

# **MetroPlus Health Plan**

**2024**

## **Quality Strategy: Essential Plan**

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This document is designed to serve as the Essential Plan Quality strategy. This document shares our commitment to provide broad access to quality health care coverage and service to our Essential Plan members.

## **Scope of Activities of the Quality Management Program**

The scope and content of the Quality Management Program (QMP) is designed to continuously monitor, evaluate, and improve the clinical care and service provided to members and their service delivery systems. MetroPlus Health Plan's QMP involves all levels of staff as well as provider and member representatives. Specifically, the QMP includes, but is not limited to the following responsibilities and monitoring of key performance measures:

## **Quality of Care**

The Plan ensures the highest quality of care is provided to members through the following processes:

### **Quality Improvement and Health Promotion Activities**

MetroPlus Health Plan systematically selects and prioritizes quality improvement and health promotion activities that have the potential to achieve the greatest benefit to members. Activities are based upon accepted clinical practice guidelines and member needs. Activities include but are not limited to:

- Development, approval, dissemination and evaluation of wellness and prevention tools that include but are not limited to web-based tools, mail, text, IVR, live outreach and reminders, member incentives, obtaining transportation (LOB specific) to support members in maintaining optimal health.
- Development, approval, and dissemination of clinical practice guidelines.
- Development of Member Rewards Program designed to support member wellness and adherence to chronic care guidelines.
- Development of Provider Pay for Performance Programs designed to encourage efficiency and quality in the delivery of healthcare services.
- Ongoing medical record reviews and coordination and continuity of care to ensure member receipt of care.
- Collaborative activities with internal and external colleagues including, but not limited to, the New York State Department of Health (NYSDOH), Centers for Medicare and Medicaid Services (CMS), OASAS and the Island Peer Review Organization (IPRO).
- Programs that meet the requirements of NYSDOH and CMS for the lines of business for which they have regulatory oversight. This includes but is not limited to the development of QIPs and PIPs.
- Participation in virtual community events and outreach.
- Analysis of member demographics to identify language, cultural, racial, and ethnic needs by geographic area and service delivery systems.

- Analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results, and other NYSDOH and CMS sponsored member satisfaction surveys to identify opportunities to address member needs.

### **Continuity and Coordination of Care**

Continuity and Coordination of Care is conducted through activities that include but are not limited to the following:

- Coordination of care between primary care, specialty and behavioral health providers treating the same patient.
- Continuity of care for transitioning members in active treatment to a new participating practitioner when the practitioner providing treatment leaves the network and for transitioning newly enrolled members in active treatment with a non-participating provider to a participating provider.
- Continuity of care post hospital/facility discharge.
- Coordination of community resources.

Activities that promote continuity and coordination include but are not limited to:

- Conducting medical record reviews to monitor documentation of continuity and coordination of care.
- Encouraging appropriate treatment and follow-up for members with comorbid conditions including behavioral and medical conditions.
- Encouraging appropriate treatment and follow up for members restricted to certain providers and/or pharmacies due to service overutilization or abuses.
- Working with the Plan's behavioral health team to improve coordination of behavioral and medical care needs.
- Identifying and notifying members of PCP's and specialists who are leaving the network including assistance with finding a new practitioner.
- Working with the HIV Special Needs Program ensuring medical and behavioral health needs are addressed in this complex population.
- Providing Care Management, Utilization Management and Quality Management programs to assist members in transitions between health care settings.
- Collaboratively working with network partners to identify and close gaps in care.
- Working with the Children's Specialized Services Program ensuring medical and behavioral health needs are addressed in this complex population.

### **Quality Improvement Projects**

Selection and prioritization of quality improvement projects is based on but not limited to the following criteria:

- Member focused and supports the MetroPlus Health Plan mission.
- Adequate resources are available to implement change.
- Adequate control over the necessary variables to influence change that will result in improvement.

- Organization possesses the ability to effectively measure the project and has a reasonable chance of attaining the goal.

Utilizing selection criteria ensures MetroPlus Health Plan selects projects that are designed to:

- Support the overall quality management strategy approved by clinical leadership.
- Generate a measurable impact, which includes attaining measure performance levels.
- Provide improvement on consumer health outcomes or internal work processes based on various factors.

## **Care Management**

The MetroPlus Integrated Care Management (ICM) program is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the services and options available to meet the health and human service needs of members with complex care needs and are at risk for increased hospital admissions and emergency room visits. The ICM program serves eligible members in the 5 boroughs of New York City. Care Managers complete a comprehensive assessment, identify/prioritize goals, coordinate based on member need and available resources and work with the primary care provider, specialist, and other members of the health care team to develop and implement a plan of care.

The goal of ICM is to provide high quality, integrated, culturally competent care management services to members assessed as having high medical and/or non-medical care management needs.

Care Managers will provide services that meet the unique racial, ethnic and language needs of our members. Care Managers will assist members in provider selection or will match members with specific health professionals who can best meet their linguistic and cultural needs thus enhance the quality of care and improve member outcomes.

### **ICM Program Objectives:**

- Improve quality and continuity of care across all lines of business.
- Prevent avoidable admissions, readmissions, and emergency room visits.
- Improve medication adherence.
- Address gaps in care.
- Continue to improve the integration of physical and behavioral health/substance abuse disorder care.
- Foster provider/member engagement.
- Empower members to be active consumers in their care.
- Address Social Determinants of Health (SDoH) needs including housing and food insecurity.
- Meet regulatory requirements.

### **ICM Program Overview:**

The ICM program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs. Our ICM program has two components, Transition of Care for members admitted to the

hospital and who are at risk for readmission and Comprehensive Care Management for members identified as having high complexity and morbidity factors.

### **Transition of Care (TOC)**

Management provides coordination and continuity of care for members transitioning from an inpatient facility setting to home. A Care Manager will support the member through the transition process by providing discharge support and coordination including self-management skills, medication reconciliation and medication adherence, enhanced care coordination of care for all member needs, and facilitation of follow up visits.

The TOC process is focused on improving quality of care and preventing avoidable admissions, readmissions, and emergency room visits. Members receive transitional care management for 30 days post hospitalization. Members who continue to have needs after the transitional period receive comprehensive care management.

### **Comprehensive Care Management**

In addition to members who have graduated from TOC and continue to have on-going needs, Comprehensive Care Management is provided to members having ongoing complex needs. Type of services provided, and duration of those services are based on the member's risk and need.

### **Member Identification:**

MetroPlusHealth utilizes our proprietary stratification algorithm to create a risk score which prioritizes members for interventions. Our stratification algorithm factors in:

- Utilization, or lack of (inpatient, ER, PCP, SNF, DME)
- Preventive care status (number of HEDIS gaps)
- Social Determinants
- Cost of care (medical, Prescription)
- Behavioral health issues (substance use, BH diagnoses)
- Complexity (i.e., number of chronic conditions, medications, and providers), and
- other indicators implying uncoordinated care practices such as members receiving care from similar specialists or members utilizing multiple pharmacies.

Our stratification process directs the selection of type of skill level required from a health professional to service members in the different risk categories, the type of services members receive and the frequency at which they receive these services.

### **High Risk OB Management**

MetroPlusHealth' High Risk OB Program focuses on attaining positive health outcomes for both mother and newborn. The Care Management Program partners with Obstetrical providers to

promote early entry into prenatal care for members identified with a High-Risk diagnosis. A Care Manager (CM) ensures that the pregnant member's needs are met through a complete initial assessment, planning, implementation, and evaluation once they have been stratified a High-Risk pregnancy. Education is provided to the member to increase understanding about pregnancy risks and necessary interventions allowing the member to develop a realistic pregnancy and delivery plan.

#### Goals/Expected Outcomes

- Identify SDOH needs food, housing and baby needs such as cribs, formula, employment support/job training
- Intervene via education and referral as needed
- Build relationships with expectant parent(s) by empowering, supporting, and educating about pregnancy
- Decrease NICU and low birth weight deliveries, via compliance with prenatal care
- Increase post-partum visit compliance prior to 7 to 84 days post-delivery
- Complete newborn Pediatric follow-up within 7 days of birth.

#### **Social Determinants of Health**

MetroPlusHealth addresses the importance of identifying ways to create social and physical environments that promote good health for our members. The Plan has taken steps to address food security, transportation needs and homelessness in conjunction with the medical management services offered through the Plan.

As ICM staff encounter members with social needs, they are encouraged to make referrals to community- based organizations and social service agencies to assist members with closing those gaps. In addition, MetroPlus has partnered with CBOs to provide tailored assistance, including home delivered medically tailored meals, and supportive housing opportunities. Metro-Plus has adopted NowPow, an electronic community-based resource platform which provides up to date information regarding community resources on a zip code level.

#### **Children with Special Health Care Needs**

The MetroPlus Integrated Care Management (ICM) stratification algorithm is applied to all members, this facilitates the identification of children with special health care needs (chronic debilitating conditions; disabilities; behavioral, developmental and/or emotional conditions) that may require health and related services to maintain or improve their health status and to prevent deterioration of their health. In addition to providing care coordination activities, where applicable care managers interact with school districts, pre-school services, early intervention officials, behavioral health, and developmental disabilities service organizations to coordinate and assure appropriate delivery of needed services. Children's Special Services (CSS) Care Managers (CM) employ a multi-generational approach to care management to assess the complex needs of members in the context of their environment, needs, and their supports. CSS

CMs assess the potential needs of their care givers to identify opportunities for linkages to services to optimize their ability to continue to support members to engage in needed care and remain safely in the community.

In conjunction with designated behavioral health care managers, CSS nurse and behavioral care managers are responsible for the review and approval of each member's Plan of Care to ensure comprehensive services meet the medical, behavioral, developmental, and psychosocial needs of members. The CSS unit has a designated Medically Fragile Liaison to ensure appropriate oversight of medical concerns is evident in communication with all members of the health care team including state agencies involved in the member's care

### **Pharmacy Management**

The Plan monitors the utilization and appropriate use of medications. When areas are identified for improvement, interventions are developed to:

- Encourage practitioners to prescribe medications appropriately and to use available resources/tools (i.e., ISTOP) to avoid dispensing of the same prescriptions, especially opioid medications, by multiple providers
- Discuss the importance of adherence to prescribed medication(s)
- Educate members about the medications that they have been prescribed
- Promote the safe use of medications
- Promote safe disposal of medications.
- Update the formulary, coverage determination and prior authorization criteria to promote clinically appropriate, cost-effective therapy to all members
- Develop medical benefit drug policies to promote clinically appropriate, cost-effective therapy to all members
- Complete internal review of Specialty Medications for Medicaid, Exchange, and Commercial lines of business to promote clinically appropriate, cost-effective therapy for all members.

### **Behavioral Health**

The Plan has a comprehensive behavioral health program to support members in need of behavioral health and substance abuse services. The Plan is responsible for the following behavioral health activities:

- Screening, identification, and referral for treatment of behavioral health through:
  - Medical and Behavioral Health Case Management
  - Peer Support
  - Utilization Management
  - Quality Management initiatives
- The Plan monitors performance using HEDIS/QARR behavioral measures and implements improvement activities as needed. Focus includes but is not limited to the following:

- Improving the percentage of members 18 years of age and older who are treated with antidepressant medications and who remain on an antidepressant drug for at least 12 weeks as well as continued treatment and remain on an antidepressant drug for at least 180 days (6 months).
  - Improving the percentage of children newly prescribed ADHD medications who have at least three follow-up care visits within a 10-month period, one of which is within 30 days (initiation) of when the first ADHD medication was dispensed and second, remain on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner (continuation) within 270 days (9 months).
  - Improving the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within seven and thirty days of discharge.
  - Improving the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who are dispensed an antipsychotic medication and have a diabetes screening test (glucose or HbA1c test).
  - Improving the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who have both an LDL-C test and an HbA1c test.
  - Improving the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease who have an LDL-C test.
  - Improving the percentage of members 18–years of age and older with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
  - Improving the percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and have metabolic testing (both blood glucose or HbA1c and LDL-C or cholesterol).
  - Improving the percentage of members 6 years of age and older who were seen in the emergency departments (ED) with a principal diagnosis of mental illness or intentional self-harm, who had a follow up visit for mental illness within seven and thirty days of discharge.
  - Improving the percentage of members 13 years of age and older who were seen in the emergency department (ED) with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD within seven and thirty days of the ED visit.
- Monitoring quality of care for members through quality-of-care reviews
  - Monitoring access and availability of behavioral health services for the Plan’s members



- Monitoring adherence with prescribed psychotropic medications and educating members and providers about compliance with the plan of care
- Referring high risk members to behavioral health case management
- Coordinating services and resources for members seeking Domestic Violence information.
- Monitoring and ensuring high risk populations receive access to care in a timely manner, including members with First Episode Psychosis (FEP) and Transition Age Youth (TAY)
- Collaborating with members' community providers, such as Intensive Mobile Treatment (IMT) teams.

### **Reporting Requirements for HEDIS®/QARR**

Data collection is conducted in accordance with NCQA guidelines and includes administrative, hybrid, electronic clinical data systems (ECDS) and supplemental data. The Plan submits audited summary and member-level data based on QARR and HEDIS® reporting specifications to NYS DOH and CMS.

The Plan is required to undergo an annual external audit of the HEDIS® and QARR data collection and rate production processes and practices before reporting to each regulatory entity. The Plan contracts with a NCQA certified audit organization for the Compliance Audit. Once all submissions requiring audit have passed, the Plan finalizes and submits them. Following receipt of the Final Audit Report, the Plan makes available a copy of the complete final report to NYS DOH and CMS.

### **CAHPS® Requirements**

The Plan is required to report results of the CAHPS® Survey. The Plan contracts with an approved MAPD/MAP/QHP/Commercial/Essential/ CAHPS® vendor for survey administration. The vendor adheres to regulatory requirements for fielding, collecting, and reporting CAHPS® data ensuring valid and reliable results.

### **Quality of Service**

Delivering on the Plan's Mission is a critical component of every customer interaction. Our goal is to provide all our members an exceptional experience each time they interact with the plan. This is delivered through some of the following:

- Making our communications easy to understand by using simple language and appropriate reading levels
- Making oral and written communications available in multiple languages, including the website
- Providing online tools to assist members in managing their health care and service needs quickly such as selecting a PCP
- Providing fast and accurate claim processing
- Answering telephone inquiries quickly, respectfully and with the right information the first time

- Customer Service Representatives who speak the same languages as our members and provision of TTY and Language Line when needed
- Proactively outreaching members that could use one or several services that could be of value to them such as Line of Business changes

Service also includes operations such as claims and enrollment as well as customer service. Members, customers, and providers routinely interact with these areas and their satisfaction with the Plan can be influenced by their interactions. Improving the experience is measured by CAHPS® as well as other satisfaction surveys conducted by the NYS DOH from time to time. These surveys are used to help improve the service provided and experience with the Plan.

### **Patient Safety**

MetroPlus Health Plan addresses patient safety through a variety of mechanisms and participates in improving safety by working within the local and regional health care community. Safety is promoted by the following activities, including but not limited to:

- Educating members and physicians about medical safety issues
- Making performance data available publicly for members, providers, and consumers
- Working with community agencies to develop and promote safety initiatives
- Promoting reporting of issues affecting member safety
- Analyzing events within organizations to evaluate the need for process improvement.

The Plan conducts the following activities to promote safety. These include, but are not limited to:

- Thorough initial credentialing and recredentialing processes that ensure a high-quality delivery system. An integral part of the initial credentialing process includes an office site visit (PCP offices, social adult day care and urgent care centers)
- Setting and monitoring standards for medical record documentation by conducting Medical Record Review and providing physician/network feedback
- A thorough process for investigation and resolution of complaints, especially quality of service and quality of care complaints against physicians and providers
- Reviewing pharmacy data for opportunities to educate members and/or physicians regarding potential adverse drug reactions or inappropriate medications
- Ensuring that qualified medical professionals make utilization management decisions
- Monitoring adherence with prescribed psychotropic medications and educating members and providers about compliance with the prescriber's plan of care
- Providing Care Management services, transition of care and care coordination services
- Including patient safety topics in the member and provider newsletters
- Working collaboratively with NYS DOH and other agencies to support patient safety and public health opportunities.

## **Accessibility**

The Plan has established and monitors appointment availability standards for preventive care, urgent care, non-urgent “sick” visits, routine primary care, prenatal care, family planning visits, well child visits, follow-up visits post emergency or hospital discharge, non-urgent mental health or substance abuse visits and PCP visits for newborns.

PCPs and OB/GYN’s are monitored for providing access to services on a twenty-four (24) hour a day, seven (7) day a week basis. Reports on accessibility are tracked, trended, and reviewed by Provider Relations and reported to the Quality Management Committee.

## **Availability**

The Plan has established and monitors availability standards based on regulatory requirements for the number and travel time/distance to offices of primary care practitioners (PCPs) and high-volume specialists.

High-volume specialists are defined as participating physicians or nurse practitioners in one of the following specialty types:

- Oncology
- Hematology/Oncology
- Ophthalmology
- Cardiology
- Cardiovascular Disease
- Behavioral Health

PCPs are defined as participating physicians or nurse practitioners, selected by or assigned to the member as their primary provider. PCPs are normally in one of the following specialty types:

- Family Practice
- Internal Medicine
- Pediatrics
- Geriatrics
- HIV
- OB/GYN
- Adolescent Medicine

## **Member Complaints, Grievances and Appeals**

The Customer Service Department is responsible for processing all member complaints (including quality of care complaints) grievances, and complaint appeals in a confidential, timely and effective manner. All cases are recorded, investigated, and resolved following the applicable regulatory timeframes and guidelines. Cases are tracked separately by physical and behavioral health issues. Root cause analysis and trending are performed to identify improvement

opportunities and potential systemic issues. All necessary corrective actions are implemented. Complaint and complaint appeal data is reported quarterly to the Complaint and Appeals Subcommittee, Combined Behavioral Health Quality Management Committee, Quality Management Committee and the Quality Assurance Performance Improvement Committee of the Board with behavioral health and children's special services related items trended and reported separately.

Members or their representatives may file their grievances orally or in writing. Complaint appeals must be filed in writing.

MetroPlusHealth will designate one or more qualified personnel to review a complaint. When the complaint pertains to clinical matters, the personnel shall include, but not be limited to, one or more licensed, certified or registered health care professionals. In addition, cases involving increased risk to a member's health shall be resolved in an expedited manner. All Complaints and Grievances are reviewed aggregately to identify possible trends and or disparities. Information on the members' race, ethnicity and gender is tracked. If needed, root cause analysis of member and provider complaints is performed to identify and resolve any disparities related specifically to race and ethnicity.

The Utilization Management Department handles all clinical appeals, external appeals, and Medicare standard clinical and expedited appeal determinations which are made in accordance with applicable state and federal regulations. The Department reports its findings to the Utilization Management Subcommittee, the Quality Management Committee which reports up to the Quality Assurance Performance Improvement Committee of the board quarterly with behavioral health and children's special services related appeals trended and reported separately.

A member or a member's designee, or a practitioner, on behalf of the member, can appeal an initial adverse determination either verbally or in writing. Individuals who conduct appeal considerations are licensed clinical peers in the same or similar specialty for clinical reviews and are neither the individual who made the original non-certification, nor the subordinate of such an individual. The Plan's staff may retrospectively apply medical necessity criteria to determine the appropriateness of a service or claim, where appropriate. Expedited appeal determinations are made in accordance with applicable state and federal regulations. All resources related to such reviews are retained by the Plan for a minimum of seven years. Utilization review appeals are analyzed, trended, and reported to the Utilization Management Subcommittee with behavioral health and children's special services related items trended and reported separately.

Clinical Quality Risk Complaints and Grievances against a physician or provider are investigated by a Quality Risk Clinical Reviewer and reviewed by the Plan's Medical Director. Clinical Quality Risk cases are presented to the Quality Assurance Performance Improvement Committee of the Board in either a detailed case presentation or summary format per the discretion of the CMO or his designee. Clinical Quality Risk Complaints and Grievances are tracked, trended, and analyzed. Results are reported to the Quality Management Committee separated by medical, children's special services and behavioral health related issues. Data from the Quality Risk process is utilized in the recertification process.

## **Member Resource Support Tools**

The Plan's website, Metroplus.org contains an array of support tools to assist members with understanding and managing their benefits and health care needs. The website is available in several languages, including, but not limited to, English, Spanish, Chinese, Hmong, Japanese, Korean, Punjabi, Russian, Tagalog and Vietnamese. Tools include but are not limited to the following:

- On-line comprehensive Provider Search Directory. Includes search capabilities to find a PCP, Specialist, Pharmacy, Dentist, Hospital, and a robust list of other Health Care Providers. Searchable criteria include gender, location, zip code, languages, etc.
- Link to MetroPlusHealth Member Rewards program where members in designated lines of business can earn rewards for making certain healthy choices.
- Link to the New York State Smokers Quitline and free downloadable material to support smoking cessation.
- Links to Health-Related Events hosted by our business and community partners. Events include wellness and chronic disease seminars, health fairs, holiday, and community events.
- Link to important COVID-19 updates and information and testing sites.
- Resources for members living with HIV/AIDS including general information, HIV counseling and testing and HIV Clinical Trials.
- LGBTQ Resource Guide that compiles resources that are specifically committed to assisting the LGBTQ community. Included is information on assistance with primary care services, health, and legal support as well as information on marriage, family planning and where to find substance abuse help and more.
- Links to social services programs addressing the social determinants of health for seniors, people with disabilities and/or low income.
- A comprehensive health library, featuring health information on extensive topics, healthy recipes, educational videos, and much more.

## **Cultural Diversity**

The Plan endeavors to provide clinical and non-clinical services in a culturally competent manner to accommodate members who have limited English proficiency in speaking and/or understanding languages other than or in addition to English, diverse cultural and ethnic background, race, gender, or health literacy.

The Plan makes available provider gender and languages spoken in its Provider Directories and on the website. Customer Service is also available to assist members find PCPs or other health care providers that meet their linguistic/gender needs.

The Plan monitors the language needs of non-English speaking members through usage patterns of the language line. Customer Service and Medical Management hire staff with multilingual skills to assist non-English speaking members.

Health education and other written materials are routinely provided in English, Spanish, Chinese Simplified, Chinese Traditional, Russian, Bengali, Urdu, and Haitian Creole. The website is available in several languages and includes our Member Newsletters.

The Plan collects member race and ethnicity data and applies it to design culturally appropriate educational and member communications programs, implement clinical and service quality improvement activities that address the unique needs of racial and ethnic subpopulations, assist members in provider selection or to “match” members with specific health professionals who can best meet their linguistic and cultural needs and thus enhance the quality of care and improve patient outcomes.

The Plan collects language data to support communication of important plan information including but not limited to health benefits, health services and health education materials. Additionally, MetroPlus uses language data to hire and match members to Plan resources such as case managers, peers and customer services staff ensuring a high level of service and understanding.

MetroPlus Health Plan’s Community offices are based in all five boroughs and offer community-based services to members. The Plan’s Community offices offer access to information and administrative services as well as health services and are offered by culturally diverse Plan employees.

The Plan provides training for clinical and non-clinical staff in cultural competency, disparities in healthcare, health literacy and other relevant topics.

MetroPlus Health Plan is in full compliance with the requirements under 45 CFR 92 that implements Section 1557 of the Affordable Care Act. Appropriate Plan publications and communications include a non-discrimination statement and taglines that are published in 15 languages other than English.

## **Monitoring and Evaluation**

### **Quality Improvement Activities and Performance Indicators**

MetroPlusHealth uses appropriate processes and methodology for conducting and evaluating quality improvement activities through appropriate study design that includes baseline measurement, root cause analysis, development and implementation of appropriate interventions and re-measurement to determine the effectiveness of the interventions, utilizing appropriate statistical analysis. Sampling methodology is developed, and the frequency of data collection is determined based on the scope of the project as needed. Studying aspects of care and service includes setting goals, comparing indicators to benchmarks and establishing thresholds for the outcome of required actions and tracking measures over time. Performance indicators are established and measured periodically to monitor multiple dimensions of performance. These indicators correlate directly to the scope of the program and are developed based on scientific evidence or are adopted from authoritative sources.

The methodology used to establish MetroPlus Health Plan's targets for 2023 are based on NCQA methodology that determines whether a measure has made a significant improvement over a three-year period and accounting for a 1-year timeframe goal setting strategy. The responsibility for monitoring and improving these rates has been assigned to the Quality Management Committee and its Subcommittee structure.

## **Data Sources**

The data sources used for quality improvement measurement, analysis of barriers and determining appropriate interventions include, but are not limited to, encounters, claims, utilization review, pharmacy, lab, enrollment, behavioral health, medical records, and appeals data. Additionally, provider and member complaints, case management and telephone data are also utilized. Other sources of data include HEDIS®/QARR data, national and regional epidemiological, demographic and census data about the New York population and practitioner, provider, and member surveys. Provider surveys include, but are not limited to provider satisfaction survey, GeoAccess studies and access and availability surveys. Member surveys include, but are not limited to, the following: CAHPS®, and Satisfaction with Care Management Services. Integrated data systems collect member, practitioner and provider information, utilization, population based and/or specific member profiling information and practitioner/provider specific information.

Software includes but is not limited to enrollment and claims systems, NCQA HEDIS® software, credentialing and recredentialing software, Microsoft products and episode based predictive modeling and care management software. In addition, MetroPlusHealth QM team members have remote access to provider electronic health record systems, including Quadramed and EPIC, the electronic medical record for members who receive care at New York City Health + Hospital (H+H) facilities as well as several high-volume providers servicing members outside of the H+H system.