NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

PLAN - SPECIFIC REPORT
FOR
NEW YORK-PRESBYTERIAN SYSTEM SELECT HEALTH LLC

Reporting Year 2009

April 2011

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Acronyms Used in This Report

(in alphabetical order)

ACOG: American College of Obstetrics and Gynecology
ALOS: Average Length of Stay
AO: Area Office

BAO: Buffalo Area Office (Region 1)

CHP: Child Health Plus
CO: Central Office
COM (C): Commercial

DBA: Doing Business As
DSS: Data Submission System

EQR: External Quality Review
EQRO: External Quality Review Organization

F/A: Failed Audit
FAR: Final Audit Report
FFS: Fee For Service
FHP: Family Health Plus
F/U: Follow-Up
FTE: Full Time Equivalent

HEDIS: Health Effectiveness Data and Information Set
HIE: Health Information Exchange
HIT: Health Information Technology
HMO: Health Maintenance Organization
HPN: Health Provider Network

LIAO: Long Island Area Office (Region 7)

MARO: Metropolitan Area Regional Office
MCO: Managed Care Organization
MED (M): Medicaid
MMC: Medicaid Managed Care
MMCOR: Medicaid Managed Care Operating Report

N: Denominator
N/A: Not Available
NCQA: National Committee for Quality Assurance
NEAO: Northeast Area Office (Region 4)
NERO: Northeast Regional Office
NP: Not Provided
NR: Not Reported
NRAO: New Rochelle Area Office (Region 5)
NV: Not Valid
NYC: New York City
NYCAO: New York City Area Office (Region 6)
NYCRR: New York Code Rules and Regulations
NYSDOH: New York State Department of Health

OB/GYN: Obstetrician/Gynecologist
OHIP: Office of Health Insurance Programs
OPMC: Office of Professional Medical Conduct
OP: Optimal Practitioner Contact

PCP: Primary Care Practitioner/Provider
PIP: Performance Improvement Project
PNDS: Provider Network Data System
POC: Plan of Corrective Action
PMPY: Per Member Per Year
PSR: Plan-Specific Report
PTMY: Per Thousand Member Years
PHSP: Prepaid Health Services Plans

Q1: First Quarter (Jan. – March)
Q2: Second Quarter (Apr. – June)
Q3: Third Quarter (July – Sept.)
Q4: Fourth Quarter (Oct. – Dec.)
QARR: Quality Assurance Reporting Requirements

R: Rotated
RAO: Rochester Area Office (Region 2)
RHIO: Regional Health Information Organization
ROS: Rest of State
RY: Reporting Year

SAO: Syracuse Area Office (Region 3)
SN: Safety Net
SOD: Statement of Deficiency
SS: Small Sample (Less than 30)
SSI: Supplemental Security Income
SWA: Statewide Average

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

New York-Presbyterian System SelectHealth LLC (Select Health) 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: S99B009
- DOH Area Office: MARO
- Corporate Status: Limited Liability Corporation (LLC)
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: June 11, 2003
- Medicaid Service Area: Bronx, Kings, New York and Queens
- Product Line(s): Medicaid
- Contact Information: 28 West 44th Street, Suite 200
New York, NY 10036
(212) 404-3093
- 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	1,424
% 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 Select Health in comparison to the statewide percentages.

Figure 2: Medicaid Enrollee Age and Sex Distribution – 2009

Age in Years	Male	Female	Total	Plan Distribution	Statewide
Under 20	48	49	97	6.8%	12.4%
20-44	375	214	589	41.4%	38.6%
45 and Over	450	288	738	51.8% ▲	49.0%
Total	873	551	1,424		
Females 15-64[1]		508		35.7%	35.9%

Data source: MEDS II

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

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

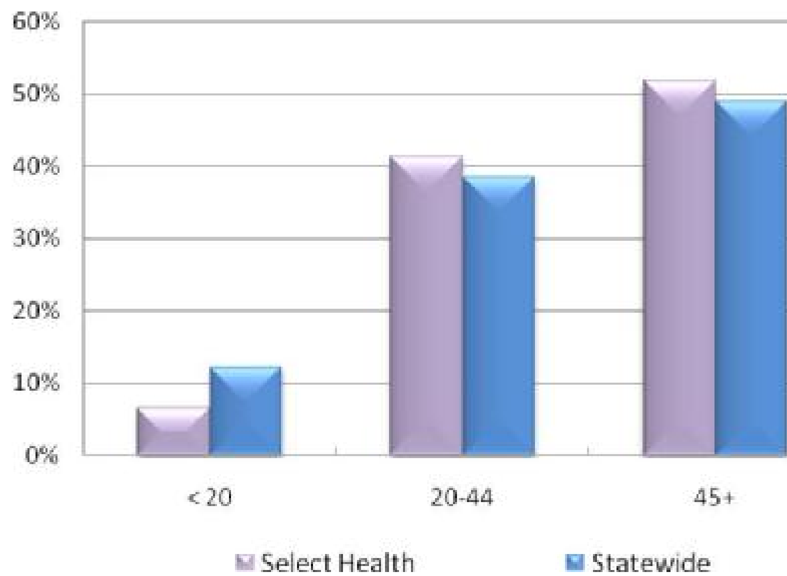


Figure 3 shows Select Health's 2009 Medicaid disenrollment rates. Rates statistically above the statewide average are indicated by ▲, and rates statistically below the statewide average are indicated by ▼. Select Health's Medicaid rates are similar to those of the average plan in the state.

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

Enrollment Status[1]	Medicaid	
	Select Health	SWA
Voluntary Disenrollment	1.90%	2.42%
Involuntary Disenrollment	0.06%	0.05%
Loss of Eligibility	0.80%	0.94%
Still Enrolled	97.23%	96.59%

[1] 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 4.1% of all providers in Select Health's provider network, which is lower than the statewide percentage of 13.1%. Other Specialties account for a higher percentage of the plan's provider network than is seen statewide, while Pediatricians, other PCPs, OB/GYNs, Behavioral Health Providers, and Non-PCP Nurse Practitioners account for lower percentages. 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	151	4.1% ▼	13.1%
Pediatrics	*37*	*1.0%* ▼	*8.3%*
Family Practice	*26*	*0.7%*	*0.8%*
Internal Medicine	*74*	*2.0%*	*3.0%*
Other PCPs	*14*	*0.4%* ▼	*1.0%*
OB/GYN Specialty[1]	196	5.4% ▼	8.4%
Behavioral Health	197	5.4% ▼	15.5%
Other Specialties	3,073	84.2% ▲	61.0%
Non-PCP Nurse Practitioners	33	0.9% ▼	1.9%
Dentistry[2]	8		
Total *(excluding dentists)*	3,650		

Data Source: HPN

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

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

Figure 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 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

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

	Select Health			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median[1] Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Median[1] Ratio of Enrollees to FTEs**
Primary Care Providers	9:1 ▲	30.8	46:1 ▲	4:1	252.5	22:1
Pediatrics (Under age 20)	3:1 ▲			1:1		
OB/GYN (Females aged 15-64)	3:1 ▲			2:1		
Behavioral Health	7:1 ▲			3:1		

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

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

The number of Medicaid PCPs with an "Open Panel" is presented in Figure 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		
	Select Health		Statewide
	Number	% of Providers	% of Providers
Providers with Open Panel	154	98.1% ▲	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 rate for Other Physician Specialists is higher than the statewide average.

Figure 5: QARR Board Certification Rates – 2009

	2009	
Provider Type	Select Health	SWA
Medicaid:		
Family Medicine	SS	86%
Internal Medicine	FA	84%
Pediatricians	SS	76%
OB/GYN	SS	70%
Geriatricians	SS	61%
Other Physician Specialists	81% ▲	74%

SS: Sample size too small to report (less than 30 providers) but included in the statewide average.
FA: Failed Audit

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 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a live voice representing the named provider is reached or if the named provider's beeper number is reached.

A random sample of 240 provider sites was selected from each region in which a health plan operated and provided primary care as 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

Region	Call Type	Select Health
6	Routine	69.3%
	Non-Urgent "Sick"	69.7%
	After Hours Access	65.0%

IV. Utilization

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

QARR Use of Services Measures

For this domain of measures, the QARR reports assess performance by indicating whether the plan's rates reached the 90th or 10th percentiles. Figure 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

	Medicaid	
	2009	SWA 2009
Measure	**Outpatient Utilization (PTMY)**	
Outpatient Visits	12,749.8	11,384.1
Outpatient ER Visits	803.5	856.1
Ambulatory/Surgery Encounters	199.9	295.8
	Inpatient ALOS	
Medicine	5.6	5.6
Surgery	9.4	9.3
Maternity	SS	4.0
Total (Medicine, Surgery & Maternity)	6.0 ▲	5.8
	Inpatient Utilization (PTMY)	
Medicine Cases	423.5 ▲	354.3
Surgery Cases	49.8 ▲	30.9
Maternity Cases	SS	15.3
Total Cases	485.9 ▲	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 statewide average.

V. Quality Indicators

To measure the quality of care provided by the plans, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports including HEDIS® 2010/QARR 2009 audit findings, as well as results of quality improvement studies, enrollee surveys and plan Performance Improvement Projects (PIPs).

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

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

Summary of HEDIS® 2010 Information System Audit™

As part of the HEDIS® 2010 Compliance Audit™, auditors assessed the plan's compliance with NCQA standards in the six designated information system categories, as follows:

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

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

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

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

The HEDIS® 2010 Final Audit Report (FAR) prepared for Select Health indicates that the plan demonstrated compliance with all areas of the Information Systems except for *IS 3.0 Practitioner Data – Data Capture, Transfer and Entry*. Issues were reported related to the completeness of provider credentialing data and the plan was therefore unable to report a rate for *Board Certification: Internal Medicine*.

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

The plan passed Medical Record Review for the two measures validated. The plan was able to report rates for all measures, except *Board Certification: Family Medicine* and *Viral Load Monitoring*.

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	88%	88%
Syphilis Screening	65%	65%
Viral Load Monitoring	FA	71%

FA: Failed Audit

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	97%	98%
45-64 years	99% ▲	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 9. 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.

Select Health is in compliance with 9 of 14 categories. The categories in which Select Health SNP is not in compliance are Complaints & Grievances (2 citations), Credentialing (1 citation), Disclosure (3 citations), Member Services (2 citations) and Service Delivery Network (1 citation).

Figure 10: Focused Review Types

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

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

Figure 11: Summary of Citations

Category	Review Type/Name (**a** indicates focused review)		Citations
Complaints and Grievances			2
a. The Plan failed to provide enrollees with the correct time frame to file an appeal. Enrollee determination letters stated the member had "a period of 60 days from the date you receive this letter to request an appeal". This not only contradicts the Plan's own policies and procedures as well as the Public Health Law 4408a which states the time frame of 60 business days but also the Member Handbook that the Plan references in its letters which states the member has 90 working days.		Operational	
b. The Plan's acknowledgement letters incorrectly state that "For all other complaints, we will tell you our decision in writing in 60 days". This contradicts the Member Handbook, as well as the Plan's own policies and procedures, the Public Health Law, and the SNP Contract, Appendix F, which gives the time frame of 45 days for all other complaints after receipt of all necessary information.		Operational	
Credentialing			1
c. The Plan failed to include the procedures for continuing care/transitional period in their notices to enrollees when a provider leaves the network.		Operational	
Disclosure			3
d. On 3/12/09 a written request was submitted to the Plan requesting the clinical review criteria to determine if coverage would be provided for an insulin pump for diabetes. The Plan sent a letter that stated approval is based on medical necessity and requires a letter of medical necessity from an endocrinologist and agreement of the treatment plan by the primary care physician. The DOH requested clinical review criteria. The SOD reflects incorrect responses to the same question for three consecutive surveys for which enforcement action may be pursued in appropriate circumstances.	a	Member Services Phone Calls	
e. On 6/11/09 a written request was submitted to the Plan requesting the clinical review criteria to determine if coverage would be provided for an insulin pump for diabetes. The Plan failed to send any information concerning this request. As such, the 1/7/09 and 4/27/09 approved Plans of Correction submitted to the Department were not appropriately implemented. This is the third consecutive SOD issued and the fourth consecutive time the Plan did not comply with this section of the Public Health Law.	a	Member Services Phone Calls	
f. There are 4 out of 11 providers from the 12/15/08 to 12/19/08 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.	a	Provider Participation - Directory	
Family Planning			0
HIV			0
Management Information Systems			0
Medicaid Contract			0
Medical Records			0
Member Services			2
g. See c. (2 citations)		Operational	
Organization and Management			0
Prenatal Care			0
Quality Assurance			0

Figure 11: Summary of Citations (Continued)

Category	Review Type/Name (**a** indicates focused review)		Citations
Service Delivery Network			1
h. The Plan's governing authority failed to ensure the implementation of their 1/7/09 and the 4/27/09 approved Plans of Correction for the repeat citation of Public Health Law 4408.2.	**a**	Member Services Phone Calls	
Utilization Review			0
Total			**9**

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
There were no external appeal determinations for this plan in 2009.

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.

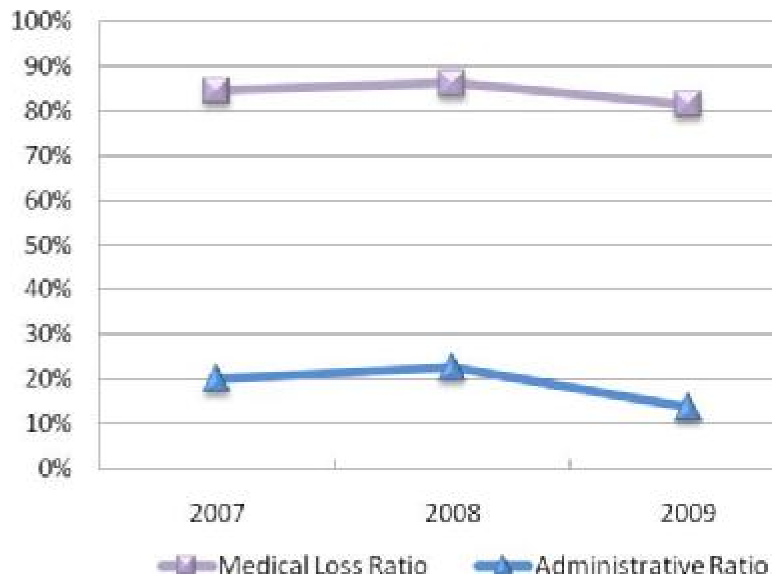
- *Assets to Net Worth*: Reflects the relationship of assets to net worth. For example, a plan with an asset to net worth ratio of 3.0 indicates the plan has $3 of assets for every $1 of net worth. The formula is total assets divided by net worth. Assets and net worth are net of intangible assets.
-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

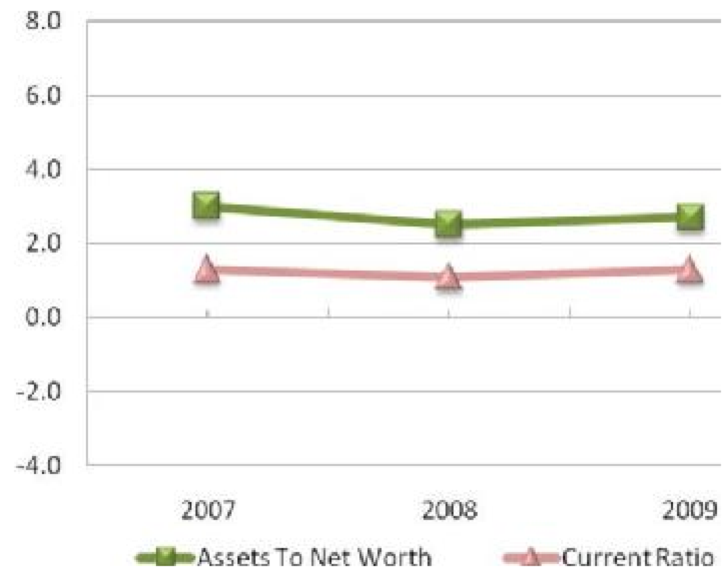
Figure 13a graphically trends selected measures from Figure 13.

Figure 13: Selected Financial Ratios – 2007-2009

	2007		2008		2009	
	Select Health	SWA	Select Health	SWA	Select Health	SWA
PROFITABILITY						
Assets To Net Worth = (Total Assets - Intangibles)/ (Net Worth - Intangibles)	3.0	2.8	2.5	2.5	2.7	2.5
Premium Surplus Ratio = Premium Income/Premium Revenue	-4.6%	12.6%	-8.8%	-3.3%	4.8%	4.6%
Medical Loss Ratio = Medical Expenses/Premium Revenue	84.6%	69.1%	86.2%	84.7%	81.6%	83.0%
Administrative Ratio = Admin Expenses/Premium Revenue	19.9%	18.4%	22.6%	18.6%	13.6%	12.4%
LIQUIDITY						
Current Ratio = Current Assets/Current Liabilities	1.3	1.4	1.1	1.7	1.3	1.5

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





VIII. Appendix

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- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory, Accessed July 1, 2010
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B. Enrollment/Provider Network

1) *Enrollment/Disenrollment*
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   - 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
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   - QARR Measurement Year, 2009
   - NYSDOH Primary Care Access and Availability Survey, 2009

C. Utilization

1) *QARR Use of Services*
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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*
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E. Deficiencies and Appeals

1) *Summary of Deficiencies*
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   - Focus Deficiencies by Plan/Survey Type/Category, 2009
2) *Appeals*
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F. Financial Data

- Medicaid Managed Care Operations Report, 2007 - 2009