

NEW YORK STATE DEPARTMENT OF HEALTH  
Office of Health Insurance Programs

**PLAN - SPECIFIC REPORT  
FOR  
AMIDA CARE, INC.**

Reporting Year 2009

April 2011

## Table of Contents

<b>I.</b>	<b>About This Report.....</b>	<b>1</b>
<b>II.</b>	<b>Corporate Profile.....</b>	<b>2</b>
<b>III.</b>	<b>Enrollment and Provider Network.....</b>	<b>3</b>
	<i>Enrollment/Disenrollment.....</i>	<i>3</i>
	<i>Provider Network.....</i>	<i>5</i>
	<i>NYSDOH Primary Care Access &amp; Availability Survey – 2009 .....</i>	<i>7</i>
<b>IV.</b>	<b>Utilization.....</b>	<b>8</b>
	<i>QARR Use of Services Measures .....</i>	<i>8</i>
<b>V.</b>	<b>Quality Indicators .....</b>	<b>9</b>
	<i>Validation of Performance Measures Reported by Plans and Performance Measures Calculated by the NYSDOH .....</i>	<i>9</i>
	<i>Summary of HEDIS® 2010 Information System Audit™ .....</i>	<i>9</i>
	<i>QARR Access to/Availability of Care Measures.....</i>	<i>10</i>
<b>VI.</b>	<b>Deficiencies and Appeals .....</b>	<b>11</b>
	<i>Compliance with NYS Structure and Operation Standards .....</i>	<i>11</i>
	<i>External Appeals Summary Report .....</i>	<i>15</i>
<b>VII.</b>	<b>Financial Data.....</b>	<b>16</b>
<b>VIII.</b>	<b>Appendix.....</b>	<b>18</b>
	<i>References.....</i>	<i>18</i>

## List of Figures

Figure 1:	Membership: Medicaid – 2009 .....	3
Figure 2:	Medicaid Enrollee Age and Sex Distribution – December 2009 .....	3
Figure 2a:	Percentage of Medicaid Enrollees by Age – December 2009 .....	4
Figure 3:	Medicaid Disenrollment Rates (by percentage of enrollees) – 2009 .....	4
Figure 4:	Medicaid Providers by Specialties – 2009 (Q4).....	5
Figure 4a:	Ratio of Enrollees to Providers for Medicaid – 2009 (Q4) .....	5
Figure 4b:	Medicaid PCPs with an Open Panel – 2009 (Q4) .....	6
Figure 5:	QARR Board Certification Rates – 2009 .....	6
Figure 6:	Primary Care Access & Availability Resurvey – 2009 .....	7
Figure 7:	QARR Use of Services – 2009 .....	8
Figure 8:	QARR Plan Performance Rates – 2009.....	10
Figure 9:	QARR Access to/Availability of Care Measures – 2009.....	10
Figure 10:	Focused Review Types .....	12
Figure 11:	Summary of Citations.....	13
Figure 12:	External Appeals – 2009.....	15
Figure 13:	Selected Financial Ratios – 2007-2009 .....	17
Figure 13a:	Trends for Selected Financial Ratios – 2007-2009 .....	17

## Acronyms Used in This Report

(in alphabetical order)

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

## **I. About This Report**

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

The Plan-Specific Reports (PSRs) are individualized reports on the managed care organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2009 External Quality Review (EQR) to evaluate access to, timeliness of and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per federal regulation 42 CFR §438.358) reported include validation of 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 technical assistance by the NYS EQRO to plans regarding 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, appeal summaries and financial ratios.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, Deficiencies and Appeals, and Financial Data. When available and appropriate, the plans' data are compared to the SNP benchmark rate, which is the rate of all three HIV SNPs. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR, 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.

In an effort to provide the most consistent presentation of this varied information, the PSR is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2009.

## II. Corporate Profile

Amida Care, Inc. (Amida Care) is a regional, not-for-profit HIV special needs plan (SNP) that services the Medicaid population. The following report presents plan-specific information for the Medicaid line of business.

- Plan ID: S99B001
- DOH Area Office: Metropolitan Area Office
- Corporate Status: Active
- Tax Status: Non-Profit
- Medicaid Managed Care Start Date: April 15, 2003
- Medicaid Service Area: Bronx, Kings and New York
- Product Line(s): Medicaid
- Contact Information: 248 West 35<sup>th</sup> Street, 7<sup>th</sup> Floor  
New York, NY 10001  
(646) 786-1800
- NCQA Accreditation as of 6/30/10: Did not apply
- Medicaid Dental Benefit Provided as of 12/09: Not Provided

### III. Enrollment and Provider Network

#### Enrollment/Disenrollment

Figure 1 depicts total membership for the plan’s Medicaid product line for calendar year 2009.

**Figure 1: Membership: Medicaid – 2009**

	2009
Number of Members	1,438
% Change From Previous Year	

Data Source: MEDS II

Figure 2 gives a breakdown of the plan’s Medicaid membership by age and sex as of December 31, 2009. The Figure also indicates whether the plan’s distribution is statistically higher (indicated by ▲) or statistically lower (indicated by ▼) than the statewide age distribution. Figure 2a displays the percentage of enrollees by age group for Amida Care in comparison to the statewide percentages.

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

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 20	24	31	55	3.8% ▼	12.4%
20-44	449	218	667	46.4% ▲	38.6%
45 and Over	482	234	716	49.8%	49.0%
<b>Total</b>	955	483	1,438		
Females 15-64 <sup>1</sup>		460		32.0% ▼	35.9%

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 2009**

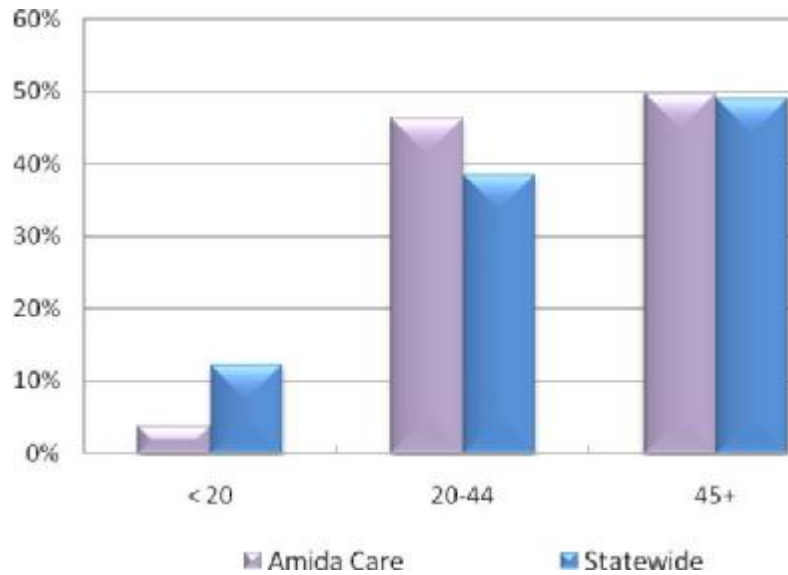


Figure 3 shows Amida Care’s 2009 Medicaid disenrollment rates. Rates statistically above the statewide average are indicated by ▲, and rates statistically below the statewide average are indicated by ▼. Amida Care’s Medicaid rates for Voluntary Disenrollment and Loss of Eligibility are higher than the average special needs plan, while Amida Care’s rate for Still Enrolled is lower.

**Figure 3: Medicaid Disenrollment Rates (by percentage of enrollees) – 2009**

Enrollment Status <sup>1</sup>	Medicaid	
	Amida Care	SWA
Voluntary Disenrollment	3.20% ▲	2.42%
Involuntary Disenrollment	0.07%	0.05%
Loss of Eligibility	1.13% ▲	0.94%
Still Enrolled	95.61% ▼	96.59%

<sup>1</sup> These data are derived from aggregating monthly enrollment figures.

### Provider Network

Figure 4 shows the percentages of various provider types in the plan for 2009 in comparison to the statewide rates. PCPs represent 9.3% of all providers in Amida Care’s network, which is similar to the statewide percentage of 13.1%. Pediatricians account for a lower percentage of the plan’s provider network than is seen statewide. For this figure, plan percentages statistically above statewide percentages are indicated by ▲, while plan percentages statistically below statewide percentages are indicated by ▼.

**Figure 4: Medicaid Providers by Specialties – 2009 (Q4)**

Specialty Type	Number	% of Total Panel	% Statewide
Primary Care Providers	386	9.3%	13.1%
<i>Pediatrics</i>	109	2.6% ▼	8.3%
<i>Family Practice</i>	52	1.3%	0.8%
<i>Internal Medicine</i>	180	4.3%	3.0%
<i>Other PCPs</i>	45	1.1%	1.0%
OB/GYN Specialty <sup>1</sup>	405	9.8%	8.4%
Behavioral Health	552	13.3%	15.5%
Other Specialties	2,724	65.6%	61.0%
Non-PCP Nurse Practitioners	83	2.0%	1.9%
Dentistry <sup>2</sup>	17		
<b>Total (excluding dentists)</b>	<b>4,150</b>		

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 4a 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 4a: Ratio of Enrollees to Providers for Medicaid – 2009 (Q4)**

Specialty Type	Amida Care			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	4:1	72.5	20:1 ▼	4:1	252.5	22:1
<i>Pediatrics (Under age 20)</i>	1:1 ▼			1:1		
OB/GYN (Females aged 15-64)	1:1 ▼			2:1		
Behavioral Health	3:1 ▼			3:1		

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 4b for 2009. Panels are considered “open” if a provider has less than 1,500 Medicaid members. For this figure, rates statistically above the statewide average are indicated by ▲, while rates statistically below the statewide average are indicated by ▼.

**Figure 4b: Medicaid PCPs with an Open Panel – 2009 (Q4)**

	2009		
	Amida Care		Statewide
	Number	% of Providers	% of Providers
Providers with Open Panel	360	97.6% ▲	90.2%

Data Source: HPN

Figure 5 displays QARR *Board Certification* rates for 2009 of providers in the plan’s network in comparison to the statewide averages (SWAs). The Figure also indicates whether the plan’s rate is statistically above (indicated by ▲) or statistically below (indicated by ▼) the statewide average. The plan’s 2009 board certification rates for pediatricians, OB/GYN and other physician specialists are higher than the statewide averages.

**Figure 5: QARR Board Certification Rates – 2009**

Provider Type	2009	
	Amida Care	SWA
<b>Medicaid:</b>		
Family Medicine	92%	86%
Internal Medicine	87%	84%
Pediatricians	87% ▲	76%
OB/GYN	81% ▲	70%
Geriatricians	SS	61%
Other Physician Specialists	83% ▲	74%

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

***NYSDOH Primary Care Access & Availability Survey – 2009***

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

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

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

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

Figure 6 illustrates the plan’s Primary Care Access & Availability Resurvey results for 2009.

**Figure 6: Primary Care Access & Availability Resurvey – 2009**

<b>Region</b>	<b>Call Type</b>	<b>Amida Care</b>
<b>6</b>	Routine	73.1%
	Non-Urgent “Sick”	76.3%
	After Hours Access	77.5%

#### 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.

##### *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 7 lists the Use of Services rates for the selected plan product lines for 2009. The Figure indicates whether the plan's rate is higher than 90% of all rates for that measure (indicated by ▲) or whether the plan's rate is lower than 90% of all rates for that measure (indicated by ▼).

**Figure 7: QARR Use of Services – 2009**

Measure	Medicaid	
	2009	SWA 2009
	Outpatient Utilization (PTMY)	
Outpatient Visits	13,171.3 ▲	11,384.1
Outpatient ER Visits	793.3 ▼	856.1
Ambulatory/Surgery Encounters	111.5 ▼	295.8
Inpatient ALOS		
Medicine	5.0 ▼	5.6
Surgery	8.6 ▼	9.3
Maternity	SS	4.0
Total (Medicine, Surgery & Maternity)	5.3 ▼	5.8
Inpatient Utilization (PTMY)		
Medicine Cases	340.1	354.3
Surgery Cases	39.5	30.9
Maternity Cases	SS	15.3
Total Cases	388.3	399.4

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> 2010/QARR 2009 audit findings, as well as results of quality improvement studies, enrollee surveys and plan Performance Improvement Projects (PIPs).

*Validation of Performance Measures Reported by Plans and Performance Measures Calculated by the NYSDOH* Performance measures are reported and validated using several methodologies. Plans submitted member and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, plans report a subset of HEDIS<sup>®</sup> measures to the NYSDOH annually, along with several NYS-specific measures. Plan-reported performance measures were validated as per HEDIS<sup>®</sup> 2010 Compliance Audit<sup>™</sup> specifications developed by the National Committee for Quality Assurance (NCQA). The results of each plan's HEDIS<sup>®</sup> 2010 Compliance Audit<sup>™</sup> are summarized in its Final Audit Report (FAR).

### *Summary of HEDIS<sup>®</sup> 2010 Information System Audit<sup>™</sup>*

As part of the HEDIS<sup>®</sup> 2010 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> 2010 Final Audit Report (FAR) prepared for Amida Care 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 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. No issues were identified with the transfer or mapping of the data elements for reporting.

The plan passed Medical Record Review for the two measures validated. The plan was able to report all measures for its Medicaid line.

Figure 8 displays 2009 QARR performance rates, as well as the SWAs. The Figure indicates whether the plan's rate is statistically better than the SWA (indicated by ▲) or whether the plan's rate is statistically worse than the SWA (indicated by ▼).

**Figure 8: QARR Plan Performance Rates – 2009**

Measure	Medicaid	
	2009	2009 SWA
Engaged in Care	91%	88%
Syphilis Screening	80% ▲	65%
Viral Load Monitoring	74%	71%

*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 9 displays the Access to/Availability of Care measures for QARR 2009. The Figure indicates whether the plan's rate is higher than 90% of all plans for that measure (indicated by ▲) or whether the plan's rate is lower than 90% of plans for that measure (indicated by ▼).

**Figure 9: QARR Access to/Availability of Care Measures – 2009**

Measure	Medicaid	
	2009	SWA 2009
	Adults' Access to Preventive/Ambulatory Services (AAP)	
20-44 years	98%	98%
45-64 years	98%	99%
65+ years	SS	100%

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

## VI. Deficiencies and Appeals

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

### *Compliance with NYS Structure and Operation Standards*

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

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

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

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in Figure 10. Plans are also required to submit POCs in response to deficiencies identified in any of these reviews.

Figure 11 reflects the total number of citations for the most current operational survey of the plan, which ended in 2009, as well as from the focused reviews conducted in 2009. This figure reflects the findings from reviews of the plan as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can have multiple citations.

Amida Care is in compliance with 9 of 14 categories. The categories in which Amida Care is not in compliance are Complaints and Grievances (4 citations), Disclosure (1 citation), Member Services (2 Citations), Organization and Management (1 citation) and Service Delivery Network (3 citations).

**Figure 10: Focused Review Types**

Review Name	Review Description
<b>Access &amp; 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 11: Summary of Citations**

Category	Review Type/Name (a indicates focused review)	Citations
<b>Complaints and Grievances</b>		4
<i>a. The Plan failed to provide the enrollee with the time to file an appeal.</i>	Operational	
<i>b. Of 40 random provider contracts selected and provided for the operational survey, 6 were noncompliant as follows: one (1) specialist contract had no incorporation language and had the 2002 Standard Clauses attached and no fee schedule attached; five (5) ancillary provider contracts had either no financial arrangements included in the contract, no incorporation language, no Standard Clauses attached, did not define the responsibilities of each party, did not establish provider participation in what program or was between the wrong parties.</i>	Operational	
<i>c. The Plan failed to provide the enrollee with the procedures for filing an appeal of determination.</i>	Operational	
<i>d. The MCO failed to develop a comprehensive provider manual that contains a description of the policies and operating procedures of the MCO for providers.</i>	Operational	
<b>Credentialing</b>		0
<b>Disclosure</b>		1
<i>e. A call was placed to the member services' toll free number by a prospective member requesting a description of the procedure for providing care 24 hours a day and coverage for emergency care. No response was received. The requested information should be sent within three weeks.</i>	a Member Services Phone Calls	
<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>		2
<i>f. The Plan failed to include the procedures for continuing care/transitional period in their notices to enrollees when a provider leaves the network. (2 citations)</i>	Operational	
<b>Organization and Management</b>		1
<i>g. The MCO failed to provide Character and Competency (C&amp;C) forms for members of the Board.</i>	Operational	
<b>Prenatal Care</b>		0
<b>Quality Assurance</b>		0
<b>Service Delivery Network</b>		3
<i>h. The Plan failed to ensure that all covered services be directly provided or arranged for within the approved provider network pursuant to written contracts developed and maintained in a form and manner described by the Commissioner.</i>	Operational	
<i>i. See f.</i>	Operational	

**Figure 11: Summary of Citations (Continued)**

Category	Review Type/Name (a indicates focused review)		Citations
<i>j. There are 3 out of 9 providers from the 12/10/08 to 12/30/08 printed/web-based provider directory verification study who were identified as non-participating providers. These providers are still listed incorrectly as participating providers in both the printed and web-based provider directories. The printed web-based directories and the HPN must be updated to reflect changes in provider status.</i>	a	Provider Directory Information	
<b>Utilization Review</b>			0
<b>Total</b>			<b>11</b>

*External Appeals Summary Report*

Figure 12 displays external appeals for 2009 for the Medicaid product line. This Figure reflects absolute numbers, and is not weighted by plan enrollment.

**Figure 12: External Appeals – 2009**

	<b>2009</b>
<b>Medicaid</b>	
Overtured	0
Overtured in Part	0
Upheld	1
<b>Medicaid Total</b>	<b>1</b>

## VII. Financial Data

The financial summary is based on data reported in each plan's 2007, 2008 and 2009 Medicaid Managed Care Operating Report (MMCOR). The data contained in the MMCOR reflect the plan's Medicaid line of business only. The data are not audited and are reported on an accrual basis; thus total expenses are impacted by a plan's estimate of services that have been incurred by plan members but have not been billed to the plan. The following is a list of the ratios displayed in Figure 13 and their definitions.

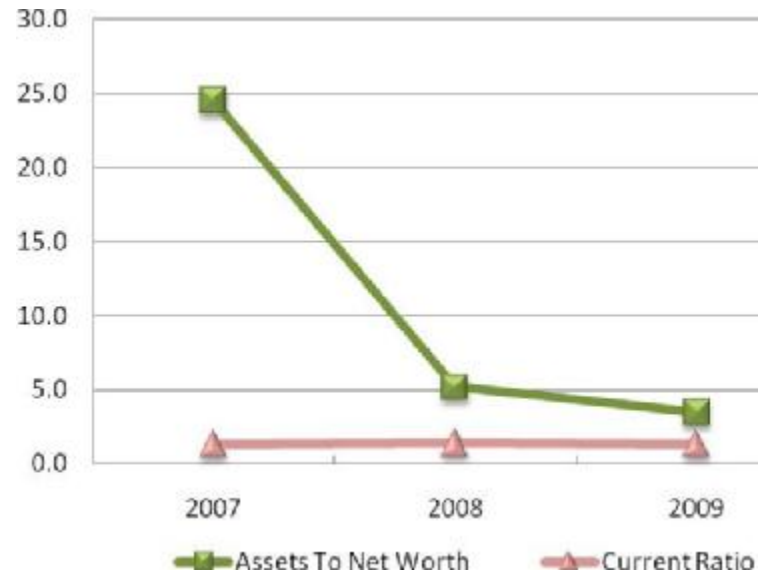
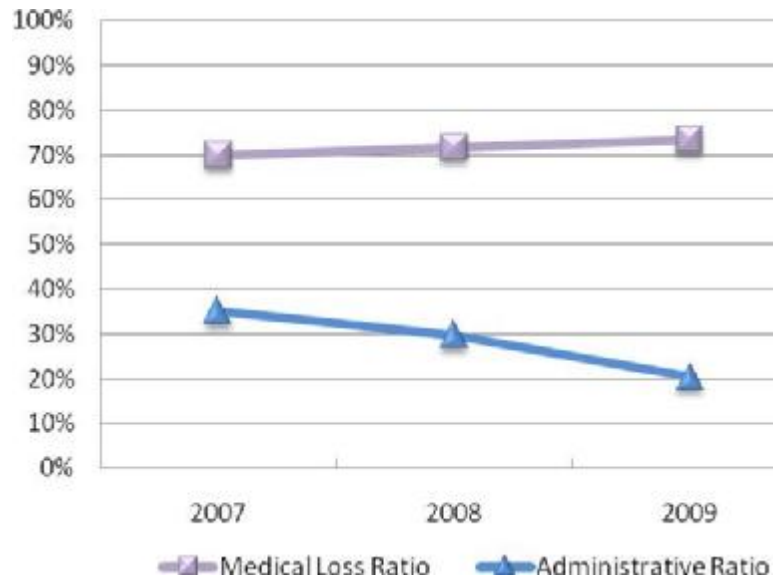
- *Assets to Net Worth*: Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has \$3 of assets for every \$1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
- *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 13a graphically trends selected measures from Figure 13.

**Figure 13: Selected Financial Ratios – 2007-2009**

	2007		2008		2009	
	Amida Care	SWA	Amida Care	SWA	Amida Care	SWA
<b>PROFITABILITY</b>						
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	24.5	2.8	5.2	2.5	3.5	2.5
Premium Surplus Ratio = Premium Income/Premium Revenue	-4.8%	12.6%	-1.3%	-3.3%	6.3%	4.6%
Medical Loss Ratio = Medical Expenses/Premium Revenue	69.8%	69.1%	71.6%	84.7%	73.3%	83.0%
Administrative Ratio = Admin Expenses/Premium Revenue	35.0%	18.4%	29.7%	18.6%	20.4%	12.4%
<b>LIQUIDITY</b>						
Current Ratio = Current Assets/Current Liabilities	1.3	1.4	1.4	1.7	1.3	1.5

**Figure 13a: Trends for Selected Financial Ratios – 2007-2009**



## VIII. Appendix

### References

#### A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory, Accessed July 1, 2010
- NCQA Accreditation website, <http://hprc.ncqa.org/index.asp>, Accessed August 4, 2010

#### B. Enrollment/Provider Network

##### 1) Enrollment/Disenrollment

- NYSDOH OMC Membership Data, 2009
- Enrollment by Age and Sex Report as of December 2009
- Enrollment Status Report, 2009

##### 2) Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, as of December, 2009
- Total Number of FTE by Managed Care Plans, as of December 31, 2009
- NYSDOH OMC Primary Care Providers Open and Closed Panels by Plans, Provider Network Data As Of December 31, 2009
- QARR Measurement Year, 2009
- NYSDOH Primary Care Access and Availability Survey, 2009

#### C. Utilization

##### 1) QARR Use of Services

- QARR Measurement Year, 2009

#### D. Quality Indicators

##### 1) Summary of HEDIS® Information Systems Audit™ Findings

- 2010 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors

##### 2) QARR Data

- QARR Measurement Year, 2009

#### E. Deficiencies and Appeals

##### 1) Summary of Deficiencies

- MMC Operational Deficiencies by Plan/Category, 2009
- Focus Deficiencies by Plan/Survey Type/Category, 2009

##### 2) Appeals

- MMC External Appeals Data, 2009

#### F. Financial Data

- Medicaid Managed Care Operations Report, 2007 - 2009