOs) participating with Medicare, Special Needs Plans (SNPs), and Fully Integrated Duals Advantage (FIDA) programs are required by CMS to conduct a Quality

Improvement Project (QIP) and Chronic Care Improvement Program (CCIP) for a topic that is relevant to these member populations. The CCIP is a five year study and the QIP is a three year study.

Contract Period	Study Topic
2012	IImprove Medication Adherence for Medicare Members with Cardiovascular Disease on Statins and/or ACEI/ARB (CCIP)
2013	Improving Cardiovascular Disease Outcomes through Medication Management (iSNP CCIP)
2013	Reduction of All Cause Hospital Readmission for Healthfirst iSNP Members through Use of Continuity of Care Medication Reconciliation Tools (iSNP QIP)
2016	Improving the health outcomes of our members with COPD through increased pharmacotherapy compliance after an acute exacerbation and Spirometry testing to monitor the efficacy of treatment and disease severity (QIP)
2016	Reduce the number of falls requiring medical intervention (FIDA QIP)
2016	Improving the rates of dilated retinal exams among our members with diabetes (FIDA CCIP)

The topic of cardiovascular disease was selected by CMS for the 2012 CCIP and 2013 iSNP CCIP. CMS selected this health issue to support the ***Million Hearts Initiative.*** Additional information on this campaign can be found at the following website: http://millionhearts.hhs.gov/about_mh.html. The 2013 QIP focuses on the reduction of 30-day, all-cause hospital readmissions. The 2016 QIP will strive to improve the health outcomes of Medicare members with COPD while the 2016 FIDA QIP addresses fall prevention and the FIDA CCIP aims to incease dilated retinal exam screenings among our diabetic FIDA population.

Member Satisfaction Surveys

The NYSDOH and CMS conduct annual member satisfaction surveys which are administered by third party survey vendors and provide the plans with their individual results. The NYSDOH and CMS use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys as well as the Qualified Health Plan Enrollee Experience Survey (QHPEES) as its survey tools. The CAHPS surveys & QHPEES are a set of standardized questions that assess member satisfaction with the experience of care. The surveys are based on randomly selected samples of members from the MCO and summarize satisfaction with the experience of care through ratings and composites. The members' perception and experience with their providers impact a major portion of these ratings and composites. It is important that providers participating with Healthfirst conduct the delivery of services in their offices and facilities at the highest quality level, ensuring that the needs of their patients (our members) are met to their satisfaction. Results of these surveys are communicated to providers through newsletters, our website, and/or special mailings. If you need more information about the CAHPS surveys, please visit the NCQA website, www.ncqa.org. If you need more information about the QHPEES, please visit www.CMS.gov.

Quality-of-Care Investigations

To ensure the quality and safety of the services provided to its members, as well as to improve member satisfaction, Healthfirst responds to any identified concerns or issues regarding provider performance through a quality review process. Review of quality-of-care referrals can include, but is not limited to, medical record review, provider contact, member contact, referral for peer review, interdepartmental review, review by the

Medical Director, and review by the clinical members of the Healthfirst Quality Committee. All clinical quality-of-care referrals are trended and tracked to identify patterns. When the inquiry/review has been completed and a final disposition is assigned to the referral, the outcome/recommendation is communicated to the referring and concerned parties, as appropriate. Information about the inquiry and review is forwarded to the Credentialing department for inclusion in the provider's files.

14.5 Quality Improvement – Medicare

Healthfirst's participation in the Medicare Advantage Program requires additional reporting requirements. The Program incorporates the mandatory quality standards for the Medicare program. The Medicare program is operated under the auspices of the U.S. Department of Health and Human Services – Centers for Medicare & Medicaid Services (CMS). It is expected that providers comply with the requirements of Healthfirst, CMS, and the Quality Improvement Organization (QIO) designated as the review agent for CMS, in order to meet these important initiatives that ensure our Medicare members receive the highest quality of care possible.
The Medicare Star Rating system, a program administered by the Centers for Medicare & Medicaid Services (CMS), measures the quality of Medicare Advantage plans and supports CMS efforts to drive improvements in Medicare quality and improve the level of accountability for the care provided by physicians, hospitals, and other providers. CMS publishes the Star Ratings each year to assist beneficiaries in finding the best plan for them and to determine MA Quality Bonus Payments.
The Star Ratings system is consistent with CMS' Three Aims (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

1. Outcomes	Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
2. Intermediate Outcomes	Intermediate outcome measures help move closer to true outcome measures.
3. Patient Experience	Patient experience measures represent beneficiaries' perspectives about the care they have received.
4. Access	Access measures reflect issues that may create barriers to receiving needed care.
5. Process	Process measures capture the method by which health care is provided.

Medicare members may be asked to provide feedback by answering up to three surveys per year. Not all Medicare members receive these three annual surveys:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey: Provided to Medicare members to rate their satisfaction with their doctors and the plan. Members may be asked questions like:
   - In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment as soon as you thought you needed one?
   - In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
   - How often did your health plan's customer service give you the information or help you needed?
2. Health Outcomes Survey (HOS): Provided to Medicare members to rate their physical and mental health. Members may be asked questions like:
   - In the past 12 months, did a doctor or other health provider advise you to start, increase, or maintain your level of exercise or physical activity?
   - Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?
   - Have you ever talked with a doctor, nurse, or other healthcare provider about leaking of urine?
3. Health Risk Assessment (HRA) Survey: The HRA survey is given to all plan members enrolled in a Special Needs Plan (SNP) once a year. Members are to complete the HRA survey within 90 days of enrolling in a SNP plan, and once a year after that. This survey asks about health status and to

identify any health conditions or concerns a member may have.

The following measures are the standard reporting requirements for the Medicare products:

Domain/Category	Measure/Description
Access/Availability of Care	Access to Primary Care Doctor Visits
	Appeals Auto-Forward
	Appeals Upheld
	Beneficiary Access and Performance Problems
	Call Answer Timeliness
	Disenrollment Reasons - Financial Reasons for Disenrollment
	Disenrollment Reasons - Problems Getting Information about Prescription Drugs
	Disenrollment Reasons - Problems Getting Needed Care, Coverage, and Cost Info
	Disenrollment Reasons - Problems with Coverage of Doctors and Hospitals
	Disenrollment Reasons - Problems with Prescription Drug Benefits and Coverage
	Drug Plan Provides Current Information on Costs and Coverage for Medicare's Website
	Engagement of Alcohol or other Drug Treatment
	Enrollment Timeliness
	Foreign Language Interpreter and TTY Availability
	Grievance Rate
	Initiation of Alcohol or other Drug Treatment
	Medicare Plan Finder – Stability
	Plan Makes Timely Decisions about Appeals
	Plan Submitted Higher Prices for Display on MPF
	Reviewing Appeals Decisions
	Timely Effectuation of Appeals
	Timely Receipt of Case Files for Appeals
	Transition monitoring - failure rate for all other drugs
	Transition monitoring - failure rate for drugs within classes of clinical concern
Patient Experience	Aspirin Use and Discussion
	Care Coordination
	Complaints about the Health Plan
	Computer Use Made Talking with Doctor Easier
	Computer Used during Office Visits
	Computer User by Doctor Helpful
	Customer Service
	Doctors who Communicate Well
	Getting Appointments and Care Quickly
	Getting Information from Drug Plan
	Getting Needed Care
	Getting Needed Prescription Drugs
	Medical Assistance With Smoking and Tobacco Use Cessation
	Members Choosing to Leave the Plan
	Rating of Drug Plan
	Rating of Health Care Quality
	Rating of Health Plan
	Reminders for Appointments

	Reminders for Immunizations
	Reminders for Screening Tests
	Reminders to Fill prescriptions
	Reminders to Take Medications
Process	Medicare Plan Finder Price Composite
	Medication Therapy Management Program Completion Rate for Comprehensive Medication Review
	SNP Care Management
Process/Effectiveness of Care	Adult BMI Assessment
	Annual Flu Vaccine
	Annual Monitoring for Patients on Persistent Medications
	Antidepressant Medication Management
	Breast Cancer Screening
	Care for Older Adults: Medication Review
	Care for Older Adults: Functional Status Assessment
	Care for Older Adults: Pain Screening
	Colorectal Cancer Screening
	Continuous Beta Blocker Treatment
	Controlling High Blood Pressure
	Diabetes Care: Eye Exam
	Diabetes Care: Kidney Disease Monitoring
	Diabetes Care: Blood Sugar Controlled
	Drug-Drug Interactions
	Follow-Up Visit after Hospital Stay for Mental Illness
	Medication Reconciliation Post-Discharge
	Non-Recommended PSA-Based Screening in Older Men
	Osteoporosis Management in Women Who Had a Fracture
	Pharmacotherapy Management of COPD Exacerbation
	Pneumonia Vaccine
	Rate of Chronic Use of Atypical Antipsychotics by Elderly Beneficiaries in Nursing Homes
	Rheumatoid Arthritis Management
	Testing to Confirm Chronic Obstructive Pulmonary Disease
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Intermediate Outcome/ Effectiveness of Care	High Risk Medication
	Medication Adherence: Diabetes
	Medication Adherence: Hypertension
	Medication Adherence: Cholesterol
Outcome	Reducing the Risk of Falling (HOS)
	Management of Urinary Incontinence in Older Adults (HOS)
	Monitoring Physical Activity (HOS)
	Osteoporosis Testing (HOS)
	Improving or Maintaining Mental Health (HOS)
	Improving or Maintaining Physical Health (HOS)
	Plan All-Cause Readmissions
Improvement	Health Plan Quality Improvement
	Drug Plan Quality Improvement

14.6 Quality Evaluation of Providers

Healthfirst uses standardized and evidence-based tools to evaluate the quality of providers acting as Primary Care Physicians for our members. Healthfirst evaluates the quality of providers using their Overall Quality Rating (OQR), a numerical score on a scale of 1.0 to 5.0 that summarizes the provider's weighted average performance on select quality measures. The quality measures used to determine OQR (as well as their cut points and target rates) are informed by Medicare STARS and the New York State Department of Health Medicaid Incentive Program which are updated on a yearly basis. Healthfirst's detailed methodology for calculating OQR is available upon request. A list of the quality measures commonly used for OQR calculation(s) is available in Appendix XVIII.

Providers are evaluated on the following domains for quality:

- Adult and Pediatric Preventive Care, including measures related to well-care visits, screenings and immunizations
- Chronic Care Management, including measures related to asthma, diabetes and HIV treatment
- Acute Care Management, including measures related to pharyngitis and bronchitis
- Efficiency of Care, including measures related to hospital utilization rates and medication adherence
- Enrollee Experience and Satisfaction with Care

Providers' OQRs are calculated by line of business. Providers will have access to their quality data and OQRs through Healthfirst reporting tools. Healthfirst will review Providers' OQRs throughout the calendar year (January-December). Healthfirst will calculate and share Final OQRs with Providers included in the evaluation by late Q2 or early Q3 of the following year.

Healthfirst will engage Providers falling at or below the Minimum Quality Rating (MQR) for the Provider network. Each MQR will be no higher than 3.0 and Providers will only be evaluated against the MQR if they have at least ten valid quality measures they can be evaluated on. Providers will be notified if they are at or below the MQR throughout the year via engagement with Network Management or Clinical Quality Managers. Providers whose Final OQR is at or below the MQR will receive a formal notification letter from Healthfirst. This letter will include an offer to furnish Providers with additional support and resources to improve their OQRs.

For Providers consistently falling below the MQR, Healthfirst may take other actions deemed necessary, including but not limited to:

- Suppression of the Provider's information from the Healthfirst Directory
- Reduction or discontinuation of quality incentive bonus payments/deductions
- Suppression from Healthfirst's Enrollee/PCP auto-assignment process
- Removal from the Healthfirst network

Providers can appeal their Overall Quality Rating. Providers may appeal by following the guidelines briefly described in Section 16.3 of this Provider Manual. Healthfirst reserves the right to deny or disqualify appeals as applicable.

For additional information, please email QualityRatings@healthfirst.org.