

NEW YORK STATE DEPARTMENT OF HEALTH  
Office of Health Insurance Programs

**PLAN - SPECIFIC REPORT  
FOR  
GHI HMO  
[GHI HMO Select, 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
GHI		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<sup>®</sup>) 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<sup>®</sup>/QARR or CAHPS<sup>®</sup>, 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

GHI HMO (GHI) is a regional for-profit health maintenance organization (HMO) servicing the Medicaid, Family Health Plus (FHP), Commercial 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, Commercial and CHP product lines.

- Plan ID: 1410199
- DOH Area Office: NRAO
- Corporate Status: HMO
- Tax Status: For-profit
- Medicaid Managed Care Start Date: August 9, 2002
- Medicaid Service Area: Albany, Bronx, Broome, Columbia, Dutchess, Greene, Kings, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Schenectady, Sullivan, Ulster and Westchester
- Product Line(s): Medicaid, FHP, Commercial and CHP
- Contact Information: 441 9<sup>th</sup> Avenue, 8<sup>th</sup> Floor  
New York, NY 10001  
(212) 615-0000
- NCQA Accreditation as of 6/30/09: Commercial – Excellent
- Medicaid Dental Benefit Provided as of 12/08: Provided except in Broome County.

### III. Enrollment and Provider Network

#### Enrollment/Disenrollment

Figure 1 depicts total membership for the plan’s Medicaid product line for calendar years 2006 to 2008, as well as, the percent change from the previous year. Membership has grown during this period, increasing by 40.6% from 2006 to 2007 and by 38.7% from 2007 to 2008. 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 – 2006-2008**

	2006	2007	2008
Number of Members	13,203	18,559	25,733
% Change From Previous Year		40.6%	38.7%

Data Source: MEDS II

**Figure 1a: Membership: Other Product Lines<sup>1</sup> – 2006-2008**

	2006	2007	2008
FHP	12,865	12,789	17,346
Commercial	29,502	22,567	15,951
CHP	2,990	3,014	3,534

<sup>1</sup> 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**

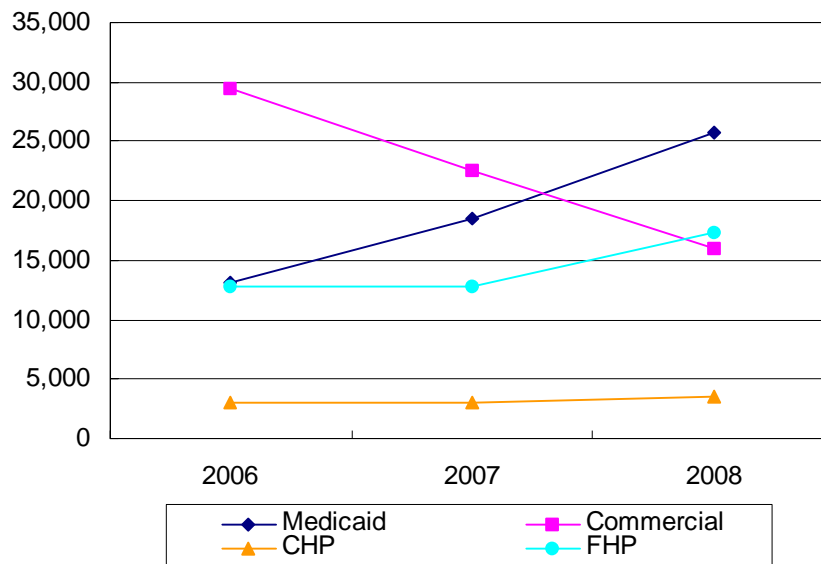


Figure 2 gives a breakdown of the plan's Medicaid membership by age and sex as of December 31, 2008. Children under 20 years of age comprise 52.8% of the total Medicaid enrollment, with 21.4% in the 5-14 age group. Thirty-two percent (32.2%) of the plan's Medicaid membership is women between the ages 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 includes a higher percentage of members aged under 1 and 20-44, as well as a lower percentage of members aged 5-14 and 15-19 in comparison to the statewide distribution. Figure 2a displays the percentage of enrollees by age group for GHI in comparison to the statewide percentages.

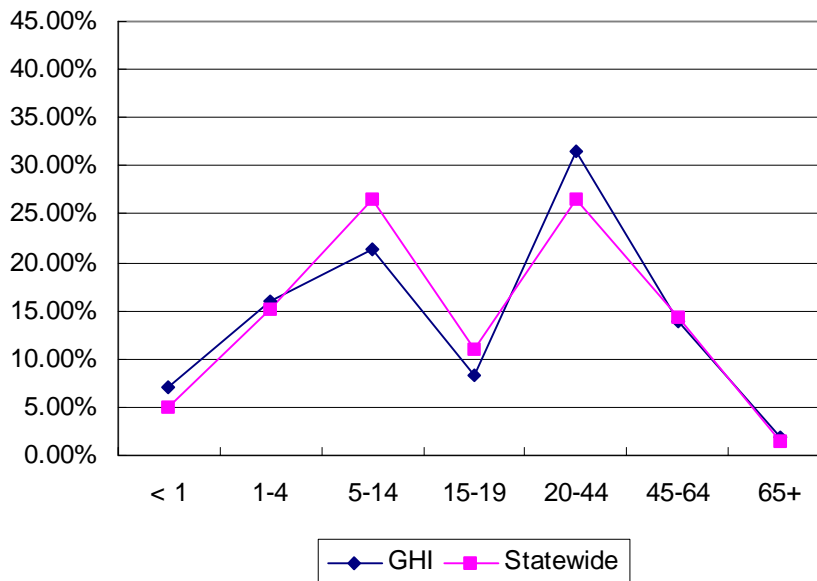
**Figure 2: Medicaid Enrollee Age and Sex Distribution – December 2008**

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 1	928	884	1,812	7.0% ▲	4.9%
1-4	2,107	2,003	4,110	16.0%	15.2%
5-14	2,815	2,695	5,510	21.4% ▼	26.6%
15-19	1,060	1,087	2,147	8.3% ▼	11.0%
20-44	2,876	5,215	8,091	31.4% ▲	26.4%
45-64	1,605	1,996	3,601	14.0%	14.3%
65 and Over	120	342	462	1.8%	1.5%
<b>Total</b>	<b>11,511</b>	<b>14,222</b>	<b>25,733</b>		
<hr/>					
Under 20	6,910	6,669	13,579	52.8% ▼	57.7%
Females 15-64 <sup>1</sup>		8,298		32.2%	32.3%

Data source: MEDS II

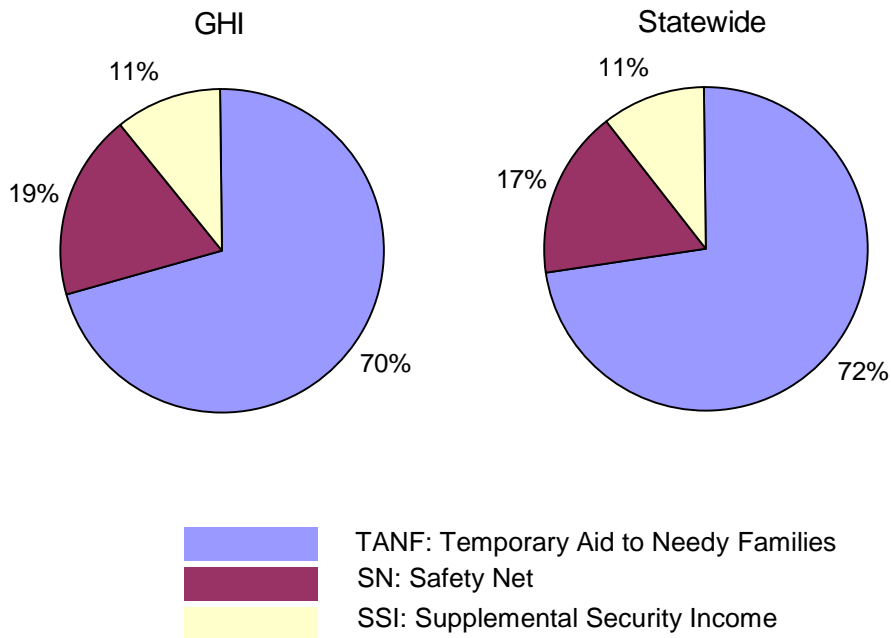
<sup>1</sup> Females between the ages of 15 to 64 were grouped for this category, since this grouping is inclusive of most women utilizing OB/GYN providers.

**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 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 2006 through 2008 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. GHI did not receive a score qualifying the plan for Medicaid auto assignment in 2006, 2007 and 2008.

**Figure 4: Method of Medicaid Enrollment – 2006-2008**

Category	2006		2007		2008	
	GHI	SWA	GHI	SWA	GHI	SWA
Auto Assigned	3.0%	8.8%	4.4%	13.6%	2.7%	13.3%
Self-Selected <sup>1</sup>	97.0%	91.2%	95.6%	86.4%	97.3%	86.7%
Qualifying Score <sup>2</sup>	N		N		N	

<sup>1</sup> These figures include new enrollees and enrollees who have transferred from another plan.

<sup>2</sup> 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 GHI'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 both Medicaid and FHP, the loss of eligibility rate was higher than those of the average plan in the state.

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

Enrollment Status <sup>1</sup>	Medicaid		FHP	
	GHI	SWA	GHI	SWA
Voluntary Disenrollment	2.01%	1.56%	0.73%	0.63%
Involuntary Disenrollment	0.08%	0.05%	0.06%	0.02%
Loss of Eligibility	1.08% ▲	0.81%	3.86% ▲	2.94%
Still Enrolled	96.83%	97.57%	95.35%	96.41%

<sup>1</sup> 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 10.2% of all providers in GHI's provider network, which was lower than the statewide percentage of 16.4%. 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	3,889	10.2% ▼	16.4%
<i>Pediatrics</i>	1,094	2.9%	4.7%
<i>Family Practice</i>	877	2.3%	3.5%
<i>Internal Medicine</i>	1,762	4.6%	7.4%
<i>Other PCPs</i>	156	0.4%	0.7%
OB/GYN Specialty <sup>1</sup>	1,671	4.4%	4.6%
Behavioral Health	6,388	16.7%	11.9%
Other Specialties	26,013	68.2%	65.7%
Non-PCP Nurse Practitioners	194	0.5%	1.5%
Dentistry <sup>2</sup>	2,708		
<b>Total (excluding dentists)</b>	38,155		

Data Source: HPN

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

<sup>2</sup> 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 90<sup>th</sup> percentile are indicated by ▲, while rates below the 10<sup>th</sup> 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	GHI			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median <sup>1</sup> Ratio of Enrollees to Providers	Total Number of FTEs	Median <sup>1</sup> Ratio of Enrollees to FTEs
Primary Care Providers	7:1 ▼	1,210.6	21:1 ▼	36:1	15,161.8	131:1
<i>Pediatrics (Under age 20)</i>	12:1 ▼			75:1		
OB/GYN (Females aged 15-64)	5:1 ▼			37:1		
Behavioral Health	4:1 ▼			45:1		

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

<sup>1</sup> 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 2006 through 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 – 2006-2008 (Q4)**

	2006			2007			2008		
	GHI		Statewide	GHI		Statewide	GHI		Statewide
	Number	% of Panel	% of Panel	Number	% of Panel	% of Panel	Number	% of Panel	% of Panel
Providers with Open Panel	4,077	97.4%	95.2%	3,968	97.5%	96.2%	4,283	98.0%	97.0%

Data Source: HPN

Figure 7 displays the QARR 2007 and 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 and Commercial board certification rates were higher than the statewide averages for Internal Medicine, Pediatricians, Geriatricians and Other Physician Specialists, while the rate for OB/GYN providers was lower.

**Figure 7: QARR Board Certification Rates – 2007-2008**

Provider Type	2007		2008	
	GHI	SWA	GHI	SWA
<b>Medicaid:</b>				
Family Medicine	77% ▼	80%	82%	82%
Internal Medicine	56% ▼	79%	89% ▲	82%
Pediatricians	54% ▼	79%	87% ▲	83%
OB/GYN	59% ▼	74%	73% ▼	76%
Geriatricians	65% ▼	74%	90% ▲	75%
Other Physician Specialists	NR	78%	87% ▲	81%
<b>Commercial:</b>				
Family Medicine	78% ▼	81%	82%	81%
Internal Medicine	60% ▼	81%	87% ▲	83%
Pediatricians	62% ▼	82%	88% ▲	84%
OB/GYN	65% ▼	78%	72% ▼	78%
Geriatricians	64% ▼	78%	86% ▲	73%
Other Physician Specialists	NR	79%	87% ▲	81%

NR: Not Report

### ***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 4<sup>th</sup> quarter 2008 and 1<sup>st</sup> 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 GHI's Dental Access & Availability results for 2008. GHI's rates for routine appointments among dentists surveyed were above the 75% threshold in Regions 5 and 6, while the Region 3 & 4 rate was below the threshold. The rate for urgent appointments among dental providers surveyed was below the 75% threshold in all regions surveyed.

**Figure 8: Dental Access & Availability Survey – 2008**

<b>Region</b>	<b>Call Type</b>	<b>GHI</b>	<b>Region Average</b>
<b>3 &amp; 4</b>	Routine	64%	75%
	Urgent	64%	71%
<b>5</b>	Routine	80%	90%
	Urgent	64%	85%
<b>6</b>	Routine	84%	89%
	Urgent	72%	86%

#### 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 2006 through 2008. 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 – 2006-2008**

	Encounters (PMPY)					
	2006		2007		2008	
	GHI	SWA	GHI	SWA	GHI	SWA
PCPs and OB/GYN	3.74	3.63	4.65	4.06	5.17	4.37
Specialty	1.42	1.39	1.67	1.62	2.03	1.81
Emergency Room	0.43	0.58	0.51	0.58	0.58	0.58
Inpatient Admissions	0.15	0.14	0.14	0.14	0.17	0.15
Dental – Medicaid			0.59	0.72	0.64	0.80
Dental – FHP			0.86	0.83	0.83	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 2006 health screening rates ranged from 8.4% to 70.2% for Medicaid and 10.0% to 82.6% for FHP, while 2007 rates ranged from 11.5% to 69.7% for Medicaid and 8.5% to 70.2% for FHP. 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 from 2006 through 2008, 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 – 2006-2008**

	2006		2007		2008	
	GHI	SWA	GHI	SWA	GHI	SWA
<b>Medicaid</b>						
Enrollee Health Screenings	36.5%	27.7%	41.4%	27.4%	36.1%	27.5%
<b>FHP</b>						
Enrollee Health Screenings	29.9%	28.0%	33.9%	30.1%	39.3%	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 90<sup>th</sup> or 10<sup>th</sup> percentiles. Figure 11 lists the Use of Services rates for the selected plan product lines for 2006 through 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 – 2006-2008**

Measure	Medicaid/FHP				Commercial				Child Health Plus			
	2006	2007	2008	SWA 2008	2006	2007	2008	SWA 2008	2006	2007	2008	SWA 2008
<b>Outpatient Utilization (PTMY)</b>												
Outpatient Visits	3,257.6 ▼	3,819.1 ▼	4,423.7	4,855.9	4,106.3	4,173.3	4,362.4	4,719.0	3,063.7	3,324.4	3,809.0	3,876.0
Outpatient ER Visits	467.4	514.6	551.5	507.5	193.9	208.1	207.8	185.0	241.4	263.0	268.5	262.3
Ambulatory/Surgery Encounters	60.0	72.6	108.5	97.7	101.7	99.6	125.4	123.7	16.0	21.6	29.9	35.8
<b>Inpatient ALOS</b>												
Medicine	3.7	3.7	3.7	3.9	3.5	3.6	4.0	3.9	SS	2.5	2.4 ▼	2.9
Surgery	5.4	6.0	5.7	5.7	5.4	4.9	4.9	4.7	SS	SS	SS	4.2
Maternity	2.8	2.8	3.0	2.8	2.7	2.8	2.9	2.8	SS	SS	SS	2.9
Total (Medicine, Surgery & Maternity)	3.7	3.7	3.7	3.8	3.9	3.8	4.1	4.0	3.9 ▲	3.0	2.4 ▼	3.2
<b>Inpatient Utilization (PTMY)</b>												
Medicine Cases	44.9	48.4	53.6	48.2	25.7	28.7	30.2 ▲	26.3	SS	13.6	13.6	12.8
Surgery Cases	17.9	16.5	18.3	15.7	20.0	18.4	19.6	18.9	SS	SS	SS	4.4
Maternity Cases	47.0	52.7	65.2	52.4	15.8	16.3	15.1	13.8	SS	SS	SS	1.9
Total Cases	99.9	104.7	118.6	100.6	59.6	61.3 ▲	63.1 ▲	57.2	14.5 ▼	19.6	19.6	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<sup>®</sup> 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<sup>®</sup> measures to the NYSDOH annually, along with several NYS-specific measures. Plan-reported performance measures were validated as per HEDIS<sup>®</sup> 2009 Compliance Audit<sup>™</sup> specifications developed by the National Committee for Quality Assurance (NCQA). The results of each plan's HEDIS<sup>®</sup> 2009 Compliance Audit<sup>™</sup> are summarized in its Final Audit Report (FAR).

### ***Summary of HEDIS<sup>®</sup> 2009 Information System Audit<sup>™</sup>***

As part of the HEDIS<sup>®</sup> 2009 Compliance Audit<sup>™</sup>, 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<sup>®</sup> Reporting
6. Control Procedures that Support HEDIS<sup>®</sup> Reporting and Integrity

In addition, two HEDIS<sup>®</sup> related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS<sup>®</sup> 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<sup>®</sup> 2009 Final Audit Report (FAR) prepared for GHI 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<sup>®</sup>/QARR reporting.

The plan used NCQA-certified software to produce HEDIS<sup>®</sup> measures. Administrative databases were used to capture additional data for the *Annual Dental Visit, Breast Cancer Screening, Cervical Cancer Screening, Comprehensive Diabetes Care, Chlamydia Screening in Women and Appropriate Testing for Children with Pharyngitis* measures. These databases were validated and determined to be HEDIS<sup>®</sup>-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 measures validated. The plan was able to report all measures required for QARR for its Medicaid and CHP product lines. The plan was also able to report all other measures for the Medicaid and Commercial 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		<b>C</b>	<b>B</b> Ambulatory Follow-Up Mental Health 30 days (C)	<b>A</b>
		<b>D</b> Cervical Cancer Screening (M) Flu Shots Adults (C)	<b>C</b> Ambulatory Follow-Up Mental Health 30 days (M) Antidepressant Meds 180 days (C) Antidepressant Meds 84 days (C) Avoid Antibiotic Adult Bronchitis (C, M) Cervical Cancer Screening (C) Chlamydia Screening 16-24* (M) COPD Bronchodilator (M) COPD Corticosteroid(M) Drug Therapy Rheumatoid Arthritis (C, M) Follow-Up for ADHD 30 days (C, M) Spirometry Testing (C, M)	<b>B</b> Antidepressant Meds 180 days (M) Antidepressant Meds 84 days (M) Chlamydia Screening 16-24* (C)
		<b>F</b>	<b>D</b>	<b>C</b>

C: Commercial

M: Medicaid and Family Health Plus

\* Chlamydia screening in 2008 decreased upper age limit to 24 yrs (2006 and 2007 included up to 25 years).

Figure 12a displays the 2006, 2007 and 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 – 2006-2008**

Measure	Medicaid/Family Health Plus				Commercial				Child Health Plus			
	2006	2007	2008	2008 SWA	2006	2007	2008	2008 SWA	2006	2007	2008	2008 SWA
Ambulatory F/U Mental Health 30 Days	75.29	79.46	78.03	78.35	87.78 ▲	78.13	83.87	78.6	NA	NA	NA	NA
Antidepressant Meds 180 days	40.91 ▲	42.67 ▲	46.27 ▲	31.67	45.1	45.95	48.53	46.84	NA	NA	NA	NA
Antidepressant Meds 84 days	57.58 ▲	62.67 ▲	61.19 ▲	48.51	57.84	64.86	66.18	62.74	NA	NA	NA	NA
Avoid Antibiotic Adult Bronchitis	24.06	30.74	21.6	24.7	20.64 ▼	18.92 ▼	20.39	23.21	NA	NA	NA	NA
Cervical Cancer Screening	69.59	R	65.21 ▼	73.44	81.27	R	79.32	81.57	NA	NA	NA	NA
Chlamydia Screening 16-24*	36.33	55.93	56.38	58.87	50 ▲	53.59 ▲	55.85 ▲	51.13	NA	NA	NA	NA
COPD Bronchodilator	NA	NA	77.08	83.79	NA	NA	SS	78.3	NA	NA	NA	NA
COPD Corticosteroid	NA	NA	64.58	64.67	NA	NA	SS	71.1	NA	NA	NA	NA
Drug Therapy Rheumatoid Arthritis	SS	SS	67.31	73.49	56.52 ▼	67.57	68.42	82.2	NA	NA	NA	NA
F/U for ADHD 30 days	SS	45.95	45.65	54.42	32.08	40	45.45	39.1	SS	SS	SS	48.3
F/U for ADHD 9 months	SS	SS	SS	60.68	SS	SS	SS	43.24	SS	SS	SS	54.08
Flu Shots Adults**	NA	NA	NA	NA	NA	42.17 ▼	43 ▼	49.85	NA	NA	NA	NA
Persistent Use Beta Blocker (C)	NA	NA	NA	NA	SS	SS	SS	78.25	NA	NA	NA	NA
Spirometry Testing COPD	SS	SS	40	41.57	48.73	41.98	44.37	46.11	NA	NA	NA	NA

R: Rotated measure

NA: Not available

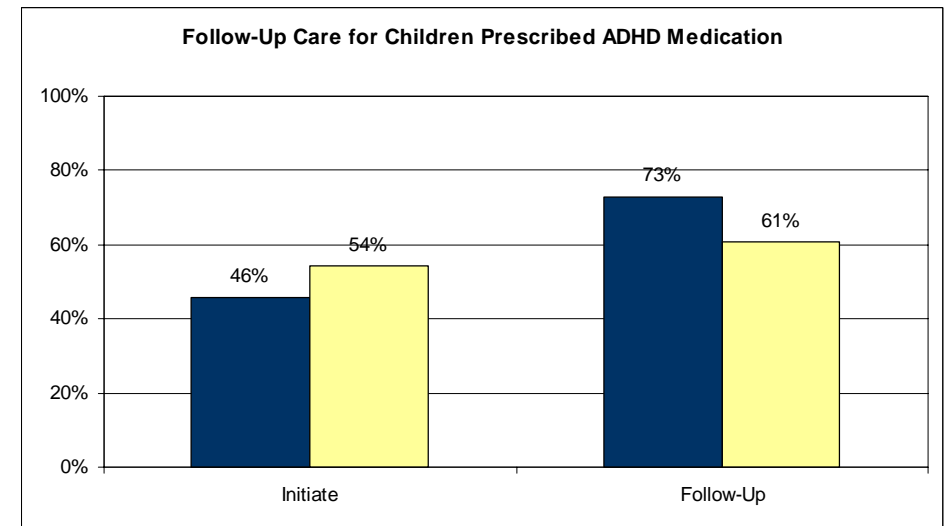
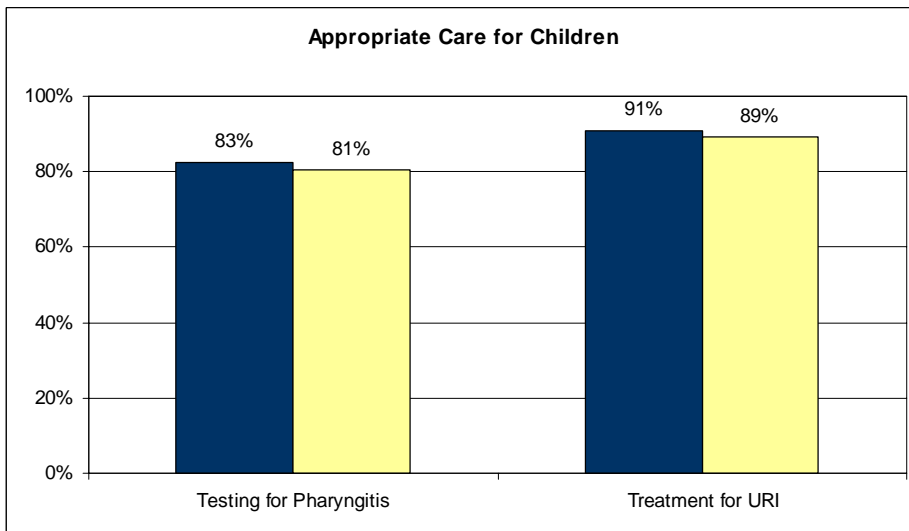
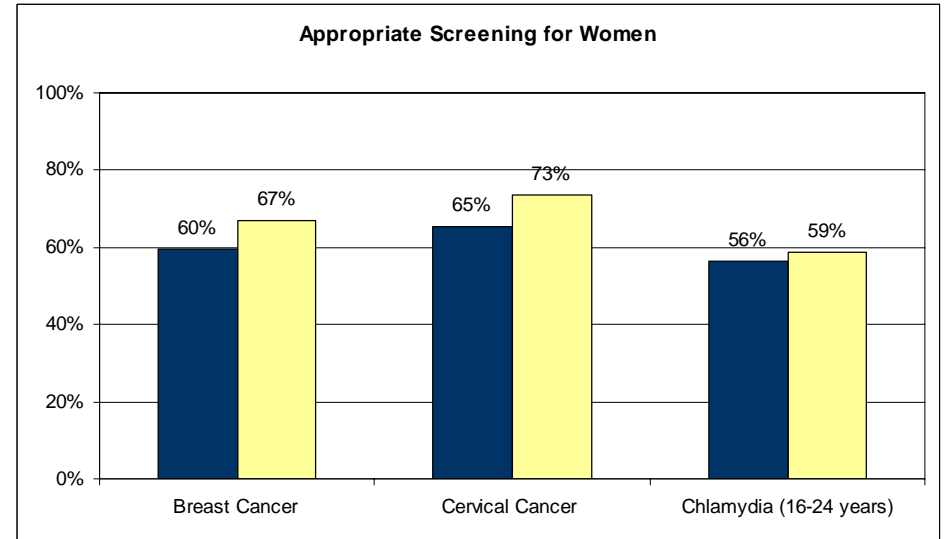
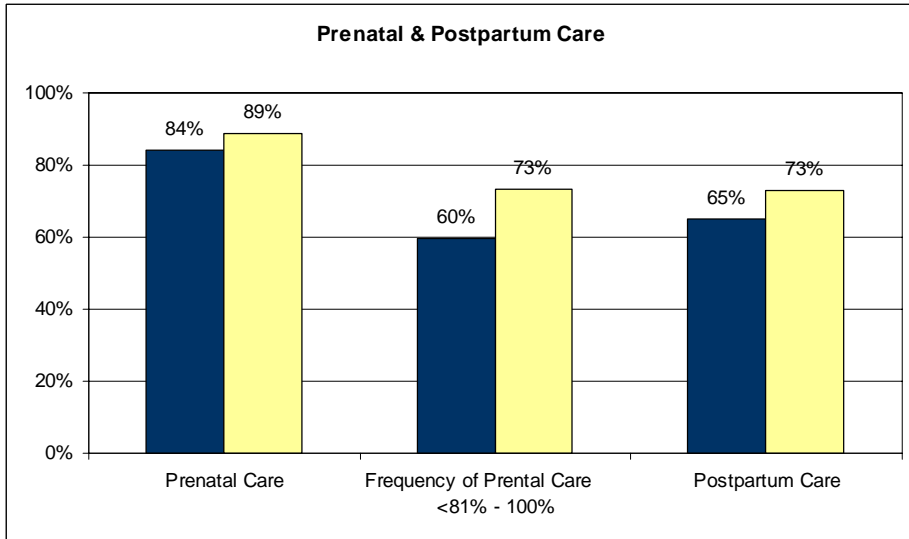
SS: Sample size too small to report (less than 30 members) but included in the SWA.

\* Chlamydia Screening: 2006 Medicaid rates have been recalculated; significance not calculated. Also, in 2008 the upper age limit was decreased to 24 years (2006 and 2007 included up to 25 years).

\*\* 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 2006 through 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 – 2006-2008**

Measure	Medicaid/FHP				Commercial				Child Health Plus			
	2006	2007	2008	SWA 2008	2006	2007	2008	SWA 2008	2006	2007	2008	SWA 2008
<b>Children and Adolescents' Access to PCPs (CAP)</b>												
12–24 months	91%	95%	97%	95%	98%	95%	97%	97%	SS	88%	SS	99%
25 months–6 years	78% ▼	85% ▼	90%	91%	92%	94%	91%	94%	89%	96%	96%	95%
7–11 years	85% ▼	85% ▼	91% ▼	94%	92%	93%	93%	95%	93%	96%	95%	97%
12–19 years	81%	77% ▼	81% ▼	90%	90%	92%	91%	92%	87%	94%	95%	94%
<b>Adults' Access to Preventive/Ambulatory Services (AAP)</b>												
20–44 years	77%	79%	81%	81%	94%	93%	92% ▼	94%				
45–64 years	83%	84% ▼	85%	88%	95%	94%	93%	95%				
65+ years	92%	81% ▼	82% ▼	88%	97%	97%	96%	95%				
<b>Access to Other Services</b>												
Timeliness of Prenatal Care	82% ▼	R	84% ▼	89%	94%	R	96%	94%				
Postpartum Care	65% ▼	R	65% ▼	73%	79%	R	85%	81%				
Annual Dental Visits <sup>1</sup>	30% ▼	40% ▼	44% ▼	48%					43% ▼	49% ▼	53% ▼	60%

R: Rotated measure

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

**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 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 – 2006-2007**

Measure	NYC				ROS			
	2006		2007		2006		2007	
	GHI	NYC Average	GHI	NYC Average	GHI	ROS Average	GHI	ROS Average
<b>Medicaid/FHP</b>								
Risk-Adjusted Low Birth Weight*	SS	7%	10%	7%	0%	7%	5%	7%
Prenatal Care in the First Trimester	SS	73%	70%	72%	79%	69%	65%	68%
% of Low Birth Weights at Facilities for High-Risk Deliveries	SS	99%	SS	99%	SS	80%	SS	81%
<b>Commercial</b>								
Risk-Adjusted Low Birth Weight*	SS	6%	SS	6%	9% ▲	5%	4%	5%
Prenatal Care in the First Trimester	SS	85%	SS	86%	84%	88%	87%	87%
% of Low Birth Weights at Facilities for High-Risk Deliveries	SS	100%	SS	100%	SS	81%	SS	83%

\*A low rate is desirable for this measure.

ROS: Rest of State

NYC: New York City

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

### Consumer Satisfaction

In 2008, the CAHPS<sup>®</sup> 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<sup>®</sup> – 2008**

Satisfaction	Medicaid		Commercial	
	GHI	SWA	GHI	SWA
Flu Shots for Adults Ages 50-64	35	43	42 ▼	49
Advising Smokers to Quit	78	74	83	80
Getting Care Needed <sup>1</sup>	73	75	82	86
Satisfaction with Provider Communication <sup>1</sup>	89	88	92	93
Care Coordination	73	74	81	80
Customer Service <sup>1</sup>	83	80	83	84
Rating of Healthcare	66	65	74	75
Rating of Health Plan – High Users	62	67	61	64
Getting Care Quickly <sup>1</sup>	81	78	87	88
Overall Rating of Health Plan	61 ▼	66	61	62
Rating of Personal Doctor	75	74	84	81
Rating of Specialist	72	71	87 ▲	81
Recommend Plan to Family/Friends <sup>2</sup>	86 ▼	90		

<sup>1</sup> These indicators are composite measures.

<sup>2</sup> New York State specific question for Medicaid; no data collected for the Commercial product line.

**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 GHI earned from 2006 to 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 GHI earned for each measure.

**Figure 16: Quality/Satisfaction/Compliance Points and Incentive – 2006-2008**

Category	2006		2007		2008	
	GHI	SWA	GHI	SWA	GHI	SWA
Total Points	56	86	36	79	52	88
<i>Satisfaction Points (30 Possible Points)</i>	10	27	0	16	10	17
<i>Quality Points (100 Possible Points)</i>	46	60	20	47	27	54
<i>Compliance Points (20 Possible Points)</i>			16	16	15	18
Percent of Financial Incentive Earned	0%		0%		0%	

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

<b>Measure</b>	<b>GHI HMO</b>
<b>Satisfaction (10 points each)</b>	<b>10</b>
Getting Care Needed (CAHPS®)	5
Customer Service and Information (CAHPS®)	5
Rating of Health Plan (CAHPS®)	0
<b>Quality (10 points each)</b>	<b>27</b>
Advising Smokers to Quit (CAHPS®)	7
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)	0
Annual Dental Visit Ages 2-18 (HEDIS®/QARR)	0
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)	0
Annual Monitoring for Patients on Persistent Medications (HEDIS®/QARR)	0
Appropriate Testing for Children with Pharyngitis (HEDIS®/QARR)	10
Postpartum Care (HEDIS®/QARR)	0
<b>Compliance (5 points each)</b>	<b>15</b>
Timeliness and Accuracy of MMCOR	5
Timeliness and Accuracy of MEDS Data	5
Timeliness of QARR Submission	5
Provider Directory Information and Participation	0
<b>Total Points Earned</b>	<b>52</b>

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 2008 PIP conducted by GHI was "Postpartum Care in the GHI HMO Medicaid/FHP HMO Population". The following interventions were implemented during the conduct of this PIP:

- Member newsletters and audio message for members when on hold during calls.
- Member and provider incentives.
- Member and provider mailed reminders.
- Postpartum visit reminder calls to members within 10 days of delivery.

Figure 17 presents a summary of GHI's 2008 PIP. Performance was maintained for the selected indicator.

Key strengths of this PIP include use of HEDIS® methodology, relevant topic, clear aim statement and barrier analysis. There were no validation findings which indicate that the credibility of the PIP results is at risk.

**Figure 17: Performance Improvement Project – 2008**

<b>Indicators</b>	<b>Results</b>
HEDIS® Postpartum Care	Performance level was maintained

***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

GHI reported that the following activities were performed in 2008 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- Examination of the Medicaid population's needs through HEDIS<sup>®</sup>/QARR rates. Additional review of the subgroups will be conducted in an integrated approach with HIP in 2009.
- Utilized HEDIS<sup>®</sup>/QARR results to determine gaps in the Medicaid/FHP receipt of services and care. Multi-channel interventions were implemented to address those gaps in care. Analysis in differences in health outcomes and health status for the Medicaid/FHP subgroups is scheduled to start in the fourth quarter of 2009 and into 2010.
- Conducted a review of postpartum care rate performance and analysis determined that there was need for continued and focused effort that reaches out to new mothers within the plan to educate them about the importance of timely postpartum visits as defined and measured by HEDIS<sup>®</sup>/QARR specifications. Moreover, GHI identified gaps care in 2008 resulting in numerous educational mailings that addressed topics such as but not limited to colorectal cancer screening, breast cancer screening, Chlamydia screening, and dental care as well as implementation of member incentive programs.
- Conducted multi-channel communications aimed to reduce and/or eliminate differences in health outcomes or health status thereby improving the quality of care for plan members identified with at-risk characteristics. In addition, GHI offered services to assist members in securing needed services. Such services included but were not limited to: 1) the language line, 2) TTY, 3) provider directory which lists the providers' gender and languages spoken, 4) member materials offered in languages in addition to English, 5) bi- and multi- lingual and culturally diverse customer service staff who assisted the member with securing services, and 6) access to after hours assistance.

## 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)<sup>1</sup>
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.

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<sup>1</sup> 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%

GHI has indicated that it performs the following HIT related activities:

- Electronic transfer/data sharing of protected information:
  - A member portal provides claims data for the subscriber and dependents, as well as information on benefits and providers visited. The member can also access personal health records (PHRs) and Health Risk Assessments (HRAs) via the member portal.
  - Providers may access protected information through [www.ghi.com](http://www.ghi.com) and [www.emblemhealth.com](http://www.emblemhealth.com). On these web sites, the plan allows providers the ability to log into a password-protected site to access member eligibility, benefits information, claims information, and copies of remits.
  - Delegated vendors receive member data via secure file transfer protocol (FTP).
- Use of telecommunications technologies:
  - Automated voice response systems are used to provide and collect health information to and from the members.
  - An integrated voice response system (IVR) is used to allow providers to access information related to eligibility, claims and remits, approvals, etc.
  - Tele-monitoring devices are used on a limited basis to collect important biometric data for members enrolled in the disease management program for heart failure.
- Use of electronic disease and/or case management systems:
  - Electronic case and disease management system allows the plan to manage authorizations and case manager assignments; enter details about members' specific issues with case management programs; assess the needs of members, and design a preventive health plan, or transition members to alternate or lower levels of care; and create customized care plans with long and short-term goals to meet the individual specific needs of members.
- Use of electronic internal registries:
  - An internal registry allows the plan to track children for the Pediatric Obesity Program and to subsequently be able to communicate electronically with registry participants.

- Use of clinical risk group software or similar software:
  - A population risk adjusted DxCG predictive model is used to identify members for case and disease management programs.
  
- Electronic communication with members and/or providers:
  - Communication with providers is conducted via the plan websites and email. Provider related information and other useful information is posted to both websites and has a dedicated area on each site for health alerts and claims-related information. Copies of the Provider Newsletter and other urgent communications are sent via email to those providers with known email addresses.
  - Providers are able to conduct specific online transactions, such as submitting medical records and claims, and receiving remits. GHI also offers providers the ability to be paid via FTP.
  - Members with known email addresses receive preventive health emails, follow-up information and reminders. Emails only contain a note telling members to go to the member's secure inbox on the GHI website, where messages containing PHI may be presented.
  
- HIT related projects/collaborations:
  - GHI is a contributor of claims data to two data aggregation initiatives sponsored by the New York Quality Alliance (NYQA) and the New York Business Group on Health (NYBGH).
  - GHI is also a participant in the electronic information exchange efforts that are sponsored by a number of health systems and communities and several of the planning/policy efforts that seek to guide their development, such as the HEAL NY 5 Advisory Committee and the New York eHealth Collaborative.
  - GHI has partnered with the New York City Department of Health and Mental Hygiene (NYCDOHMH) and is engaged in a recruitment campaign to bring physicians into the Primary Care Information Project (PCIP). Physicians who join PCIP receive a comprehensive Certification Commission for Health information Technology (CCHIT) certified electronic medical record (EMR) that includes among other things e-prescribing and registry functions. The plan provides a subsidy to encourage targeted high-volume physicians to participate in PCIP and the subsidy is contingent upon full implementation and use.
  - GHI launched a new program in 2008 to assist providers in transforming to medical homes. The pilot will be evaluated by the University of Connecticut, which received a grant from the Commonwealth Fund to study the adoption of the medical home principle among providers.
  
- Future plans to implement additional HIT initiatives may include:
  - Participation with RHIOs, specifically the New York Clinical Information Exchange (NYCLIX), Long Island Patient Information Exchange Home (LIPIX) and Brooklyn RHIO, including Provision of financial support for its medical groups with electronic medical records (EMRs) to join these RHIOS.

## 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.

GHI was in compliance with 12 of 14 categories. The categories in which GHI was not in compliance were Organization and Grievances (1 citation) and Service Delivery Network (10 citations).

**Figure 19: Focused Review Types**

<b>Review Name</b>	<b>Review Description</b>
<b>Access and Availability</b>	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.
<b>Complaints</b>	Investigations of complaints that result in an SOD being issued to the plan.
<b>Contracts</b>	Citations reflecting non-compliance with requirements regarding the implementation, termination or non-renewal of MCO provider and management agreements.
<b>Disciplined/Sanctioned Providers</b>	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.
<b>MEDS (Medicaid Encounter Data Set)</b>	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
<b>Member Services Phone Calls</b>	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
<b>Other</b>	Used for issues that do not correspond with the available focused review types.
<b>Provider Directory Information</b>	Provider Directories are reviewed to ensure that they contain the required information.
<b>Provider Info-Web</b>	Review of MCO's web-based provider directory to assess accuracy and required content.
<b>Provider Network</b>	Quarterly review of HPN network submissions for adequacy, accessibility and correct listing of primary, specialty and ancillary providers for enrolled population.
<b>Provider Participation – Directory (In addition to the routine Provider Participation – Directory surveys, in 2008 there was a survey specific to dental)</b>	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.
<b>QARR (Quality Assurance Reporting Requirements)</b>	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
<b>Ratio of PCPs to Medicaid Clients</b>	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
<b>Complaints and Grievances</b>			0
<b>Credentialing</b>			0
<b>Disclosure</b>			0
<b>Family Planning</b>			0
<b>HIV</b>			0
<b>Management Information Systems</b>			0
<b>Medicaid Contract</b>			0
<b>Medical Records</b>			0
<b>Member Services</b>			0
<b>Organization and Management</b>			1
<i>a. The Plan renewed its management contract services agreements (MSAs) with CareCore National, LLC and Doral Services of New York, Inc. on 8/22/08 and 9/1/08, respectively, without submitting an application for renewal at least 90 days prior to the expiration date of existing MSAs, or receiving prior authorization of the Commissioner of Health to renew the MSAs.</i>	a	Contracts	
<b>Prenatal Care</b>			0
<b>Quality Assurance</b>			0
<b>Service Delivery Network</b>			10
<i>b. There were 11 of 46 providers who were identified as non-participating providers in the December 10 – 31, 2007 printed directory verification study. These providers are still incorrectly listed as participating providers in the current printed provider directory.</i>	a	Provider Directory Information	
<i>c. There is no way to access Public Health Programs Dental Providers on the web-based provider directory.</i>	a	Provider Information – Web	
<i>d. There was 1 of 33 Medicaid/Family Health Plus providers from the August 10 – 31, 2007 provider directory verification study who was identified as a non-participating Medicaid provider. This provider is still incorrectly listed as a participating Medicaid provider in the current printed and web-based directories. [Repeat Deficiency]</i>	a	Provider Participation – Directory	
<i>e. The governing authority failed to ensure that its web-based provider directory contained information that was of accurate nature. Sixteen (16) of 50 participating providers sampled from the web-based directory were incorrectly listed as participating providers. [Repeat Deficiency]</i>	a	Provider Participation – Directory	
<i>f. The governing authority failed to ensure that its printed provider directory contained information that was of an accurate nature. Thirty (30) of 100 Medicaid/Family Health Plus providers sampled from the printed provider directory were incorrectly listed as participating providers. [Repeat Deficiency]</i>	a	Provider Participation – Directory	
<i>g. The governing authority failed to ensure that its printed provider directory contained information that was of accurate nature. Thirty-seven (37) of 100 Medicaid/FHP providers sampled from the printed provider directory were incorrectly listed as participating providers. [Repeat Deficiency]</i>	a	Provider Participation – Directory	
<i>h. The Plan failed to ensure that its printed provider directory contained information that was of an accurate nature. Twenty-four (24) of 75 Commercial/Child Health Plus providers sampled from the printed provider directory were inaccurate in content.</i>	a	Provider Participation – Directory	

Category	Review Type/Name (a indicates focused review)		Citations
<i>i. There were 19 providers who were identified as non-participating providers in the June 20-30, 2008 printed provider directory verification study. Eight (8) of these providers are still incorrectly listed as participating providers in the current web-based provider directories.</i>	a	Provider Participation – Directory	
<i>j. The Plan failed to ensure that its web-based provider directory contained information that was of an accurate nature. Nineteen (19) of 50 providers sampled from the web-based provider directory were inaccurate in content.</i>	a	Provider Participation – Directory	
<i>k. The Plan failed to ensure that its printed provider directory contained information that was of an accurate nature. Twenty-two (22) of 75 Medicaid/Family Health Plus providers sampled from the printed provider directory were inaccurate in content. [Repeat Deficiency]</i>	a	Provider Participation – Directory	
<b>Utilization Review</b>			<b>11</b>
<b>Total</b>			

No operational survey conducted in 2008.

**External Appeals Summary Report**

Figure 21 displays external appeals for 2006 to 2008 for the Medicaid and Commercial product lines. This Figure reflects absolute numbers, and is not weighted by plan enrollment.

**Figure 21: External Appeals – 2006-2008**

	2006	2007	2008
<b>Medicaid</b>			
Overtured	0	0	0
Overtured in Part	0	0	0
Upheld	0	0	4
<b>Medicaid Total</b>	<b>0</b>	<b>0</b>	<b>4</b>
<b>Commercial</b>			
Overtured	2	1	4
Overtured in Part	2	2	0
Upheld	1	3	5
<b>Commercial Total</b>	<b>5</b>	<b>6</b>	<b>9</b>

## VIII. Financial Data

The financial summary is based on data reported in each plan's 2006, 2007 and 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.

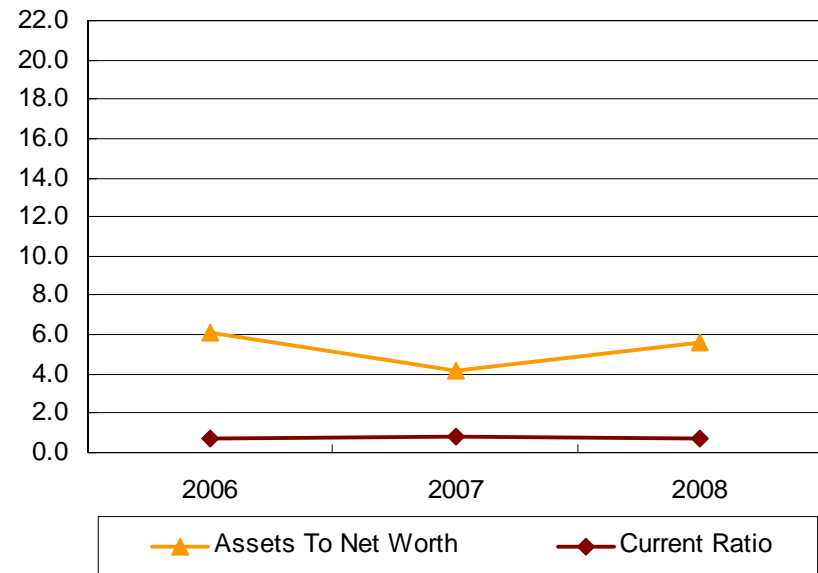
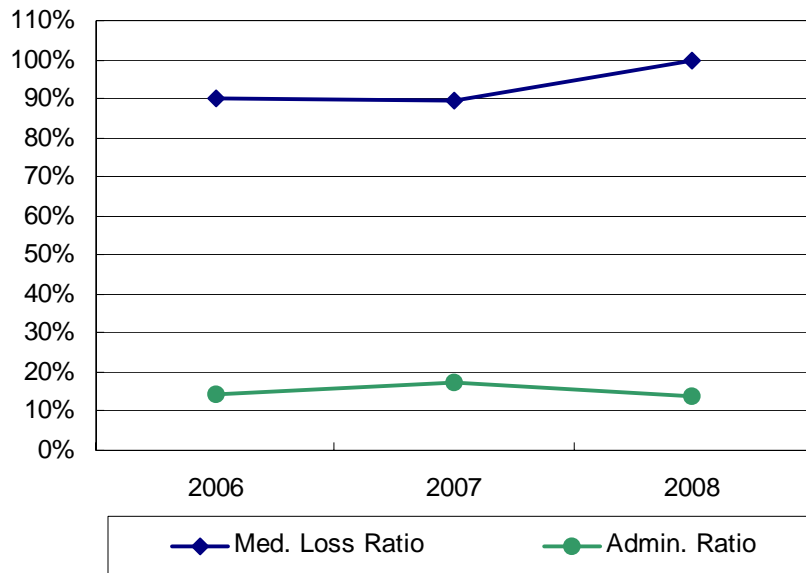
- *Assets to Net Worth*: Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has \$3 of assets for every \$1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
- *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 22a graphically trends selected measures from Figure 22.

**Figure 22: Selected Financial Ratios – 2006-2008**

	2006		2007		2008	
	GHI	SWA	GHI	SWA	GHI	SWA
<b>PROFITABILITY</b>						
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	6.1	2.1	4.2	2.0	5.6	2.2
Premium Surplus Ratio = Premium Income/Premium Revenue	-4.3%	-0.1%	-6.7%	-0.6%	-13.5%	-0.7%
Medical Loss Ratio = Medical Exp/Prem Revenue	90.0%	86.6%	89.3%	87.7%	99.8%	88.9%
Administrative Ratio = Admin Exp/Prem Revenue	14.3%	13.4%	17.3%	13.0%	13.6%	11.8%
<b>LIQUIDITY</b>						
Current Ratio = Current Assets/Current Liabilities	0.7	1.3	0.8	1.4	0.7	1.2

**Figure 22a: Trends for Selected Financial Ratios – 2006-2008**



## IX. Strengths and Opportunities for Improvement<sup>1</sup>

This section summarizes the accessibility, timeliness, and quality of services provided by GHI 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<sup>®</sup> Audit revealed no significant problems and the plan was able to report all rates for QARR.
- The plan demonstrated improvement as indicated by better than average rates on the HEDIS<sup>®</sup>/QARR *Board Certification* measure for Internal Medicine, Pediatricians and Other Physician Specialists.
- The plan continues to demonstrate strong performance in regard to the HEDIS<sup>®</sup>/QARR *Antidepressant Medication Management –180 days* and *–84 days* measures exceeding the statewide averages for three consecutive reporting periods.
- As indicated on the EQRO 2009 HIT Survey, the plan conducts a variety of member and provider activities that rely on HIT. In addition, the plan indicates that it has future plans to implement additional HIT initiatives.

### **Opportunities for Improvement**

- The plan did not receive quality, satisfaction and compliance scores that qualified it for the available financial incentive or for the auto-assignment of new members. (Note: the qualifying score was identified as an opportunity for improvement in the previous year's report.)
- The plan continues to demonstrate an opportunity for improvement with regard to dental access. The plan has reported below average rates for the HEDIS<sup>®</sup>/QARR *Annual Dental Visit* measure for three consecutive reporting periods. In addition, on the EQRO 2008 Dental Access & Availability Survey, the plan did not meet the 75% threshold for routine appointments in Regions 3 & 4, nor did it meet the threshold for urgent appointments in Regions 3 & 4, 5 and 6. (Note: dental access was identified as an opportunity for improvement in the previous year's report.)
- The plan performed below the statewide average on the HEDIS<sup>®</sup>/QARR *Cervical Cancer Screening* measure, indicating an opportunity for improvement.
- The plan continues to demonstrate an opportunity for improvement in regard to access. The plan's rates for the HEDIS<sup>®</sup>/QARR *Children and Adolescents' Access to Primary Care Practitioners* measure for age groups 7-11 years and 12-19 years and *Adults' Access to Preventive/Ambulatory Services* measure for the 65 and older age group were in the 10<sup>th</sup> percentile. (Note: child/adolescent and adult access were opportunities for improvement in the previous year's report.)
- The plan has performed below the statewide average on the HEDIS<sup>®</sup>/QARR *Timeliness of Prenatal Care* and *Postpartum Care* measures for two consecutive reporting periods, indicating an opportunity for improvement.

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<sup>1</sup> 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.

- While the plan demonstrated significant improvement on the HEDIS<sup>®</sup>/QARR *Board Certification* measure for specific provider types, the plan continues to demonstrate an opportunity for improvement in regard to board certification for OB/GYN providers. (Note: board certification for OB/GYN providers was an opportunity for improvement in the previous year's report.)
- While the plan has demonstrated some improvement in the area of member satisfaction, the plan's CAHPS<sup>®</sup> rates for *Overall Rating of Health Plan* and *Recommend Plan to Family/Friends* continue to perform below the statewide average. (Note: CAHPS<sup>®</sup> scores reported in this version of the Plan-Specific Report were also reported in last year's Plan-Specific Report.)
- In regard to compliance with NYS structure and operation standards, the plan received a total of 11 focused review citations related to Contracts, Provider Directory Information, Provider Information –Web and Provider Participation –Directory in the following categories: Organization & Management and Service Delivery Network. (Note: compliance with NYS structure and operation standards was an opportunity for improvement in the previous year's report.)

### **Recommendations**

- To ensure that the plan receives a percentage of the available financial incentive and qualifies for auto-assignment of members, the plan should investigate the decline in its quality and satisfaction scores. The plan should specifically focus on improving HEDIS<sup>®</sup>/QARR Effectiveness of Care rates as they tie into the State's formula for calculating the qualifying score. The plan should continue the interventions implemented to address this area as described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- The plan should work to address the problems noted in the focused reviews, with specific attention to the information presented in the provider directories to ensure that members have access to accurate and up to date information regarding the plan's provider network. *[Repeat recommendation.]*
- The plan should continue its efforts to improve access to dental care and monitor the effectiveness of the initiatives implemented to address this area, as described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*
- The plan should investigate its below average performance on the HEDIS<sup>®</sup>/QARR *Cervical Cancer Screening, Timeliness of Prenatal Care* and *Postpartum Care* measures, and implement initiatives to address these areas of care. As the plan continues to report a below average rate of board certified OB/GYN providers, the plan should continue to monitor the adequacy of its provider network and evaluate the interventions outlined in the plan's response to the previous year's recommendation to ensure that its female members can access needed services. *[Repeat recommendation.]*
- The plan should continue with its various quality improvement activities as described in the plan's response to the previous year's recommendations.

### **Response to Previous Year's Recommendations**

- **2007 Recommendation:** To ensure that the plan receives a percentage of the available financial incentive and qualifies for the auto-assignment of members, the plan should investigate the decline in its quality and satisfaction scores. Specifically, the plan should continue its efforts to improve its CAHPS<sup>®</sup> scores and its rates for quality of care measures; and measure the effectiveness of the initiatives implemented to address these areas, as described in the plan's response to the previous year's recommendation. *[Repeat recommendation.]*

**Plan Response:** GHI HMO continues its commitment to qualify for member auto-assignment and share in the Medicaid quality financial incentive.

Interventions targeted to improve member satisfaction have produced consistent results on the most recent CAHPS<sup>®</sup> survey. Interventions included but were not limited to:

- Implementation of outbound telephone Member Satisfaction Survey to members who had recently contacted the call center.
- Improved timeliness in correspondence and web mail cycle times.
- Improved average speed of answer.
- Additional training for Customer Service Representatives to improve the percentage of inquiries resolved during the call (first call resolution).

GHI continued quality initiatives throughout 2008 utilizing a prioritized schedule of activities. Quality improvement activities were selected based on several factors including measure results comparison to previous year's rates and statewide averages, monitoring of targeted HEDIS®/QARR measures, root cause analyses and available resources. Members needing care and preventive screenings continue to be targeted for interventions based on these priorities.

In late 2008, within the corporate-wide EmblemHealth integration plan, GHI and HIP initiated a merger of quality programs creating an enhanced process that utilizes valuable resources from both MCOs. A more encompassing systematic approach is now used to ensure improvement in quality scores and members' receipt of care. This process using a complex quality matrices formula assesses all quality of care measures, assigns weight to each measure based on regulatory and accreditation requirements, benchmark indicators, population affected, project duration and the amount of resources needed to effect change. These criteria were used for selection of 2009 initiatives and are being used to select all clinical initiatives in 2010.

- **2007 Recommendation:** The plan should work to address the problems noted in the Article 44 review and in the focused reviews, possibly by increasing oversight of its UR vendor(s) and by devoting more staff to ensure the accuracy of information published in the provider directories. [*Repeat recommendation.*]

**Plan Response:** Problems noted in the Article 44 review were addressed as noted below:

*Citation 1- The plan does not demonstrate adequate and accurate systems for identifying HIV+ enrollees in order to offer case management services, as evidenced by inconsistencies between the case management roster and the comprehensive list of HIV+ patients provided by the plan.*

GHI HMO reviewed the processes used to identify HIV+ and AIDS cases for potential inclusion in case management and made many enhancements to internal systems and reports. We have expanded our criteria for our trigger list reports that pull claims of members who have tests and procedures that are possibly indicative of HIV disease. An example of this is the addition of diagnosis codes V08 and .042. These claims reports are run monthly and include claims with any DOS that falls in the year. This report was also run one-time for all of 2008 claims to ensure that we did not fail to identify any members. The HIV Case Management team continues to perform outreach on any newly identified member. Health Risk Assessments that are received by the plan continue to be reviewed. Members who self-identify on the Health Risk Assessment form and/or report that they are sick right now are contacted by a case manager for assessment of case management services and possible entry into the HIV case management program. Interdepartmental communication for referrals has also been increased. UM staff and other key departments (i.e. Customer Service) have been reminded of the importance of referring any known HIV+ member to the HIV case manager. The GHI algorithm for extracting cases from claims data has been replaced by the legacy HIP process as of March 2009. The GHI UM Director participated in a state-wide conference on the topic of identification of AIDS cases, sponsored by the NYSDOH in June 2008. Quarterly audits of cases began the first quarter of 2009. A report on this quarterly review was presented to the Care Management Committee (CMC) in April 2009. The CMC reports to the Quality Improvement Committee.

*Citation 2- The Plan did not provide evidence that policies and procedures to offer case management to all HIV+ enrollees were implemented. The Plan did not provide documentation of offering case management to 61 of 70 persons the plan identified as HIV positive. Case management services, when provided, were not initiated in a reasonable time frame. The gap between enrollment and offering case management services for all but one enrollee ranged from 6 months to 25 months.*

Actions listed in the first response will have a positive impact on offering case management services to HIV+ enrollees and lessening the gap between enrollment and offering of case management services; specifically the replacement of the GHI algorithm for extracting cases from claims data with the HIP algorithm and process in March 2009.

Enhancements to the web based HIV case management database allow better tracking and time managing of identification /notification of possible HIV to member outreach.

Responsibilities for AIDS falls under a single clinical and administrative leadership structure as a result of the merger of GHI and HIP processes and operate in parallel on separate systems until they are merged later in 2009.

*Citation 3- The plan did not provide evidence of either contractor-based case management or referrals to community based case management even for enrollees with very complex needs. Staff stated in interview that one organization had been contacted but no payment mechanism was in place.*

Members who are enrolled in case management are routinely educated on and referred to community based resources. Welcome letters include a discussion about community resources. In addition, the case manager discusses with the member and can facilitate for the member access to HIV Specialists as PCPs and referrals to Designated AIDS Centers when appropriate.

The effort to enhance the quality of the GHI HMO provider directory continues to be a primary focus. GHI HMO continues proactive outreach to medical provider offices to confirm participation and identify demographic updates. Providers who are unreachable by phone, based on directory phone numbers, are further researched using correspondence and telephone directory assistance. Providers who still cannot be located are removed from the network.

GHI HMO provider directory books are updated on a monthly basis and the web-based directory is updated weekly. Members and providers are routinely advised in quarterly newsletters and through website updates that up to date provider lists are available on our website, or may be ordered in print version.

- **2007 Recommendation:** The plan should continue its efforts to improve access to dental care and measure the effectiveness of the initiatives implemented to address this area, as described in the plan's response to the previous year's recommendation. [*Repeat recommendation.*]

**Plan Response:** Annual dental visit rates for both the Medicaid and Child Health Plus population continue to improve as evidenced in the three-year rate comparison. The Medicaid Annual Dental Visit goal for QARR 2008 established at 43% was exceeded by two percentage points.

Annual Dental Exam	QARR 2006	QARR 2007	QARR 2008
GHI HMO Medicaid	30%	40%	45%
NYS Average Medicaid	44%	45%	49%
GHI HMO Child Health Plus	43%	49%	53%
NYS Average	54%	57%	60%

Interventions completed in 2008 and 2009 include:

- Member incentives upon completion of a dental visit (8/08 and 7/09)
- Medicaid member newsletter articles as reminders of the importance of regular dental visits and dental care (Summer and Fall 2008, Winter and Spring 2009)
- Provider incentive to selected high volume dentists (11/08)
- Member incentive reminder (11/08)
- SoundCare messages while members and providers are on hold when contacting Customer Service (2/09)
- Review of dental network to ensure access adequacy (ongoing)

Planned interventions:

- Member Medicaid dental incentive reminder (10/09)
- Provider incentive mailing (11/09)

Activities designed to improve dental health care are continually examined for effectiveness. The member incentive program initiated in 2007 continues to be a successful intervention.

- **2007 Recommendation:** The plan should monitor the adequacy of its provider network to ensure optimal access to quality providers and work to resolve issues that may prohibit timely access to services for primary care for children and adults.

**Plan Response:** GHI HMO continues to monitor the adequacy of the provider network. Activities dedicated to this effort include:

- On a quarterly basis, provider network by county reports are produced and analyzed to ensure adequate provider accessibility. Reports are reviewed, deficiencies are identified and resources are assigned to address areas lacking adequate provider accessibility.
- In 2007, Customer Service began notifying Provider Relations on a weekly basis about non-participating providers who were part of a participating group. This process continued through 2008 into 2009. In 2008, approximately 105 providers were identified as being a non-participating provider in a par group. Those identified were investigated by the appropriate Provider Relations Representative and contacted for conversion to participating status. In addition, non par providers identified by Utilization Management via the authorization process and claim denials, were funneled to Provider Relations on a monthly basis. Those names were incorporated into a recruitment list for Provider Relations. Numbers have decreased significantly since 2007. The April 2009 report indicated only a few non-participating providers within a par group. Provider satisfaction is monitored annually through review of the provider satisfaction survey and monthly by review of provider appeals and complaints. Areas of dissatisfaction are identified, discussed and addressed as appropriate.
- Key recruitment areas continue to be Central New York and the Hudson Valley. (7/09)

- **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:** GHI continued quality initiatives throughout 2008 utilizing a schedule of activities based on prioritization. Quality improvement activities were selected based on several factors including measure results comparison to previous year's rates and statewide averages, monthly monitoring of targeted HEDIS®/QARR measures, root cause analyses and available resources. Members needing care and preventive screenings continue to be targeted for interventions based on these priorities. Quality initiatives are now selected using the clinical initiative selection criteria mentioned above in response #1.

Quality improvement activities outlined in the previous EQR report response and continued throughout 2008 included the following: Well child visits for adolescents and children ages 3-6, prenatal and postpartum care, annual dental visits, and diabetes eye exam. In addition, GHI continued quality activities for cervical and colorectal cancer screening.

*Comprehensive Diabetes Care:* Although this was a rotated measure and therefore was not collected in 2008, initiatives to improve members' compliance with annual retinal eye exam included a member incentive for receipt of care, reminders to members who did not have an exam and lists of non-compliant members to respective primary care providers. The diabetes disease management program, PATH (Positive Action Towards Health) program also provides case management to members to ensure that they are receiving appropriate care.

*Adolescent Well-Care Visits and Well-Child Visits Ages 3-6:* Adolescent well care, with an emphasis on PCP access, continues to be a focus. Interventions continued throughout 2008 for all pediatric age groups. Interventions included member incentives, provider bonuses, outreach to newly enrolled members, birthday cards to all members in birth month listing recommended preventive care services including well visits, and outreach to members who did not receive PCP care within the past 12 months. Although these QARR measures were rotated, an administrative rate comparison illustrates the effectiveness of these interventions in 2008.

GHI HMO Medicaid	Administrative Data	
	QARR 2007	QARR 2008
Well child visit Ages 3 to 6	70.52%	75.23%
Adolescent Well Visit	43.15%	46.14%

Current interventions continue in 2009. Since the QARR 2009 pediatric well visit measures will be collected using the administrative method, the goals for GHI HMO Medicaid population are established at 76% for well child visit ages 3-6 and at 48% for adolescent well-care visits.

*Prenatal and Postpartum Care:* Enhancement of the prenatal and postpartum care program continued into and throughout 2008. Several ongoing initiatives were utilized to improve prenatal and postpartum care in 2008 and continue through 2009. Among the initiatives were the Mom-To-Be program, the member incentive program, medical record review of OB charts for compliance, Welcome Home Calls and outreach to highly utilized OB/GYN providers (August 2009).

Although not attaining statewide averages, the timeliness of prenatal care rate continues to improve.

Timeliness of Prenatal Care	QARR 2006	QARR 2007	QARR 2008
GHI HMO Medicaid	82%	82% (rotated)	84%
NYS Average	86%	86% (rotated)	89%

The postpartum care rate improved in 2007; however, a rate decline was evidenced in 2008. Several challenges contributing to this decline included mid-year changes in prenatal/postpartum program design and in member incentives, member postpartum visits outside of established timeframes and data collection issues; i.e. limitations in the medical record collection process in the NYC area and OB office practice resources unavailable to submit charts for review.

<b>Postpartum Care</b>	<b>QARR 2006</b>	<b>QARR 2007</b>	<b>QARR 2008</b>
GHI HMO Medicaid	64.72%	72.40%	64.96%
NYS Average	70%	69%	73%

GHI HMO continues to focus on prenatal and postpartum care. Next steps include:

- Provider Focus Group in Fall 2009 to jointly define barriers that patients explain to providers about why they do not keep postpartum appointments; learn about proactive tracking/recall systems that practices are using to ensure members come in for their postpartum visit and understand from the providers how the health plan can ensure timely postpartum visits.
- Integrate with HIP using a multi-faceted educational approach focusing on members and providers.
  - General health educational messages to reach largest numbers of members.
  - Targeted member interventions to Medicaid members who are not in the Mom-to-Be Program (our maternity program).
  - Creation of a Hospital Visitation Program.
  - Continued education to providers about advantages of using unbundled maternity coding.
  - Continued education to providers about the importance of timely postpartum visits.
  - Identify potential access issues for populations not receiving services.

## **X. Appendix**

### **References**

#### **A. Corporate Profile**

- Updated Corporate Profile information provided by the NYSDOH
- 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**

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- Auto Assignment Data, 2006 - 2008
- Auto Assignment Quality Algorithm Scores, 2006 - 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
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- QARR Measurement Year, 2006 - 2008
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#### **C. Utilization**

##### *1) Encounter Data*

- MMC Encounter Data System, 2006 - 2008

##### *2) Health Screening Data*

- Medicaid and Family Health Plus Managed Care Enrollee Health Screening, 2006 - 2008

##### *3) QARR Use of Services*

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**D. Quality Indicators**

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  - 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*
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- 5) *Performance Improvement Project*
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**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, 2006 - 2008

**G. Financial Data**

- Medicaid Managed Care Operations Report, 2006 - 2008