

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

PLAN - SPECIFIC REPORT
FIDELIS CARE NEW YORK
[New York State Catholic Health Plan, Inc.]

Reporting Year 2009

April 2011

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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	OB/GYN:	Obstetrician/Gynecologist
DBA:	Doing Business As	OHIP:	Office of Health Insurance Programs
DSS:	Data Submission System	OPMC:	Office of Professional Medical Conduct
EQR:	External Quality Review	OP:	Optimal Practitioner Contact
EQRO:	External Quality Review Organization	PCP:	Primary Care Practitioner/Provider
F/A:	Failed Audit	PIP:	Performance Improvement Project
FAR:	Final Audit Report	PNDS:	Provider Network Data System
FFS:	Fee For Service	POC:	Plan of Corrective Action
FHP:	Family Health Plus	PMPY:	Per Member Per Year
F/U:	Follow-Up	PSR:	Plan-Specific Report
FTE:	Full Time Equivalent	PTMY:	Per Thousand Member Years
HEDIS:	Health Effectiveness Data and Information Set	PHSP:	Prepaid Health Services Plans
HIE:	Health Information Exchange	Q1:	First Quarter (Jan. – March)
HIT:	Health Information Technology	Q2:	Second Quarter (Apr. – June)
HMO:	Health Maintenance Organization	Q3:	Third Quarter (July – Sept.)
HPN:	Health Provider Network	Q4:	Fourth Quarter (Oct. – Dec.)
LIAO:	Long Island Area Office (Region 7)	QARR:	Quality Assurance Reporting Requirements
MARO:	Metropolitan Area Regional Office	R:	Rotated
MCO:	Managed Care Organization	RAO:	Rochester Area Office (Region 2)
MED (M):	Medicaid	RHIO:	Regional Health Information Organization
MMC:	Medicaid Managed Care	ROS:	Rest of State
MMCOR:	Medicaid Managed Care Operating Report	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 2009 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, PQI/compliance/satisfaction/quality 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 2009.

II. Corporate Profile

Fidelis Care New York (Fidelis) is a statewide, not-for-profit prepaid health services plan (PHSP) that services Medicaid, Family Health Plus (FHP), Child Health Plus (CHP) and Managed Long Term Care (MLTC) 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: 2060193
- DOH Area Office: MARO, WRO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: November 3, 1993
- Medicaid Service Area: Albany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Kings, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Tompkins, Ulster, Warren, Washington, Wayne and Westchester
- Product Line(s): Medicaid, FHP, FHP EBI, CHP and MLTC
- Contact Information: 95-25 Queens Boulevard
Rego Park, New York 11374
(718) 896-6500
- NCQA Accreditation as of 6/30/10: Did not apply
- Medicaid Dental Benefit Provided as of 12/09: Provided

III. Enrollment and Provider Network

Enrollment/Disenrollment

Figure 1 depicts total membership for the plan’s Medicaid product line for calendar years 2007 to 2009, as well as, the percent change from the previous year. Membership has grown over this period, increasing by 40.8% from 2007 to 2008 and by 34.0% from 2008 to 2009. Figure 1a represents the membership for other product lines carried by the plan. Figure 1b trends Medicaid membership and membership in these other product lines.

Figure 1: Membership: Medicaid – 2007-2009

	2007	2008	2009
Number of Members	206,372	290,543	389,291
% Change From Previous Year		40.8%	34.0%

Data Source: MEDS II

Figure 1a: Membership: Other Product Lines¹ – 2007-2009

	2007	2008	2009
FHP	45,071	88,427	64,857
CHP	38,270	50,119	59,972

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 1b: Enrollment Trends – All Product Lines

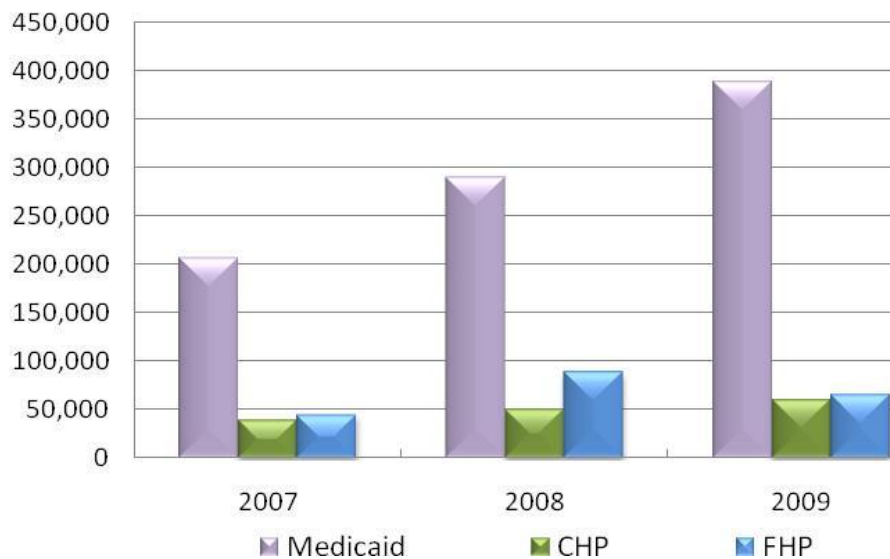


Figure 2 gives a breakdown of the plan's Medicaid membership by age and sex as of December 31, 2009. Children under 20 years of age comprise 52.2% of the total Medicaid enrollment, with 24.6% in the 5-14 age group. Thirty-three percent (33.4%) of the plan's Medicaid membership is women between the ages 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 Fidelis in comparison to the statewide percentages.

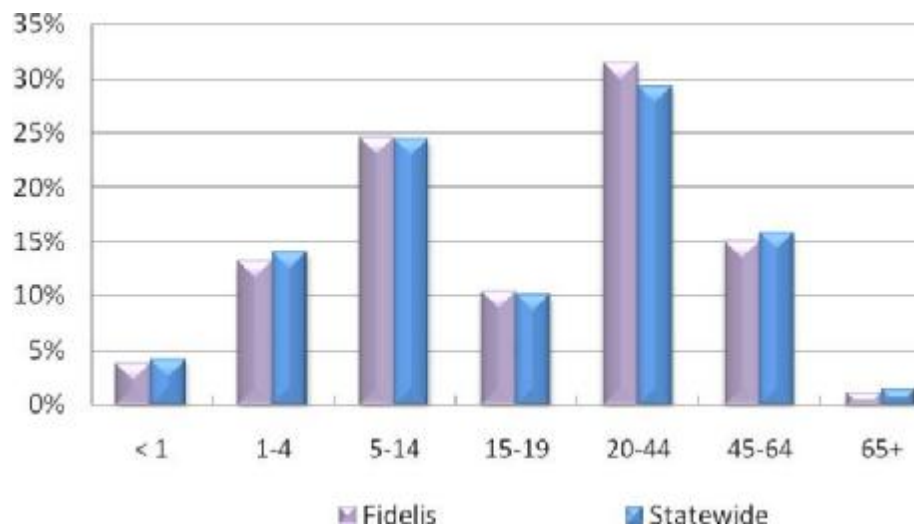
Figure 2: Medicaid Enrollee Age and Sex Distribution – December 2009

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 1	7,747	7,303	15,050	3.9%	4.3%
1-4	26,543	25,108	51,651	13.3%	14.1%
5-14	48,939	46,890	95,829	24.6%	24.5%
15-19	20,046	20,759	40,805	10.5%	10.2%
20-44	47,181	75,504	122,685	31.5%	29.4%
45-64	24,993	33,893	58,886	15.1%	15.9%
65 and Over	1,588	2,797	4,385	1.1%	1.6%
Total	177,037	212,254	389,291		
Under 20	103,275	100,060	203,335	52.2%	53.1%
Females 15-64 ¹		130,156		33.4%	33.6%

Data source: MEDS II

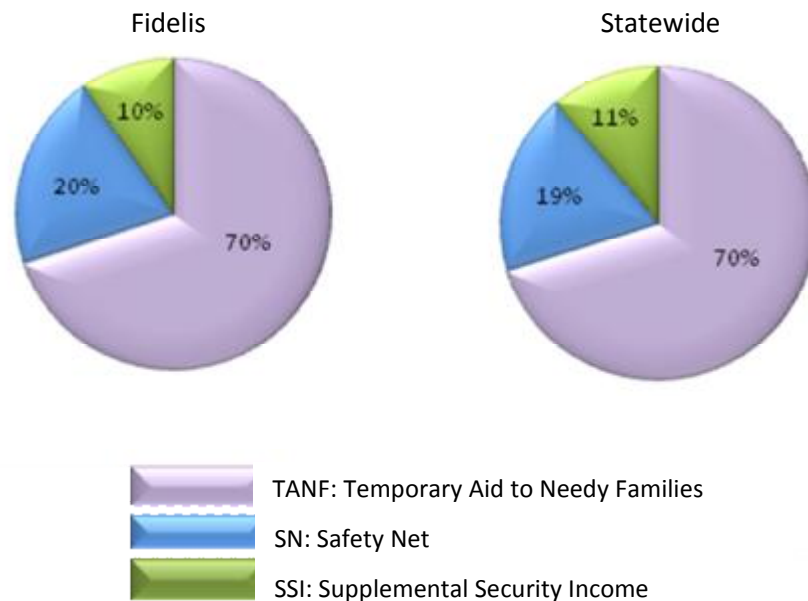
¹ Females between the ages of 15 to 64 were grouped for this category, since this grouping is inclusive of most women utilizing OB/GYN providers.

Figure 2a: Percentage of Medicaid Enrollees by Age – December 2009



A breakdown of plan membership by aid category, as reported by the NYSDOH for December 31, 2009, is shown in Figure 3. The distribution of members in the three aid categories is similar to the statewide distribution.

Figure 3: Medicaid Enrollees by Aid Category – December 2009



The percentage of members by each method of enrollment in the plan’s Medicaid product line for 2007 through 2009 is presented in Figure 4. Whether a plan received a qualifying Medicaid auto assignment quality algorithm score is also available for each of these years. These scores determine 75% of auto-assignee distribution. Fidelis received a score qualifying the plan for Medicaid auto assignment in 2007, 2008 and 2009.

Figure 4: Method of Medicaid Enrollment – 2007-2009

Category	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
Auto Assigned	18.9%	13.6%	18.4%	13.3%	6.2%	7.3%
Self-Selected ¹	81.1%	86.4%	81.6%	86.7%	93.5%	92.8%
Qualifying Score ²	Y		Y		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 17.

Figure 5 shows the plan’s 2009 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, the rates were similar to those of the average plan in the state.

Figure 5: Medicaid and FHP Disenrollment Rates (by percentage of enrollees) – 2009

Enrollment Status ¹	Medicaid		FHP	
	Fidelis	SWA	Fidelis	SWA
Voluntary Disenrollment	0.65%	3.83%	0.59%	3.92%
Involuntary Disenrollment	0.06%	0.12%	0.03%	0.05%
Loss of Eligibility	2.28%	2.58%	2.85%	2.89%
Still Enrolled	97.01%	93.48%	96.54%	93.14%

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 2009 in comparison to the statewide rates. PCPs are 15.4% of all providers in Fidelis’ provider network, which is lower than the statewide percentage of 23.4%. Other Specialties account for a higher percentage of the plan’s provider network than is seen statewide, while Internal Medicine and Behavioral Health providers account for smaller percentages. 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 – 2009 (Q4)

Specialty Type	Number	% of Total Panel	% Statewide
Primary Care Providers	6,331	15.4% ▼	23.4%
<i>Pediatrics</i>	1,732	4.2%	5.8%
<i>Family Practice</i>	1,445	3.5%	4.2%
<i>Internal Medicine</i>	2,599	6.3% ▼	11.3%
<i>Other PCPs</i>	555	1.4%	2.1%
OB/GYN Specialty ¹	2,207	5.4%	5.0%
Behavioral Health	2,726	6.6% ▼	22.6%
Other Specialties	28,670	69.8% ▲	46.3%
Non-PCP Nurse Practitioners	1,146	2.8%	2.6%
Dentistry ²	3,023		
Total (excluding dentists)	41,080		

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 – 2009 (Q4)

Specialty Type	Fidelis			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	61:1	2,246.3	173:1	50:1	14,096.2	153:1
<i>Pediatrics (Under age 20)</i>	117:1			93:1		
OB/GYN (Females aged 15-64)	59:1			68:1		
Behavioral Health	143:1			44:1		

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 quarters of 2007 through 2009. 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 – 2007-2009 (Q4)

	2007			2008			2009		
	Fidelis		Statewide	Fidelis		Statewide	Fidelis		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Providers with Open Panel	6,006	97.0%	96.2%	7,357	97.7%	97.0%	7,784	96.9%	96.3%

Data Source: HPN

Figure 7 displays QARR *Board Certification* rates for 2007 through 2009 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 2009 Medicaid board certification rates are higher than the statewide averages for Family Medicine and Other Physician Specialists.

Figure 7: QARR Board Certification Rates – 2007-2009

Provider Type	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
Medicaid:						
Family Medicine	82%	80%	84% ▲	82%	86% ▲	81%
Internal Medicine	81% ▲	79%	81%	82%	83%	83%
Pediatricians	81%	79%	82%	83%	84%	82%
OB/GYN	77% ▲	74%	74% ▼	76%	77%	77%
Geriatricians	74%	74%	74%	75%	72%	73%
Other Physician Specialists	80% ▲	78%	81%	81%	80% ▲	79%

NYSDOH Primary Care Access & Availability Survey – 2009

On behalf of the NYSDOH’s Division of Managed Care, the NYS EQRO annually conducts the Medicaid Managed Care Access & Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid/Family Health Plus Managed Care Contract. The 2009 survey evaluated the availability of routine and non-urgent “sick” office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after hours access.

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee’s request, while non-urgent “sick” office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a live voice representing the named provider is reached or if the named provider’s beeper number is reached.

A random sample of 240 provider sites was selected from each region in which a health plan operated and provided primary care as a Medicaid and/or Family Health Plus benefit. Of these 240 provider sites, 120 were surveyed for routine appointments, 80 were surveyed for non-urgent “sick” appointments and 40 were surveyed for after hours access. For MCOs with less than the 240 available provider sites, all providers were selected.

For call type categories in which compliance is below the 75% threshold, plans will receive a Statement Of Deficiency (SOD) issued by the NYSDOH and will be 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 the plan’s Primary Care Access & Availability results for 2009. Fidelis exceeded the 75% threshold for routine appointments in Region 6, and exceeded the threshold for non-urgent “sick” appointments in Region 5. The plan exceeded the 75% threshold for after hours access in Regions 3, 4, 5 and 7.

Figure 8: Primary Care Access & Availability Survey – 2009

Region	Call Type	Fidelis	Region Average
1	Routine	53.3%	59.5%
	Non-Urgent “Sick”	49.4%	56.3%
	After Hours Access	70.0%	77.8%
2	Routine	38.3%	41.1%
	Non-Urgent “Sick”	46.1%	50.0%
	After Hours Access	70.0%	73.9%
3	Routine	41.6%	39.3%
	Non-Urgent “Sick”	44.2%	43.8%
	After Hours Access	80.0%	80.0%
4	Routine	60.5%	63.7%
	Non-Urgent “Sick”	61.0%	63.4%
	After Hours Access	82.5%	80.6%

Figure 8: Primary Care Access & Availability Survey – 2009 (Continued)

Region	Call Type	Fidelis	Region Average
5	Routine	73.9%	69.3%
	Non-Urgent "Sick"	75.9%	71.8%
	After Hours Access	80.0%	78.7%
6	Routine	75.6%	71.3%
	Non-Urgent "Sick"	71.3%	65.3%
	After Hours Access	65.0%	63.0%
7	Routine	56.7%	63.5%
	Non-Urgent "Sick"	60.0%	65.4%
	After Hours Access	82.5%	70.0%

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 2007 through 2009. The plan's rates for these periods 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 – 2007-2009

	Encounters (PMPY)					
	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
PCPs and OB/GYN	4.14	4.06	4.19	4.37	4.08	4.32
Specialty	2.30	1.62	2.44 ▲	1.81	1.98	1.76
Emergency Room	0.55	0.58	0.55	0.58	0.58	0.68
Inpatient Admissions	0.15	0.14	0.16	0.15	0.14	0.15
Dental – Medicaid	1.11	0.72	1.15 ▲	0.80	1.36	0.95
Dental – FHP	1.42 ▲	0.83	1.49 ▲	0.91	2.04 ▲	1.10

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 2007 rates ranged from 11.5% to 69.7% for Medicaid and 8.5% to 70.2% for FHP, while plan statewide rates for 2008 ranged from 13.5% to 61.5% for Medicaid and 9.9% to 60.1% for FHP. Plan statewide 2009 rates ranged 11.1% to 63.6% for Medicaid and 11.0% to 58.3% for FHP. Figure 10 summarizes the percentage of Medicaid and FHP enrollees receiving health screenings within 30 days of enrollment from 2007 through 2009, in addition to displaying the statewide averages for these years. For this figure, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼.

Figure 10: Health Screenings – 2007-2009

	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
Medicaid						
Enrollee Health Screenings	21.5%	27.4%	13.5% ▼	27.5%	17.9% ▼	33.8%
FHP						
Enrollee Health Screenings	23.6%	30.1%	16.9%	26.9%	22.3%	32.6%

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 2007 through 2009. 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 – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	SWA 2009	2007	2008	2009	SWA 2009
Outpatient Utilization (PTMY)								
Outpatient Visits	3,971.8	4,227.4	4,918.8	5,389.1	3,355.6	3,241.4	3,663.1	4,243.8
Outpatient ER Visits	531.1	540.2	574.8	583.0	270.0	268.9	314.1	312.5
Ambulatory/Surgery Encounters	62.5	94.7	92.1	100.2	28.1	32.0	31.0	34.2
Inpatient ALOS								
Medicine	4.0	3.8	3.3 ▼	3.8	2.9	3.2	2.8	2.9
Surgery	5.4	5.5	5.6	6.0	4.8	3.4	3.8	5.1
Maternity	2.7	2.7	2.6 ▼	2.9	2.9	2.5 ▼	2.7 ▼	2.8
Total (Medicine, Surgery & Maternity)	3.7	3.6	3.5 ▼	3.8	3.4	3.2	3.1	3.5
Inpatient Utilization (PTMY)								
Medicine Cases	46.4	47.9	56.0	55.1	12.8	13.9	11.5	13.2
Surgery Cases	13.3	13.4	17.2	14.3	4.3	2.5 ▼	5.5	4.9
Maternity Cases	56.2	55.2	36.4	48.3	3.7	2.4	2.0	1.9
Total Cases	97.8	99.1	99.3	103.4	19.2	17.9	18.1	19.3

PTMY: Per Thousand Member Years

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

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[®] 2010/QARR 2009 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[®] 2010 Compliance Audit[™] specifications developed by the National Committee for Quality Assurance (NCQA). The results of each plan's HEDIS[®] 2010 Compliance Audit[™] are summarized in its Final Audit Report (FAR).

Summary of HEDIS[®] 2010 Information System Audit[™]

As part of the HEDIS[®] 2010 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[®] 2010 Final Audit Report (FAR) prepared for Fidelis indicates that the plan had no significant problems in any area related to reporting. Though the plan demonstrated compliance with all areas of the Information Systems, there were some minimal issues noted with *IS 5.0 Supplemental data – Capture, Transfer and Entry*. However, the plan was in compliance in all areas of measure determination required for successful HEDIS[®]/QARR reporting.

The plan used NCQA-certified software to produce HEDIS[®] measures. Supplemental databases were used to capture additional data for *Annual Monitoring for Patients on Persistent Medications, Appropriate Treatment for Children with Pharyngitis, Breast Cancer Screening and Follow-Up for Mental Illness After Hospitalization*. These databases were validated and determined to be HEDIS[®]-compliant by the auditors. 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. The plan was able to report all measures for its Medicaid and CHP product lines.

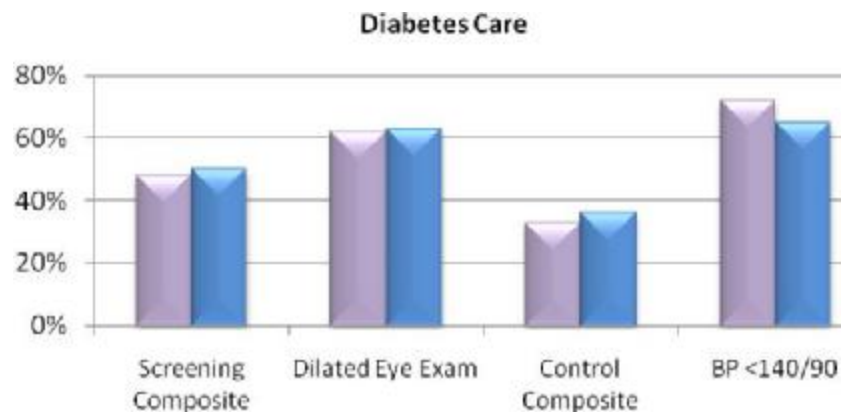
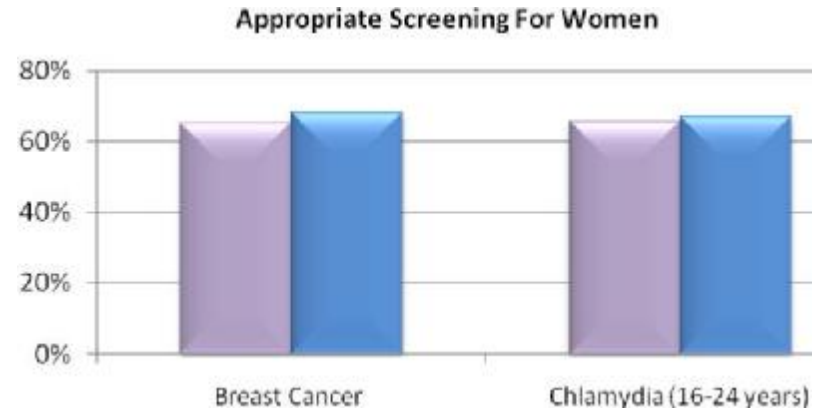
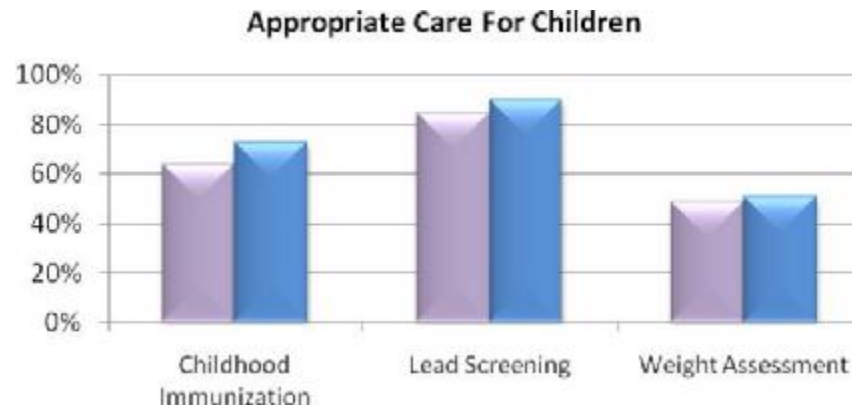
Figure 12 displays 2007, 2008 and 2009 QARR performance rates, as well as the SWAs. The Figure indicates whether the plan's rate was statistically better than the SWA (indicated by ▲) or whether the plan's rate was statistically worse than the SWA (indicated by ▼). Figure 12a illustrates selected 2009 measures for the Medicaid product line in comparison to the SWAs.

Table Notes for Figure 12	
R:	Rotated measure
NR:	Not reported
FY:	First year measure. Data collected but plan specific rates not publicly reported.

Figure 12: QARR Plan Performance Rates – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	2009 SWA	2007	2008	2009	2009 SWA
Adult BMI Assessment	FY	48	55	55				
Annual Dental Visit (2-18 years)	54 ▲	56 ▲	58 ▲	52	59 ▲	62 ▲	65 ▲	63
Appropriate Asthma Medication: 3+ Controller Dispensing Events		77	76	75		FY	76	78
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	23 ▼	21 ▼	21 ▼	26				
Breast Cancer Screening	61 ▼	64 ▼	65 ▼	68				
Childhood Immunization Status (Combo 3)	62 ▼	R	64 ▼	73	76 ▲	R	76 ▲	66
Chlamydia Screening for Sexually Active Women (16-24 years)	59 ▲	60	66 ▼	67				
Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Control <100 mg/dL)	47	R	54	51				
Diabetes BP < 140/90	64	R	72 ▲	65				
Diabetes Control Composite	33	R	33	36				
Diabetes Dilated Eye Exam	65	R	62	63				
Diabetes Screening Composite	48	R	48	50				
Discussing Smoking Cessation Medications	50	R	40 ▼	52				
Discussing Smoking Cessation Strategies	43	R	36 ▼	47				
Follow-Up After Hospitalization for Mental Illness – 7 Days	68 ▲	72 ▲	71 ▲	68				
Follow-Up After Hospitalization for Mental Illness – 30 Days	82 ▲	85 ▲	83 ▲	80				
Follow-Up Care for Children Prescribed ADHD Medication	65 ▲	64	62	62	71 ▲	67 ▲	68 ▲	53
Lead Screening in Children	80 ▼	R	85 ▼	90	78	R	86 ▲	82
Medical Assistance With Smoking Cessation (CAHPS®)	71	R	67	74				
Rating of Health Plan (CAHPS®)	65	R	68	69				
Use of Imaging Studies for Low Back Pain	75 ▼	NR	78 ▼	80				
Use of Spirometry Testing in the Assessment & Diagnosis of COPD	38	38	40 ▼	45				
Weight Assessment (BMI Percentile) for Children/Adolescents (3-17 years)		FY	49	51		FY	55	55

Figure 12a: QARR Medicaid/FHP Rates for Selected Measures – 2009



 Fidelis

 Statewide

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 2007 through 2009. 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 – 2007-2009

Measure	Medicaid/FHP				Child Health Plus			
	2007	2008	2009	SWA 2009	2007	2008	2009	SWA 2009
Children and Adolescents' Access to PCPs (CAP)								
12–24 months	96%	97%	96% ▲	95%	97%	99%	99%	99%
25 months–6 years	90%	92%	92% ▼	92%	94%	95%	95% ▼	96%
7–11 years	92%	93%	94% ▼	95%	96%	97%	97% ▼	98%
12–19 years	87%	88%	90% ▼	91%	92%	94%	95% ▼	95%
Adults' Access to Preventive/Ambulatory Services (AAP)								
20–44 years	81%	80%	82% ▼	82%				
45–64 years	86%	85%	87% ▼	88%				
65+ years	84%	84%	87% ▼	88%				
Access to Other Services								
Timeliness of Prenatal Care	R	92% ▲	R	R				
Postpartum Care	R	78% ▲	R	R				
Annual Dental Visit*	54% ▲	56% ▲	57% ▲	51%	59% ▲	62% ▲	65% ▲	63%

R: Rotated measure

*For the Annual Dental Visit measure, the Medicaid/FHP age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

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 2006 through 2008. 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 – 2006-2008

Measure	Medicaid/FHP					
	2006		2007		2008	
	Fidelis	NYC/ROS Average	Fidelis	NYC/ROS Average	Fidelis	NYC/ROS Average
	NYC					
Risk-Adjusted Low Birth Weight*	7%	7%	7%	7%	7%	8%
Prenatal Care in the First Trimester	70% ▼	73%	69% ▼	72%	67%	70%
% of Low Birth Weights at Facilities for High-Risk Deliveries	100%	99%	100%	99%	100%	100%
	ROS					
Risk-Adjusted Low Birth Weight*	7%	7%	7%	7%	7%	7%
Prenatal Care in the First Trimester	64% ▼	69%	64% ▼	68%	67%	68%
% of Low Birth Weights at Facilities for High-Risk Deliveries	81%	80%	77%	81%	69%	78%

*A low rate is desirable for this measure.

NYC: New York City

ROS: Rest of State

Consumer Satisfaction

In 2010, 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 measurement years 2008 and 2010. 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 and 2010

Measure	Medicaid			
	2008	2008 SWA	2010	2010 SWA
Flu Shots for Adults Ages 50-64	40	43	33	35
Medical Assistance With Smoking Cessation	71	74	67	74
Getting Care Needed ¹	75	75	74	74
Satisfaction with Provider Communication ¹	90	88	88	86
Care Coordination	74	74	75	74
Customer Service ¹	80	80	80	80
Rating of Healthcare	70 ▲	65	66	65
Rating of Health Plan – High Users	69	67	67	71
Getting Care Quickly ¹	81	78	79	77
Overall Rating of Health Plan	65	66	68	69
Rating of Personal Doctor	72	74	76	74
Rating of Specialist	74	71	70	67
Getting Needed Counseling/Treatment			68	66
Rating of Counseling/Treatment			58	57
Recommend Plan to Family/Friends	88	90	89	90

¹ These indicators are composite measures.

*Quality Performance Matrix Analysis 2009 Measurement Year
(Effectiveness of Care Measures)*

Figure 16 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 sixteen for the Medicaid product line, fourteen for Commercial 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 D and F categories, the MCO is not required to follow-up.

Figure 16: Quality Performance Matrix – 2009 Measurement Year

		Statewide Statistical Significance		
Trend *		Below Average	Average	Above Average
↑ No Change ↓	C		B	A Lead Testing in Children (CHP)
	D Breast Cancer Screening (M) Child Immunization Combo 3 (M) Discuss Smoking Cessation Medication (M) Discuss Smoking Cessation Strategies (M) Lead Testing in Children (M)		C Adult BMI Assessment (M) Cholesterol Management (LDL-C <100) (M) Diabetes Control Composite (M) Diabetes Screening Composite (M) Rating of Health Plan (M)	B Child Immunization Combo 3 (CHP)
	F		D	C

M: Medicaid and Family Health Plus

CHP: Child Health Plus

*Trending analysis used rates from 2007 when the measure was not collected in 2008.

Quality Incentive – PQI/Compliance/Satisfaction/Quality Points

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 2009 rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores conducted in spring 2010, and compliance information from 2008 and 2009. The total score, based out of 150 possible points, determines what percent of the 3% available premium increase the plan qualifies for. For 2009, 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 17 displays the points the plan earned from 2007 to 2009, as well as the percent of the financial incentive that these points generated based on the previous measurement year’s data. Figure 17a displays the measures that were used to calculate the 2009 incentive, as well as the points Fidelis earned for each measure.

Figure 17: Quality Incentive – PQI/Compliance/Satisfaction/Quality Points – 2007-2009

Category	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
Total Points (150 Possible Points)	94	79	119	88	74	67
<i>PQI Points</i> (20 Possible Points)					10	10
<i>Compliance Points</i> (-20 Possible Points)	14	16	20	18	-2	-5
<i>Satisfaction Points</i> (30 Possible Points)	10	16	15	17	15	16
<i>Quality Points</i> (100 Possible Points)	70	47	84	54	51	46
Percent of Financial Incentive Earned	50%		67%		33%	

Figure 17a: Quality Incentive – PQI/Compliance/Satisfaction/Quality Measures and Points – 2009

Measure	Fidelis
<i>PQI (10 points each)</i>	10
Adult PQI	5
Pediatric PQI	5
<i>Compliance (-4 points each, except where noted)</i>	-2
MMCOR	0
MEDS	0
Access & Availability (-2 points)	-2
Provider Directory (-2 points)	0
Member Services	0
QARR	0
<i>Satisfaction (10 points each)</i>	15
Getting Care Needed (CAHPS®)	5
Customer Service and Information (CAHPS®)	5
Rating of Health Plan (CAHPS®)	5
<i>Quality (10 points each, except where noted)</i>	51
Follow-Up After Hospitalization for Mental Illness -7 Days (HEDIS®/QARR)	7
Use of Appropriate Medications for People with Asthma -3 or More Controller Dispensing Events (QARR)	7
Chlamydia Screening in Women (HEDIS®/QARR)	7
Cholesterol Management for Patients with Cardiovascular Conditions (HEDIS®/QARR)	10
Annual Dental Visit -Ages 2-18 (HEDIS®/QARR)	10
Comprehensive Diabetes Care -Blood Pressure Below 140/90 (HEDIS®/QARR)	10
Comprehensive Diabetes Care -Screening Composite (QARR) (20 points)	0
Childhood Immunization Status -Combo 3 (HEDIS®/QARR)	0
Medical Assistance with Smoking Cessation (CAHPS®)	0
Total Points Earned	74

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

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.

Fidelis' 2009-2010 PIP topic is "Pediatric Obesity". In 2009, the plan implemented the following interventions:

- Established BabyCare program for pregnant members.
- Collected data on pregnancy weight gain, and provided education, support and encouragement of breastfeeding via mailing and telephone.
- Published articles in Member Newsletter.
- Mailed information to providers regarding PIP topic along with materials for distribution to patients.
- Collaborated with the Perinatal Network for continuous onsite education for BabyCare Associates and high-risk OB nurses on pregnancy related issues.

Figure 18: Performance Improvement Project – 2009-2010

Results not displayed; 2009 was the first phase of a two-year study.

Clinical Study

Statewide case management trigger and enrollment data for New York Medicaid Managed Care organizations MCOs have not been previously collected. In order to better understand which MCO members are targeted for case management in NYS, the NYS EQRO, on behalf of the NYSDOH, conducted a study in 2008 and 2009 to describe New York MCOs' case managed populations using Clinical Risk Groups (CRGs) to identify members' health status complexity and severity, which are associated with future resource utilization. It was postulated that the CRG system, a predictive modeling system designed to project future resource utilization, would identify the same potential high resource users that MCOs target for case management, since cost and utilization are common drivers for establishing case management programs among MCOs.¹

The overall proportion of members enrolled in case management was small, as would be expected for an intervention as resource intensive as case management. Less than 1% of the study population was enrolled in case management, and only 3% of the total population was triggered for assessment for case management.

Adults (age greater than or equal to 20) were more likely than children to be triggered and to be enrolled in case management. This is not unexpected, since chronic conditions increase with age, and chronic conditions are associated with increased resource use, a common driver for case management program enrollment. Women were more likely to be triggered and to be enrolled than men, and female gender was predictive of triggering and enrollment, likely due to the prevalence of pregnant women among case managed members. While the MCOs' practice of targeting pregnant women is undoubtedly reflected in this finding, it is also possible that other factors impact gender differences in triggering and enrollment, such as differential case management refusal rates or differential practitioner and self referral rates. There may also have been gender differences in prevalence of diagnoses that are specifically targeted for case management by MCOs.

Black, Hispanic, and other racial/ethnic minority groups were less likely to be triggered and enrolled in case management than white members were, and Hispanics were less likely to be enrolled than all other races combined. This apparent disparity warrants further study, since it is not possible from study data to ascertain the reasons for differential enrollment. Contributing factors could include language and cultural barriers, and, as noted above, differential refusal and referral rates.

Members with a Supplemental Security Income (SSI) eligibility category were significantly more likely to be triggered and enrolled than members in other eligibility categories. This is consistent with the prevalence of chronic conditions and disability among SSI recipients that would make these members likely candidates for case management. However, it should be noted that some case managed members receiving SSI benefits were in Health Status 1 and 2 rather than in the chronic condition health status categories, and could have been identified by referral or Health Risk Assessment, which has been shown to be equivalent to claims-based risk modeling in predicting the need for case management among SSI recipients.²

There was wide variation among MCOs for rates of triggering and enrollment in case management, as well as for the distribution of case managed members across CRG categories. This is not surprising, given the broad range of target populations, triggering processes, and enrollment criteria among MCOs' case management programs. Aside from one of the smallest MCOs, which had very high rates, trigger rates ranged from only 0.4% of members to 7.7% of members, and the percentage of members actually enrolled in case management also

¹ New York State DOH Medicaid MCO Case Management Workgroup. Gap Analysis Comparing New York State Health Plans with URAC's CM and DM Standards and CMSA's Standards of Practice. 2005.

² Drozda JP, Libby D, Keiserman W. et al. Case management decision support tools: predictive risk report or health risk assessment? *Population Health Management* 2008; 11(4): 193-196.

varied widely, from .1% to 4.2% of members. This would suggest that some MCOs may enroll only the few members thought to be at very high risk or those who are thought to be high cost.

There was a strikingly broad range of percentages of triggered members who were enrolled across MCOs, from a low of 1.4% to 100%. One of the three MCOs that reported 100% enrollment indicated that they enroll every member who is triggered, but there may have been triggered but not enrolled members who were not captured for the other two MCOs reporting 100% enrollment. The wide range of enrollment proportions illustrates the philosophical differences of MCOs regarding case management programs; it also demonstrates the balance between “sensitivity” versus “specificity” in identifying members for case management. Some MCOs appear to opt for procedures which are sensitive, i.e. identifying all possible case management candidates and enrolling few, while other MCOs appear to have more specific triggering criteria, i.e., they trigger few but enroll a high proportion of those triggered. This was not a consistent pattern; some MCOs had relatively high rates of both triggered and enrolled members.

The study found that there was a notable overlap of members targeted for case management and members identified as high risk by CRGs, and the predominant populations in case management were those for whom case management has been demonstrated to be of benefit (members who are pregnant or who have chronic conditions). However, there appeared to be risk factors identified by MCOs for case management that were not evident in the CRG system, and members identified as high risk by the CRG grouper who were not triggered or enrolled by MCOs. The variation in MCO triggering practices, enrollment criteria and focus of MCO case management programs was reflected by the varied distribution of case managed members among CRG categories in different plans. Some MCOs had very high proportions of case managed members among the healthy populations, with some MCOs appearing to be very successful in identifying case management candidates among non-users of the health care system. This finding may be due to the different case finding mechanisms among MCOs, which may include HRA or referral systems, and result in very different target populations than predictive modeling or identification based on past utilization or cost.³ These case selection variations resulted in a widely variable scope and CRG distribution across MCO case management programs.

³ Weir S, Aweh G, Clark RE. Case selection for a Medicaid chronic care management program. Health Care Financing Review 2008; 30(1):61-74.

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

Fidelis reported that the following activities were performed in 2009 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- Continued its efforts to improve immunization rates among the plan's Hasidic Jewish population in the Orange and Rockland Counties in the Hudson Valley Region. An analysis at the practice level identified six practices with large member panels and significantly low immunization rates. All of the practices agreed on the cultural and social (not religious) barriers encountered with regard to immunizations and faced the same challenges. Some of the recommendations brought forth included: greater role of nursing staff in discussing the importance of vaccinations, all doctors in the practice advocating the necessity of immunizations (no "lenient" doctors who members will go to if they want to delay immunizations), and the reinforcement by all staff at every visit (including front desk staff).
- Fidelis had a significant population growth in the Hudson Valley and New York City in 2007 and 2008. These areas had the greatest decline in Cervical Cancer Screening rates from 2006 to 2008 (7% and 16%, respectively). An analysis showed that the members enrolled for a minimum of 3 years were significantly more likely to have a cervical cancer screening than the newer enrollees (1 or 2 years continuous). Follow-up actions included Provider Relations and Quality Management staff working directly with office staff to develop strategies for improvement in workflows and reporting. Partnership meetings with the Top 100 providers by membership were initiated which included the facilities in the Hudson Valley and NYC. Partnership meeting topics include discussions on retention efforts and how they can have an effect on quality of care.

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 19 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 19: 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%

Fidelis 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:
 - Protected information is shared with providers via secure email.
 - Data is transferred to and from vendors using file transfer protocol (FTP) sites and secure transfer via the Internet.
- Use of electronic disease and/or case management systems:
 - Clinical Care Advance (CCA) is used for case and disease management.
- Use of electronic internal registries:
 - CCA and CareEnhance Resource Management Software (CRMS) are used to create registries for case and disease management and health promotion outreach activities.
- Electronic communication with members and/or providers:
 - Some communication with providers is conducted via email and a secure portal on the plan’s website.

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 an operational survey. The on-site component includes review of the following: policy and procedures, 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 20. Plans are also required to submit POCs in response to deficiencies identified in any of these reviews.

Figure 21 reflects the total number of citations for the most current operational survey of the plan, which ended in 2009, as well as from the focused reviews conducted in 2009. 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.

Fidelis was in compliance with 10 of 14 categories. The categories in which Fidelis was not in compliance were Medicaid Contract (1 citation), Organization and Management (2 citations), Quality Assurance (1 citation) and Utilization Review (2 citations).

Figure 20: Focused Review Types

Review Name	Review Description
Access & 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 21: Summary of Citations

Category	Review Type/Name (a indicates focused review)	Citations
Complaints and Grievances		0
Credentialing		0
Disclosure		0
Family Planning		0
HIV		0
Management Information Systems		0
Medicaid Contract		1
<i>a) Several adverse determination letters (initial and final) issued by the Plan contained rationales that were potentially confusing to the enrollees in that they contained abbreviations and anachronisms of medical terminology that the general population is typically not familiar with.</i>	Operational	
Medical Records		0
Member Services		0
Organization and Management		2
<i>b) The Plan failed to submit written notice to the Department immediately upon departure of a board member and replacement of a board member. The Plan did not submit information necessary for the determination by the Commissioner of character, competence and performance of Mr. Bendetto until 12 months after being appointed to the board of directors. (2 citations)</i>	a Other	
Prenatal Care		0
Quality Assurance		1
<i>c) The Plan failed to develop and implement a quality management program, that is supervised by the medical director and that includes organization arrangements and ongoing procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in health care administration and delivery to enrollees. The Plan also failed to include standards for management of access to, continuity and quality of care and, except for PCPCPs, utilization and cost of services.</i>	a Access and Availability	
Service Delivery Network		
Utilization Review		2
<i>d) See a. (2 citations)</i>	Operational	
Total		6

External Appeals Summary Report

Figure 22 displays external appeals for 2007 to 2009 for the Medicaid product line. This Figure reflects absolute numbers, and is not weighted by plan enrollment.

Figure 22: External Appeals – 2007-2009

	2007	2008	2009
Medicaid			
Overtured	1	7	7
Overtured in Part	0	2	1
Upheld	9	7	14
Total	10	16	22

VIII. Financial Data

The financial summary is based on data reported in each plan's 2007, 2008 and 2009 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 23 and their definitions.

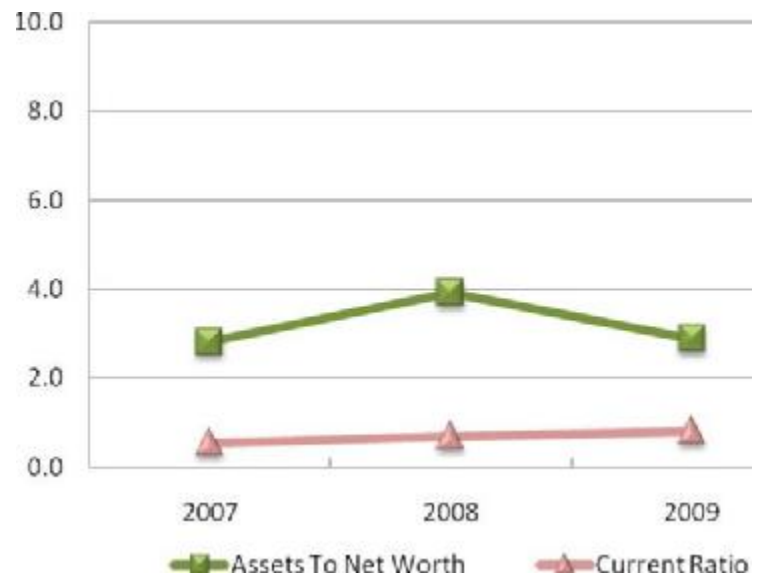
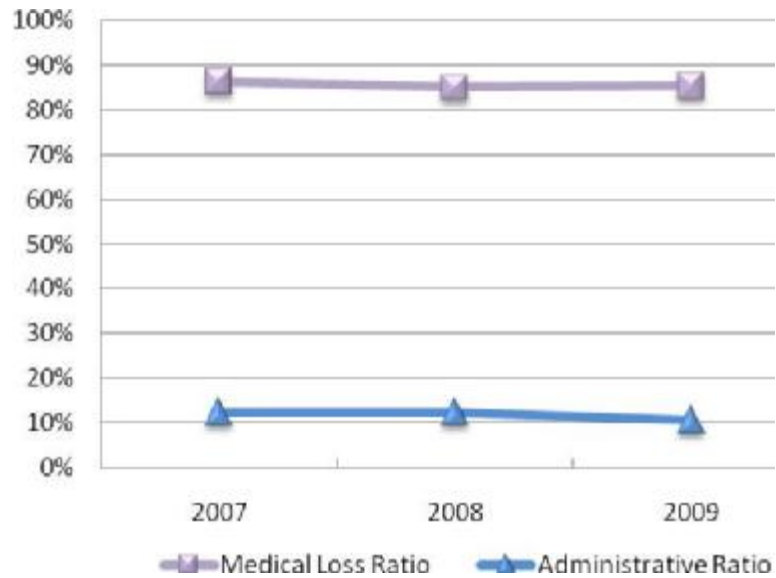
- *Assets to Net Worth*: Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has \$3 of assets for every \$1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
- *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 23a graphically trends selected measures from Figure 23.

Figure 23: Selected Financial Ratios – 2007-2009

	2007		2008		2009	
	Fidelis	SWA	Fidelis	SWA	Fidelis	SWA
PROFITABILITY						
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	2.8	2.0	3.9	2.2	2.9	2.1
Premium Surplus Ratio = Premium Income/Premium Revenue	1.2%	-0.6%	2.6%	-0.7%	4.0%	1.6%
Medical Loss Ratio = Medical Expenses/Premium Revenue	86.4%	87.7%	85.1%	88.9%	85.5%	87.4%
Administrative Ratio = Admin Expenses/Premium Revenue	12.3%	13.0%	12.3%	11.8%	10.6%	11.0%
LIQUIDITY						
Current Ratio = Current Assets/Current Liabilities	0.6	1.4	0.7	1.2	0.8	1.1

Figure 23a: Trends for Selected Financial Ratios – 2007-2009



IX. Strengths and Opportunities for Improvement¹

This section summarizes the accessibility, timeliness, and quality of services provided by Fidelis 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 2010 HEDIS[®] Audit revealed no significant problems with the Medicaid product line, and the plan was able to report all required Medicaid rates for QARR.
- The plan received PQI, compliance, satisfaction and quality scores that qualified it for 33% of the available financial incentive, as well as for the auto-assignment of new members. It is noted however, that the plan is declining in this area as the plan received 67% of the available financial incentive in 2008.
- The plan continues to demonstrate strong performance in regard to behavioral health. The plan has exceeded the statewide average for at least three consecutive reporting periods on the HEDIS[®]/QARR *Follow-Up After Hospitalization for Mental Illness -7 Days* and *-30 Days* measures.
- The plan also continues to demonstrate strong performance in regard to dental care as indicated by better than average rates on the HEDIS[®]/QARR *Annual Dental Visit* measure.
- In regard to the EQRO's 2009 Primary Care Access & Availability Survey, the plan exceeded the 75% threshold for after hours access in Regions 3, 4, 5 and 7, and for non-urgent "sick" appointments in Region 5, and for routine appointments in Region 6.

Opportunities for Improvement

- The plan demonstrates an opportunity for improvement in regard to its overall HEDIS[®]/QARR performance. The plan's rates for the HEDIS[®]/QARR *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Breast Cancer Screening* measures have performed below the statewide average for at least three consecutive reporting periods. Additionally, the plan performed below the statewide averages for the following measures as well: *Childhood Immunization Status*, *Chlamydia Screening*, *Discussing Smoking Cessation Medications*, *Discussing Smoking Cessation Strategies*, *Lead Screening in Children*, *Use of Imaging Studies for Low Back Pain* and *Use of Spirometry Testing Assessment & Diagnosis of COPD*.
- The plan demonstrates an opportunity for improvement in regard to access. The plan reported rates in the 10th percentile for the HEDIS[®]/QARR *Children and Adolescents' Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* measures for age groups *25 months-6 years*, *7-11 years* and *12-19 years*, *20-44 years*, *45-64 years* and *65 years and older*.
- In regard to compliance with NYS structure and operation standards, the plan received a total of 6 citations, including 3 Article 44 Review citations in the categories of Medicaid Contract and Utilization Review; and 3 focused review citations related to Access & Availability and Other in the following

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.

categories: Organization and Management and Quality Assurance. (Note: compliance with NYS structure and operation standards was an opportunity for improvement in the previous year's report.)

- Despite exceeding the 75% threshold for after hours access in Regions 3, 4, 5 and 7, and for non-urgent "sick" appointments in Region 5, and for routine appointments in Region 6 on the 2009 Primary Care Access & Availability Survey, the plan demonstrates an opportunity for improvement as the plan performed poorly for other call types in these regions and did not meet the 75% threshold for any call type in Regions 1 and 2.

Recommendations

- To ensure that the plan continues to receive a percentage of the available financial incentive and qualifies for the auto-assignment of members, the plan should investigate and work to improve the decline in its qualifying score. The plan should specifically focus on improving member satisfaction and HEDIS®/QARR Effectiveness of Care measures as they tie into the State's formula for calculating the qualifying score.
- The plan should work to address HEDIS®/QARR measures that performed below the statewide average with specific attention to measures for which the plan continuously reports below average rates.
- The plan should investigate member access to primary care and implement initiatives to address identified barriers. In addition, the plan should monitor the adequacy of its provider network as the plan's percentage of primary care providers is lower than the statewide average.
- The plan should work to address the problems noted in the Article 44 Survey and focused reviews. *[Repeat recommendation.]*
- To ensure that members have timely access to primary care, the plan should investigate its low performance on the EQRO's 2009 Primary Care Access & Availability Survey, and implement initiatives to address identified barriers.

Response to Previous Year's Recommendations

- **2008 Recommendation:** The plan should continue to work to address the problems noted in the Article 44 review and in the focused surveys. Specifically, the plan should work to improve its vendor contract management process to ensure compliance with the NYS Medicaid Contract. *[Repeat recommendation.]*

Plan Response: The report notes that the plan failed to notify the NYSDOH when a contract expired between itself and Doral Services and that the vendor was operating without a contract. This administrative issue involved only the Management Services Agreement (MSA) between Fidelis and Doral Services of New York, Inc. and was immediately corrected. A new MSA was filed with the Division of Managed Care on August 6th, 2008 and approved by the Division of Managed Care on November 6th, 2008. Fidelis will continue to monitor and improve its contract management process to ensure compliance with the NYS regulations.

Fidelis acknowledges that its vision benefits provider, Davis Vision, was not adhering to the guidelines of the Medicaid Managed Care/Family Health Plus Contract. In response Davis Vision submitted a corrective action plan to Fidelis. The corrective action plan, which was implemented in June 2008, included the following remedies: retraining of staff on the importance of regulatory compliance and the process of classifying cases as Utilization Review ("UR") determinations, non-UR (or administrative) determinations, action appeals, complaints, and appeals of complaint resolutions; revision of Utilization Management policies and procedures; revision of Quality Assurance policies and procedures; revision of letter templates for denials, appeals, and complaint resolution; as well as periodic ongoing audits of service authorization requests.

Fidelis monitors Davis Vision's compliance with regulatory obligations on an ongoing basis, and Delegation Audits in both 2009 and 2010 found Davis Vision's utilization review procedures, quality management policies, and letter templates to be 100% in compliance with the guidelines set forth in the Medicaid Managed Care/Family Health Plus Contract.

Regarding the citation related to disclosure, all Member Service Associates were trained on the process to handle disclosure requests. This includes refresher training on an annual basis and implementation in the new employee training. This training included the identification of the different types of documentation requests and the process in which we handle the different types. The process includes the following:

- All documentation received via mail is date stamped and logged into the Facets system for tracking.
 - All documentation requests for clinical disclosures are handled by Member Services Management as a request to the Quality Health Care Management department.
 - Once requested documentation is received, the information requested is mailed to the member via certified mail.
- **2008 Recommendation:** The plan should continue to investigate prenatal care in the first trimester and evaluate the effectiveness of the initiatives described in the plan's response to the previous year's recommendation. [*Repeat recommendation.*]

Plan Response: Fidelis' BabyCare Program continues to utilize an ancillary database to capture pertinent obstetrical information about pregnant members. Fidelis implemented a new case management software system, Clinical Care Advance, in July 2009 that utilizes claims data, pharmacy, and lab data to better identify, stratify, and manage pregnant members earlier in their pregnancy. Identification and management of pregnant members in their first trimester has increased by 12% since 2008. Fidelis also currently uses fee-for-service data provided by the NYSDOH to identify pregnant members through category codes.

Outreach calls and letters continue to be sent to the members to educate about the BabyCare Program and how we can assist them to coordinate appointments and to identify obstetrical providers if needed. An article was published in Fidelis' member newsletter in the 2009 winter edition titled "A Healthy Pregnancy Starts With Early Prenatal Care" to educate members on the importance of early prenatal care.

Outreach calls continue to be made to obstetrical providers to educate on the BabyCare Program and encourage participation in the BabyCare Incentive Program for earlier identification of pregnant members. Obstetrical provider submission of prenatal member information to the BabyCare Program has increased by 3% from 2009 to 2010. Letters continue to be generated on a weekly basis to servicing providers to educate on the incentive program and obtain additional clinical information to help identify members who need case management intervention.

Delivery reports are reviewed on a monthly basis to identify areas of improvement to engage pregnant members earlier in their prenatal period.

- **2008 Recommendation:** The plan should continue its efforts to improve access to and availability of routine and urgent dental care, specifically for members residing in Region 4. [*Repeat recommendation.*]

Plan Response: DentaQuest IPA of New York, LLC (formerly Doral IPA of New York, LLC) is the dental vendor for Fidelis Care New York. In response to the findings of the 2008 IPRO Dental Access & Availability Survey, a plan of correction (POC) was submitted to the NYSDOH on February 3rd, 2010 and approved by the NYSDOH on March 8th, 2010. If there is an urgent case DentaQuest notifies the plan and we do approve non-participating providers for access as necessary. Doral Dental IPA of New York, LLC made phone calls to the provider offices listed in the IPRO surveys who failed the access standards in 2006, 2007, 2008, 2009 and 2010 to review availability standards. In addition, a number of actions were taken in accordance with the approved POC in an effort to improve provider awareness of access standards and ensure member access to dental care.

In January, February, and March of 2010 office signs were distributed to providers in Regions 1 and 4. These signs announce that the office is a participating provider and serve as a reminder to the office staff that the provider participates with Fidelis. These signs also serve to announce to Fidelis patients that the office accepts their plan.

In March, a letter was sent by DentaQuest to the entire dental network reminding providers of their participation and the expectations for appointment availability (i.e. schedule routine appointments within 28 days and urgent appointments within 24 hours). Additionally, a fax blast was sent to the provider network at the beginning of the third and fourth quarters with the same information. The appointment expectations were also reiterated on banner messages that were added to provider checks beginning in February.

DentaQuest also implemented the Personal URL (PURL) Notification system. A postcard was mailed to providers in July and a follow-up postcard is planned for November. The postcards instruct providers to log-in to their PURL site to review letters, updates, and other important information. The above referenced letter was posted on this system.

DentaQuest conducts continuing education on an ongoing basis when meetings and orientations are conducted with providers. Monthly meetings are held to address any issues or concerns between Fidelis Care New York and DentaQuest. Additionally, Fidelis and DentaQuest continue to monitor access through the complaint process, and we rarely receive this type of complaint.

The actions described in this response fostered a better awareness of appointment and availability standards in the dental network, and through this awareness, the access of Fidelis Care New York members to the dental treatment they need was also positively impacted.

X. Appendix

References

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 - Managed Care Plan Directory, Accessed July 1, 2010
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- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, as of December, 2009
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- NYSDOH OMC Primary Care Providers Open and Closed Panels by Plans, Provider Network Data As Of December 31, 2009
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1) Encounter Data

- MMC Encounter Data System, 2007 - 2009

2) Health Screening Data

- Medicaid and Family Health Plus Managed Care Enrollee Health Screening, 2007 - 2009

3) QARR Use of Services

- QARR Measurement Year, 2007 - 2009

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- 1) *Summary of HEDIS® Information Systems Audit™ Findings*
 - 2010 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors
- 2) *QARR Data*
 - Performance Category Analysis, Quality Performance Matrix (2009 Measurement Year)
 - QARR Measurement Year, 2007 - 2009
- 3) *CAHPS® 2010 Data*
 - QARR Measurement Year, 2009
- 4) *Quality/Satisfaction Points and Incentive*
 - Quality/Satisfaction Points and Incentive, 2007 - 2009
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 - 2009-2010 PIP Interim Report
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G. Financial Data

- Medicaid Managed Care Operations Report, 2007 - 2009