

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

**PLAN - SPECIFIC REPORT
FOR
AmeriChoice by UnitedHealthcare, Inc.**

Reporting Year 2008

April 2010

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Acronyms Used in This Report

(in alphabetical order)

ACOG:	American College of Obstetrics and Gynecology	NRAO:	New Rochelle Area Office (Region 5)
ALOS:	Average Length of Stay	NV:	Not Valid
AO:	Area Office	NYC:	New York City
BAO:	Buffalo Area Office (Region 1)	NYCAO:	New York City Area Office (Region 6)
CHP:	Child Health Plus	NYCRR:	New York Code Rules and Regulations
CO:	Central Office	NYSDOH:	New York State Department of Health
COM (C):	Commercial		
DBA:	Doing Business As	OB/GYN:	Obstetrician/Gynecologist
DSS:	Data Submission System	OHIP:	Office of Health Insurance Programs
EQR:	External Quality Review	OPMC:	Office of Professional Medical Conduct
EQRO:	External Quality Review Organization	OP:	Optimal Practitioner Contact
F/A:	Failed Audit	PCP:	Primary Care Practitioner/Provider
FAR:	Final Audit Report	PIP:	Performance Improvement Project
FFS:	Fee For Service	PNDS:	Provider Network Data System
FHP:	Family Health Plus	POC:	Plan of Corrective Action
F/U:	Follow-Up	PMPY:	Per Member Per Year
FTE:	Full Time Equivalent	PSR:	Plan-Specific Report
HEDIS:	Health Effectiveness Data and Information Set	PTMY:	Per Thousand Member Years
HIE:	Health Information Exchange	PHSP:	Prepaid Health Services Plans
HIT:	Health Information Technology	Q1:	First Quarter (Jan. – March)
HMO:	Health Maintenance Organization	Q2:	Second Quarter (Apr. – June)
HPN:	Health Provider Network	Q3:	Third Quarter (July – Sept.)
LIAO:	Long Island Area Office (Region 7)	Q4:	Fourth Quarter (Oct. – Dec.)
MARO:	Metropolitan Area Regional Office	QARR:	Quality Assurance Reporting Requirements
MCO:	Managed Care Organization	R:	Rotated
MED (M):	Medicaid	RAO:	Rochester Area Office (Region 2)
MMC:	Medicaid Managed Care	RHIO:	Regional Health Information Organization
MMCOR:	Medicaid Managed Care Operating Report	ROS:	Rest of State
MI:	Mental Illness	RY:	Reporting Year
N:	Denominator	SAO:	Syracuse Area Office (Region 3)
N/A:	Not Available	SN:	Safety Net
NCQA:	National Committee for Quality Assurance	SOD:	Statement of Deficiency
NEAO:	Northeast Area Office (Region 4)	SS:	Small Sample (Less than 30)
NERO:	Northeast Regional Office	SSI:	Supplemental Security Income
NP:	Not Provided	SWA:	Statewide Average
NR:	Not Reported	TANF:	Temporary Aid to Needy Families
		UR:	Utilization Review

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Health Insurance Programs (OHIP) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans and to maintain the continuity of care to the public.

The Plan-Specific Reports (PSRs) are individualized reports on the managed care organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2008 External Quality Review (EQR) to evaluate access to, timeliness of and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per federal regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of plan-reported and NYSDOH-calculated performance measures and review for plan compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per federal regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS[®]) by an NCQA-certified vendor and technical assistance by the NYS EQRO to plans regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment and disenrollment data, provider network information, encounter data summaries, quality/satisfaction/compliance points and incentive, appeal summaries and financial ratios.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, Health Information Technology, Deficiencies and Appeals, and Financial Data. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the plans' Family Health Plus (FHP), Commercial and Child Health Plus (CHP) product lines. Additionally, when available and appropriate, the plans' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS[®]/QARR or CAHPS[®], comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section IX provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness and quality of services. For areas in which the plan has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has addressed effectively the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

In an effort to provide the most consistent presentation of this varied information, the PSR is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2008.

II. Corporate Profile

UnitedHealthcare of New York, Inc. (UnitedHC) is a regional, for-profit health maintenance organization (HMO) servicing Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP) populations. UnitedHC acquired AmeriChoice of New York, Inc. on January 1, 2008 and utilizes the DBA AmeriChoice by UnitedHealthcare (AmeriChoice). AmeriChoice services Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the FHP and CHP product lines.

- Plan ID: 1260187
- DOH Area Office: MARO
- Corporate Status: HMO
- Tax Status: For-profit
- Medicaid Managed Care Start Date: April 1, 1995
- Medicaid Service Area: Bronx, Herkimer, Kings, Nassau, New York, Oneida, Onondoga, Oswego, Queens, Richmond and Suffolk
- Product Line(s): Medicaid, FHP, and CHP
- Contact Information: 7 Hanover Square, 5th Floor
New York, NY 10004
(212) 898-8400
- NCQA Accreditation as of 6/30/09: Did not apply
- Medicaid Dental Benefit Provided as of 12/08: Provided for Bronx, Kings, Nassau, New York, Queens, Richmond and Suffolk counties.

III. Enrollment and Provider Network

Enrollment/Disenrollment

Figure 1 depicts total membership for the plan's Medicaid product line for calendar year 2008. Figure 1a represents the membership for other product lines carried by the plan.

Figure 1: Membership: Medicaid – 2008

	2008
Number of Members	163,622
% Change From Previous Year	

Data Source: MEDS II

Figure 1a: Membership: Other Product Lines¹ – 2008

	2008
FHP	46,927
CHP	14,501

¹ While the Medicaid membership data presented in Figure 1 are derived from MEDS II in order to ensure consistency with the MEDS II data presented in Figure 2, the enrollment data in Figure 1a are obtained from the NYSDOH's Managed Care Enrollment Report.

Figure 2 gives a breakdown of the plan's Medicaid membership by age and sex as of December 31, 2008. Children under 20 years of age comprise 56.5% of the total Medicaid enrollment, with 26.2% in the 5-14 age group. Thirty-one percent (30.9%) of the plan's Medicaid membership is women between the ages of 15-64 (women most likely to utilize OB/GYN services). The Figure also indicates whether the plan's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average. The plan's age distribution of enrollees is similar to the statewide distribution. Figure 2a displays the percentage of enrollees by age group for AmeriChoice in comparison to the statewide percentages.

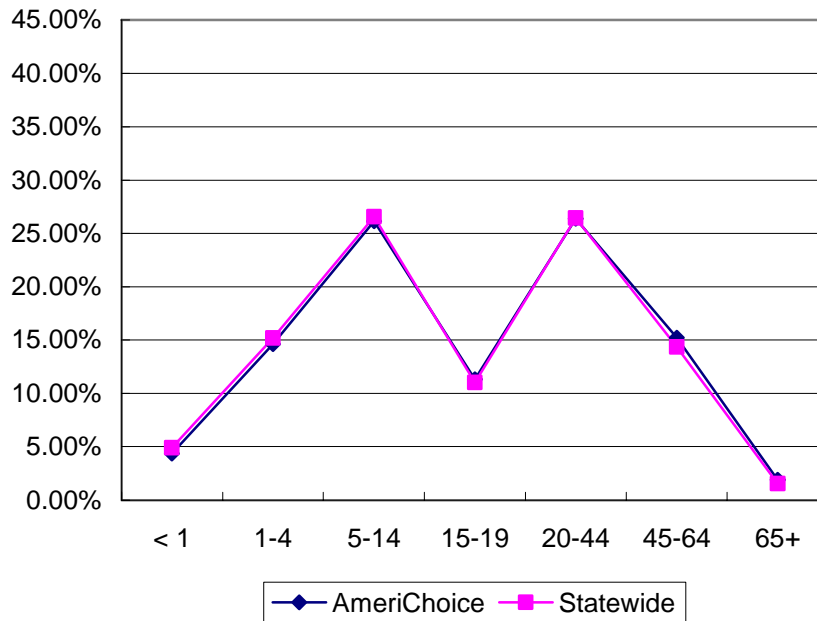
Figure 2: Medicaid Enrollee Age and Sex Distribution – December 2008

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 1	3,644	3,473	7,117	4.3%	4.9%
1-4	12,251	11,672	23,923	14.6%	15.2%
5-14	22,052	20,739	42,791	26.2%	26.6%
15-19	9,337	9,199	18,536	11.3%	11.0%
20-44	16,652	26,537	43,189	26.4%	26.4%
45-64	10,056	14,850	24,906	15.2%	14.3%
65 and Over	1,112	2,048	3,160	1.9%	1.5%
Total	75,104	88,518	163,622		
Summary					
Under 20	47,284	45,083	92,367	56.5%	57.7%
Females 15-64 ¹		50,586		30.9%	32.3%

Data source: MEDS II

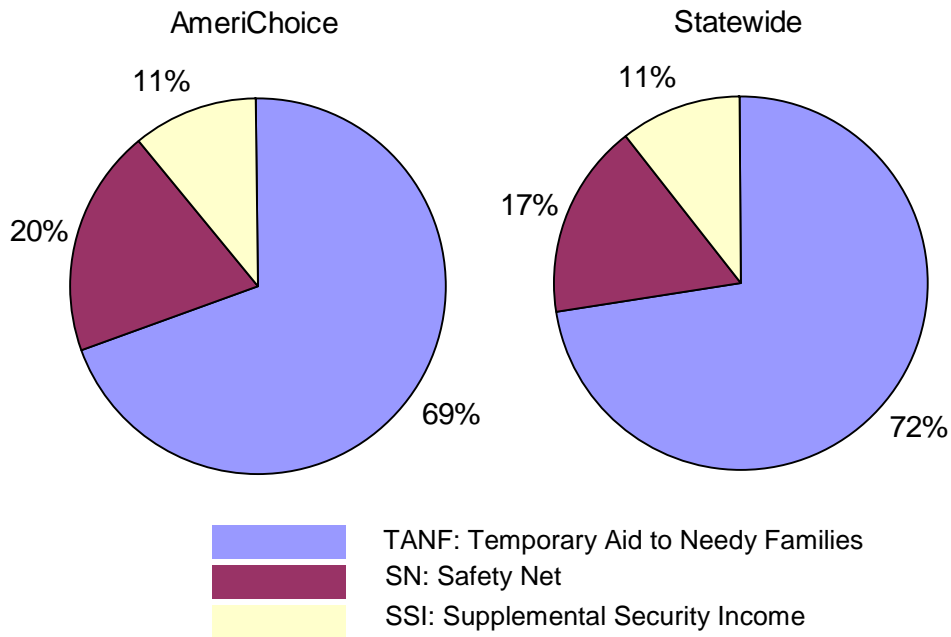
¹ Females between the ages of 15 to 64 were grouped for this category, since this grouping is inclusive of most women utilizing OB/GYN providers.

Figure 2a: Percentage of Medicaid Enrollees by Age – December 2008



A breakdown of plan membership by aid category, as reported by the NYSDOH for December 31, 2008, is shown in Figure 3. The distribution of the members in the three aid categories was similar to the statewide distribution.

Figure 3: Medicaid Enrollees by Aid Category – December 2008



The percentage of members by each method of enrollment in the plan's Medicaid product line for 2008 is presented in Figure 4. Whether a plan received a qualifying Medicaid auto assignment quality algorithm score is also available. These scores determine 75% of auto-assignee distribution. AmeriChoice received a score qualifying the plan for Medicaid auto assignment in 2008.

Figure 4: Method of Medicaid Enrollment – 2008

Category	2008	
	AmeriChoice	SWA
Auto Assigned	4.7%	13.3%
Self-Selected ¹	95.3%	86.7%
Qualifying Score ²	Y	

¹ These figures include new enrollees and enrollees who have transferred from another plan.

² Qualifying scores are based on the quality, satisfaction and compliance points that a plan achieves. For further information on how these scores are calculated, see Figure 16.

Figure 5 shows AmeriChoice's 2008 Medicaid and FHP disenrollment rates. Rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. For Medicaid and FHP, rates were similar to those of the average plan in the state.

Figure 5: Medicaid and FHP Disenrollment Rates (by percentage of enrollees) – 2008

Enrollment Status ¹	Medicaid		FHP	
	AmeriChoice	SWA	AmeriChoice	SWA
Voluntary Disenrollment	1.51%	1.56%	0.44%	0.63%
Involuntary Disenrollment	0.05%	0.05%	0.02%	0.02%
Loss of Eligibility	0.64%	0.81%	2.25%	2.94%
Still Enrolled	97.80%	97.57%	97.29%	96.41%

¹ These data are derived from aggregating monthly enrollment figures.

Provider Network

Figure 6 shows the percentages of various provider types in the plan for the fourth quarter of 2008 in comparison to the statewide rates. PCPs were 20.1% of all providers in AmeriChoice’s provider network, which was similar to the statewide percentage of 16.4%. All specialty types had a similar percentage of the plan’s provider network as seen statewide. For this figure, plan percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Figure 6: Medicaid Providers by Specialties – 2008 (Q4)

Specialty Type	Number	% of Total Panel	% Statewide
Primary Care Providers	6,602	20.1%	16.4%
<i>Pediatrics</i>	1,889	5.8%	4.7%
<i>Family Practice</i>	1,446	4.4%	3.5%
<i>Internal Medicine</i>	3,202	9.8%	7.4%
<i>Other PCPs</i>	65	0.2%	0.7%
OB/GYN Specialty ¹	1,416	4.3%	4.6%
Behavioral Health	4,698	14.3%	11.9%
Other Specialties	19,903	60.7%	65.7%
Non-PCP Nurse Practitioners	163	0.5%	1.5%
Dentistry ²	1,303		
Total (excluding dentists)	32,782		

Data Source: HPN

¹ Includes OB/GYN specialists, certified nurse midwives and OB/GYN nurse practitioners.

² Dental providers are not included in the provider distribution by specialty or total provider count, since not all plans provide a dental benefit.

Figure 6a displays the ratio of enrollees to providers as well as the number of Full Time Equivalents (FTEs) and the ratio of enrollees to FTEs. Statewide data are also included. For this figure, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Figure 6a: Ratio of Enrollees to Providers for Medicaid – 2008 (Q4)

Specialty Type	AmeriChoice			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median ¹ Ratio of Enrollees to Providers	Total Number of FTEs	Median ¹ Ratio of Enrollees to FTEs
Primary Care Providers	25:1	1,428.4	115:1	36:1	15,161.8	131:1
<i>Pediatrics (Under age 20)</i>	49:1			75:1		
OB/GYN (Females aged 15-64)	36:1			37:1		
Behavioral Health	35:1			45:1		

Data Source: Derived ratios calculated from MEDS II enrollment data and HPN provider data.

¹ The statewide median was used for this Figure as opposed to an average to control for substantial variability due to outliers.

The number of Medicaid PCPs with an “Open Panel” is presented in Figure 6b for the fourth quarter of 2008. Panels are considered “open” if a provider has less than 1,500 Medicaid members. For this figure, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Figure 6b: Medicaid PCPs with an Open Panel – 2008 (Q4)

	2008		
	AmeriChoice		Statewide
	Number	% of Panel	% of Panel
Providers with Open Panel	12,368	97.1%	97.0%

Data Source: HPN

Figure 7 displays the QARR 2008 *Board Certification* rates of providers in the plan's network in comparison to the statewide averages (SWAs). The Figure also indicates whether the plan's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average. The plan's 2008 Medicaid board certification rates were similar to the statewide averages for all provider types.

Figure 7: QARR Board Certification Rates – 2008

Provider Type	2008	
	AmeriChoice	SWA
Medicaid:		
Family Medicine	78%	82%
Internal Medicine	82%	82%
Pediatricians	84%	83%
OB/GYN	81%	76%
Geriatricians	73%	75%
Other Physician Specialists	78%	81%

NYSDOH Dental Access & Availability Survey – 2008

On behalf of the NYSDOH's Division of Managed Care, the NYS EQRO annually conducts Medicaid Managed Care Access & Availability Surveys to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements per the NYS Medicaid/FHP Managed Care Contract. The 2008 survey evaluated the availability of routine and urgent office hour appointments with dentists.

To conduct the survey, EQRO surveyors informed the dental office that they were conducting a survey on behalf of the New York State Department of Health. Using a hypothetical situation, the surveyor attempted to get appointments for both routine and urgent care. Surveyors requested the earliest possible appointment. For dental access and availability, the timeliness standard for routine and preventive office hour care appointments is within 28 days of the enrollee's request, and for urgent office hour dental care, appointments must be scheduled within 24 hours as clinically indicated.

Providers were randomly selected from plan 4th quarter 2008 and 1st quarter 2009 submissions to the NYSDOH's Provider Network Data System (PNDS). For the purposes of the study, plans and their provider networks were categorized into seven regions. Plans were surveyed from each of the regions in which they operate: Region 1 – Buffalo; Region 2 – Rochester; Region 3 – Syracuse; Region 4 – Northeastern; Region 5 – New Rochelle; Region 6 – New York City; and Region 7 – Long Island.

For call type categories in which compliance was below the 75% threshold, plans received a Statement Of Deficiency (SOD) issued by the NYSDOH and were required to develop a Plan Of Correction (POC). These POCs must be approved by the NYSDOH before implementation. Following an allowable time period for plans to execute their POCs, a resurvey will be conducted of the failed providers.

Figure 8 illustrates AmeriChoice's Dental Access & Availability results for 2008. AmeriChoice exceeded the 75% threshold for routine appointments in Region 6 and 7, but did not meet the threshold in Region 3. The plan met or exceeded the 75% threshold for urgent appointments in all regions surveyed.

Figure 8: Dental Access & Availability Survey – 2008

Region	Call Type	AmeriChoice	Region Average
3	Routine	72%	79%
	Urgent	75%	76%
6	Routine	92%	89%
	Urgent	90%	86%
7	Routine	90%	93%
	Urgent	84%	87%

IV. Utilization

This section of the report explores utilization of the health plan's services by examining encounter and health screening data, as well as QARR Use of Services rates.

Encounter Data

Figure 9 depicts selected Medicaid encounter data for 2008. The plan's rates for this period are also compared to the average plan rates. For this figure, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Figure 9: Medicaid/FHP Encounter Data – 2008

Encounters (PMPY)		
	2008	
	AmeriChoice	SWA
PCPs and OB/GYN	5.87 ▲	4.37
Specialty	1.41	1.81
Emergency Room	0.41	0.58
Inpatient Admissions	0.11	0.15
Dental – Medicaid	1.03 ▲	0.80
Dental – FHP	1.24	0.91

Data Source: MEDS II

PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a)(ii) of the Medicaid Managed Care and Family Health Plus Model Contract, plans must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone or by mail and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. Plans are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the plan was able to complete health screenings. Plan statewide rates for 2008 ranged from 13.5% to 61.5% for Medicaid and 9.9% to 60.1% for FHP. Figure 10 summarizes the percentage of Medicaid and FHP enrollees receiving health screenings within 30 days of enrollment for 2008, in addition to displaying the statewide average. For this figure, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼.

Figure 10: Health Screenings – 2008

	2008	
	AmeriChoice	SWA
Medicaid		
Enrollee Health Screenings	23.2%	27.5%
FHP		
Enrollee Health Screenings	11.9% ▼	26.9%

QARR Use of Services Measures

For this domain of measures, the QARR reports assess performance by indicating whether the plan's rates reached the 90th or 10th percentiles. Figure 11 lists the Use of Services rates for the selected plan product lines for 2008. The Figure indicates whether the plan's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of all rates for that measure (indicated by ▼).

Figure 11: QARR Use of Services – 2008

Measure	Medicaid/FHP		Child Health Plus	
	2008	SWA 2008	2008	SWA 2008
Outpatient Utilization (PTMY)				
Outpatient Visits	6,149.6 ▲	4,855.9	4,702.0	3,876.0
Outpatient ER Visits	300.8 ▼	507.5	241.2	262.3
Ambulatory/Surgery Encounters	77.6	97.7	32.8	35.8
Inpatient ALOS				
Medicine	3.8	3.9	2.5	2.9
Surgery	5.4	5.7	3.3 ▼	4.2
Maternity	2.7	2.8	SS	2.9
Total (Medicine, Surgery & Maternity)	3.7	3.8	2.7	3.2
Inpatient Utilization (PTMY)				
Medicine Cases	34.9	48.2	13.4	12.8
Surgery Cases	15.2	15.7	5.0	4.4
Maternity Cases	43.7	52.4	SS	1.9
Total Cases	81.5	100.6	19.3	18.4

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

SS: Sample size too small to report (less than 30 members) but included in the SWA.

V. Quality Indicators

To measure the quality of care provided by the plans, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports including HEDIS[®] 2009/QARR 2008 audit findings, as well as results of quality improvement studies, enrollee surveys and plan Performance Improvement Projects (PIPs).

Validation of Performance Measures Reported by Plans and Performance Measures Calculated by the NYSDOH

Performance measures are reported and validated using several methodologies. Plans submitted member and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, plans report a subset of HEDIS[®] measures to the NYSDOH annually, along with several NYS-specific measures. Plan-reported performance measures were validated as per HEDIS[®] 2009 Compliance Audit[™] specifications developed by the National Committee for Quality Assurance (NCQA). The results of each plan's HEDIS[®] 2009 Compliance Audit[™] are summarized in its Final Audit Report (FAR).

Summary of HEDIS[®] 2009 Information System Audit[™]

As part of the HEDIS[®] 2009 Compliance Audit[™], auditors assessed the plan's compliance with NCQA standards in the six designated information system categories, as follows:

1. Sound Coding Methods for Medical Data
2. Data Capture, Transfer and Entry – Medical Data
3. Data Capture, Transfer and Entry – Membership Data
4. Data Capture, Transfer and Entry – Practitioner Data
5. Data Integration Required to Meet the Demands of Accurate HEDIS[®] Reporting
6. Control Procedures that Support HEDIS[®] Reporting and Integrity

In addition, two HEDIS[®] related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS[®] Reporting Functions

The NYS EQRO provided technical assistance to plans throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new plans, 3) serving as a liaison between the plans and NCQA to clarify questions regarding measure specifications, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to plan questions regarding the submission of member- and provider-level data, as well as, general questions regarding the audit process.

The HEDIS[®] 2009 Final Audit Report (FAR) prepared for AmeriChoice indicates that the plan had no significant problems in any area related to reporting. The plan demonstrated compliance with all areas of the Information Systems Audit and all areas of measure determination required for successful HEDIS[®]/QARR reporting.

The plan used NCQA-certified software to produce HEDIS[®] measures. No issues were identified with the transfer or mapping of the data elements for reporting.

The plan passed Medical Record Review for the two measures validated. All rates were reportable for both the Child Health Plus and Medicaid product lines.

**Quality Performance Matrix Analysis 2008 Measurement Year
(Effectiveness of Care Measures)**

Figure 12 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. This year's matrix includes fourteen measures for the Commercial product line, twelve for Medicaid and two that apply to Child Health Plus. The matrix diagrams the plan's performance in relation to its previous year's quality rates and also compares its rates to the SWA.

With the issuance of the 2008 measurement year (MY) matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY matrix, MCOs are now required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO has more than three measures reported in the F category, the MCO must submit root cause analyses and plans of action on all measures reported in the F category. If an MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the F and D categories, the MCO is not required to follow-up.

Figure 12: Quality Performance Matrix – 2008 Measurement Year

		Statewide Statistical Significance		
Trend		Below Average	Average	Above Average
No Change	↑	C Ambulatory F/U Mental Health 30 days (M)	B	A
		D Chlamydia Screening 16-24 (M)	C Antidepressant Meds 180 days (M) Cervical Cancer Screening (M) COPD Bronchodilator (M) COPD Corticosteroid(M) Drug Therapy Rheumatoid Arthritis (M) Follow-Up for ADHD 30 days (CHP)	B Antidepressant Meds 84 days (M) Avoid Antibiotic Adult Bronchitis (M) Spirometry Testing COPD (M)
	↓	F Follow-Up for ADHD 30 days (M) Follow-Up for ADHD 9 months (M)	D	C

M: Medicaid and Family Health Plus
 CHP: Child Health Plus

Figure 12a displays the 2008 performance rates, as well as the SWAs. The Figure indicates whether the plan's rate was statistically better than the SWA (indicated by ▲) or whether the plan's rate was statistically worse than the SWA (indicated by ▼). Figure 12b illustrates selected 2008 measures for the Medicaid product line in comparison to the SWAs.

Figure 12a: QARR Plan Performance Rates – 2008

Measure	Medicaid/Family Health Plus		Child Health Plus	
	2008	2008 SWA	2008	2008 SWA
Ambulatory F/U Mental Health 30 days	73.57 ▼	78.35	NA	NA
Antidepressant Meds 180 days	35.05	31.67	NA	NA
Antidepressant Meds 84 days	53.33 ▲	48.51	NA	NA
Avoid Antibiotic Adult Bronchitis	33.62 ▲	24.7	NA	NA
Cervical Cancer Screening	70.4	73.44	NA	NA
Chlamydia Screening 16-24	54.14 ▼	58.87	NA	NA
COPD Bronchodilator	82.68	83.79	NA	NA
COPD Corticosteroid	63.78	64.67	NA	NA
Drug Therapy Rheumatoid Arthritis	68.18	73.49	NA	NA
F/U for ADHD 30 days	49.2 ▼	54.42	58.82	48.3
F/U for ADHD 9 months	49.07 ▼	60.68	SS	54.08
Flu Shots Adults**	NA	NA	NA	NA
Persistent Use Beta Blocker (C)	NA	NA	NA	NA
Spirometry Testing COPD	51.83 ▲	41.57	NA	NA

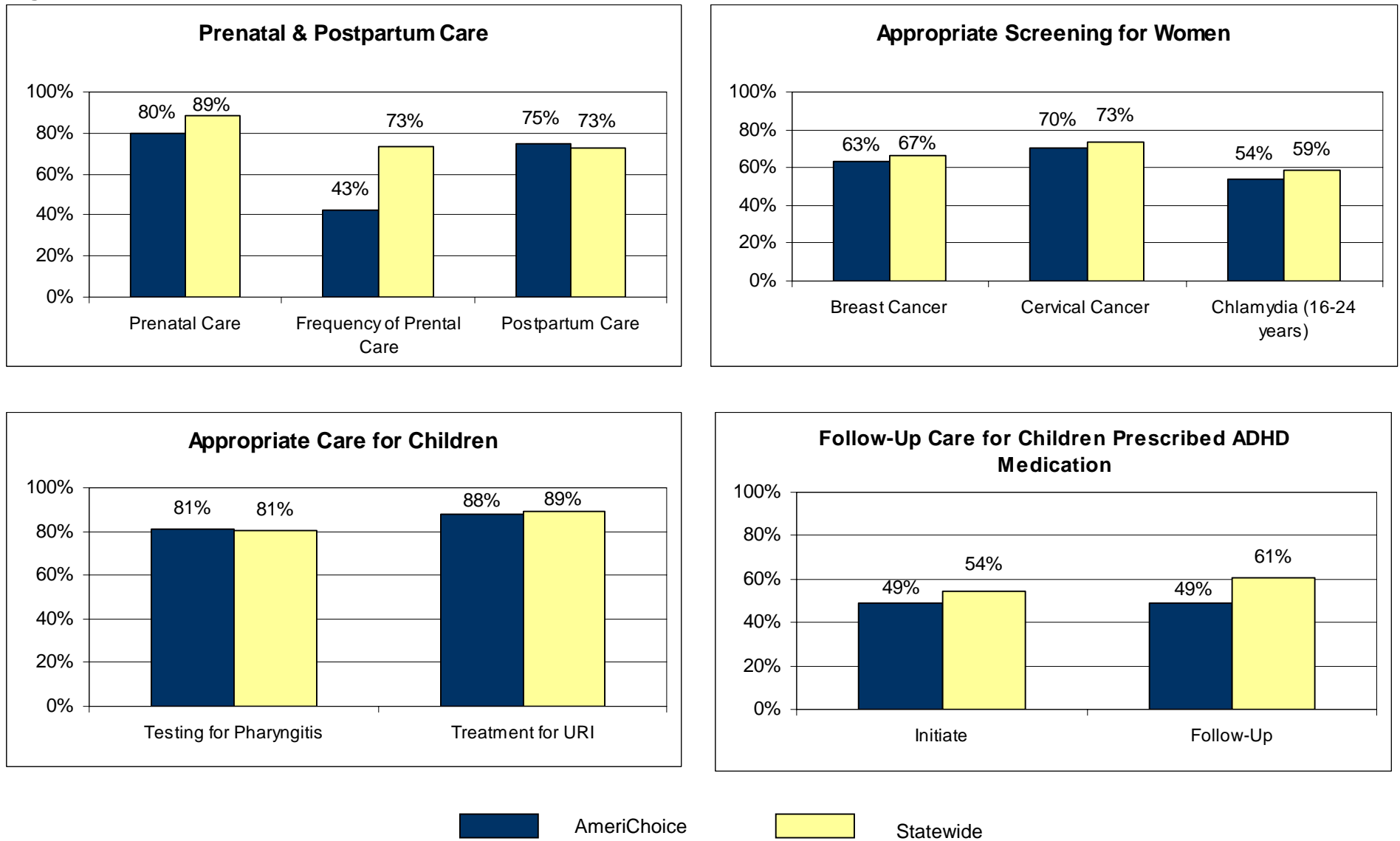
NA: Not available

SS: Sample size too small to report (less than 30 members) but included in the SWA.

** Flu Shots Adults: Medicaid rate not reported in this table, however, it is available in Table 15: CAHPS 2008.

(C) Measure reported for Commercial product lines only.

Figure 12b: QARR Medicaid/FHP Rates for Selected Measures – 2008



QARR Access to/Availability of Care Measures

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care and dental services for selected product lines. Figure 13 displays the Access to/Availability of Care measures for QARR 2008. The Figure indicates whether the plan's rate was higher than 90% of all plans for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of plans for that measure (indicated by ▼).

Figure 13: QARR Access to/Availability of Care Measures – 2008

Measure	Medicaid/FHP		Child Health Plus	
	2008	SWA 2008	2008	SWA 2008
Children and Adolescents' Access to PCPs (CAP)				
12–24 months	96%	95%	99%	99%
25 months–6 years	94% ▲	91%	98%	95%
7–11 years	95%	94%	99% ▲	97%
12–19 years	91%	90%	97% ▲	94%
Adults' Access to Preventive/Ambulatory Services (AAP)				
20–44 years	84%	81%		
45–64 years	90%	88%		
65+ years	89%	88%		
Access to Other Services				
Timeliness of Prenatal Care	80% ▼	89%		
Postpartum Care	75%	73%		
Annual Dental Visits	49% ▲	48%	55% ▼	60%

QARR Prenatal Care Measures Calculated by the NYSDOH

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the plans as well as from NYSDOH's Vital Statistics Birth File. Since some health events such as low birth weight births and cesarean deliveries do not occur randomly across all plans, risk adjustment is used to remove or reduce the effects of confounding factors that may influence a plan's rate. Figure 14 presents prenatal care rates calculated by the NYSDOH for QARR 2007. This Figure indicates whether the plan's rate was significantly better than the average (indicated by ▲) or whether the plan's rate was significantly worse than the average (indicated by ▼).

Figure 14: QARR Prenatal Care Measures Calculated by the NYSDOH – 2007

Measure	2007			
	NYC		ROS	
	AmeriChoice	NYC Average	AmeriChoice	ROS Average
Medicaid/FHP				
Risk-Adjusted Low Birth Weight*	7%	7%	5%	7%
Prenatal Care in the First Trimester	78% ▲	72%	70%	68%
% of Low Birth Weights at Facilities for High-Risk Deliveries	97%	99%	91%	81%

*A low rate is desirable for this measure.

ROS: Rest of State
 NYC: New York City

Consumer Satisfaction

In 2008, the CAHPS[®] survey of adult Medicaid managed care plan enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Each selected category is compared to the respective SWA. Plans with a Commercial product line also collected these data from their Commercial members, using an NCQA-certified survey vendor. Figure 15 gives the question category, the plan's rate and the SWA for selected product lines for measurement year 2008. The Figure indicates whether the plan's rate was significantly better than the SWA (indicated by ▲) or whether the plan's rate was significantly worse than the SWA (indicated by ▼).

Figure 15: CAHPS[®] – 2008

Satisfaction	Medicaid	
	AmeriChoice	SWA
Flu Shots for Adults Ages 50-64	42	43
Advising Smokers to Quit	71	74
Getting Care Needed ¹	69 ▼	75
Satisfaction with Provider Communication ¹	86	88
Care Coordination	72	74
Customer Service ¹	74	80
Rating of Healthcare	56 ▼	65
Rating of Health Plan – High Users	57 ▼	67
Getting Care Quickly ¹	79	78
Overall Rating of Health Plan	55 ▼	66
Rating of Personal Doctor	69 ▼	74
Rating of Specialist	64	71
Recommend Plan to Family/Friends	87	90

¹ These indicators are composite measures.

Quality/Satisfaction/Compliance Points and Incentive

The percentage of the potential financial incentive that a plan receives is based on quality of care, consumer satisfaction and compliance. Points earned are derived from an algorithm that considers QARR 2008 rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores conducted in spring 2008, and compliance information from 2007 and 2008. The total score, based out of 150 possible points, determines what percent of the 3% available premium increase the plan qualifies for. For 2008, there were three levels of incentive awards that could be achieved by plans based on the results (3%, 2% or 1% per member per month premium increase). Figure 16 displays the points AmeriChoice earned in 2008 as well as the percent of the financial incentive that these points generated based on the previous measurement year’s data. Figure 16a displays the measures that were used to calculate the 2008 incentive, as well as the points AmeriChoice earned for each measure.

Figure 16: Quality/Satisfaction/Compliance Points and Incentive – 2008

Category	2008	
	AmeriChoice	SWA
Total Points	86.5	88
<i>Satisfaction Points (30 Possible Points)</i>	5	17
<i>Quality Points (100 Possible Points)</i>	64	54
<i>Compliance Points (20 Possible Points)</i>	17.5	18
Percent of Financial Incentive Earned	33%	

Figure 16a: Quality/Satisfaction/Compliance Measures and Points – 2008

Measure	AmeriChoice
Satisfaction (10 points each)	5
Getting Care Needed (CAHPS®)	0
Customer Service and Information (CAHPS®)	5
Rating of Health Plan (CAHPS®)	0
Quality (10 points each)	64
Advising Smokers to Quit (CAHPS®)	0
Follow-Up After Hospitalization for Mental Illness – 7 Days (HEDIS®/QARR)	0
Use of Appropriate Medications for People with Asthma –3 or more controller dispensing events (QARR)	7
Annual Dental Visit Ages 2-18 (HEDIS®/QARR)	7
Frequency of Ongoing Prenatal Care – 81% or more of required visits (HEDIS®/QARR)	0
Controlling High Blood Pressure (HEDIS®/QARR)	10
Breast Cancer Screening (HEDIS®/QARR)	10
Annual Monitoring for Patients on Persistent Medications (HEDIS®/QARR)	10
Appropriate Testing for Children with Pharyngitis (HEDIS®/QARR)	10
Postpartum Care (HEDIS®/QARR)	10
Compliance (5 points each)	17.5
Timeliness and Accuracy of MMCOR	5
Timeliness and Accuracy of MEDS Data	5
Timeliness of QARR Submission	5
Provider Directory Information and Participation	2.5
Total Points Earned	86.5

MMCOR: Medicaid Managed Care Operating Report

Performance Improvement Project

Each plan is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating plan and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, plans and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to plans throughout the PIP process in the following forms: 1) review of the plan's Project Proposal prior to the start of the PIP, 2) quarterly teleconferences with the plan for progress updates and problem-solving, 3) feedback on methodology, data collection tools and implementation of interventions, and 4) feedback on drafts of the plan's final report.

In addition, the NYS EQRO validated the plan's PIP by reviewing the project topic, aim statement, performance indicators, study population, sampling methods (if sampling was used), data collection procedures, data analysis and interpretation of project results, as well as assessing the plan's improvement strategies, the likelihood that the reported improvement is "real" improvement and whether the plan is likely to be able to sustain its documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

The topic of the 2007-2008 PIP conducted by Americhoice was "Improving Care for Members with ADHD". The following interventions were implemented during the conduct of this PIP:

- Dissemination of guidelines to participating providers.
- Dissemination of standardized tools to participating providers, e.g., Vanderbilt.
- Engage providers in using standardized tools for treatment and follow-up.
- Provision of an ADHD care-manager at the plan to provide support to the family and participating providers.
- Provision of plan-sponsored education for participating providers by the REACH institute.
- Provision of educational materials, listings of mental health providers, informational handouts and websites to participating providers.
- Facilitation of participating providers' access to telephonic psychiatric consultation through the United Behavioral Health Psychiatric Information line.
- Outreach to other providers in the plan's network and provision of academic detailing to these practices.

Figure 17 presents a summary of Americhoice's 2008 PIP. Improvement was demonstrated in several but not all areas.

Key strengths of this PIP include a straightforward study design, use of multifaceted interventions, partnering with provider practices and outreaching to other practices, and a comprehensive set of indicators ranging beyond the HEDIS® indicator. There were no validation findings which indicate that the credibility of the PIP results is at risk.

Figure 17: Performance Improvement Project – 2007-2008

Indicators	Results
Percents of new and existing patients with documented assessment tools, treatment plans, care coordination and meeting DSM-IV criteria and types of treatment modalities	Demonstrated statistical improvement in several but not all areas. Lack of statistical significance was likely due to the small study populations.

Clinical Studies

There were no statewide NYSDOH-sponsored clinical studies concluded in 2008. The NYS EQRO clinical study on Clinical Risk Groups/Case Management was still in progress. Therefore, no plan data are available to report in this edition of the Plan-Specific Reports.

Health Disparities

For this year's technical report, the NYSDOH EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

1. Characterization, identification or analysis of the Plan's Medicaid population according to at-risk characteristics
2. Identification of differences in health outcomes or health status that represent measurable gaps between the Plan's Medicaid population and other types of health care consumers
3. Identification of gaps in quality of care for the Plan's Medicaid members and/or Medicaid subgroups
4. Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations
5. Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for plan members with at-risk characteristics

AmeriChoice reported that no activities were performed in 2008 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.

VI. Health Information Technology

According to the US Department of Health & Human Services, health information technology (HIT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT will improve health care quality, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork and expand access to affordable care.

In 2009, the NYSDOH EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

1. Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
2. Use of telecommunications technologies
3. Use of electronic Disease and/or Case Management Systems
4. Use of electronic internal registries
5. Use of clinical risk group (CRG) or similar software
6. Secure electronic transfer of member data between the Plan, its vendors and network providers
7. Electronic communication with providers
8. Electronic communication with members
9. Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)¹
10. Participation in State, Federal or privately funded HIT initiatives
11. Participation in a medical home pilot or program
12. Future plans to implement HIT

Figure 18 displays the statewide results of the HIT survey. The most utilized forms of HIT include secure electronic transfer of member data, use of electronic Disease and/or Case Management systems, and electronic communication with providers. Seventy-four percent (74%) of MCOs reported having future HIT initiatives planned.

¹ Regional Health Information Organizations/Health Information Exchanges are organizations that exist to enable interoperable health information exchange through governance and collaboration with an overall mission to improve health care quality and safety, and reduce costs.

Figure 18: MCO Use of Health Information Technology – 2009 Survey of NYS MCOs

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Use of electronic Disease and/or Case Management Systems	95%
Electronic communication with providers	95%
Secure electronic transfer of protected health information to patients and/or providers	84%
Future plans to implement HIT	74%
Use of telecommunications technologies	68%
Use of clinical risk group (CRG) or similar software	68%
Participation in State, Federal or privately funded HIT initiatives	58%
Use of electronic internal registries	53%
Electronic communication with members	53%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	53%
Participation in a medical home pilot or program	47%

AmeriChoice has indicated that it does not have any future plans to implement HIT; however, it performs the following HIT related activities:

- Electronic transfer/data sharing of protected information:
 - Member data is shared electronically with vendors and/or network providers via secure email, fax and file transfer protocol (FTP).
- Use of telecommunications technologies:
 - Case managers conduct administrative activities and discuss patient care and health education with members and providers via the telephone.
- Use of electronic disease and/or case management systems:
 - Care Planner and Care One are utilized as the disease and case management systems.
- Use of clinical risk group software or similar software:
 - Impact Pro is utilized to determine risk scores for case management activities.
 - Care Planner produces individual member utilization reports.
- Electronic communication with members and/or providers:
 - Electronic communication with vendors and/or network providers is conducted via secure email, fax and file transfer protocol (FTP).
 - Electronic communication with members is conducted via secure email.
- HIT related projects/collaborations:
 - AmeriChoice currently participates in the New York City Department of Health & Mental Hygiene’s (NYC DOHMH) Primary Care Information Project (PCIP).

VII. Deficiencies and Appeals

This section of the report examines deficiencies identified by the NYSDOH in operational and focused surveys as well as external appeals as part of the EQRO's evaluation of the plan's compliance with State structure and operation standards.

Compliance with NYS Structure and Operation Standards

To assess the compliance of a health plan with Article 44 of the Public Health Law and part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the plan's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories in Figure 20. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the plan is not in compliance.

The full monitoring review consists of two on-site components: a medical record review and a general operational survey. The on-site component includes review of the following: executed contracts and credentialing files of randomly selected providers; adverse determination utilization review files; complaints and grievances files; meeting minutes and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys." The NYSDOH retains the option to deem compliance with standards for credentialing/recredentialing, quality assurance/improvement and medical record review.

The monitoring review report documents any data obtained and deficiencies cited in the survey tools. Any statements of deficiencies (SODs) are submitted to the plan after the monitoring review and the plan is required to respond with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and plans are required to resubmit. Ultimately, all plans with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the plan to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in Figure 19. Plans are also required to submit POCs in response to deficiencies identified in any of these reviews.

Figure 20 reflects the total number of citations for the most current operational survey of the plan, which ended in 2008, as well as from the focused reviews conducted in 2008. This figure reflects the findings from reviews of the plan as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can have multiple citations.

AmeriChoice was in compliance with 8 of 14 categories. The categories in which AmeriChoice was not in compliance were Complaints and Grievances (2 citations), Disclosure (2 citations), Member Services (1 citation), Organization and Management (2 citations), Service Delivery Network (3 citations) and Utilization Review (3 citations).

Figure 19: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability, for routine and urgent visits; re-audits are performed when results are below 75%. See Figure 8 for a more detailed description.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HPN Networks to ensure providers that have been identified as having their license revoked or surrendered or otherwise sanctioned, are not listed as participating with the MCO.
MEDS (Medicaid Encounter Data Set)	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider Directories are reviewed to ensure that they contain the required information.
Provider Info-Web	Review of MCO's web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HPN network submissions for adequacy, accessibility and correct listing of primary, specialty and ancillary providers for enrolled population.
Provider Participation – Directory (In addition to the routine Provider Participation – Directory surveys, in 2008 there was a survey specific to dental)	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR (Quality Assurance Reporting Requirements)	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCP with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent sick and urgent appointments.

AO: Area Office
 HPN: Health Provider Network
 SOD: Statement of Deficiency

Figure 20: Summary of Citations

Category	Review Type/Name (a indicates focused review)		Citations
Complaints and Grievances			2
<i>a. In 3 cases, the Plan failed to meet the required 30-day timeframe to make a grievance determination.</i>		Operational	
<i>b. Plan failed to provide a detailed reason for its determination(s) and/or to make a determination in a grievance procedure case. [Repeat Deficiency]</i>		Operational	
Credentialing			0
Disclosure			2
<i>c. Plan failed to send a member handbook as requested; a provider directory was sent instead. The same request made in the previous quarter was also not honored as the Plan failed to send the handbook.</i>	a	Member Services Phone Calls	
<i>d. A 12/2/08 written request for clinical review criteria to determine if coverage would be provided for an insulin pump was not honored. Plan failed to send any information concerning this request as of 1/8/09. This is the second consecutive quarter that the Plan failed to forward the requested information.</i>	a	Member Services Phone Calls	
Family Planning			0
HIV			0
Management Information Systems			0
Medicaid Contract			0
Medical Records			0
Member Services			1
<i>e. The governing authority failed to ensure that its web-based provider directory contained information that was of an accurate nature; 15 out of 50 providers sampled from the directory were inaccurate in content. In addition, the Plan failed to update the provider directory in a timely manner, not publishing the quarterly update until April 2008.</i>	a	Provider Directory Part - Dental	
Organization and Management			2
<i>f. Plan failed to correct the signature block of the IPA/provider contract with Mary Immaculate Hospital as of 9/08.</i>		Operational	
<i>g. Plan failed to provide the Department with written notification of Southampton Hospital's termination with the Plan within the 45-day regulatory timeframe.</i>	a	Other – Hospital Terminations	
Prenatal Care			0
Quality Assurance			0
Service Delivery Network			3
<i>h. See f., above. (2 citations)</i>		Operational	
<i>i. The governing authority failed to ensure that its printed provider directory contained information that was of an accurate nature; 27 out of 50 providers in the MCD/FHP sample and 23 out of 50 providers in the CHP sample were inaccurate in content. An additional 37 out of 50 providers were incorrectly listed as participating providers. In the web-based directory, 7 out of 9 providers were incorrectly listed as participating providers.</i>	a	Provider Participation - Directory	
Utilization Review			3
<i>j. Plan could not provide documentation that it gave required verbal notice of an adverse determination to the enrollee and health care provider within 3 business days of receipt.</i>	a	Complaints	

Category	Review Type/Name (a indicates focused review)		Citations
<i>k. Plan did not give a provider appropriate instructions on how to request an appeal or how to request a reconsideration of an adverse UR determination.</i>	a	Complaints	
<i>l. Plan did not provide the clinical rationale or the availability, upon request, of the clinical review criteria relied upon to make an adverse UR determination.</i>	a	Complaints	
Total			13

External Appeals Summary Report

Figure 21 displays external appeals for 2008 for the Medicaid product line. This Figure reflects absolute numbers, and is not weighted by plan enrollment.

Figure 21: External Appeals – 2008

	2008
Medicaid	
Overtured	5
Overtured in Part	1
Upheld	7
Total	13

VIII. Financial Data

The financial summary is based on data reported in the plan's 2008 Medicaid Managed Care Operating Report (MMCOR). The data contained in the MMCOR reflect the plan's Medicaid line of business only. The data are not audited and are reported on an accrual basis; thus total expenses are impacted by a plan's estimate of services that have been incurred by plan members but have not been billed to the plan. The following is a list of the ratios displayed in Figure 22 and their definitions.

- *Assets to Net Worth:* Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has \$3 of assets for every \$1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
- *Premium Surplus Ratio:* Indicates what percentage of premium dollars goes towards surplus. This ratio is calculated by dividing premium income by total premium revenue. It indicates whether a plan is generating sufficient revenue from its premiums to cover medical and administrative expenses.
- *Medical Loss Ratio:* Indicates what percentage of premium dollars is spent on medical costs. This ratio is calculated by dividing total medical costs by total premium revenue.
- *Administrative Ratio:* Indicates what percentage of premium dollars is spent on administrative costs. This ratio is calculated by dividing total administrative costs by total premium revenue.
- *Current Ratio:* Reflects to what degree current assets cover current liabilities. The formula is current assets divided by current liabilities.

Figure 22: Selected Financial Ratios – 2008

	2008	
	AmeriChoice	SWA
PROFITABILITY		
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	1.7	2.2
Premium Surplus Ratio = Premium Income/Premium Revenue	2.6%	-0.7%
Medical Loss Ratio = Medical Exp/Prem Revenue	86.8%	88.9%
Administrative Ratio = Admin Exp/Prem Revenue	10.6%	11.8%
LIQUIDITY		
Current Ratio = Current Assets/Current Liabilities	0.7	1.2

IX. Strengths and Opportunities for Improvement¹

This section summarizes the accessibility, timeliness, and quality of services provided by AmeriChoice to Medicaid recipients based on data presented in the previous sections of this report. The plan's strengths in each of these areas are noted, as well as, opportunities for improvement. Recommendations for enhancing the quality of healthcare are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the plan was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths

- The 2009 HEDIS[®] Audit revealed no significant problems, and the plan was able to report all rates for HEDIS[®] and QARR.
- The plan received quality, satisfaction and compliance scores that qualified it for 33% of the financial incentive, as well as for the auto-assignment of new members.
- The plan performed well in regard to dental care. The plan's HEDIS[®]/QARR *Annual Dental Visit* rate exceeded the statewide average. In addition, in regard to the EQRO 2008 Dental Access & Availability Survey, the plan exceeded the 75% threshold for routine appointments in two of three regions surveyed, while meeting or exceeding the threshold for urgent appointments in all three regions.
- The plan performed better than the statewide average on the HEDIS[®]/QARR *Antidepressant Medication Management –84 Days, Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measures.
- The plan's Performance Improvement Project (PIP) "Improving Care for Members with ADHD" included a comprehensive set of indicators and multifaceted interventions. The final results of the PIP demonstrated statistical improvement in some areas.

Opportunities for Improvement

- The plan demonstrates an opportunity for improvement on several HEDIS[®]/QARR measures as indicated by below average performance on the *Follow-Up After Hospitalization for Mental Illness –30 Days, Chlamydia Screening in Women, and Follow-Up Care for Children Prescribed ADHD Medication –30 Days and –9 Months* measures. (Note: behavioral health, and specifically the HEDIS[®]/QARR *Follow-Up After Hospitalization for Mental Illness –30 Days* measure were opportunities for improvement in the previous year's report.)
- Despite exceeding the NYC average for prenatal care in the first trimester, the plan demonstrates an opportunity for improvement in regard to the HEDIS[®]/QARR *Timeliness of Prenatal Care* as indicated by below average performance. It is noted that the most recent data for the prenatal care in the first trimester measure is for 2007, while data for the HEDIS[®]/QARR measure is for 2008.
- The plan demonstrates a significant opportunity for improvement in regard to member satisfaction. The plan reported below average rates on the following CAHPS[®] measures: *Getting Care Needed, Rating of Health Care, Rating of Health Plan – High Users, Overall Rating of Health Plan* and *Rating of Personal Doctor*. (Notes: CAHPS[®] scores reported in this version of the Plan-Specific Report were also reported in last year's Plan-Specific Report. Also, member satisfaction was an opportunity for improvement in the previous year's report.)

¹ This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement" rather than "Strengths" and "Weaknesses" as indicated in federal regulations.

- In regard to the EQRO 2009 Health Disparities Survey, the plan indicated that no activities were conducted to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.
- In regard to compliance with NYS structure and operation standards, the plan received a total of 13 citations, including five Article 44 Review citations in the categories of Complaints & Grievances, Organization & Management and Service Delivery Network; and eight focused review citations related to Member Services Phone Calls, Provider Directory Part –Dental, Other-Hospital Terminations, Provider Participation –Directory and Complaints in the following categories: Disclosure, Member Services, Organization & Management, Service Delivery Network and Utilization Review.

Recommendations

- To ensure that the plan continues to receive a percentage of the available financial incentive and qualifies for the auto-assignment of members in the future, the plan should continue its efforts to improve member satisfaction. *[Repeat recommendation.]*
- In addition, the plan should investigate HEDIS®/QARR Effectiveness of Care measures that perform below the statewide average as these measures tie into the State's formula for calculating the qualifying score. Specifically, the plan should continue to work with its behavioral health vendor to improve HEDIS®/QARR behavioral health related measures, as well as evaluate the effectiveness of the interventions implemented to address this area as described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- With regard to care for children with ADHD, the plan should also continue the interventions conducted in the Performance Improvement Project.
- The plan should allocate resources towards identifying disparities in care and/or health outcomes within its Medicaid population, and implement initiatives to address the identified gaps in order to ensure that its members can access needed care.
- The plan should continue to work to address the problems noted in the operational and focused reviews, possibly by devoting more staff to implementing corrective actions. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

- **2007 Recommendation:** The plan should continue to work to address the problems noted in the focused reviews, with specific attention to ER focused review findings, by evaluating and expanding upon the interventions described in the response to the previous year's recommendation. *[Repeat recommendation.]*

Plan Response: AmeriChoice by UnitedHealthcare addressed the problems in 2007-2008 related to the ER focus survey with a full action plan. Problems addressed were:

- Quality Assurance Governance
- Inpatient Case Management Process
- Clinical Peer Review Standards
- Utilization Management Program
- Complaints, Grievance and Appeal Process
- HEDIS®/QARR Program
- Provider Directory
- Access and Availability

The plan has a comprehensive quality committee structure, which monitors all interventions implemented, and reports these to Compliance and subsequently to the Board of Directors with associated corrective action plans.

The staffing issue previously identified has stabilized with the hiring of eight HEDIS®/QARR nurses to fully focus on reaching our quality goals. The current program is a fulltime year round process focusing on all quality measures, compliant and non-compliant members along with physician education. In addition, there are seven outreach team coordinators working with our non-complaint members assisting them in obtaining appointments for their care. Our outreach team also works with our members prenatal and postpartum. The plan is working closely with our providers for accurate and timely data captured on the frequency of prenatal visits and postpartum care. The plan identified a large portion of the pregnant population traveling to upstate NY in the summer and established a prenatal/postpartum location for continuity of care.

The plan has partnered with the NYSDOH in implementing a low literacy prenatal care education program, which will integrate health literacy concepts into our existing prenatal program through training on health literacy and cultural competency for all clinical and clerical staff at one of our network provider groups located in Nassau County.

The plan will be underwriting the Baby Basics Health Education training and program for the Nassau County DOH. This training, programming and technical assistance will be open to all of the perinatal consortium partners educators/case managers/home visitors. Monitoring of the program will be conducted by measuring the impact on patient satisfaction and improving the number of prenatal visits and returns for postpartum care.

- **2007 Recommendation:** The plan should focus on improving member satisfaction. This is a particularly important area for the plan because a significant number of CAHPS® measures were below the statewide average, and because satisfaction scores are considered in the State's formula for qualifying the plan for auto-assignment of new members and for a financial incentive.

Plan Response: The plan continues to focus on member satisfaction. The plan conducts self-satisfaction surveys quarterly in the different parts of the State of New York. The plan is monitoring and evaluating the answers for patterns and changes if any the plan could accommodate.

The plan has improved our access and availability survey follow-up, where providers are requested to submit a plan of correction by the Physician Advisory Committee if the office fails the survey two times. The plan also has a program where physician offices are visited by Medical Directors, the Director of Business Solutions and the Provider Relations team. Quality and member satisfaction is foremost on their agenda.

- **2007 Recommendation:** The plan should investigate its provider network to determine the cause for below average rates for the HEDIS®/QARR *Board Certification* measure and ensure that members have adequate access to providers, since the ratio of enrollees to providers is higher than the statewide median.

Plan Response: The plan has a vigorous action plan and team in place to insure the plan can accurately describe and account for our provider directory. Many issues have been identified and corrected and the plan continuously reviews and monitors our HPN for deficiencies.

- **2007 Recommendation:** The plan should continue to work with its behavioral health vendor to monitor its behavioral network and to improve related measures. [*Repeat recommendation.*]

Plan Response: The plan holds monthly Joint Operating Committee meetings with our behavioral health vendor to improve the quality measures and monitor their network. The vendor has implemented a program, Bridge on Discharge with some of their contracted

hospitals whereby the member is seen upon discharge from the facility. Another program with the Visiting Nurse Service has been instituted whereby mental health professionals meet the patient in the hospital and conduct the follow-up appointment upon discharge. The plan submits our 7-day and 30-day mental health follow-up rates monthly to the NYSDOH.

- **2007 Recommendation:** The plan should monitor HEDIS[®]/QARR rates that perform below average rates, specifically in regard to child and adolescent care, and behavioral health.

Plan Response: As described above our HEDIS[®]/QARR program has eight nurses focused on meeting and exceeding the statewide average quality goals. The current program is a full-time year round process focusing on all quality measures, compliant and non-compliant members and physician education. The HEDIS[®]/QARR nurses are out in provider offices working with them on non-compliance and correcting specific HEDIS[®]/QARR coding issues. The plan is also working with the IT department to ensure correct lab and claim/encounter data correctly.

- **2007 Recommendation:** The plan should continue with its various quality improvement activities as described in the plan's response to the previous year's recommendations.

Plan Response: The plan continues to work on quality improvement activities. The plan is involved in domestic violence, childhood obesity and ADHD programs, as well as, continuous quality improvement programs associated with HEDIS[®]/QARR measures.

The plan was very successful with our programs in 2008 with an award of a quality incentive bonus and auto-enrollment. This has not interrupted our mission to ensure our members are receiving the best of care available.

X. Appendix

References

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- NYSDOH OMC DataLink Reports
 - Managed Care Plan Directory, July 10, 2009
- NCQA Accreditation website, <http://hprc.ncqa.org/index.asp>, Accessed July 2009

B. Enrollment/Provider Network

1) Enrollment/Disenrollment

- NYSDOH OMC Membership Data, 2008
- Enrollment by Age and Sex Report as of December 2008
- Enrollment Status by Aid Category and County as of December 2008
- Auto Assignment Data, 2008
- Auto Assignment Quality Algorithm Scores, 2008
- Enrollment Status Report, 2008

2) Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, as of December, 2008
- Total Number of FTE by Managed Care Plans, as of December 31, 2008
- NYSDOH OMC Primary Care Providers Open and Closed Panels by Plans, Provider Network Data As Of December 31, 2008
- QARR Measurement Year, 2008
- NYSDOH Dental Access and Availability Survey, 2008

C. Utilization

1) Encounter Data

- MMC Encounter Data System, 2008

2) Health Screening Data

- Medicaid and Family Health Plus Managed Care Enrollee Health Screening, 2008

3) QARR Use of Services

- QARR Measurement Year, 2008

D. Quality Indicators

- 1) *Summary of HEDIS® Information Systems Audit™ Findings*
 - 2009 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors
- 2) *QARR Data*
 - Performance Category Analysis, Quality Performance Matrix (2008 Measurement Year)
 - QARR Measurement Year, 2006 - 2008
- 3) *CAHPS® 2008 Data*
 - QARR Measurement Year, 2007
- 4) *Quality/Satisfaction Points and Incentive*
 - Quality/Satisfaction Points and Incentive, 2008
- 5) *Performance Improvement Project*
 - 2007-2008 PIP Final Report
 - 2007-2008 PIP Summary Report
- 6) *Health Disparities*
 - NYSDOH Health Disparities Survey, 2009

E. Health Information Technology

- NYSDOH Health Information Technology Survey, 2009

F. Deficiencies and Appeals

- 1) *Summary of Deficiencies*
 - MMC Operational Deficiencies by Plan/Category, 2008
 - Focus Deficiencies by Plan/Survey Type/Category, 2008
- 2) *Appeals*
 - MMC External Appeals Data, 2008

G. Financial Data

- Medicaid Managed Care Operations Report, 2008