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New York State Medicaid Managed Care Health and Recovery Plan

2021 External Quality Review Annual Technical Report

April 2023

Prepared on behalf of:
The New York State Department of Health
Office of Quality and Patient Safety

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About This Report

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual, external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The New York State Department of Health contracted with IPRO, an external quality review organization, to conduct the 2021 external quality review of the managed care plans that comprised New York's Health and Recovery Medicaid managed care program. The results of this review are summarized in this report.

This external quality review technical report focuses on three federally required activities (performance improvement projects, performance measures, and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted between January 1, 2021, and December 31, 2021, or measurement year 2021.

Table 1: Health and Recovery Plan Activities Performed for 2021

What Did the Department of Health Do?	What Did the Medicaid Managed Care Plans Do?	What Did IPRO Do?
Required all Health and Recovery Plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on care transitions after emergency department and inpatient admissions.	Evaluated how the Health and Recovery Plans conducted performance improvement projects.
Required all Health and Recovery Plans to collect and report certain health data. These data are called performance measures.	Collected and reported performance measure data to the Department of Health.	Reviewed data collection methods used by the Health and Recovery Plans to calculate performance measures rates.
Required all Health and Recovery Plans to comply with federal and state Medicaid standards; and conducted an evaluation to determine the Health and Recovery Plans compliance with these standards.	Presented evidence of compliance with Medicaid standards to the Department of Health.	Reviewed the results of an evaluation of Health and Recovery Plan compliance with Medicaid standards.
Sponsored a quality-of-care survey for all Health and Recovery Plans.	Used these findings in planning future activities to address or enhance member experience.	Reviewed data collection and analysis methods and results of a survey on member experience with Health and Recovery Plans.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted managed care plans. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services.[1] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through *(d)* requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that managed care plans furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the managed care plans with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the Department of Health has contracted with IPRO, an external quality review organization, to conduct the 2021 external quality review of the managed care plans that comprised New York's Health and Recovery Plan program.

2021 External Quality Review

This external quality review technical report focuses three federally required activities (validation of performance improvement projects, validation of performance measures, and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted for measurement year 2021. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[5] published in October 2019. The external quality review activities and corresponding protocols are described in Table 2.

[1] The Centers for Medicare and Medicaid Services website: https://www.cms.gov/.
[2] prepaid inpatient health plan.
[3] prepaid ambulatory health plan.
[4] primary care case management.
[5] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

Table 2: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed Health and Recovery Plan performance improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS®[6]) audit results provided by the managed care plans' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance auditors, member-level files, and reported rates to validate that performance measures were calculated according to Department of Health specifications.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by the Department of Health of Health and Recovery Plan compliance with Medicaid standards. Specifically, this review assessed compliance with *Code of Federal Regulations Part 438 Subpart D*, *Code of Federal Regulations 438.330,* the *Medicaid Managed Care/ HIV Special Needs Plan/Health and Recovery Plan Model Contract*, *New York State Public Health Law*[7] *Article 44* and *Article 49*, and *New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*.[8]
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO subcontracted with DataStat, an NCQA-certified survey vendor, to administer the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS®[9]) survey to evaluate member experience with New York's Health and Recovery Plan program.

The results of IPRO's external quality review are reported under each activity section.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that the Information Systems Capabilities Assessment is a required component of the mandatory external quality review activities, the Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of the NCQA HEDIS® Compliance Audit™ for External Quality Review Activity 2. Validation of Performance Measures may be substituted for an Information Systems Capabilities Assessment. IPRO's validation methodology included a review of the systems reviews summarized by each managed care plan's NCQA HEDIS Auditor in the HEDIS Final Audit Report for measurement year 2021.

[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] New York State Legislature Website: http://public.leginfo.state.ny.us/navigate.cgi?NVMUO.
[8] New York State New York Codes, Rules, and Regulations Website: https://regs.health.ny.gov/volume-2-title-10/content/subpart-98-1-managed-care-organizations.
[9] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

History of the New York State Medicaid Managed Care Program

The New York State Medicaid managed care program began in 1997 when New York State received approval from the Centers for Medicare & Medicaid Services to mandatorily enroll Medicaid members in a managed care program through a Section 1115 Demonstration Waiver.[10] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The New York State Section 1115 Demonstration Waiver project began with these goals:

- Increasing access to health care for the Medicaid population.
- Improving the quality of health care services delivered.
- Expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

New York State's Medicaid managed care program offers a variety of managed care plans to coordinate the provision, quality, and payment of care for its enrolled members. Medicaid members not in need of specialized services are enrolled into health maintenance organizations or prepaid health services plans (referred to as "mainstream Medicaid"). Members with specialized health care needs can opt to join available specialized managed care plans. Current specialized Medicaid plans include HIV Special Needs Plans, Health and Recovery Plans, and Managed Long-Term Care plans.

New York State Medicaid Quality Strategy

New York maintains rigorous standards to ensure that approved health plans have networks and quality management programs necessary to serve all enrolled populations. The quality strategy developed by the Department of Health is intended to be the quality framework for the New York State Medicaid program and participating managed care plans. The Department of Health performs periodic reviews of its Medicaid quality strategy to determine the need for revision and to ensure managed care plans are compliant with regulatory standards and have committed adequate resources to perform internal monitoring and ongoing quality improvement. The Department of Health updates the Medicaid quality strategy as needed, but no less than once every three years.

New York State's 2020–2022 Medicaid Quality Strategy[11] focuses on achieving measurable improvement and reducing health disparities through ten high-priority goals. Based on the Triple Aim framework, the state organized its goals by these aims: 1) improved population health; 2) improved quality of care; and 3) lower per-capita cost. New York State's Medicaid quality strategy aims and corresponding goals are:

- Triple Aim 1: Improved Population Health
  Goal 1: Improve maternal health

[10] Medicaid.gov About 1115 Demonstrations Website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

[11] The New York State Medicaid/Child Health Plus Insurance Program Quality Strategy Website: https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-03-14_chplus_quality_strategy_final.pdf.

Goal 2: Ensure a healthy start
Goal 3: Promote effective and comprehensive prevention and management of chronic disease
Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings
Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Triple Aim 2: Improved Quality of Care
  Goal 6: Improve quality of substance use disorder and opioid use disorder treatment
  Goal 7: Promote prevention with access to high-quality care
  Goal 8: Support members in their communities
  Goal 9: Improve patient safety

- Triple Aim 3: Lower Per-Capita Cost
  Goal 10: Pay for high-value care

The state has further identified 24 metrics to track progress towards the ten goals listed above. These metrics were selected from the New York State Quality Assurance Reporting Requirements measurement set, the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System and Behavioral Risk Factor Surveillance System, the National Survey on Drug Use and Health, 3M's Potentially Preventable Admissions, the Centers for Medicare & Medicaid Services' *Early and Periodic Screening, Diagnostic and Treatment Annual Participation Report* and other New York State-specific measures. Table 3 presents a summary of the state's Medicaid quality strategy measurement plan, including metric names, Medicaid populations included in the calculation of the metrics, baseline data, and targets. Unless indicated otherwise, baseline measurements are from measurement year 2019 (January 1, 2019 through December 31, 2019), year 1 re-measurement rates are from measurement year 2020 (January 1, 2020 through December 31, 2020), and year 2 re-measurement rates are from measurement year 2021 (January 1, 2021 through December 31, 2021).

Table 3: New York State Medicaid Quality Strategy Metrics and Performance Rates

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Triple Aim 1: Improved Population Health					
Goal 1: Improve maternal health	Postpartum care (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	83%	80%	81.33%	84%
	Maternal mortality rate per 100,000 live births (All New York State)	18.9[1]	18.1[3]	19.3[4]	16.0
Goal 2: Ensure a healthy start	Lead screening in children (Mainstream Medicaid, Child Health Plus)	89%	87%	81.18%	90%
	Members receiving oral health services by a non-dentist provider (Mainstream Medicaid)	0.8%	1.25%	1.38%	1.6%
Goal 3: Promote effective & comprehensive prevention and management of chronic disease	Comprehensive diabetes care – HbA1c testing (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	93%	86%	89.49%	94%
	Asthma medication ratio, 5-18 years (Mainstream Medicaid, Child Health Plus)	66%	68%	65.47%	67%
	Asthma medication ratio, 19-64 years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	55%	49%	49.59%	56%
	Controlling high blood pressure (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	67%	56%	64.82%	68%
	Follow-up after emergency department visit for mental illness – 30 days (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	72%	67%	66.53%	73%
Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings	Depression screening and follow-up for adolescents and adults (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	Not Applicable	Not Applicable	New Measure	To Be Determined

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder	High school students reporting current use of alcohol on at least one day during the past 30 days (Subset of high school students in New York State)	26.4%	Non-Survey Year	2021 Data Scheduled for 2023 Release	23.6%
	High school students reporting binge drinking on at least one day during the past 30 days (Subset of high school students in New York State)	12.7%	Non-Survey Year	2021 Data Scheduled for 2023 Release	10.8%
	High school students reporting current use of marijuana on at least one day during the past 30 days (Subset of high school students in New York State)	19.1%	Non-Survey Year	2021 Data Scheduled for 2023 Release	17.1%
	Adult alcohol binge drinking (All New York State)	25.48%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	24.0%
	Adult use of marijuana (All New York State)	10.05%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	9.14%
	Adult use of cocaine (All New York State)	2.82%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.37%
	Adult use of heroin (All New York State)	0.3%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	0.17%
	Adult use of illicit drug use other than marijuana (All New York State)	3.42%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.94%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
	Medicaid smoking prevalence (Mainstream Medicaid, Fee-For-Service)	23%	22.9%	19.1%	21.4%
Triple Aim 2: Improved Quality of Care					
Goal 6: Improve Quality of Substance Use Disorder and Opioid Use Disorder Treatment	Initiation of pharmacotherapy upon new episode of opioid dependence (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	37%	45%	42.68%	38%
	Initiation of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	50%	50%	48.99%	51%
	Engagement of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	20%	20%	18.68%	21%
Goal 7: Promote Prevention with Access to High Quality Care	Mainstream Managed Care population impacted by patient-centered medical home sites with NCQA recognition of 2014 Level 3 and up, active sites (Mainstream Medicaid)	69%	72%	67%	70%
Goal 8: Support Members in Their Communities	Potentially avoidable hospitalizations for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection (Managed Long-Term Care)	2.76	No data due to COVID-19	No data due to COVID-19	2.7
	Members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses such as high blood pressure or diabetes as good or excellent (Managed Long-Term Care)	86%	Non-Survey Year	87.3%	87%
Goal 9: Improve Patient Safety	Appropriate treatment for upper respiratory infections, 3 months-17 years (Mainstream Medicaid, Child Health Plus)	94%	94%	96.16%	95%
	Appropriate treatment for upper respiratory infection, 18-64 Years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	72%	75%	81.18%	73%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Triple Aim 3: Lower Per Capita Cost					
Goal 10: Pay for High-Value Care	Potentially preventable admissions per 100,000 members (Mainstream Medicaid)	1,153	847	916.84	1,124-1,181
	Potentially preventable admission expenditures/Total inpatient expenditures (Mainstream Medicaid)	9.97	8.29	8.55	7.47-12.47
	Potentially preventable admissions per 100,000 members (Mainstream Medicaid, Fee-For-Service)	1,097	820	834.95	1,069-1,124
	Potentially preventable admission expenditures/Total inpatient expenditures (Mainstream Medicaid, Fee-For-Service)	10.33	8.95	9.07	7.83-12.83

[1] Baseline rate is from measurement year 2015-measurement year 2017.
[2] Baseline rate is from measurement year 2017-measurement year 2018.
[3] Year 1 Remeasurement rate is from measurement year 2016-measurement year 2018.
[4] Year 2 Remeasurement rate is from measurement year 2017-measurement year 2019.

To achieve the overall objectives of the New York State Medicaid managed care program and to ensure New York Medicaid recipients have access to the highest quality of health care, the New York State Medicaid quality strategy focuses on measurement and assessment, improvement, redesign, contract compliance and oversight, and enforcement. The state targets improvement efforts through several activities such as clinical focus studies, clinical and non-clinical performance improvement projects, quality incentives, the quality performance matrix, performance reports, quality improvement conferences and trainings, and plan technical assistance. Descriptions of interventions planned by the Department of Health to achieve the goals of its Medicaid quality strategy are described below.

Triple Aim 1: Improved Population Health

Goal 1: Improve maternal health

- Conduct an administrative and medical record analysis of New York State Medicaid managed care and fee-for-service members who were diagnosed with maternal sepsis to inform strategies to reduce maternal mortality and morbidity. The analysis will evaluate the characteristics, identification, and management of sepsis associated with pregnancy, delivery, postpartum, and post-abortion obstetrical states. Results will be used to identify women at risk for maternal sepsis and modifiable factors associated with maternal sepsis morbidity and mortality.
- Launch a New York State birth equity improvement project, aimed at addressing bias, racism, and disparities impacting maternal health through a birthing-facility-based learning collaborative.
- Lead the New York State Perinatal Quality Collaborative to reduce pregnancy complications, improve maternal and neonatal outcomes, and reduce racial/ethnic and geographic disparities.
- Establish a perinatal data module to support access to perinatal outcome data through the state's All Payer Database.
- Prioritize the public health focus of the New York State regional perinatal system through adoption of updated regulations that strengthen the role of regional perinatal centers, increase focus on obstetrical care, and incorporate birthing centers and midwifery birth centers into the system.
- Increase the number of midwifery birth centers statewide as a first level of care for low-risk pregnancies.
- Update standards for Medicaid providers who provide maternity care.
- Evaluate potential strategies for expanding access to childbirth education classes for pregnant individuals.
- Support the expansion of perinatal telehealth access, with a focus on rural hospitals and health care providers.
- Implement the recommendations of the New York State Postpartum Workgroup.
- Ensure postpartum home visits are available to all individuals on Medicaid who agree to have them.
- Work with maternal/perinatal infant community health collaboratives to expand and enhance community health worker services to address key barriers that impact maternal outcomes.
- Support a perinatal mood, anxiety, and depression education campaign.

Goal 2: Ensure a healthy start

- Continue 2019–2021 Kids Quality Agenda performance improvement project that aims to increase blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.
- Continue to promote the use of fluoride varnish in the primary care setting.
- Develop tools and resources for fluoride varnish training at the local level through an Oral Health Workforce grant.
- Increase fluoride varnish application in the medical setting through public health detailing of pediatric and family medicine practitioners by local health departments.

Goal 3: Promote effective and comprehensive prevention and management of chronic disease

- Continue the National Diabetes Prevention Program as a covered benefit for New York State adult Medicaid members to address the increasing challenges of prediabetes and type 2 diabetes.
- Proceed with the integration of primary care and behavioral health services through a variety of mechanisms.
- Continue interventions of the New York State Asthma Control Program:
  - Provide clinical and quality improvement resources and training to clinical sites to support the delivery of guideline-based medical care, including working with health systems to develop and implement asthma templates into their electronic health record systems to increase the meaningful use of health information technology.
  - Engage home nursing agencies and community-based organizations delivering home-based asthma services to provide training and resources to ensure in-home asthma services include multi-component approaches to asthma trigger reduction and self-management education for high-risk patients.
  - Build cross-sector linkages between health, housing, and energy to advance New York's "health across all policies" approach and integrate related initiatives into New York's value-based payment framework, in partnership with managed care plans, to ensure sustainability.
  - Promote evidence-based approaches to delivery of asthma-self management education across providers and settings (clinical, home, school, or community).
  - Drive collaborations across settings (home, school, community, and clinical) to build bi-directional communication and referral systems structured to support care coordination for people with asthma.
  - Partner with stakeholders to facilitate and promote environmental policies designed to support asthma control (e.g., smoke-free school grounds, anti-idling, and clean diesel policies), regionally and statewide.
- Continue partnership with New York State Primary Care Association and Community Health Center Association of New York State to:
  - Support federally qualified health centers in monitoring and tracking patient- and population-level clinical quality measures for hypertension prevalence, hypertension control, and undiagnosed hypertension.
  - Support providers in the use of patient- and population-level hypertension registries that are stratified by age, gender, race, and ethnicity.
  - Support practices in implementing team-based approaches to care using patient hypertension registries and electronic pre-visit planning tools.
  - Support federally qualified health centers in referring patients to home blood pressure monitoring with provider follow-up.
  - Support federally qualified health centers in implementing bi-directional referrals to community-based programs that support patients in their chronic disease self-management.

Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings

- New York State will be supporting the Zero Suicide model led by the Suicide Prevention Office at the Office of Mental Health. The Zero Suicide model approach calls for:
  - A fundamental commitment from health system leadership to reduce suicide attempts and deaths among those receiving care.
  - Systematic screening and assessment for the identification of those at-risk.
  - Delivery of evidence-based interventions by a competent and caring workforce.
  - Monitoring of those at risk between care episodes, especially care transitions.
  - Data-driven quality improvement to track and measure progress.
- Major demonstration projects are underway in Article 31 licensed mental health clinics, inpatient psychiatric units, substance use disorder settings, Comprehensive Psychiatric Emergency Programs, medical emergency departments, and primary care.

Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Provide a comprehensive smoking cessation benefit for all Medicaid enrollees without cost sharing, prior authorization requirements, or limits on quit attempts. Enrollees are allowed concurrent use of products (two or more medications at once). Medicaid also pays for over-the-counter nicotine patches, gum, and lozenges (with a prescription from a provider).
- Continue providing access to the New York State Smokers' Quitline. The New York State Smokers' Quitline serves as a clinician treatment extender in New York's population-level, evidence-based approach to cessation, which focuses on health system changes to increase the delivery of tobacco dependence treatment, especially for subpopulations with high smoking prevalence, including Medicaid enrollees. The free and confidential Smokers' Quitline provides resources and technical assistance to assist Medicaid enrollees and other disparate populations in accessing and using cost-effective cessation benefits.
- Implementation of evidence-based, strategic, culturally appropriate, and high-impact paid media campaigns targeted at tobacco-related disparate populations to prevent initiation, increase cessation, increase awareness and use of Medicaid tobacco cessation benefits and the Smokers' Quitline, and prevent tobacco use relapse.
- Prevention of alcohol and substance use, misuse, and disorder through the Strategic Prevention Framework which includes a five-step, data-driven planning process designed to guide state and local communities in the selection, implementation, and evaluation of effective, culturally responsive, and sustainable prevention activities. Interventions included are:
    - Environmental change strategies
        - Policies (e.g., alcohol advertising restrictions, social host liability laws)
        - Enforcement (e.g., party patrols, compliance checks, sobriety checkpoints)
        - Media (e.g., social marketing campaign, media advocacy, social norms campaign)
    - Community-based substance use prevention coalitions
    - Family-focused prevention programming (e.g., Strengthening Families, Triple P – Positive Parenting Program®)
    - School-based prevention curricula
        - Universal (e.g., Too Good for Drugs, PAX Good Behavior Game®, Guiding Good Choices®, Positive Action®, LifeSkills® Training, Second Step®)
        - Selective/Indicated (e.g., Teen Intervene, PreVenture)
- New York State supports many strategies to address the opioid crisis and reduce opioid use such as:
    - Creation of policies
    - Provider and member education
    - Requirement of a written opioid treatment plan
    - Encourage the use of non-opioid alternatives
    - Increased access to drugs used for substance use disorder treatment
    - Participation in the Centers for Disease Control and Prevention's Prescription Drug Overdose Prevention initiative
    - Opioid use disorder/substance use disorder screening in primary care practices through the Delivery System Reform Incentive Payment program
    - Mandatory prescriber education program

Triple Aim 2: Improved Quality of Care

Goal 6: Improve quality of substance use disorder and opioid use disorder treatment

- Initiatives focused on improving treatment access to high-quality, evidence-based treatment for opioid use disorder and other substance use disorders. These include learning collaboratives for prescribing professionals to encourage increased access to buprenorphine-waivered professionals across the state; regulatory changes that require medication for opioid use disorder in all Office of Addiction Services and Supports-certified settings; and peers to provide linkage between levels of care and to connect people directly to care from emergency rooms or high-intensity care.
- Expansion of take-home methadone dosing program. Providing weekly, bi-monthly, or monthly take-home doses to patients who are stable will allow them to receive care in a more person-centered way, which should foster recovery and increase treatment retention.

Goal 7: Promote prevention with access to high-quality care

- Use of patient-centered medical homes to support the state's goal of improving primary care and promoting the Triple Aim: improving health, lowering costs, and improving patients' experience of care.
- Maximize workforce distribution by committing to consistent funding for Doctors Across New York. This will help to address workforce shortages with an annual cycle and predictable timeline for the application process and increase student exposure to rural and non-hospital settings through support of community rural training sites.
- Creation of a provider wellness survey that will seek to both establish baseline levels of burnout among New York State providers and uncover how the COVID-19 pandemic has affected providers' self-reported stress, burnout, and job satisfaction. Additionally, the survey will gauge the extent to which meeting regulatory reporting requirements for clinicians increases clinician burden and stress. Data will be shared between the Department of Health's Office of Quality and Patient Safety, the New York Chapter of American College of Physicians, and the Center for Health Workforce Studies.
- Promoting the use of community health workers to increase knowledge about the enrollee services and improve utilization among health care providers and agencies.
- Perform network adequacy analyses to ensure that managed care plans operating in New York State have an adequate number and variety of health care providers in their networks to provide appropriate access to care for their enrollees, which includes being geographically accessible (meeting time/distance standards based on geographic location), being accessible for the disabled, and promoting and ensuring the delivery of services in a culturally competent manner.
- New York State Medicaid has expanded coverage of telehealth services to include:
    - Additional originating and distant sites
    - Additional telehealth applications (store-and-forward telemedicine and remote patient monitoring)
    - Additional practitioner types
- Provide safe, reliable transportation through contracts with two professional transportation managers across five geographic regions to administer Medicaid's transportation benefit.
- The Department of Health strongly encourages plans to participate in collaborative studies with a common theme. Examples of common-themed performance improvement projects include Perinatal Care and The Kids Quality Agenda Performance Improvement Project for mainstream Medicaid managed care plans; Inpatient Care Transitions and Care Transitions after Emergency Department and Inpatient Admissions for Health and Recovery Plans; and Transitions of Care and Emergency Department/Hospitalization Reduction for managed long-term care plans.
- Focused clinical studies, conducted by the external quality review organization, usually involve medical record review, measure development, surveys, and/or focus groups. Managed care plans are typically required to participate in one clinical focus study a year. Studies are often population specific (Medicaid managed care/HIV Special Needs Plan, Managed Long-Term Care, Health and Recovery Plan). Upon completion, the

external quality review organization provides recommendations for improvement to the Department of Health, plans, and providers. Past studies have addressed frailty indices, the provision of advanced directives, functional assessment of inter-rater reliability, validation of vital statistics reporting, use of developmental screening tools, care transitions, and provision of prenatal care.

Goal 8: Support members in their communities

- Increase access to palliative care programs and hospice for persons with serious illnesses and life-threatening conditions to help ensure care and to understand, address, and meet end-of-life planning needs prior to decisions to seek further aggressive care.
- Use of the Integrated Palliative Care Outcomes Scale to measure access to palliative care services for patients most in need.
- Home- and community-based services are designed to allow enrollees to participate in a vast array of habilitative services. They are based on the idea that state services, programs, and activities should be administered in the most integrated and least restrictive setting appropriate to a person's needs. Home and community-based services include managed long-term care services and supports, care coordination, skill building, family and caregiver support services, crisis and planned respite, prevocational services, supported employment services, community advocacy and support, youth support and training, non-medical transportation, habilitation, adaptive and assistive equipment, accessibility modifications, and palliative care.
- Nursing home transition and diversion waiver includes the following home and community-based services: assistive technology, community integration counseling, community transitional services, congregate and home delivered meals, environmental modifications services, home and community-support services, home visits by medical personnel, independent living skills training, moving assistance, nutritional counseling/educational services, peer mentoring, positive behavioral interventions and supports, respiratory therapy, respite services, structured day program services, and wellness counseling service.
- Community First Choice Option Waiver program is being phased in and includes the following home and community-based services: assistive technology; activities of daily living and instrumental activities of daily living skill acquisition, maintenance, and enhancement; community transitional services; moving assistance; environmental modifications; vehicle modifications; and non-emergency transportation.
- Children's Home and Community-Based Services program consolidates multiple 1915(c) children's waiver programs from different agencies, including:
    - The Department of Health's Care at Home Waiver for children with physical disabilities
    - The Office of Mental Health's Waiver for Children and Adolescents with Serious Emotional Disturbance
    - The Office for People with Developmental Disabilities' Care at Home Waiver
    - The Office of Children and Family Services' Bridges to Health Serious Emotional Disturbance Waiver, Bridges to Health Developmental Disability Waiver, and Bridges to Health Medically Fragile Waiver

Goal 9: Improve patient safety

- Improve appropriate use of antibiotics in outpatient healthcare settings to combat antibiotic resistance. Improvement in outpatient settings is done through targeted outreach to healthcare providers, development of clinician resources to support appropriate use of antibiotics, presentation of the data to clinicians to demonstrate the need for improvement, and the development of educational materials for patients. Additionally, collaborative efforts with stakeholders have helped promote the goal to reduce inappropriate antibiotic use.
- Continue to analyze Medicaid claims and pharmacy data, including a separate analysis of antibiotic prescribing for acute upper respiratory infection in pediatric and adult populations. Prescribing rates over time for each population by county of healthcare visit, in both tabular and map formats, have been made publicly available on the Health Data NY website. Data are prepared and presented by county to provide local data for local

action. Data are shared through broad public health messaging and direct presentation upon request of stakeholders.

- Require acute care hospitals in New York State that provide care to patients with sepsis to develop and implement evidence-informed sepsis protocols which describe their approach to both early recognition and treatment of sepsis patients. In addition, hospitals were required to report to the Department of Health sufficient clinical data to calculate each hospital's performance on key measures of early treatment and protocol use. Each hospital submits clinical information on each patient with severe sepsis and or septic shock to allow the Department of Health to develop a methodology to evaluate risk-adjusted mortality rates for each hospital. Risk adjustment permits comparison of hospital performance and takes into consideration the different mix of demographic and comorbidity attributes, including sepsis severity, of patients cared for within each hospital.
- The Medicaid Breast Cancer Selective Contracting policy was implemented in 2009 and mandates that Medicaid enrollees receive breast cancer surgery, i.e., mastectomy and lumpectomy procedures associated with a primary diagnosis of breast cancer, at high-volume hospital and ambulatory surgery centers. Research conducted by the Department of Health demonstrated improved 5-year survival for patients receiving breast cancer surgery at high-volume facilities.

Triple Aim 3: Lower Per-Capita Cost

Goal 10: Pay for high-value care

- Implement Medicaid reform and the move to value-based payments. This transformation promoted community-level collaboration and sought to reduce avoidable hospital use by 25% over the 5–year demonstration period, while financially stabilizing the state's safety-net providers. In just a few years, New York State has significantly moved its Medicaid program from almost exclusively fee-for-service to primarily value-based payment strategies.
- Continue to require certain value-based payment arrangements to include social determinants of health interventions and contractual agreements with one or more community-based organizations. New York State was the first state in the nation to require this. Every value-based payment risk arrangement (56% of Medicaid managed care expenditure) has a defined social determinants of health intervention and includes community-based-human and -social-services organizations.
- Continue to use the core measure set strategy implemented in 2018 which identifies the highest priorities for quality measurement and improvement and provides alignment with other national measurement sets such as the Merit-based Incentive Payment System.
- Promote data sharing via the Statewide Health Information Network for New York. The Statewide Health Information Network for New York "information highway" allows clinicians and consumers to make timely, fact-based decisions that can reduce medical errors, reduce redundant testing, and improve care coordination and quality. The successful implementation of the Statewide Health Information Network for New York is one of the drivers improving health care quality, reducing costs, and improving outcomes for all New Yorkers. Additionally, the Statewide Health Information Network for New York has been leveraged during the COVID-19 pandemic to support disease surveillance activities and assess hospital capacity. Work in this area continues, and the Statewide Health Information Network for New York will become an important component in all Department of Health emergency preparedness initiatives.
- Reduce avoidable hospital use by 25% over 5 years through New York State's Delivery System Reform Incentive Payment program. This program has a formal evaluation plan and state-contract independent evaluator. The final Summative Evaluation is currently being completed, with preliminary results not yet published, but demonstrating significant progress was made towards the achievement of targets.

IPRO's Assessment of the New York State Medicaid Quality Strategy

The 2020-2022 NYS Medicaid quality strategy generally meets the requirements of *42 Code of Federal Regulation 438.340 Managed Care State Quality Strategy,* and acts as a framework for the managed care plans to follow while aiming to achieve improvements in the quality of, timeliness of, and access to care. Goals and aims are clearly stated and supported by well-designed interventions, and methods for measuring and monitoring managed care plan progress toward improving health outcomes incorporate external quality review activities. The strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

Between measurement year 2020 and measurement year 2021, statewide performance met or exceeded targets in areas related to the reduction of smoking prevalence, initiation of treatment for substance abuse, treatment for upper respiratory infection, member experience with health plan assistance managing chronic conditions, and the reduction of preventable admissions. Further findings from the 2021 external quality review activities highlight managed care plan commitment to achieving the goals of the New York State Medicaid quality strategy.

Opportunities to improve health outcomes exist statewide. As evidenced by measurement year 2021 performance, continued attention to population health and quality of care, is appropriate.

Opportunities to strengthen the effectiveness of the New York State Medicaid quality strategy also exist. The Department of Health is unable to trend its performance from baseline for nine quality strategy metrics due to data collection limitations. Additionally, there are two metrics for which no data has been captured and no target has been established.

Recommendations to the New York State Department of Health

Per *42 Code of Federal Regulation 438.364 External quality review results (a)(4)*, this report is required to include recommendations on how the Department of Health can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the quality of, timeliness of, and access to health care services furnished to New York Medicaid managed care enrollees. As such, IPRO recommends the following to the Department of Health:

- To fully comply with *42 Code of Federal Regulation 438.340(b)(1)*, the Department of Health should consider updating the 2020-2022 Medicaid quality strategy to include New York State specific network adequacy and availability of services standards for Medicaid managed care plans.
- The Department of Health should consider extending the quality strategy target date for improvement beyond 2022 to allow itself more time to collect sufficient data for all metrics; and as data becomes available for newer metrics, the Department of Health should update the quality strategy to include baseline data and targets where applicable. If the Department of Health remains unable to collect data for certain metrics, the Department of Health should consider the use of alternative metrics.
- To increase the transparency and overall understanding of state-led compliance review activities, the Department of Health should consider revising related policies and procedures, and technical methods of data collection and analysis.
- Although quality rating protocols have not yet been issued by the Centers for Medicare & Medicaid Services, the Department of Health should include the results of its Consumer Guide Star Rating as a component of the annual external quality review report.

Health and Recovery Plan Profiles

At the beginning of 2021, the New York State Medicaid Health and Recovery Plan program was comprised of 12 managed care plans. By the end of the year, there were only 11 "health and recovery" managed care plans as Affinity Health Plan, Inc. was acquired by Molina Healthcare of New York, Inc.

Table 4 displays an overview of each Health and Recovery plan's profile. For each Health and Recovery plan, the table displays the product lines carried, the total Health and Recovery Plan enrollment for calendar year 2021, and the NCQA accreditation rating achieved, where available. The New York State Medicaid managed care program does not require NCQA accreditation; managed care plans voluntarily decide to seek accreditation. The NCQA accreditation survey includes an assessment of managed care plan systems and processes, and an evaluation of key dimensions of care and services provided by the managed care plan. NCQA awards health plans a rating based on these survey results.

Table 4: Health and Recovery Plan Corporate Profiles

Managed Care Plan	Product Line(s)	Health and Recovery Plan Enrollment as of 12/2021[1]	NCQA Accreditation Status [2]
Affinity Health Plan, Inc. (Affinity)[3]	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	No Enrollment[3]	Not Accredited
Capital District Physician's Health Plan Inc. (CDPHP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	4,682	Accredited (Medicaid and Commercial)
Excellus Health Plan Inc. (Excellus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	11,655	Accredited (Medicaid and Commercial)
Healthfirst PHSP, Inc. (Healthfirst)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	32,597	Not Accredited
HealthPlus HP, LLC (Empire BCBS HealthPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	7,896	Accredited (Medicaid)
Health Insurance Plan of Greater New York, Inc. (HIP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	5,659	Accredited (Commercial)
Independent Health Association, Inc. (IHA)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	2,853	Accredited (Commercial)

Managed Care Plan	Product Line(s)	Health and Recovery Plan Enrollment as of 12/2021[1]	NCQA Accreditation Status [2]
MetroPlus Health Plan, Inc. (MetroPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan, Commercial	13,850	Not Accredited
Molina Healthcare of New York, Inc. (Molina)[3]	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	9,911	Not Accredited
MVP Health Plan, Inc. (MVP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	7,827	Accredited (Commercial)
New York Quality Healthcare Cooperation (Fidelis Care)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	53,931	Accredited (Medicaid)
UnitedHealthcare of New York, Inc. (UHCCP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	11,145	Accredited (Medicaid)
	Total HARP Enrollment	162,006	

[1] Data Source: New York State Office of Health Insurance Programs Medicaid DataMart.
[2] Status is as of 09/15/2022. For more detail on the managed care plans' accreditation status and ratings, please see the NCQA website: https://reportcards.ncqa.org/health-plans.
[3] Affinity Health Plan, Inc. was acquired by Molina Healthcare of New York, Inc. on 11/01/2021, and therefore had no Medicaid enrollment as of 12/2021. The external quality review results presented in this report for Affinity Health Plan, Inc. are based the managed care plan's Medicaid enrollment from 01/01/2021 to 10/31/2021.
NCQA: National Committee of Quality Assurance.
Accredited: Service and quality meet or exceed rigorous requirements for consumer protection and quality improvement.

External Quality Report Activity 1. Validation of Performance Improvement Projects

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans do projects to improve the value or quality of health care for New Yorkers. These types of projects are called performance improvement projects. The New York Medicaid managed care plans are required to conduct a performance improvement project every year. The New York State Department of Health and the managed care plans select the topics for the performance improvement project.

IPRO reviews these projects to verify if they were conducted in a logical way. This is called "validation." Each year, IPRO validates the performance improvement projects conducted by the managed care plans. IPRO decides if the projects make sense and if the results are accurate.

In 2021, the Health and Recovery Plans all had the same topic for the performance improvement projects. The projects focused on care transitions after emergency department visits and inpatient behavioral health admissions.

2021 Performance Improvement Projects Summary

Validation Process

- Does the report have a topic, identify a population, have a clear and meaningful focus?
- There is a review of the managed care plan's sampling methods, data collection, and the results.
- Are the improvement strategies appropriate? Was there an improvement?

Validation Results

- All performance improvement projects passed validation.

Performance Improvement Project Results

- Of the managed care plan performance improvement project results included in this report:
  - 31% of the performance indicator rates for 2021 exceeded their target.
  - 69% of the performance indicator rates for 2021 did not meet their target.

For more information about validation of performance improvement projects, please read the rest of this section.

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid managed care plans to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by a managed care plan. Further, managed care plans are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by *Section 18.15 (a)(xi)(B) of the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, New York State Medicaid managed care plans must conduct at least one performance improvement project in a priority topic area of its choosing with the mutual agreement of the Department of Health and the external quality review organization, and consistent with federal requirements. Beginning in 2019 and continuing through 2021, the Health and Recovery Plans were required to conduct the Care Transitions after Emergency Department and Inpatient Admissions Performance Improvement Project.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for the Care Transitions after Emergency Department and Inpatient Admissions Performance Improvement Project.

The Care Transitions after Emergency Department and Inpatient Admissions Performance Improvement Project aimed to facilitate successful transition for Health and Recovery Plan members from emergency department visits and inpatient mental health care to community care and from inpatient substance use disorder detoxification or inpatient substance use disorder rehabilitation to a lower level of care. While interventions were managed care plan-specific, the performance indicator measures were consistent across all managed care plans; these measures are from HEDIS and the Quality Assurance Reporting Requirements, which are already required to be reported for Health and Recovery Plans.

Technical Methods for Data Collection and Analysis

The Centers for Medicare & Medicaid Services' *Protocol 1 – Validation of Performance Improvement Projects* was used as the framework to assess the quality of each performance improvement project, as well as to score the compliance of each performance improvement project with both federal and state requirements. IPRO's evaluation involves the following elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the managed care plan's enrollment and generalizable to the managed care plan's total population.

4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the managed care plan achieved sustained improvement.

Following the review of the listed elements, the review findings were considered to determine whether the performance improvement project outcomes should be accepted as valid and reliable. The element is determined to be "met" or "not met."

A determination was made as to the overall credibility of the results of each performance improvement project, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
- The validation findings generally indicate that the credibility for the performance improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the performance improvement project results. The concerns that put the conclusion at risk are enumerated.

IPRO provided performance improvement project report templates to each managed care plan for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Received

For the 2021 external quality review, IPRO reviewed managed care plan performance improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of each managed care plan's performance improvement project methodology found that there were no validation findings that indicated that the credibility of the performance improvement project results was at risk. A summary of the validation assessments is in Table 5.

Performance indicator rates are in Table 6 and Table 7.

Details of each managed care plan's performance improvement project activities are described in the Health and Recovery Plan-Level Reporting section of this report.

Table 5: Performance Improvement Project Validation Findings, Measurement Year 2021

Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[1]	Achieved Sustained Improvement[1]
Affinity	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
CDPHP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Excellus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Healthfirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
HIP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
IHA	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MVP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
UHCCP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

[1] When performance improvement was reported by the managed care plan, IPRO determined that the improvement was real and sustained based on its validation of the performance improvement project methodology; the "met determination" does not mean that all performance indicators demonstrated improvement.

Table 6: Performance Improvement Project Rates, Measurement Year 2021

Transition of Care Rates[1]								
Managed Care Plan	Follow-Up After Hospitalization for Mental Illness – 7 Days	Follow-Up After Hospitalization for Mental Illness – 30 Days	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day	Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	Follow-Up After High Intensity Care for Substance Use Disorder – 30 Days
Affinity	60.90%	81.12%	62.09%	75.00%	32.81%	41.96%	56.38%	84.45%
CDPHP	48.21%	67.43%	43.35%	67.38%	29.51%	38.97%	33.33%	62.69%
Empire BCBS HealthPlus	53.88%	68.81%	63.43%	77.27%	28.51%	37.67%	39.73%	64.96%
Excellus	49.53%	71.23%	56.88%	74.16%	32.93%	43.90%	50.95%	74.33%
Fidelis Care	54.27%	74.25%	56.54%	72.61%	31.89%	40.48%	40.23%	68.48%
Healthfirst	68.86%	80.66%	40.72%	59.32%	27.11%	36.25%	32.88%	59.82%
HIP	46.09%	69.13%	53.10%	74.02%	31.11%	39.17%	32.30%	55.76%
IHA	50.00%	77.59%	79.17%	84.72%	43.42%	51.97%	46.13%	73.24%
MetroPlus	35.51%	60.31%	40.89%	60.59%	26.83%	35.51%	39.46%	63.11%
Molina	40.00%	69.09%	34.11%	56.59%	26.87%	37.07%	41.62%	65.90%
MVP	50.11%	65.01%	38.73%	56.94%	23.49%	31.38%	42.16%	69.41%
UHCCP	58.46%	75.60%	36.56%	56.53%	27.15%	35.65%	42.10%	66.52%

[1] Rates presented in this table are unenhanced, and may differ from the rates presented in the managed care plan-specific performance measure validation tables. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Table 7: Performance Improvement Project Rates (Continued), Measurement Year 2021

Transition of Care Rates[1]				
Managed Care Plan	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Potentially Preventable Mental Health Related Readmission Rate – 30 Days	Use of Pharmacotherapy for Alcohol Abuse or Dependence
Affinity	67.42%	25.69%	Not Available	22.50%
CDPHP	65.07%	49.31%	Not Available	26.15%
Empire BCBS HealthPlus	67.08%	34.62%	Not Available	24.86%
Excellus	66.04%	50.25%	Not Available	28.63%
Fidelis Care	65.76%	44.83%	Not Available	28.01%
Healthfirst	65.70%	30.18%	Not Available	26.09%
HIP	68.09%	31.94%	Not Available	21.51%
IHA	65.26%	30.23%	10.16%	26.45%
MetroPlus	65.50%	35.96%	Not Available	27.89%
Molina	65.30%	53.00%	Not Available	22.71%
MVP	66.54%	48.95%	20.89%	27.51%
UHCCP	64.56%	28.77%	Not Available	25.78%

[1] Rates presented in this table are unenhanced, and may differ from the rates presented in the managed care plan-specific performance measure validation tables.

Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

External Quality Review Activity 2. Validation of Performance Measures

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	**External Quality Review Activity 2. Validation of Performance Measures**
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans collect information on the health status of New Yorkers on Medicaid and the services they receive. They share this information with the New York State Department of Health and its partners in many ways. One way is through performance measures. A performance measure describes health care and health status using numbers. These numbers are percentages or rates. Performance measure rates often use the "%" symbol.

The information used to calculate the performance measure rates must be accurate. The information must also be complete. The managed care plans check that the rates are accurate and complete. This is called "validation." The person who does the validation is called an "auditor." Auditors are certified to do the validation. Each year, the managed care plans work with auditors to validate performance measures.

The performance measures show how well the managed care plans are caring for their members. For this reason, the New York State Department of Health monitors the performance measures regularly.

2021 Performance Measure Validation Summary

Validation Process

- Can managed care plans collect, store, analyze and report health information?
- Are reporting practices and performance measure specifications compliant?
- Is each performance measure accurate? Is it complete?

Validation Results

- Auditors validated performance measures of all 12 managed care plans.
- All managed care plans passed validation.
- All managed care plans met validation requirements to report performance measures to New York State.

Performance Measure Rates

- Of the managed care plan performance measure rates included in this report:
  - 17% performed significantly better than statewide Health and Recovery performance
  - 18% performed significantly worse than statewide Health and Recovery performance
  - 66% did not differ in performance from statewide Health and Recovery performance

For more information about validation of performance measures, please read the rest of this section.

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must identify standard performance measures relating to the performance of managed care plans and that the state requires each managed care plan to annually measure and report to the state on its performance using the standard measures required by the state.

As required by *Section 18.15 (a)(v) of the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract,* New York State Medicaid managed care plans are required to report all applicable performance measures included in the Quality Assurance Reporting Requirements program and to follow NCQA HEDIS and New York State technical specifications for rate calculations. Further, the Office of Health Insurance Programs incorporates select Quality Assurance Reporting Requirements results into its methodology for the Quality Incentive Program.[12]

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for measurement year 2021.

Technical Methods for Data Collection and Analysis

The 2021 Quality Assurance Reporting Requirements program consisted of measures developed by NCQA for HEDIS and CAHPS and by the Department of Health. Measures required for the 2021 Quality Assurance Reporting Requirements program are available in Appendix A of this report. The major domains of performance included in the 2021 Quality Assurance Reporting Requirements program for the Health and Recovery Plans were:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data

Each of these domains included NCQA HEDIS and CAHPS measures, as well as several New York State-specific measures for areas of importance to the Department of Health and for which there were no nationally recognized standard measures. Many of these measures were calculated through the managed care plans' NCQA HEDIS data submissions, while others were calculated by the Department of Health using encounter data, prenatal data, and Quality Assurance Reporting Requirements submissions reported by the managed care plans.

[12] New York's Medicaid Managed Care Quality Incentive Program began in early 2001. The Quality Incentive Program incorporates results from managed care plan Quality Assurance Reporting Requirements submissions and Medicaid CAHPS survey results.

For measurement year 2021, the New York State managed care plans were required to submit performance measure data to the Department of Health based on the *2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual.*[13]

To ensure compliance with reporting requirements, each managed care plan contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor. Table 8 displays vendors and compliance auditors by managed care plan.

Table 8: HEDIS Vendors and Compliance Auditors

Managed Care Plan	NCQA-Certified HEDIS Vendor	NCQA-Certified HEDIS Compliance Auditor
Affinity	Cotiviti Inc.	Aqurate Health Data Management, Inc.
CDPHP	Cotiviti Inc.	Aqurate Health Data Management, Inc.
Empire BCBS HealthPlus	Inovalon, Inc. and Cotiviti Inc.	DTS Group
Excellus	Cotiviti Inc.	Advent Advisory Group
Fidelis Care	Cotiviti Inc.	Aqurate Health Data Management, Inc.
Healthfirst	Cotiviti Inc.	Aqurate Health Data Management, Inc.
HIP	Cognizant	Aqurate Health Data Management, Inc.
IHA	SPH Analytics	Attest Health Care Advisors
MetroPlus	Inovalon, Inc.	Aqurate Health Data Management, Inc.
Molina	Cognizant TriZetto Software Group, Inc.	Advent Advisory Group
MVP	Inovalon, Inc.	Aqurate Health Data Management, Inc.
UHCCP	SPH Analytics	Attest Health Care Advisors

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance.

The HEDIS vendor collected data and calculated performance measure rates on behalf of the managed care plan for measurement year 2021. The HEDIS vendor calculated rates using NCQA's HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans and the Department of Health's 2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual.

The HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement, and they also validated the managed care plan's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated the managed care plan's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities
2. HEDIS Specification Standards

HEDIS compliance auditors consider managed care plan compliance with the information system capabilities and HEDIS specification standards to fully assess the organization's HEDIS reporting capabilities.

[13] New York State Department of Health 2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual (2020-2021 QARR/HEDIS 2020-2021) Website: https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2021/docs/qarr_specifications_manual.pdf

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed the managed care plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 9 displays these standards as well as the elements audited for the standard.

Table 9: Information System Capabilities Standards

Information System Capabilities Categories	Elements Audited
1.0 Medicaid Services Data	Sound Coding Methods and Data Capture, Transfer and Entry
2.0 Enrollment Data	Data Capture, Transfer and Entry
3.0 Practitioner Data	Data Capture, Transfer and Entry
4.0 Medical Record Review Processes	Training, Sampling, Abstraction and Oversight
5.0 Supplemental Data	Capture, Transfer and Entry
6.0 Data Preproduction Processing	Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
7.0 Data Integration and Reporting	Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the managed care plan had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

HEDIS Specification Standards

HEDIS compliance auditors use the HEDIS specification standards to assess the managed care plan's compliance with conventional reporting practices and HEDIS technical specifications. These standards describe the required procedures for specific information, such as proper identification of denominators and numerators, and verification of algorithms and rate calculations.

Performance Measure Validation

Each managed care plan's calculated rates for the NCQA HEDIS Measurement Year 2021 and New York State 2021 Quality Assurance Reporting Requirements measure sets were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 10 presents these outcome designations and their definitions. Performance measure validation activities included, but were not limited to:

- Confirmation that rates were produced with certified code or Automated Source Code Review approved logic
- Medical record review validation
- Review of supplemental data sources
- Review of system conversions/upgrades, if applicable
- Review of vendor data, if applicable
- Follow-up on issues identified during documentation review or previous audits

Table 10: Performance Measure Outcome Designations

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	**Reportable**. A reportable rate was submitted for the measure.
NA	**Small Denominator.** The organization followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures when the denominator is fewer than 30. b. For utilization measures that count member months when the denominator is fewer than 360 member months. c. For all risk-adjusted utilization measures when the denominator is fewer than 150. d. For electronic clinical data systems measures when the denominator is fewer than 30.
NB	**No Benefit.** The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	**Not Reported.** The organization chose not to report the measure.
NQ	**Not Required.** The organization was not required to report the measure.
BR	**Biased Rate.** The calculated rate was materially biased.
UN	**Unaudited.** The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

NCQA: National Committee for Quality Assurance.

Each managed care plan's HEDIS compliance auditor produced a Final Audit Report and Audit Review Table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each managed care plan submitted these documents, as well as other required Quality Assurance Reporting Requirements files, to the Department of Health and IPRO.

To augment the performance measure validation conducted by each managed care plan's HEDIS auditor, IPRO validated the files submitted by the managed care plans for the New York State Quality Assurance Reporting Requirements program.

IPRO reviewed each managed care plan's Final Audit Report and Audit Review Table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with Department of Health requirements. To assess the accuracy of the reported rates, IPRO:

- Recalculated performance measure rates using denominator and numerator member-level data and compared these recalculated rates to the rates reported by the managed care plan to NCQA via the Interactive Data Submission System tool;
- Compared each managed care plan's patient-level data files, enhancement files, and prenatal files to the tool;
- Compared performance measure rates reported by the managed care plans to NCQA's Quality Compass regional Medicaid benchmarks; and
- Analyzed performance-measure-rate–level trends to identify drastic changes in performance.

Lastly, IPRO reviewed source code used by the Department of Health to calculate rates for certain New York State-specific performance measures. The data used by the Department of Health to calculate these rates were validated by IPRO.

Description of Data Received

For the 2021 external quality review, IPRO obtained each managed care plan's Final Audit Report and a locked copy of the Audit Review Table that were produced by the HEDIS compliance auditor.

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; Table 10).

The Audit Review Table displayed performance-measure–level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the Audit Review Table: administrative rate before exclusions; minimum required sample size, and minimum required sample size numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

The Quality Assurance Reporting Requirements data file included the final validated rate for each performance measure reported by the Health and Recovery Plans, as well as the results of statewide calculations and statistical significance testing conducted by the Department of Health. Within the file, performance measures were presented by product line by managed care plan by domain. For each performance measure, the data file also presented data collection methodology, eligible population count, exclusion count, numerator event count, eligible population count, denominator count, numerator event count, and state Health and Recovery Plan Medicaid benchmarks when applicable.

Comparative Results

Validation of Performance Measures and Quality Assurance Reporting Requirements Rates for Quality Incentive Measures

Each managed care plan's HEDIS compliance auditor determined that the NCQA HEDIS and New York State Quality Assurance Reporting Requirements rates reported by the managed care plan for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditors for any managed care plan. Table 11 displays the results of the Information System Capabilities review for each managed care plan.

Further, the results of IPRO's performance measure validation activities determined that each Health and Recovery Plan successfully calculated and reported rates to the Department of Health according to contractual requirements. There were no data collection or reporting issues identified by IPRO for any managed care plan.

Twenty-nine (29) measures from the 2021 Quality Assurance Reporting Requirements program were selected by the Department of Health for inclusion in its evaluation of Health and Recovery Plans performance under the 2021–2022 Quality Incentive Program. These measures cover primary care, HIV, mental health, and substance use, and fall into one of the following major domains:

- Effectiveness of Care, or
- Access/Availability of Care.

As the 2021 Quality Assurance Reporting Requirements measures included in the 2021–2022 Quality Incentive Program represent high-priority areas of care for Health and Recovery Plans, rates for these measures are presented in this report.

Table 12 through Table 16 display managed care plan rates, statewide averages, and national Medicaid benchmarks for measurement year 2021.

Table 11: Information Systems Capabilities Review Results

NCQA's Information Systems Standards							
Managed Care Plan	1.0 Medical Services Data	2.0 Enrollment Data	3.0 Practitioner Data	4.0 Medical Record Review Processes	5.0 Supplemental Data	6.0 Data Preproduction Processing	7.0 Data Integration and Reporting
Affinity	Met	Met	Met	Met	Met	Met	Met
CDPHP	Met	Met	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Met	Met	Met
Excellus	Met	Met	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Met	Met	Met
Healthfirst	Met	Met	Met	Met	Met	Met	Met
HIP	Met	Met	Met	Met	Met	Met	Met
IHA	Met	Met	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Met	Met	Met
MVP	Met	Met	Met	Met	Met	Met	Met
UHCCP	Met	Met	Met	Met	Met	Met	Met

NCQA: National Committee for Quality Assurance.

Table 12: Effectiveness of Care Performance Measures – Primary Care, Measurement Year 2021

Effectiveness of Care – Primary Care Measures							
Benchmark/Managed Care Plan	Antidepressant Medication Management – Effective Acute Phase Treatment	Antidepressant Medication Management – Effective Continuation Phase Treatment	Asthma Medication Ratio (19–64 Years)	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women (21–24 Years)	Colorectal Cancer Screening
Health and Recovery Plan Statewide	53.62%	39.96%	41.20%	54.63%	63.77%	72.96%	55.13%
National 2021 Medicaid Mean	60.80%	44.06%	Not Available	51.00%	56.26%	60.60%	Not Available
National 2021 Medicaid 90th Percentile	71.26%	56.24%	Not Available	61.27%	66.88%	70.29%	Not Available
Affinity	51.92%	38.08%	49.59%	63.13%	72.26%	83.64%	62.29%
CDPHP	61.16%	44.90%	60.90%	52.03%	61.78%	81.67%	61.04%
Empire BCBS HealthPlus	52.08%	37.50%	43.05%	51.19%	58.76%	86.59%	52.07%
Excellus	52.87%	38.57%	48.54%	57.56%	68.35%	67.46%	58.77%
Fidelis Care	55.58%	41.64%	35.63%	51.81%	63.99%	68.41%	53.77%
Healthfirst	52.66%	38.06%	40.38%	61.88%	65.21%	79.23%	62.56%
HIP	53.28%	40.15%	46.03%	52.61%	58.35%	62.86%	45.01%
IHA	60.96%	45.45%	69.77%	56.68%	67.11%	Sample Size Too Small To Report	60.69%
MetroPlus	47.49%	35.26%	32.78%	48.82%	57.91%	77.11%	46.72%
Molina	47.17%	31.45%	56.52%	52.70%	65.69%	72.97%	54.35%
MVP	50.60%	41.65%	37.33%	47.77%	63.75%	72.41%	53.15%
UHCCP	55.18%	43.84%	50.99%	48.10%	59.37%	69.57%	44.77%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Table 13: Effectiveness of Care Performance Measures (Continued) – Primary Care, Measurement Year 2021

Effectiveness of Care – Primary Care Measures (Continued)							
					Medical Assistance with Tobacco Cessation		
Benchmark/Managed Care Plan	Comprehensive Diabetes Care - Eye Exam	Comprehensive Diabetes Care - HbA1c Poor Control (>9%)[1]	Controlling High Blood Pressure	Flu Shots for Adults	Advising Smokers to and Tobacco Users to Quit	Discussing Cessation Medications	Discussing Cessation Strategies
Health and Recovery Plan Statewide	56.74%	40.91%	63.25%	47.31%	83.42%	68.96%	59.37%
National 2021 Medicaid Mean	50.81%	42.26%	58.63%	40.13%	72.45%	50.83%	45.25%
National 2021 Medicaid 90th Percentile	63.75%	30.90%	69.19%	50.70%	78.70%	60.10%	52.69%
Affinity	63.50%	24.82%	74.94%	39.76%	87.02%	65.38%	59.85%
CDPHP	55.53%	34.40%	73.43%	49.24%	86.93%	68.83%	61.04%
Empire BCBS HealthPlus	46.72%	47.45%	49.64%	45.60%	78.91%	64.06%	56.69%
Excellus	63.26%	36.25%	60.74%	51.87%	82.89%	71.52%	60.13%
Fidelis Care	57.42%	44.04%	60.34%	44.00%	83.97%	75.32%	65.82%
Healthfirst	63.02%	38.69%	69.27%	48.54%	87.02%	68.99%	66.41%
HIP	48.42%	45.99%	62.47%	46.59%	77.78%	62.14%	51.06%
IHA	63.01%	25.00%	67.39%	50.14%	86.19%	71.35%	54.70%
MetroPlus	45.74%	39.66%	65.21%	48.38%	81.12%	67.61%	59.44%
Molina	58.64%	43.55%	63.02%	54.00%	80.93%	72.02%	63.02%
MVP	49.88%	48.91%	56.20%	46.95%	80.41%	62.76%	52.38%
UHCCP	49.88%	41.61%	61.07%	40.41%	88.03%	74.13%	61.54%

[1]Lower rate indicates better performance.

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 14: Effectiveness of Care Performance Measures (Continued) – Primary Care and HIV, Measurement Year 2021

	Effectiveness of Care – Primary Care Measures (Continued)			Effectiveness of Care – HIV Measure
Benchmark/Managed Care Plan	Kidney Health Evaluation for Patients with Diabetes (Total)	Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	Viral Load Suppression
Health and Recovery Plan Statewide	31.97%	64.47%	27.71%	65.59%
National 2021 Medicaid Mean	33.45%	70.21%	24.80%	Not Available
National 2021 Medicaid 90th Percentile	46.76%	81.25%	33.97%	Not Available
Affinity	70.92%	60.00%	40.79%	69.35%
CDPHP	39.24%	61.21%	41.49%	81.20%
Empire BCBS HealthPlus	29.29%	60.93%	30.53%	61.57%
Excellus	40.83%	73.50%	22.16%	75.64%
Fidelis Care	31.11%	63.74%	28.19%	67.95%
Healthfirst	31.75%	66.38%	27.40%	63.68%
HIP	28.35%	65.18%	33.80%	54.46%
IHA	34.87%	70.42%	26.92%	83.08%
MetroPlus	22.75%	64.86%	24.66%	52.42%
Molina	31.92%	63.53%	21.98%	86.44%
MVP	31.33%	58.76%	21.38%	79.41%
UHCCP	22.78%	61.83%	26.58%	61.62%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 15: Effectiveness of Care Performance Measures (Continued) –Mental Health, Measurement Year 2021

Effectiveness of Care – Mental Health Measures					
Benchmark/Managed Care Plan	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	Potentially Preventable Mental Health Related Readmission Rate – 30 Days
Health and Recovery Plan Statewide	65.95%	79.90%	49.11%	57.82%	Not Available
National 2021 Medicaid Mean	59.65%	79.20%	40.08%	38.44%	Not Available
National 2021 Medicaid 90th Percentile	72.94%	86.28%	60.58%	54.55%	Not Available
Affinity	67.42%	81.00%	62.27%	62.16%	Not Available
CDPHP	65.07%	76.16%	42.61%	49.17%	Not Available
Empire BCBS HealthPlus	67.08%	80.92%	63.84%	55.67%	Not Available
Excellus	66.04%	76.01%	57.31%	57.66%	Not Available
Fidelis Care	65.76%	79.22%	56.63%	56.78%	Not Available
Healthfirst	65.70%	81.96%	40.93%	71.83%	Not Available
HIP	68.09%	75.65%	53.67%	50.22%	Not Available
IHA	65.26%	76.63%	79.17%	54.13%	Not Available
MetroPlus	65.50%	83.51%	40.92%	40.39%	Not Available
Molina	65.30%	74.62%	34.11%	40.00%	Not Available
MVP	66.54%	79.50%	38.84%	53.61%	Not Available
UHCCP	65.06%	79.39%	36.33%	59.82%	Not Available

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 16: Effectiveness of Care and Access/Availability of Care Performance Measures– Substance Use, Measurement Year 2021

	Effectiveness of Care – Substance Use Measures			Access/Availability of Care – Substance Use Measures		
Benchmark/Managed Care Plan	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	Pharmacotherapy for Opioid Use Disorder	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Use of Pharmacotherapy for Alcohol Abuse or Dependence
Health and Recovery Plan Statewide	29.41%	42.87%	30.44%	20.73%	41.05%	26.88%
National 2021 Medicaid Mean	13.35%	30.36%	28.00%	13.87%	Not Available	Not Available
National 2021 Medicaid 90th Percentile	21.97%	49.39%	41.67%	22.12%	Not Available	Not Available
Affinity	32.81%	53.77%	17.65%	12.36%	25.69%	22.50%
CDPHP	29.51%	34.66%	32.78%	19.25%	49.31%	26.15%
Empire BCBS HealthPlus	28.51%	50.56%	29.97%	16.81%	34.62%	24.86%
Excellus	32.93%	53.93%	31.44%	20.16%	50.25%	28.63%
Fidelis Care	32.11%	42.47%	32.93%	24.76%	44.83%	28.01%
Healthfirst	27.11%	38.90%	28.71%	16.99%	30.18%	26.69%
HIP	31.11%	36.46%	28.10%	21.54%	31.94%	21.51%
IHA	43.42%	49.65%	35.37%	24.46%	30.23%	26.45%
MetroPlus	26.94%	43.92%	26.08%	20.37%	35.96%	27.89%
Molina	26.87%	41.62%	30.86%	18.09%	53.00%	22.71%
MVP	23.49%	44.35%	33.26%	21.75%	48.95%	27.51%
UHCCP	26.96%	40.52%	28.52%	19.85%	45.62%	25.61%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

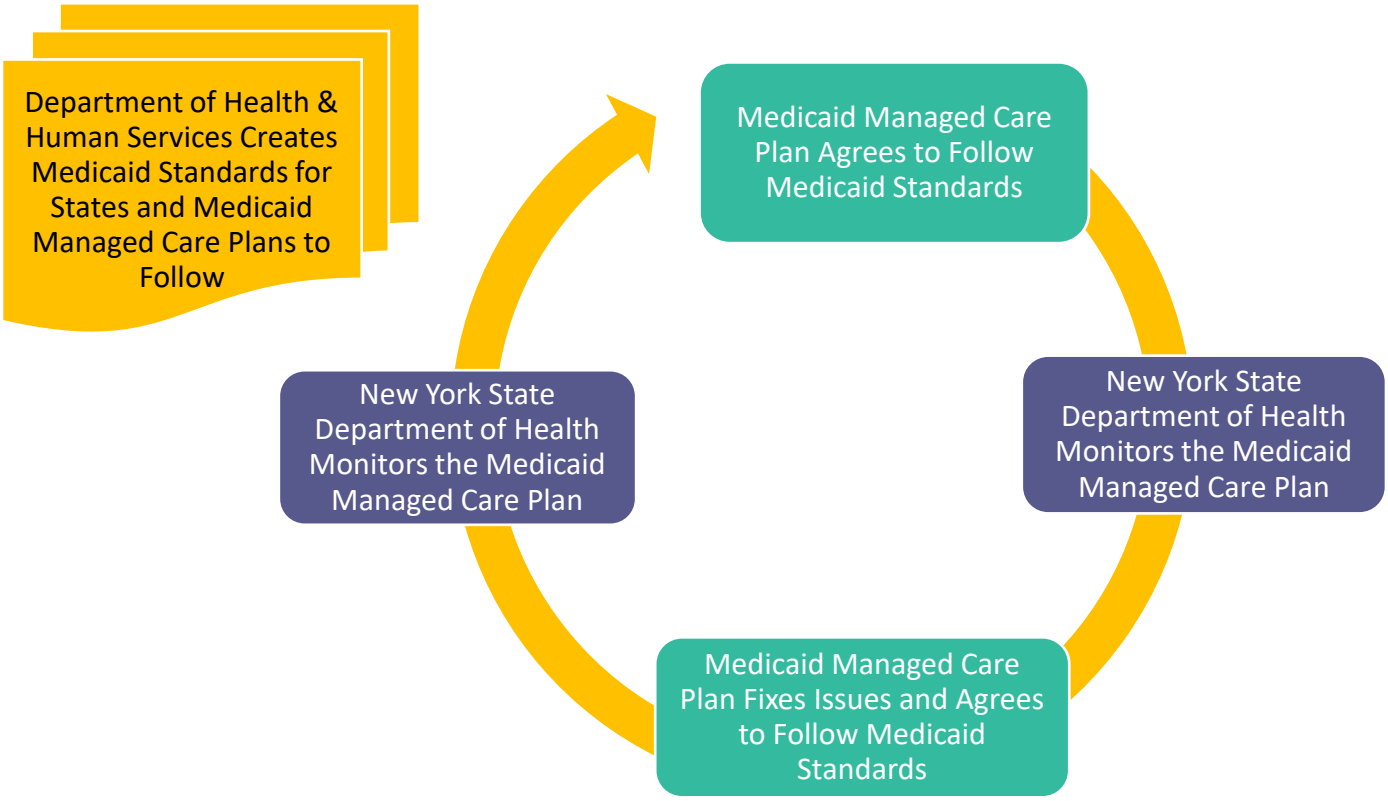
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	**External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards**
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

The United States Department of Health & Human Services determines how the Medicaid program should work. The Department of Health & Human Services created a set of rules for states and Medicaid managed care plans to follow. These rules are called Medicaid standards. These Medicaid standards protect people who receive health care through state Medicaid programs. All Medicaid managed care plans in the country are required to follow these standards.

The Department of Health is responsible for making sure that the New York Medicaid managed care plans follow the Medicaid standards. The Department of Health continuously monitors the Medicaid managed care plans. The main way that the New York Medicaid managed care plans are monitored is through the Managed Care Operational Survey. During the survey, the Department of Health reviews Medicaid managed care plan documents and interviews staff. The Medicaid managed care plan is responsible for fixing any issues found during the survey.



Technical Summary – Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan's compliance with the standards of *Title 42 Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards* and the standards of *Title 42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Department of Health conducts a variety of oversight activities to ensure that the managed care plans are in compliance with federal and state Medicaid requirements and the standards of *Code of Federal Regulations Part 438 Managed Care Subpart D*, *Code of Federal Regulations 438.330*, the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, *New York State Public Health Law Article 44* and *Article 49*, and *New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*. These activities include the Managed Care Operational Survey, which is completed on a continuous timeline. This survey activity centers on the provision of Medicaid services and is conducted for the Health and Recovery Plans.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review, referenced in *Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii),* to determine managed care compliance with federal Medicaid standards. To meet this federal regulation, the Department of Health provided IPRO with the results of the Managed Care Operational Survey conducted for the Health and Recovery Plans in 2019, 2020, and 2021 for review.

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services granted New York State a Section 1135 (under the Social Security Act) Waiver to suspend the requirements of *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full onsite biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely. The granting of this waiver allowed the Department of Health to "pend" oversight activities that were scheduled for the remainder of 2020. Therefore, the Managed Care Operational Survey for 2020 was not conducted for some Health and Recovery Plans.

The results of the most recent compliance activities conducted for the Health and Recovery Plans by the Department of Health for 2019, 2020, and 2021 are presented in this report.

Technical Methods of Data Collection and Analysis

The Department of Health's primary method for managed care plan assessment and determination of compliance with federal and state Medicaid requirements is the Managed Care Operational Survey. The Managed Care Operational Survey is conducted by the Department of Health every 2 to 3 years based on a continuous timeline and is comprised of two parts: the Comprehensive Operational Survey and the Target Operational Survey.

The Comprehensive Operational Survey is a full review of state and federal Medicaid requirements which covers the following:

- Organization and Management
- Service Delivery
- Fraud, Waste, Abuse, and Program Integrity
- Management Information Systems
- Medicaid Contract
- Member Services

- Utilization Review Management
- Complaints and Grievances, Non-Utilization Review
- Behavioral Health Services
- Person Centered Care Management
- Quality Initiatives, Quality Assurance, Quality Improvement

The Target Operational Survey is a follow-up review to the Comprehensive Operational Survey and includes some standard reporting and review in addition to a follow-up of all areas and issues identified to be noncompliant during the Comprehensive Operational Survey. The Target Operational Survey includes, but is not limited to, the following:

- An evaluation of managed care plan changes related to the board of directors, officers, organizational changes, as well as modification to the managed care plan's utilization review and/or quality programs.
- An evaluation that the managed care plan has corrected the noncompliance identified during the Comprehensive Operational Survey and implemented a plan of correction.
- If the managed care plan was subject to complaints, was found to be deficient as a result of other Department of Health monitoring activities, or has undergone operational changes during the past year, a review of these areas is conducted.

Each 2019, 2020 and 2021 Comprehensive Operational Survey and Target Operational Survey was conducted over a 6-week period in three phases:

Phase 1 - Pre-onsite Visit

Each survey team lead, or facilitator, completed a review of the managed care plans previous operational survey results, as well as complaints history, external quality review activity results, and fair hearing data in preparation for the upcoming operational survey.

Each operational survey commenced with the issuance of an announcement letter to the managed care plan, along with a request for pertinent documents and data reports to serve as evidence of managed care plan compliance with the Medicaid standards under review. The requested documents included, but were not limited to, organization structure, policies and procedures, contracts and credentialing, utilization management and care management data, complaints, and grievances data.

Upon receipt of the requested documentation, the Department of Health survey staff reviewed the documentation for evidence of managed care plan compliance and to identify areas needing further review during the Department of Health's onsite visit to the managed care plan. The survey teams utilized Department of Health-developed tools throughout the survey process to ensure that standardization of the evaluation of evidence for compliance was maintained.

Phase 2 - Onsite Visit

During the onsite visit, the Department of Health survey staff continued its evaluation of documentation materials, reviewed quality assurance committee and board of directors meeting minutes, conducted staff and management interviews, and performed observations as needed.

Phase 3 - Post-onsite Visit

Six-to-eight weeks following the onsite visit, results were issued to the managed care plan. The survey results included written citations identifying the areas of the managed care plan's noncompliance with state and federal Medicaid standards. The written citations were issued to the managed care plan either as "deficiencies" for noncompliance with New York State *Public Health Law* and *New York Code, Rules, and Regulations* or as "findings" for noncompliance with the requirements of the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*. For areas of noncompliance, the managed care plan was required to submit a plan

of correction to the Department of Health for approval. Once the plan of correction was approved, the operational survey activity was considered closed.

Description of Data Received

To evaluate managed care plan compliance with federal and state Medicaid standards, IPRO reviewed the Department of Health-produced *Operational Deficiencies by Plan/Category Report* and the *Operational Plan Deficiencies Report*. The *Operational Deficiencies by Plan/Category Report* included a summary of noncompliance by review area for each managed care plan, while the *Operational Plan Deficiencies Report* included detailed information on the areas of noncompliance for each managed care plan. Both reports reflected the date of when the results were issued by the Department of Health to the managed care plan, the plan of correction submission date, and the plan of correction approval date.

Comparative Results

Managed care plan results for the operational survey activities conducted for 2019, 2020, and 2021 are presented by federal Medicaid standards in Table 17. In Table 17, a "C" indicates that the managed care plan was in compliance with all standard requirements and an "NC" indicates that the managed care plan was not in compliance with at least one standard requirement. The details for each "NC" designation are presented in the Health and Recovery Plan-Level Reporting section of this report.

Table 17: Managed Care Plan Operational Survey Results, 2019, 2020, and 2021

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Affinity	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2021 Pended[1]											
CDPHP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	NC	C	C	C	C	C	NC	C	C	C	C
	2021 Pended[1]											
Empire BCBS HealthPlus	2019 Activity	C	C	C	C	NC	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	NC	C	C	NC	C
Excellus	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	NC	C	C	C	C
Fidelis	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	NC	C	NC	C	C	C	C
Healthfirst	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											
HIP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	C	C	C	C	C	C	C	C	C	C	C
	2021 Activity	C	C	C	C	C	C	NC	C	C	C	C
IHA	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											
MetroPlus	2019 Activity	C	C	C	NC	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	C	C	C	C	C
Molina	2019 Activity	C	C	C	NC	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											
MVP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	NC	C	C	C	NC	C	NC	C	C	C	C
	2021 Pended[1]											

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
UHCCP	2019 Activity	NC	C	C	NC	C	C	NC	C	C	C	NC
	2020 Pended[1]											
	2021 Activity	NC	C	C	C	NC	C	C	C	C	C	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.

C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

External Quality Review Activity 6. Administration of Quality-of-Care Surveys

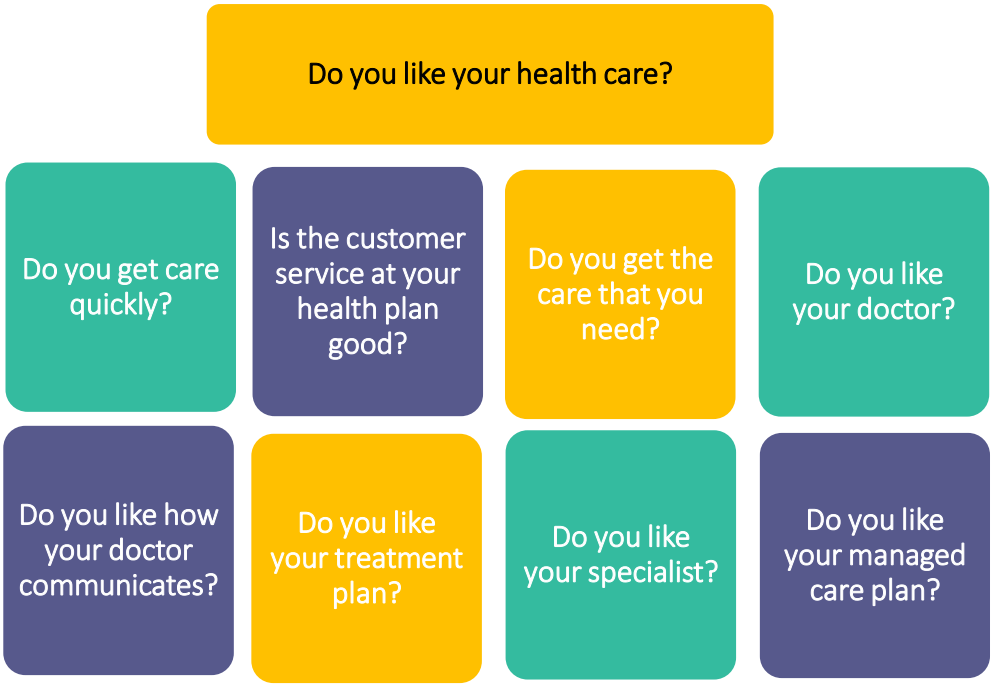
Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Understanding the experiences that New Yorkers have with the Medicaid managed care program is a priority for the Department of Health. IPRO administers a survey on behalf of the Department of Health every year, alternating between adults and kids. The survey is sent to a group of New Yorkers that received care through one of the Medicaid managed care plans. IPRO asks these New Yorkers to rate their experiences with the Health and Recovery Plans, health care services, personal doctors, and specialists. This survey is called the Consumer Assessment of Healthcare Providers and Systems.

IPRO ensures that the survey is conducted properly and that the results are calculated correctly.

The Department of Health uses the survey results to monitor Health and Recovery Plan and provider performance. Health and Recovery Plans use the survey results to understand the experience New Yorkers have with the Medicaid program.

In 2022, IPRO surveyed adult New Yorkers who received care in 2021 through a Health and Recovery Plan.



For more information about the 2021 survey, please read the rest of this section.

Technical Summary – Administration of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality-of-care may be performed by using information derived during the preceding 12 months. Further, *Title 42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

The Department of Health sponsors a member experience survey every other year for adults enrolled in a Medicaid managed care plan. The goal of the survey is to get feedback from these members about how they view the health care services they receive. The Department of Health uses results from the survey to determine variation in member satisfaction among the managed care plans.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the quality-of-care survey activity. To meet this federal regulation, the Department of Health contracted with IPRO to administer this survey. For measurement year 2021, IPRO subcontracted with DataStat, an NCQA-certified CAHPS vendor, to administer the *2022 Health and Recovery Plan CAHPS 5.1H Adult Medicaid Survey* on behalf of all Health and Recovery Plans.

This external quality review report presents the 2022 CAHPS results for measurement year 2021.

Technical Methods for Data Collection and Analysis

The standardized survey instrument administered in 2021 was the *2022 Health and Recovery Plan CAHPS 5.1H Adult Medicaid Survey*. The majority of question items addressed members' experiences with their health care, such as getting care quickly, communication with doctors, and overall satisfaction with health care and with the health plan. The questionnaire was expanded to include 24 supplemental questions of particular interest to the Department of Health. Rounding out the instrument was a set of questions collecting demographic data. In total, the questionnaire consisted of 69 questions.

Table 18 provides more detail on how the 69 survey questions are categorized.

Table 18: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Customer Service	Never, Sometimes, Usually, Always *(Top-level performance is considered responses of "usually" or "always.")*
Global Rating Measures	
▪ Rating of All Health Care ▪ Rating of Personal Doctor ▪ Rating of Specialist Talked to Most Often ▪ Rating of Health Plan ▪ Rating of Treatment or Counseling	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

Adults who were current members of a New York State Health and Recovery Plan, ages 21 to 64 years, as of September 2021, and who had been enrolled for five out of the last six months were eligible to be randomly selected for the survey. A stratified random sample of 2,000 members was drawn for each managed care plan, resulting in a statewide sample size of 24,000 members.

Members were surveyed in English or Spanish. The survey was administered over a 13-week period using a mail-only three-wave protocol. The protocol consisted of a first questionnaire packet and reminder postcard to all selected members, followed by a second questionnaire packet and reminder postcard to individuals who had not responded to the initial mailings, concluding with a third questionnaire packet to individuals who had not responded to either the initial or secondary mailings.

Table 19 provides a summary of the technical methods of data collection.

Table 19: CAHPS Technical Methods of Data Collection Summary

Category	Data Collection Information
Survey Vendor	DataStat, Inc.
Survey Tool	5.1H Adult Medicaid Health Plan Survey
Number of Managed Care Plans	12
Type of Medicaid Managed Care Plan	Health and Recovery Plans
Survey Timeframe	10/14/21 to 1/13/22
Method of Collection	Mail only, three waves
Sample Size	24,000
Number of Completed Surveys	3,711
Response Rate	15.5%

DataStat, Inc. calculated the results in accordance with HEDIS specifications for survey measures.

Member responses to questionnaire items are summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. In general, somewhat positive responses are included with positive responses as achievements. For example, a response of "Usually" or "Always" to the question "How often did you get an appointment for health care at a doctor's office or clinic as soon as you needed?" is considered an achievement, as are responses of "8", "9", or "10" to rating questions with a scoring range of 0–10.

Achievement scores based on fewer than 30 responses were not considered reliable and were suppressed by DataStat.

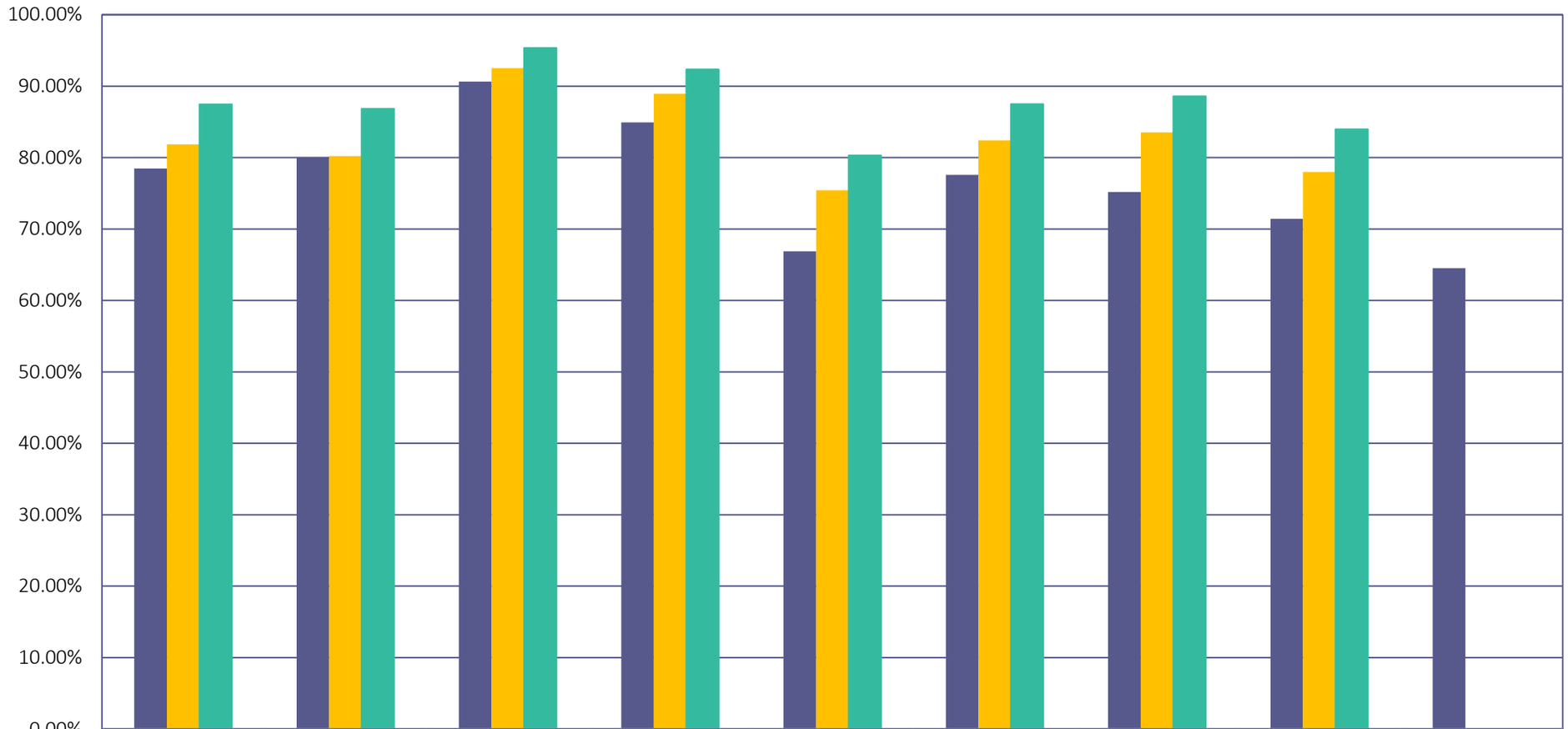
Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Description of Data Obtained

IPRO received a copy of the *New York State Health and Recovery Plans CAHPS 5.1H Adult Medicaid Survey* that was produced by DataStat, Inc. in April 2022. The report included comprehensive descriptions of the project objectives, methodology, and data analysis, as well as results at the statewide, region (New York City and rest of state) and managed care plan levels.

Comparative Results

New York State achievement scores for the composite measures and global rating measures and national 2021 Medicaid benchmarks are presented in Figure 1. Achievement scores for the managed care plans are presented in Table 20.



	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Talked to Most Often	Rating of Health Plan	Rating of Treatment or Counseling
Statewide Health and Recovery Plan	78.48%	80.03%	90.62%	84.93%	66.87%	77.57%	75.17%	71.44%	64.51%
National 2021 Medicaid Mean	81.86%	80.22%	92.51%	88.91%	75.41%	82.38%	83.52%	77.98%	Not Available
National 2021 Medicaid 90th Percentile	87.47%	86.85%	95.37%	92.34%	80.32%	87.50%	88.60%	83.98%	Not Available

Figure 1: 2021 Member Satisfaction Achievement Scores. Achievement scores for Medicaid managed care statewide (dark blue), National Medicaid Mean for (yellow) and National Medicaid 90th Percentile (green) for 2021.

Table 20: CAHPS Achievement Scores by Managed Care Plan, Measurement Year 2021

Region/Managed Care Plan	Getting Needed Care[1]	Getting Care Quickly[1]	How Well Doctors Communicate[1]	Customer Service[1]	Rating of All Health Care[2]	Rating of Personal Doctor[2]	Rating of Specialist Talked to Most Often[2]	Rating of Health Plan[2]	Rating of Treatment or Counseling[2]
Statewide Health and Recovery Plan	78.48%	80.03%	90.62%	84.93%	66.87%	77.57%	75.17%	71.44%	64.51%
National 2021 Medicaid Mean	81.86%	80.22%	92.51%	88.91%	75.41%	82.38%	83.52%	77.98%	Not Available
National 2021 Medicaid 90th Percentile	87.47%	86.85%	95.37%	92.34%	80.32%	87.50%	88.60%	83.98%	Not Available
Affinity	71.03%	68.43%	89.04%	78.23%	66.39%	72.32%	71.20%	63.87%	60.90%
CDPHP	88.56%	83.69%	88.93%	92.01%	71.42%	76.57%	86.60%	80.83%	70.00%
Empire BCBS HealthPlus	80.20%	83.28%	91.60%	83.69%	68.76%	77.60%	73.06%	68.81%	61.23%
Excellus	76.72%	81.52%	92.56%	87.51%	68.80%	80.50%	75.49%	75.47%	59.30%
Fidelis Care	81.66%	83.69%	90.90%	82.52%	70.37%	80.17%	79.84%	69.09%	67.32%
Healthfirst	78.98%	82.49%	94.16%	85.52%	67.00%	83.33%	82.55%	77.69%	65.66%
HIP	77.66%	75.11%	88.75%	78.42%	66.36%	78.21%	69.23%	69.15%	63.63%
IHA	79.90%	83.47%	91.42%	91.93%	69.08%	80.96%	72.53%	81.85%	71.35%
MetroPlus	72.99%	77.51%	89.03%	80.24%	64.60%	71.19%	73.94%	65.82%	60.57%
Molina	76.85%	81.52%	90.30%	80.88%	54.17%	76.47%	73.86%	62.50%	68.49%
MVP	81.18%	82.58%	90.69%	91.21%	69.56%	81.39%	71.96%	72.88%	67.78%
UHCCP	76.02%	77.11%	90.01%	86.95%	65.93%	72.14%	71.76%	69.33%	57.92%

[1] Measure represents the percent of members who responded “usually” or “always.”

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded “8” or “9” or “10.”

Green shading indicates managed care plan’s 2021 performance is statistically significantly better than the statewide Health and Recovery Plan 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan’s 2021 performance is statistically significantly worse than the statewide Health and Recovery Plan 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Health and Recovery Plan-Level Reporting

To assess the impact of Medicaid managed care on the quality of, timeliness of, and access to health care services, IPRO considered managed care plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2021 external quality review:

- External Quality Review Mandatory Activity 1: Performance Improvement Projects
- External Quality Review Mandatory Activity 2: Performance Measures
- External Quality Review Mandatory Activity 3: Compliance with Medicaid and Children's Health Insurance Plan Standards
- External Quality Review Optional Activity 6: Quality of Care Survey, Member Satisfaction
- Managed Care Plan Follow-Up on 2020 External Quality Review Recommendations

Performance Improvement Project Summary and Results

This section displays the Health and Recovery Plan's 2021 performance improvement project topic, validation assessment, summary of interventions, and results achieved. The corresponding tables display performance indicators, baseline rates, interim rates, final rates, and targets/goals.

Performance Measure Results

This section displays the Health and Recovery Plan-level performance rates for measurement years 2019, 2020, and 2021, as well as the statewide average rates for measurement year 2021. The corresponding tables indicate whether the managed care plan's rate was statistically better than the statewide average rate (indicated by green shading) or whether the managed care plan's rate was statistically worse than the statewide average rate (indicated by red shading). A managed care plan statistically exceeding the statewide average rate for a measure was considered a strength during this evaluation, while a managed care plan rate reported statistically below the statewide average rate was considered an opportunity for improvement.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

This section displays Health and Recovery Plan results for the most recent Managed Care Operational Survey. A managed care plan being in compliance with federal Medicaid standards was considered a strength during this evaluation, while noncompliance with a requirement standard was considered an opportunity for improvement.

Quality-of-Care Survey Results – Member Experience

This section displays the Health and Recovery Plan-level Adult CAHPS performance for 2021. The corresponding tables display the satisfaction domains, individual supplemental questions, managed care plan scores, and the statewide average scores for measurement year 2021. The table also indicates whether the managed care plan's score was significantly better than the statewide average score (indicated by green shading) or whether the managed care plan's score was significantly worse than the statewide average score (indicated by red shading). A managed care plan scoring statistically better than the statewide average score for a satisfaction domain was considered a strength during this evaluation, while a managed care plan scores statistically worse than the statewide average score was considered an opportunity for improvement.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCP, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each managed care plan describe how its organization addressed the recommendations from the 2020 External Quality Review Technical Report. Managed care plan responses are reported in this section of the report.

Table 21 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the 2020 external quality review recommendations.

Table 21: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed care plan's quality improvement response resulted in demonstrated improvement.
Partially Addressed
Managed care plan's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Strengths, Opportunities for Improvement, and Recommendations

The Health and Recovery Plan strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the quality of, timeliness of, and access to care are presented. These three elements are defined as:

- Quality is the extent to which a managed care plan increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- Timeliness is the extent to which care and services are provided within the periods required by the New York State model contract with managed care plans, federal regulations, and as recommended by professional organizations and other evidence-based guidelines.
- Access is the timely use of personal health services to achieve the best possible health outcomes.

Affinity

Performance Improvement Project Summary and Results

Table 22: Affinity's Performance Improvement Project Summary, Measurement Year 2021

Affinity's Performance Improvement Project Summary
Title: Health and Recovery Plan Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Affinity aims to implement streamlined consent forms, provider facility education, enhanced outreach to members, and an incentive program. Member-Focused 2021 Interventions ▪ Conducted in-person outreach to members with high-utilization rates prior to, during, or after discharge. Social workers encouraged members to engage with their health homes, assisted with the scheduling of follow-up care, and educated members on benefits of attending the follow-up visit. ▪ Conducted enhanced outreach to all members who recently discharged from an inpatient facility. ▪ Implemented an incentive program for all members who recently discharged from an inpatient facility to encourage accessing follow-up care within seven days of discharge with a mental health provider, substance abuse provider, or alcohol or other drug -specific provider. Provider-Focused 2021 Interventions ▪ Partnered with four health homes to engage with members with high-utilization rates who had an emergency department visit or discharge from an inpatient facility. Outreach was conducted within three days of the event with the goal of encouraging members to attend follow-up visits within seven days of discharge. Managed Care Plan-Focused 2021 Interventions ▪ Implemented processes that ensured consistent and timely receipt of data for members with a recent emergency department visit.

Table 23: Affinity's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	54.68%	58.93%	53.54%	60.90%	60.20%
Follow-Up After Hospitalization for Mental Illness – 30 Days	76.30%	79.91%	75.33%	81.12%	79.31%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	53.33%	61.47%	63.36%	62.09%	64.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	70.22%	75.58%	76.51%	75.00%	79.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	27.12%	22.07%	32.76%	32.81%	31.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	44.10%	42.97%	42.98%	41.96%	48.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	27.20%	35.56%	41.99%	56.38%	28.00%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	52.70%	65.82%	65.37%	84.45%	57.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.03%	68.22%	67.64%	67.42%	73.00%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	24.19%	28.18%	27.80%	25.69%	30.92%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	15.84%	19.62%	15.04%	Not Available	18.00%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	10.87%	11.83%	22.39%	22.50%	12.15%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 24: Affinity's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Affinity Measurement Year 2019	Affinity Measurement Year 2020	Affinity Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.85%	45.31%	51.92%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	35.93%	34.77%	38.08%	39.96%
Asthma Medication Ratio (19–64 Years)	40.50%	49.62%	49.59%	41.20%
Breast Cancer Screening	58.89%	58.94%	63.13%	54.63%
Cervical Cancer Screening	75.43%	72.26%	72.26%	63.77%
Chlamydia Screening in Women (21–24 Years)	82.14%	82.46%	83.64%	72.96%
Colorectal Cancer Screening	60.83%	62.77%	62.29%	55.13%
Comprehensive Diabetes Care – Eye Exam	60.34%	58.39%	63.50%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	36.50%	28.95%	24.82%	40.91%
Controlling High Blood Pressure	78.35%	68.37%	74.94%	63.25%
Flu Shots for Adults[2]	56.99%	56.99%	39.76%	47.31%
Advising Smokers to Quit[2]	84.00%	84.00%	87.02%	83.42%
Discussing Smoking Cessation Medications[2]	74.00%	74.00%	65.38%	68.96%
Discussing Smoking Cessation Strategies[2]	63.27%	63.27%	59.85%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	70.92%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	57.73%	63.10%	60.00%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	34.74%	38.36%	40.79%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	66.23%	65.91%	69.35%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.22%	67.64%	67.42%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.21%	82.23%	81.00%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	61.39%	63.48%	62.27%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	58.93%	55.74%	62.16%	57.82%

Measure	Affinity Measurement Year 2019	Affinity Measurement Year 2020	Affinity Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	19.62%	15.04%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	22.07%	32.76%	32.81%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	43.07%	53.77%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	27.98%	17.65%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	17.05%	13.76%	12.36%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	28.18%	Not Available	25.69%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	11.83%	Not Available	22.50%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 25: Affinity's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	C	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	C	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	NC	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Affinity failed to ensure the delegate DentaQuest issued initial adverse determination notices included the correct instructions on how to initiate an external appeal. Specifically, the phone number for which an enrollee may contact Affinity to request an external appeal application and instructions was not included. Affinity failed to provide the current external appeal instructions and application to the enrollee. Specifically, the address for Department of Financial Services was not correct, the applications did not include the placeholders for the enrollee's Date of Birth, and gender. *(Contract Article 4903. 5(b))*
- Affinity failed to submit and/or report an accurate 2nd quarter 2020 provider network. The network submission incorrectly reported seven of 20 providers who Affinity determined during the targeted operational survey were no longer participating. *(Contract Article 2005-98-1.16(j), 2005-98-1.16(i))*
- Affinity failed to ensure that delegates DentaQuest and EviCore included the correct information on how to file an appeal. Affinity failed to ensure that the delegate DentaQuest issued initial adverse determination notices that included the correct required timeframe to resolve an expedited appeal within 72 hours of receipt of request, in accordance with *42 Code of Federal Regulations Part 438.408(3)*. *Title 42 Code of Federal Regulations Part 438.402(b)* changes effective May 1, 2018, a standard appeal after an upheld expedited appeal is no longer available for Medicaid, Child Health Plus, and individual insurance. *(Contract Article 4904. 2)*
- Affinity failed to submit and/or report an accurate second quarter of 2020 for the provider network. The network submission incorrectly reported seven of 20 providers who Affinity determined during the targeted operational survey were no longer participating. *(Contract Article 2005-98-1. 6(a), 2005-98-1.11(g))*

Quality-of-Care Survey Results – Member Experience

Table 26: Affinity's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Affinity	Health and Recovery Plan Average
Getting Needed Care[1]	71.03%	78.48%
Getting Care Quickly[1]	68.43%	80.03%
How Well Doctors Communicate[1]	89.04%	90.62%
Customer Service[1]	78.23%	84.93%
Rating of All Health Care [2]	66.39%	66.87%
Rating of Personal Doctor [2]	72.32%	77.57%
Rating of Specialist Talked to Most Often[2]	71.20%	75.17%
Rating of Health Plan[2]	63.87%	71.44%
Rating of Treatment or Counseling[2]	60.90%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 27: Affinity's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
Validation of Performance Improvement Projects					
As indicated in Affinity's Health and Recovery Plan performance improvement project interim 2 report, the findings demonstrate that the Health and Recovery Plan population is not fully engaged in care and there is significant room for improvement in *Follow-up after Hospitalization for Mental Illness*. The managed care plan should continue with the changes put in place in October 2020, which includes improvements to member outreach initiatives and the	X			Managed care plan combined its response for two external quality review recommendations: Since the close of the 2019-2021 Health and Recovery Plan performance improvement project, Affinity has been acquired by Molina Healthcare of New York and the legacy delegation arrangement with Beacon Health Options was terminated at the end of December 31, 2021. These two events are important to highlight because they brought about foundational changes in how the managed care plan approaches the management of its behavioral health population. First, when compared to the Upstate New York (Molina) market's model and performance, Affinity showed less health home engagement and little-to-no collaborative relationship with health homes in its network. Since January 1, 2022, the managed care plan has included the downstate health homes into its round of monthly one-on-one meetings where quality score cards are generated, reviewed, and performance improvement plans are developed and monitored. A Health Home Oversight Committee meets quarterly and is comprised of the managed care plan's clinical and quality leadership. The Committee is responsible for reviewing overall health home performance, monitoring the progress of corrective action plans, and for developing/implementing measures that address low performance among health homes serving managed care plan members. In October 2022, the managed care plan conducted a health home roundtable discussion where every health home serving a managed care plan member was invited to participate in a "brainstorming" session to address obstacles affecting health homes'	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
creation of a monthly workgroup. The managed care plan should consider conducting a member satisfaction survey to determine additional barriers to members accessing follow-up appointments.				ability to carry out their due diligence for our members. We believe the close collaboration with health homes and the investment in their partnership will extend the work of our internal care management staff, especially among harder-to-reach members. The managed care plan is also taking advantage of data solutions to assist with the time identification of members requiring follow-up behavioral health care. We are receiving and loading hospital admission, discharge, and transfer alerts from three regional health information organizations within our catchment area into our primary care management system. The frequent alert updates (15-minute intervals) has commenced; however, because some diagnostic information around substance use is protected, the behavioral health and case management departments are exploring the possibility of embedding staff in specific high-volume substance treatment facilities to allow engagement with members prior to discharge to potentially increase the likelihood of connecting members to appropriate, ongoing outpatient services and medication assisted treatment while the members' location and whereabouts are still known to the managed care plan (and reducing the potential for members getting lost to care). Another area of renewed focus is on medication management and medication adherence for members on antidepressant or antipsychotic medications. In the past, most interventions were passive in nature, mainly limited to mailings. The managed care plan has since worked with its pharmacy benefit manager, Caremark, to develop pharmacy reports that identity members at-risk of falling outside the recommended threshold for medication adherence. From these reports, the managed care plan initiates a text and/or email refill reminder for the first missed refill incident. If a second missed refill incident occurs, the managed care plan's quality staff performs live outreach calls to remind and educate members on the	
Validation of Performance Measures					
Affinity demonstrates an opportunity to improve members' access to certain behavioral health services. In 2020, Affinity's low rate of members accessing alcohol and drug abuse treatments might be directly affected by the low percentage of members being assessed for home and community-based services. Affinity should evaluate its current	X		X		

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
behavioral health case management program to evaluate member outreach and participation. Additionally, Affinity would benefit from evaluating its provider network to identify inadequacies that could be affecting members accessing substance abuse treatments. The managed care plan could assess if advancements in telehealth technologies would benefit these provider types and provide resources to support implementation.				importance of maintaining their medication regimen. The live call also affords us the opportunity to warm transfer members directly to Caremark or connect them to the prescriber's office if the cause of their non-adherence is due to questions, concerns, or side effects from their medication. Regarding feedback from members, the managed care plan has launched a program called "Care4Care" that deploys contact center staff to call members with at least one complaint against the managed care plan within a calendar quarter. The purpose of this contact is to ascertain if the member's complaint was handled timely, appropriately, and to their satisfaction, to elicit suggestions on how the managed care plan can prevent their issue from happening again, and to use the feedback to inform changes in company procedures and performance improvement activities with our providers. Additionally, we have a current program that will send out post-doctor visit surveys to members following a primary care visit. After evaluating the effectiveness of the primary care survey, the managed care plan will expand the survey to post-specialty care visits as well—specifically, behavioral health. Finally, in 2021, the managed care plan contracted with Teladoc to offer telepsychiatry services to managed care plan members as a means of expanding provider capacity and affording members continuity in care, especially during crisis. Notably, the highest telepsychiatry utilization was among the Health and Recovery Plan population and surpassed its use for basic telemedicine services by three times. However, we will further investigate with behavioral health providers if the managed care plan can assist with implementing telehealth modalities for their specific sites to expand their individual capacity.	
Compliance with Medicaid Standards					

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
The managed care plan should investigate opportunities to ensure appeal policies and procedures are being followed by its delegates, DentaQuest and EviCore.	X	X	X	As part of its plan of correction submitted to the Department of Health following the 2020 Article 44 Comprehensive Plan Survey, Affinity reviewed a random sample of appeal notices prepared by DentaQuest and EviCore to ensure appeal policies and procedures are being adhered to. Any issues identified required a corrective action plan to be submitted by the delegates, where a follow up review would be conducted to confirm the issues are resolved. This internal process of auditing delegated vendors' appeals policies has since been incorporated into the policies and procedures of Molina Healthcare of New York since the acquisition of Affinity, effective November 1, 2021.	Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 28: Affinity's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Affinity's measurement year 2021 performance improvement project passed validation.	X	X	X
	Affinity exceeded target rates for six performance indicators.	X	X	X
Performance Measures	Affinity met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Affinity performed significantly better than the Health and Recovery Plan program on nine measures of effectiveness of care related to primary care, HIV, mental health measures, or substance use measures.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2020, Affinity was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Affinity did not meet target rates for five performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Affinity performed significantly worse than the Health and Recovery Plan program on two measures of effectiveness of care related to primary care or substance use.	X	X	
Performance Measures – Access/Availability of Care	Affinity performed significantly worse than the Health and Recovery Plan program on three measures of access/availability of care related to substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, Affinity was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Affinity performed significantly worse than the Health and Recovery Plan program on three measures of member satisfaction.	X		

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Performance Measures	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Compliance with Federal Managed Care Standards	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Quality-of-Care Survey	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			

CDPHP

Performance Improvement Project Summary and Results

Table 29: CDPHP's Performance Improvement Project Summary, Measurement Year 2021

CDPHP's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim CDPHP aims to conduct member education and implement an incentive program, support post-discharge visits, promote medication-assisted treatment, and use their regional health information organization to inform member outreach. Member-Focused 2021 Interventions ▪ Promoted bridge visits from local inpatient mental health facilities post-discharge. ▪ Case managers attended follow-up discharge appointments with members readmitted within 30 days. ▪ Educated readmitted members with the teach-back method. ▪ Offered $50 gift card incentive to members who completed three continuous months of antipsychotics. ▪ Case managers discussed health home program benefits and provided warm handoffs to interested members. Provider-Focused 2021 Interventions ▪ Case managers requested that hospital staff offer medication assistance treatment during utilization reviews and discharge planning. Managed Care Plan-Focused 2021 Interventions ▪ Created a list received from the regional health information organization identifying members who visited the emergency department for a diagnosis of mental illness to inform member outreach.

Table 30: CDPHP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days[2]	53.64%	65.05%	63.14%	48.21%	66.51%
Follow-Up After Hospitalization for Mental Illness – 30 Days[2]	76.63%	80.26%	83.14%	67.43%	95.03%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	40.63%	42.41%	50.00%	43.35%	50.16%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	60.63%	66.52%	69.83%	67.38%	78.69%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	30.51%	34.05%	26.42%	29.51%	38.27%
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	37.71%	41.58%	37.42%	38.97%	47.82%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days[2]	28.32%	38.08%	40.17%	33.33%	29.00%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days[2]	60.12%	71.51%	72.30%	62.69%	60.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.05%	71.33%	67.97%	65.07%	85.09%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	35.65%	41.64%	49.31%	47.82%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days[2]	18.90%	15.69%	Not Available	Not Available	16.25%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	Not Available	17.18%	16.78%	26.15%	23.90%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

[2] Rate calculated based on Office of Quality and Patient Safety technical specifications which differ from HEDIS Technical Specifications.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 31: CDPHP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	CDPHP Measurement Year 2019	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	50.49%	53.72%	61.16%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	32.90%	39.53%	44.90%	39.96%
Asthma Medication Ratio (19–64 Years)	43.40%	51.91%	60.90%	41.20%
Breast Cancer Screening	62.90%	55.47%	52.03%	54.63%
Cervical Cancer Screening	73.10%	72.26%	61.78%	63.77%
Chlamydia Screening in Women (21–24 Years)	86.79%	82.46%	81.67%	72.96%
Colorectal Cancer Screening	62.11%	58.76%	61.04%	55.13%
Comprehensive Diabetes Care – Eye Exam	71.05%	55.06%	55.53%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	33.33%	36.54%	34.40%	40.91%
Controlling High Blood Pressure	76.01%	68.37%	73.43%	63.25%
Flu Shots for Adults[2]	50.85%	56.99%	49.24%	47.31%
Advising Smokers to Quit[2]	88.64%	88.64%	86.93%	83.42%
Discussing Smoking Cessation Medications[2]	72.73%	72.73%	68.83%	68.96%
Discussing Smoking Cessation Strategies[2]	65.52%	65.52%	61.04%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	39.24%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	68.75%	63.10%	61.21%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	28.07%	22.99%	41.49%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	77.78%	84.21%	81.20%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.33%	71.97%	65.07%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.62%	72.81%	76.16%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	42.41%	48.17%	42.61%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	65.05%	63.14%	49.17%	57.82%

Measure	CDPHP Measurement Year 2019	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	15.69%	24.55%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	34.05%	25.77%	29.51%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	40.17%	34.66%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	34.21%	32.78%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	20.77%	19.97%	19.25%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	43.57%	Not Available	49.31%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	17.18%	Not Available	26.15%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 32: CDPHP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	NC	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	C	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	C	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Based on staff interview and review of the Child Health Plus initial adverse determination and final adverse determination notices, CDPHP failed to ensure its delegate, Delta Dental, provided clinical rationale explanations that included the term "not medically necessary" or enrollee-specific information in six of 10 Child Health Plus pre-authorization cases. *(Contract Article 98-2.9(e)(1))*
- Based on staff interview and review of the Child Health Plus final adverse determination notices, CDPHP and its delegate Delta Dental failed to ensure that the notices included the contact person for CDPHP. This was evident in five of 10 Child Health Plus standard appeal utilization review cases. *(Contract Article 98-2.9 (e)(3,4,5,6,7))*
- CDPHP failed to ensure that the written notices issued to the enrollees were factual and accurate in nature for three of 16, (#37, 38, and 40) Delta Dental Child Health Plus pre-authorization utilization review cases reviewed during the Comprehensive Operational Survey. Specifically, the Delta Dental Child Health Plus pre-authorization initial adverse determination notices did not include correct information to identify the dentist that completed the review and made the denial determination. *(Contract Article 98-1.13 (a))*
- CDPHP failed to provide evidence that two of 55 providers were sent an amendment to incorporate the 2017 New York State Department of Health Standard Clauses for Managed Care Provider/Independent Physician Association/Accountable Care Organization Contracts. *(Contract Article 98-1.13(a))*
- CDPHP failed to notify the Department of Health of three new board members and the resignation of three board members. *(Contract Article 2005-98-1.13(c)(2))*

Quality-of-Care Survey Results – Member Experience

Table 33: CDPHP's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	CDPHP	Health and Recovery Plan Average
Getting Needed Care[1]	88.56%	78.48%
Getting Care Quickly[1]	83.69%	80.03%
How Well Doctors Communicate[1]	88.93%	90.62%
Customer Service[1]	92.01%	84.93%
Rating of All Health Care [2]	71.42%	66.87%
Rating of Personal Doctor [2]	76.57%	77.57%
Rating of Specialist Talked to Most Often[2]	86.60%	75.17%
Rating of Health Plan[2]	80.83%	71.44%
Rating of Treatment or Counseling[2]	70.00%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 34: CDPHP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
Validation of Performance Improvement Projects					
CDPHP should continue conducting routine evaluations of the interventions associated with the 2019-2021 performance improvement project. As indicated in the Health and Recovery Plan performance improvement project interim 2 report, CDPHP has made multiple changes to data collection processes including supplementing manual reporting rates with HEDIS data, revising intervention tracking methods,				<u>What has the managed care plan done or planned to do to address the recommendation?</u> The Experience of Care and Health Outcomes survey was conducted to assess the quality of behavioral health services by focusing on the patient's experiences with care. Questions included: ▪ Seeing someone as soon as they wanted. ▪ Wait times for counseling for an urgent problem. ▪ Wait time for a routine appointment for a new versus established patient. ▪ Number of visits to an emergency room or crisis center. ▪ Whether clinicians listened carefully, explained things in a way they understood, and showed respect for what they had to say. ▪ Satisfaction with customer service from the provider's office. ▪ Informed of self-help or support groups. ▪ Provider set goals for treatment. ▪ Copays or deductibles prevented treatment. ▪ Helped by the counseling or treatment received. ▪ Satisfaction with the coordination of care between clinician and primary care doctor. ▪ Difficulty getting a provider who met special needs. <u>When and how will this be accomplished?</u> The data collection technique was a three-wave mailing to sampled members from August 2021 to October 2021. Results were reviewed at quality committee meetings in 2022. The	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
and updates to data collection software. CDPHP should also consider conducting member satisfaction surveys to identify additional barriers to members' accessing follow-up care.				same survey is being administered in 2022, with data collection closing in October 2022. What are the expected outcomes or goals of the actions to be taken? Based on the responses, health plan staff can review trends and encourage provider offices to remain aware of the quality of care given to their patients. CDPHP will continue promoting virtual telehealth options with new and existing platforms, along with maintaining an internal document containing providers who are known to have more timely appointment availability. What is the managed care plan's process for monitoring the actions to determine their effectiveness? Results of the member satisfaction surveys are reviewed at quality committee meetings consisting of network providers and facility administrators. Feedback is incorporated into daily health plan conversations and strategies to assist members in obtaining follow-up care. HEDIS rates are reviewed monthly to determine trends. A report is being created in measurement year of 2022 to drill down to specific hospital *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* scores.	
Validation of Performance Measures					
CDPHP demonstrates an opportunity to improve members' access to certain behavioral health services. In 2020, CDPHP's low rate	X		X	What has the managed care plan done or planned to do to address the recommendation? When the COVID-19 pandemic began in early 2020, many places were shut down and in-person assessment had stopped causing a reduction in services. Home and community-based services and community-oriented recovery and empowerment services do not have a focus on substance use disorders, but rather mental health and social determinants of health. Since	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
of members accessing alcohol and drug abuse treatments could be directly affected by the low percentage of members being assessed for home and community-based services. CDPHP should evaluate its current behavioral health case management program to evaluate member outreach and participation. Additionally, CDPHP would benefit from evaluating its provider network to identify inadequacies that could be affecting members accessing substance abuse treatments. The managed care plan could assess if				then, health homes continue to have trouble retaining their workforce, especially since the reimbursement model for health homes is being revised under the Health Home Outreach and Optimization funds project, which will eliminate the ability for health homes to bill for outreach, and only be reimbursed for their ability to enroll and maintain engagement with a member. Next steps include CDPHP continuing to employ certified recovery peer advocates to engage members with substance use disorder needs, promoting monetary incentives to encourage medication assisted treatment, connecting members to telehealth, scheduling appointments before members discharge from inpatient facilities and emergency rooms, and reestablishing care management collaboration between hospital staff through an on-site presence at high-volume facilities. CDPHP established a monthly internal workgroup consisting of contracting and healthcare network strategy to review the substance use disorder provider network to identify inadequacies that could be affecting members accessing substance abuse treatments. The telehealth companies CDPHP contracts with have experienced difficulties finding and retaining providers to prescribe medication assisted treatment services, but their search efforts continue. There is currently a care management delegation agreement in ongoing negotiations with one telehealth company that will allow for sharing of member information and direct outreach and engagement. <u>When and how will this be accomplished?</u> In measurement year 2022, monthly clinical follow-up meetings between CDPHP and the health home discuss members in real-time and connect them to additional supports through their county resources. The care management team	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
advancements in telehealth technologies would benefit these provider types and provide resources to support implementation.				educates and assesses all new Health and Recovery Plan enrollees at initial contact for health homes and home and community-based services/community-oriented recovery and empowerment services. Care management also offers referrals for these services throughout their work with the member based on needs identified by the member. The healthcare network strategy and contracting departments meet monthly to review potential substance use disorder facilities to outreach for contracting. What are the expected outcomes or goals of the actions to be taken? The members who are identified as living with substance use disorders will be connected to care timelier if the substance use disorder network has more providers available within a certain timeframe after using the emergency room or discharging from an intensive care setting. What is the managed care plan's process for monitoring the actions to determine their effectiveness? Quarterly meetings with hospitals and clinics allow for the opportunity to share HEDIS data and feedback regarding importance of timely communication regarding care status, and process improvement ideas.	
Compliance with Medicaid Standards					
The managed care plan should investigate opportunities to improve the areas in which noncompliance was identified and	X	X	X	What has the managed care plan done or planned to do to address the recommendation? The goals were not reached for *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Emergency Department Visit for Mental Illness*, *Initiation of Pharmacotherapy for Opioid Use Disorder*, and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*.	Addressed. (As CDPHP's submitted response did not address the recommendation, IPRO based its assessment of CDPHP's response to

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
routinely monitor the effectiveness of the interventions to ensure full compliance achieved during the next compliance review.				There were organizational changes within CDPHP over the period from the second quarter of 2022 into the third quarter of 2022, with new teams being created to address transitions of care from inpatient and emergent levels of care and embed directly onsite at the hospitals. When and how will this be accomplished? Priorities and goals are being set for the substance use disorder measures and researching providers that have not yet been contracted with through the Healthcare Network Strategy department. The telehealth companies are being solicited to serve as a bridge for members with mental health and substance use disorder after-care therapy appointment needs and are meeting with inpatient hospital and emergency room staff to obtain buy-in as trusted referral options. The CDPHP care management team continues to engage members and offer support by promoting follow up in-person and telehealth visits performing teach-back, offering financial incentives for medication adherence, working with prescribing providers to make them aware of member adherence, encouraging medication assisted treatment and finding resources, and assisting with health home enrollment. What are the expected outcomes or goals of the actions to be taken? The members who are engaged with embedded CDPHP staff and hospital, emergency room, or telehealth therapists will be connected to care timelier if the providers, health plan, and members are able to establish a relationship at the point of care. Increased coordination between the three will result in members receiving higher quality care and increased health outcomes.	the 2020 recommendation on CDPHP's corrective action plan that was accepted by the Department of Health on 08/19/2021.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				What is the managed care plan's process for monitoring the actions to determine their effectiveness? CDPHP holds monthly staff meetings that focus on care management and member feedback about daily activities in the hospitals, with HEDIS rates reviewed monthly to determine and monitor trends. Quarterly meetings are held with network facilities from various disciplines to establish and maintain relationships, so continuity and coordination of care are as seamless as possible and challenges to member health and access to care are reviewed in real time.	

Strengths, Opportunities for Improvement, and Recommendations

Table 35: CDPHP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	CDPHP's measurement year 2021 performance improvement project passed validation.	X	X	X
	CDPHP exceeded target rates for four performance indicators.	X	X	X
Performance Measures	CDPHP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	CDPHP performed significantly better than the Health and Recovery Plan program on eight measures of effectiveness of care related to primary care, HIV, or substance use.	X	X	
Performance Measures – Access/Availability of Care	CDPHP performed significantly better than the Health and Recovery Plan program on one measure of effectiveness of care related to substance use.			
Compliance with Federal Managed Care Standards	During measurement year 2020, CDPHP was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	CDPHP performed significantly better than the Health and Recovery Plan program on four measures of member satisfaction.	X		
Opportunities for Improvement				
Performance Improvement Project	CDPHP did not meet target rates for seven performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	CDPHP performed significantly worse than the Health and Recovery Plan program on two measures of effectiveness of care related to mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2020, CDPHP was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, CDPHP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	CDPHP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, CDPHP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	CDPHP should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the measurement year 2020 compliance findings. CDPHP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	CDPHP should work to improve its performance on measures of member satisfaction for which it did not meet the Health and Recovery Plan average.	X	X	X

Empire BCBS HealthPlus

Performance Improvement Project Summary and Results

Table 36: Empire BCBS HealthPlus's Performance Improvement Project Summary, Measurement Year 2021

Empire BCBS HealthPlus's Performance Improvement Project Summary
Title: Health and Recovery Plan Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Empire BCBS HealthPlus aims to implement real-time data collection, obtain regional health information organization consent, collaborate with providers to facilitate robust discharge planning, increase inpatient providers using medication assisted treatment, and increase prescription adherence. Member-Focused 2021 Interventions ▪ Identified members that kept their seven-day post-discharge appointment through claims reports. ▪ Utilized the SICONNECT (Staten Island Hospital's discharge resource system) to ensure resources were utilized by members seven days post-discharge. ▪ Reminded members to fill/refill medications and addressed any barriers to prescription filling through telephonic outreach by case managers. Provider-Focused 2021 Interventions ▪ Identified facilities that were underperforming in discharge action plan completion and provided them with the areas of deficiency of their discharge action plans. ▪ Contacted aftercare providers pre-discharge to confirm member's discharge plan. ▪ Collaborated with inpatient and outpatient providers to encourage members to consent to case coordination. ▪ Educated providers on the benefits of medication assisted treatment in a training offered via telephone or email. Managed Care Plan-Focused 2021 Interventions ▪ Utilized real-time emergency room reports, claims reports, and comprehensive psychiatric emergency program notifications to identify *Follow-Up After Emergency Department Visit for Mental Illness/Follow-Up After Emergency Department Visit for Substance Use* events for timely case coordination outreach.

Table 37: Empire BCBS HealthPlus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	50.63%	54.49%	56.61%	53.88%	66.60%
Follow-Up After Hospitalization for Mental Illness – 30 Days	66.55%	74.40%	73.57%	68.81%	80.60%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	64.21%	72.10%	68.29%	63.43%	75.20%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	80.88%	84.35%	79.02%	77.27%	86.80%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	26.27%	24.32%	23.24%	28.51%	36.20%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	32.97%	31.08%	30.15%	37.67%	43.90%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	26.22%	43.13%	47.08%	39.73%	46.20%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	53.46%	72.60%	77.17%	64.96%	76.50%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.80%	71.64%	68.93%	67.08%	72.80%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	32.24%	36.18%	43.23%	34.62%	40.20%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	16.94%	19.40%	Not Available	Not Available	15.50%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	10.41%	14.99%	25.61%	24.86%	18.40%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 38: Empire BCBS HealthPlus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Empire BCBS HealthPlus Measurement Year 2019	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	46.21%	47.65%	52.08%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	36.02%	37.04%	37.50%	39.96%
Asthma Medication Ratio (19–64 Years)	42.15%	41.62%	43.05%	41.20%
Breast Cancer Screening	61.00%	54.43%	51.19%	54.63%
Cervical Cancer Screening	67.64%	62.02%	58.76%	63.77%
Chlamydia Screening in Women (21–24 Years)	80.60%	78.46%	86.59%	72.96%
Colorectal Cancer Screening	56.20%	54.99%	52.07%	55.13%
Comprehensive Diabetes Care – Eye Exam	53.77%	46.72%	46.72%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	43.55%	50.85%	47.45%	40.91%
Controlling High Blood Pressure	53.04%	47.20%	49.64%	63.25%
Flu Shots for Adults[2]	44.80%	44.80%	45.60%	47.31%
Advising Smokers to Quit[2]	87.62%	87.62%	78.91%	83.42%
Discussing Smoking Cessation Medications[2]	70.19%	70.19%	64.06%	68.96%
Discussing Smoking Cessation Strategies[2]	67.65%	67.65%	56.69%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	29.29%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	68.72%	56.02%	60.93%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	39.44%	45.10%	30.53%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	68.36%	63.31%	61.57%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.64%	68.93%	67.08%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.20%	69.64%	80.92%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	72.10%	68.46%	63.84%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.49%	56.61%	55.67%	57.82%

Measure	Empire BCBS HealthPlus Measurement Year 2019	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	19.40%	18.89%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	24.32%	23.53%	28.51%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	47.08%	50.56%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	35.08%	29.97%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	19.02%	17.94%	16.81%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	36.18%	Not Available	34.62%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	14.99%	Not Available	24.86%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 39: Empire BCBS HealthPlus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	NC	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	NC
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and review of final adverse determination notices Empire BCBS HealthPlus's delegate, Liberty, failed to ensure required enrollee information was included in the notices. *(Contract Article 98-2.9(e)(3))*
- Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus failed to ensure enrollees were provided the correct appeal documents. *(Contract Article 98-2.9(h)(1)(i))*
- Based on staff interview and review of initial adverse determination notices Empire BCBS HealthPlus and the delegates, AIM, American Specialty Health, Ingenio, Liberty, Evolent and Superior Vision failed to ensure the notices included the required appeal language. *(Contract Article 98-2.9(h)(1), 4904(2)(b) Appeal of adverse determinations by utilization review agents)*
- Based on staff interview and review of the prior authorization and approval case notes, Empire BCBS HealthPlus and its delegates, Ingenio, AIM, and SOMOS failed to ensure the enrollee, their designee and/or the health care provider were notified of the determination by telephone within three business days. Specifically, telephone notification was not provided to the member and/or provider. *(Contract Article 4903(2)(a) Utilization review determinations)*
- Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus and its delegate, Liberty, failed to ensure members enrolled in individual insurance plans received the correct appeal rights. *(Contract Article 4903.2 § 4405 Health maintenance organizations)*
- Based on staff interview and review of case notes, Empire BCBS HealthPlus and its delegate, Liberty, failed to ensure requests for additional information were conducted by telephone and in writing to both the member and the provider. *(Contract Article 98-2.9(b))*

- Based on interviews with Empire BCBS HealthPlus network and claims staff on September 30, 2021, review of claims denial documents, and follow up responses, Empire BCBS HealthPlus failed to appropriately process and pay claims. *(Contract Article 98-2.9(e)(4) Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1)*

Quality-of-Care Survey Results – Member Experience

Table 40: Empire BCBS HealthPlus's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Empire BCBS HealthPlus	Health and Recovery Plan Average
Getting Needed Care[1]	80.20%	78.48%
Getting Care Quickly[1]	83.28%	80.03%
How Well Doctors Communicate[1]	91.60%	90.62%
Customer Service[1]	83.69%	84.93%
Rating of All Health Care [2]	68.76%	66.87%
Rating of Personal Doctor [2]	77.60%	77.57%
Rating of Specialist Talked to Most Often[2]	73.06%	75.17%
Rating of Health Plan[2]	68.81%	71.44%
Rating of Treatment or Counseling[2]	61.23%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 41: Empire BCBS HealthPlus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Validation of Performance Improvement Projects					
The managed care plan demonstrates an opportunity for improvement with members accessing alcohol and other drug abuse treatment. This could be directly affected by the low performing performance improvement project interventions targeting the *Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence* indicator. The managed care plan should consider routinely investigating the barriers to members accessing behavioral health services. The managed care plan should also consider implementing changes to	X	X		In 2021, Empire Blue Cross Blue Shield Health Plus held a monthly behavioral health workgroup that focused on behavioral health quality measures. Attendees were managers from behavioral health and the Health and Recovery Plan along with medical directors. In 2022, Empire Blue Cross Blue Shield Health Plus implemented a HEDIS Domain Work Group entitled Behavioral Health and Health and Recovery Plan Domain workgroup. The HEDIS Domain Work Group includes managers from behavioral health and the Health and Recovery Plan, along with medical directors, and expanded to a cross-functional collaboration across all departments, responsible for strategies development, execution, and closely monitoring rates and initiative outcomes. During the monthly workgroup, we review the HEDIS/Quality Assurance Reporting Requirements performance rates and evaluates measure performance throughout the measurement year. Collaboratively, we focus on interventions and strategies to address lower performing HEDIS/ Quality Assurance Reporting Requirements measures. Upon analysis, we continue to implement strategically targeted interventions that would lead to improvements in the areas identified as consistently reporting below statewide averages and year-over-year decreases. In-flight Interventions in 2021 and ongoing: ▪ Utilize data in Healthix (health information exchange) to identify members that went to the emergency room primarily for substance use.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
the data collection process to improve inaccurate and inconsistent data received from other resources.				▪ Utilize daily claims report to identify members that went to the emergency room primarily for substance use. ▪ Telephonic outreach to members identified on Healthix or claims report that went to the emergency room primarily for substance use. ▪ Dashboard with quality measures including denominator, numerator, and rate (for *Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence* and other measures) are shared with health homes for enrolled members monthly, and quarterly calls held to review the quality dashboards with health homes. ▪ Case conferences with the care management agencies and other providers discussing members that are high utilizers of the emergency room. ▪ Rounds with the physical team and medical directors to discuss members that are high utilizer of the emergency room. ▪ Comprehensive Psychiatric Emergency Program and emergency room reports are run to identify members that are high utilizers of the emergency room. Case managers conduct outreach to these identified members. In 2022, the following interventions were developed and implemented: ▪ Work with hospital facilities to set up an admission, discharge, transfer feed to receive real-time emergency room data. ▪ Hold discussions with our top facilities regarding their rates and discuss ways that we can partner with them. ▪ Our case manager conducts telephonic outreach to the member and will complete an assessment and assist member with scheduling appointment(s) with providers and discuss any barriers in keeping their appointment.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ The Behavioral Health Emergency Department Incentive Program was developed: hospitals were identified to participate in this program if they had a high volume of emergency room visits for mental health and substance use. ▪ Training is offered for all providers in our network, specific to the substance use HEDIS quality measure and codes that can be billed. Some providers can receive continuing medical education and continuing education units. ▪ Two telehealth agencies were added to the network in 2022 that offer medication assisted treatment. ▪ The Behavioral Health Operations Team is offering smoking cessation and Screening, Brief Intervention, and Referral to Treatment trainings with primary care providers, discussing the importance of screening members for nicotine and substance use. High volume primary care providers are offered an individual training and other primary care providers' offices are offered a Webex®[14] training.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve adults receiving the flu immunization.	X	X		Empire Blue Cross Blue Shield Health Plus conducts analyses of our performance on Consumer Assessment of Healthcare Providers and Systems measures to identify barriers (such as barriers related to members receiving their flu shot). In-flight Interventions in 2021 and ongoing: ▪ Article regarding the importance of receiving a flu shot posted to the member portal.	Addressed

[14] Webex® is a registered trademark of Cisco Systems, Inc.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Text reminders to members that they can get a free flu shot with a link to the website where they can access additional information about the flu. ▪ Members who fill their prescriptions at CVS pharmacies in the fourth quarter receive a health tag message (attached to prescription bag) discussing importance of getting their flu shot. ▪ Provider education article in the third quarter of 2022 posted to provider portal discussing billing codes for flu shot. ▪ Fax blast sent to primary care providers discussing billing codes for flu shot. ▪ Reminder training for behavioral health and Health and Recovery Plan case managers to remind members to receive their flu shot. ▪ Coordination with case management agencies to discuss importance of members receiving their flu shot. ▪ Social media post to remind members to receive their flu shot.	
The managed care plan should investigate opportunities to improve the health of members with diabetes and hypertension.	X	X		In 2022, Empire Blue Cross Blue Shield Health Plus implemented a HEDIS Domain Work Group entitled Chronic Conditions HEDIS Domain workgroup. The HEDIS Domain Work Group focuses on cross-functional collaboration across all departments, responsible for strategies development, execution, and closely monitoring rates and initiatives. In 2022, Empire Blue Cross Blue Shield Health Plus has focused on a population health perspective. One of the population health workgroups, Chronic Conditions, focuses solely on diabetes and blood pressure. Reports were developed to analyze trends and new interventions were implemented in 2022. ▪ In-flight Interventions in 2021 and ongoing: ▫ Gaps-in-care reports and provider report cards.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Text/interactive voice response message for diabetes and blood pressure control (multi-lingual: English/Spanish/Chinese). ▫ Healthy Rewards Member Incentive ($10/quarter for adherence fills for blood pressure medication). ▫ Care delivery team outreach and education to providers (value-based payment providers and high-volume providers). ▫ Chart collection review and supplemental data review. ▫ Pharmacy providing provider education via fax for *Controlling High Blood Pressure* measure. ▫ CVS Health Tag- member education attached to prescription bags regarding HbA1c testing. ▫ Dashboard with quality measures (including *Controlling High Blood Pressure* and HbA1c measures) are shared with health homes for enrolled members monthly, and quarterly calls held to review the quality dashboards with health homes. ▫ Telephonic outreach to members that had diagnosis of diabetes but had not received their HbA1c test, and outreach to members with high blood pressure. ▪ In 2022, the following interventions were developed and implemented: ▫ Case managers conduct telephonic outreach to members that are diabetic: if the member consents, the case managers assist with a referral to a diabetes educator. For members that do not consent to a referral to a diabetes educator, educational brochures regarding diabetes are shared with the member.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Case managers discuss with members the importance of (at least) an annual primary care provider visit to receive HbA1c testing and blood pressure reading. Health and Recovery Plan case managers discuss with members the importance of knowing their numbers. For members that report smoking, Health and Recovery Plan case managers provide information regarding smoking cessation. ▫ Case managers review any gaps in refilling medication with members, discuss any barriers to refill their medication, and address the barriers with the member. ▫ Utilization management teams coordinate with hospitals for all Health and Recovery Plan members admitted with diabetes and request that the member receive individual diabetes education by a diabetes educator or another staff member while the member is inpatient. ▫ Utilization management teams coordinate with hospitals for all Health and Recovery Plan members admitted with diabetes and request, if member consents, that they receive a referral to an outpatient diabetes educator. ▫ Training offered for all providers in our network, specific to diabetes and hypertension care HEDIS quality measure and codes that can be billed. Some providers can receive continuing medical education and continuing education units. ▫ Current Procedural Terminology Category II Code Provider Incentive Program for providers. Added current procedural terminology codes for blood pressure values/A1C values. ▫ Provider bulletin for telehealth controlling blood pressure posted on health plan provider website.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Home visits for all members that were non-compliant for the past three years for diabetes and blood pressure. ▫ Empire BlueCross BlueShield HealthPlus medically tailored meals pilot as a social determinant of health intervention to assist members with high-risk needs. Members diagnosed with diabetes that met other program requirements and provide consent can be enrolled in the program. ▫ Care delivery team is working with high volume providers regarding supplemental data exchange files. ▫ Reimplementation of the Pay for Quality Provider Incentive Program for all providers in our network that are not in value-based payment arrangements launched July 2022, including diabetes control and hypertension. ▫ Diabetes education was presented by a licensed nurse at the Member Health Advisory meetings which are held quarterly. ▪ Developed a list of certified diabetes educators that was shared internally with our case managers so they can refer members to these services.	
The managed care plan should investigate opportunities to improve follow-up care for members with substance abuse disorders.	X	X		In 2021, Empire Blue Cross Blue Shield Health Plus held a monthly behavioral health workgroup that focused on behavioral health, including substance use quality measures. In 2022, Empire Blue Cross Blue Shield Health Plus implemented a HEDIS Domain Work Group entitled Behavioral Health and Health and Recovery Plan Domain workgroup. During the monthly workgroup, we focus on interventions and strategies to address lower performing HEDIS/ Quality Assurance Reporting Requirements measures, such as measure involving follow-up care for members with substance abuse disorders.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				In-flight Interventions in 2021 and ongoing: ▪ Utilize data in Healthix (health information exchange) to identify members that went to the emergency room primarily for substance use. ▪ Utilize daily claims report to identify members that went to the emergency room primarily for substance use. ▪ Telephonic outreach to members identified on Healthix or claims report that went to the emergency room primarily for substance use. ▪ Utilization manager requests the facility inquire if the member is willing to sign a 1515 consent form for care coordination for all members that are inpatient. ▪ Telephonic outreach by case managers to all members that went inpatient for substance use to remind members of follow-up appointments, discussing any barriers in keeping appointments, and inquire if member consents to bridge referral. ▪ Dashboard with quality measures, including denominator, numerator, and rate for *Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence* and *Follow-up After High-Intensity Care for Substance Use Disorder,* are shared with health homes for enrolled members monthly, and quarterly calls are held to review the quality dashboards with health homes. ▪ An alcohol initiative was developed and implemented in June 2021. Reports are run bi-monthly. Health and Recovery Plan managers, the medical director, and outreach care specialist identify members through the report for ongoing follow-up by the Health and Recovery Plan case managers. Case managers have huddles with the physical health utilization management	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				team on all hospital admissions. Case managers conduct telephonic outreach to members to provide care coordination and discussion of referrals and resources available to the members. ▪ Case conferences are held with the care management agencies and other providers discussing members that are high utilizers of the emergency room. ▪ Rounds with the physical team and medical directors are held to discuss members that are high utilizers of the emergency room. ▪ Comprehensive Psychiatric Emergency Program and emergency room reports are run to identify members that are high utilizers of the emergency room. Case managers conduct outreach to these identified members. In 2022, the following interventions were developed and implemented: ▪ Hold discussions with facilities regarding their rates and discuss ways that we can partner with them. ▪ Our case managers conduct telephonic outreach to members to conduct an assessment and assist with scheduling appointment(s) with providers; case managers also discuss any barriers the member may have in keeping the appointment. ▪ The Behavioral Health Emergency Department Incentive Program was developed: hospitals were identified to participate in this program if they had a high volume of emergency room visits for mental health and substance use. ▪ Training is offered for all providers in our network, specific to substance use HEDIS quality measure and codes that can be billed. Some providers can receive continuing medical education and continuing education units.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Two telehealth agencies were added to the network in 2022 that offer medication assisted treatment. ▪ The Behavioral Health Operations Team is offering smoking cessation and Screening, Brief Intervention trainings with primary care providers, discussing the importance of screening members for nicotine and substance use. High volume primary care providers are offered an individual training and other primary care provider offices are offered a Webex training.	
The managed care plan should investigate opportunities to improve members' access to alcohol and substance abuse treatments.	X	X	X	During the monthly Behavioral Health and Health and Recovery Plan HEDIS domain workgroup, we review the HEDIS/ Quality Assurance Reporting Requirements performance rates and evaluate measure performance throughout the measurement year. Upon analysis, we continue to implement strategically targeted interventions that would lead to improvements in the areas identified as consistently reporting below statewide averages and year-over-year decreases. In-flight Interventions in 2021 and ongoing: ▪ Telephonic outreach is conducted by case managers to all members that went inpatient for substance use to remind members of follow-up appointments, discuss any barriers in keeping appointments, and inquire if the member consents to a bridge referral. ▪ Case managers, when outreaching members, assist with referrals to substance use providers as well as discuss importance of primary care provider visits. ▪ Telephonic outreach is conducted by case managers to all members that we are aware of that went to an emergency room for substance use to remind those members of follow-up appointments, discuss any barriers in keeping the appointments, and provide referrals for members.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Every member new to the Health and Recovery Plan completes a health risk assessment. Case managers conduct telephonic outreach to members that screen positive for alcohol and substance use to assist with referrals to providers. ▪ Case conferences with care management agencies and other providers are held to discuss members that are high utilizers of the emergency room. ▪ The Alcohol Initiative was developed and implemented in June 2021. Reports are run bi-monthly. Health and Recovery Plan managers, the medical director, and outreach care specialist identify members through the report for ongoing follow-up by the Health and Recovery Plan case managers. Case managers have huddles with the physical health utilization management team on all hospital admissions. Case managers conduct telephonic outreach to members to provide care coordination and discussion of referrals and resources available to the members. ▪ Utilization managers request the facility inquire if inpatient members are willing to sign 1515 consent forms for care coordination. ▪ Case managers assist members with referrals to address social determinants of health. ▪ Peer support is offered to members. Peer support provides assistance with linkage to providers, navigating person-centered recovery goals, and providing other supports to members. In 2022, the following interventions were developed and implemented: ▪ Two telehealth agencies were added to the network in 2022 that offer medication assisted treatment.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Training is offered for all providers in our network, specific to the substance use HEDIS quality measure and codes that can be billed. Some providers can receive continuing medical education and continuing education units. ▪ The Behavioral Health Operations Team is offering smoking cessation and Screening, Brief Intervention trainings with primary care providers, discussing the importance of screening members for nicotine and substance use. High volume primary care providers are offered an individual training, and other primary care provider offices are offered a Webex training. ▪ The Behavioral Health Emergency Department Incentive Program was developed: hospitals were identified to participate in this program if they had a high volume of emergency room visits for mental health and substance use. ▪ Discussions were held with facilities regarding their rates for measures related to follow-up care after emergency room utilization or inpatient for mental health and substance use to identify ways that we can partner with them to assist with discharge planning, scheduling outpatient appointments with primary care providers and specialists, and assist with community supports for the member.	
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the Measurement Year 2019 Operational	X	X	X	The Department of Health conducted its 2019 Targeted Operational Survey of HealthPlus on October 2 – 4, 2019. Only one deficiency was received: HealthPlus HP, LLC failed to provide the Department of Health with approval letters that correspond with 3 of the 27 contracts reviewed for compliance. Empire BCBS HealthPlus was unable to provide evidence that the three contracts were executed on a contract, or a contract template that had been reviewed and approved by the Department of Health.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Survey conducted by the Department of Health.				The plan of correction addressed this deficiency as follows: ▪ The three contracts were redrafted on the most current Department of Health-approved template and fully executed. ▪ An in-depth review of all Medicaid contracts was conducted in order to identify any others needing to be re-papered to the current Department of Health approved template. Monthly updates were provided to leadership throughout the review and re-papering process. ▪ All contract managers completed refresher training. The training covered multiple aspects of contracting, including the need to maintain accurate contract files and obtain all required Department of Health approvals for contract submission. The managed care plan's subsequent audit, the 2021 Operational Survey, confirmed the successful implementation of the above plan of correction: no provider contract-related deficiencies were identified.	

Strengths, Opportunities for Improvement, and Recommendations

Table 42: Empire BCBS HealthPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus' measurement year 2021 performance improvement project passed validation.	X	X	X
	Empire BCBS HealthPlus exceeded the target rate for one performance indicator.	X	X	X
Performance Measures	Empire BCBS HealthPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Empire BCBS HealthPlus performed significantly better than the Health and Recovery Plan program on two measures of effectiveness of care related to mental health or substance use.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, Empire HealthPlus was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Empire BCBS HealthPlus did not meet target rates for ten performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Empire BCBS HealthPlus performed significantly worse than the Health and Recovery Plan program on three measures of effectiveness of care related to primary care.	X	X	
Performance Measures – Access/Availability of Care	Empire BCBS HealthPlus performed significantly worse than the Health and Recovery Plan program on two measures of access/availability of care related to substance use.		X	X
Compliance with Federal Managed Care Standards	During the period under review, Empire BCBS HealthPlus was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Empire BCBS HealthPlus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	Empire BCBS HealthPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Empire BCBS HealthPlus should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Empire BCBS HealthPlus should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

Excellus

Performance Improvement Project Summary and Results

Table 43: Excellus's Performance Improvement Project Summary, Measurement Year 2021

Excellus's Performance Improvement Project Summary
Title: Transitions of Care Improvement for Mental Health and Substance Use Services **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Excellus aims to implement telephonic outreach within three business days of discharge from inpatient mental health services and within five business days from inpatient substance use services, implement timely notification of members' emergency department discharges for mental health or substance use, and identify key barriers in the inpatient and emergency department discharges process. Member-Focused 2021 Interventions ▪ Outreached to members to discuss transition process expectations within three business days post-discharge for mental health and seven business days for substance use. ▪ Outreached to members with emergency department discharges within two business days post-discharge. ▪ Members with an emergency room primary substance use diagnoses and no health home enrollment were linked to an Office of Addiction Services and Supports peer engagement specialist. Managed Care Plan-Focused 2021 Interventions ▪ Enhanced the identification process for members at-risk for readmission. ▪ Developed and implemented a clinical bridge program. ▪ Conducted targeted medical record reviews for members non-compliant for seven-day and 30-day follow-up care post discharge to verify barriers to treatment.

Table 44: Excellus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	35.69%	37.43%	54.44%	49.53%	41.31%
Follow-Up After Hospitalization for Mental Illness – 30 Days	56.08%	51.71%	73.33%	71.23%	69.91%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	45.75%	42.35%	52.70%	56.88%	52.96%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	72.27%	67.72%	75.13%	74.16%	83.66%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	27.82%	33.17%	35.39%	32.93%	32.20%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	39.08%	33.17%	46.52%	43.90%	45.24%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	Not Available	57.77%	54.96%	50.95%	63.70%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	Not Available	79.28%	77.57%	74.33%	87.40%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.00%	69.33%	71.74%	66.04%	82.27%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	34.85%	39.01%	40.08%	50.25%	40.34%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	14.12%	14.75%	Not Available	Not Available	12.01%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	18.73%	19.25%	28.27%	28.63%	23.33%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 45: Excellus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Excellus Measurement Year 2019	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	53.86%	49.68%	52.87%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	40.92%	37.36%	38.57%	39.96%
Asthma Medication Ratio (19–64 Years)	45.64%	48.72%	48.54%	41.20%
Breast Cancer Screening	63.83%	57.61%	57.56%	54.63%
Cervical Cancer Screening	67.84%	65.03%	68.35%	63.77%
Chlamydia Screening in Women (21–24 Years)	74.24%	61.26%	67.46%	72.96%
Colorectal Cancer Screening	61.73%	57.04%	58.77%	55.13%
Comprehensive Diabetes Care – Eye Exam	70.00%	64.07%	63.26%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	31.71%	37.19%	36.25%	40.91%
Controlling High Blood Pressure	69.34%	56.45%	60.74%	63.25%
Flu Shots for Adults[2]	51.94%	51.94%	51.87%	47.31%
Advising Smokers to Quit[2]	88.79%	88.79%	82.89%	83.42%
Discussing Smoking Cessation Medications[2]	82.61%	82.61%	71.52%	68.96%
Discussing Smoking Cessation Strategies[2]	70.69%	70.69%	60.13%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	40.83%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	66.67%	72.64%	73.50%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	38.27%	22.40%	22.16%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	80.87%	76.92%	75.64%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.46%	71.74%	66.04%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.75%	59.85%	76.01%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	42.80%	53.39%	57.31%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	58.75%	60.87%	57.66%	57.82%

Measure	Excellus Measurement Year 2019	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	14.75%	14.15%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	33.22%	35.39%	32.93%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	57.26%	53.93%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	40.08%	31.44%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	20.36%	22.81%	20.16%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	44.13%	Not Available	50.25%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	19.73%	Not Available	28.63%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 46: Excellus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	C	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	NC	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and review of the final adverse determination notices, Excellus failed to ensure the notices for the delegates EviCore and HealthPlex included the utilization review agent's contact person in four of 11 commercial standard appeal and two of 10 Commercial Expedited Appeal cases. *(Contract Article 2005-98-1.11(k))*
- Based on staff interview and review of the final adverse determination notices, the final adverse determination notices included incorrect information. The cases reviewed were expedited appeals, however, the subject line in the notice was labeled as "final adverse determination standard internal appeal." *(Contract Article 98-2.9(e)6)*

Quality-of-Care Survey Results – Member Experience

Table 47: Excellus's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Excellus	Health and Recovery Plan Average
Getting Needed Care[1]	76.72%	78.48%
Getting Care Quickly[1]	81.52%	80.03%
How Well Doctors Communicate[1]	92.56%	90.62%
Customer Service[1]	87.51%	84.93%
Rating of All Health Care [2]	68.80%	66.87%
Rating of Personal Doctor [2]	80.50%	77.57%
Rating of Specialist Talked to Most Often[2]	75.49%	75.17%
Rating of Health Plan[2]	75.47%	71.44%
Rating of Treatment or Counseling[2]	59.30%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 48: Excellus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
Validation of Performance Improvement Projects					
The managed care plan demonstrates an opportunity for improvement regarding the 2019-2021 performance improvement plan indicators. As indicated in the Health and Recovery Plan performance improvement project interim year 2 report, the COVID-19 pandemic contributed negatively or restricted several interventions to achieve full impact as originally planned. The managed care plan should consider routinely investigating the barriers to members accessing behavioral health services. The managed care plan should also consider	X	X		This three-year quality improvement project was designed and implemented across the managed care plan's network to address critical barriers for successful transition from both inpatient mental health and substance use services and discharge from the emergency department for mental health and substance use issues. Identification of process and transition issues, plus implementation of interventions to address these process fragmentations were anticipated to address successful re-entry into the community, engagement with life supporting services and community, as well as reduce hospital readmissions and frequent use of emergency department services. The planned interventions for inpatient behavioral health services were embedded case managers to meet face-to-face with members and aid in post-discharge transition needs. A regional health system impatient unit allowed the embedded model on the mental health unit, but this changed in year two and three when all access to inpatient services was eliminated. The managed care plan pivoted from in-person to telephonic outreach. The embedded staff were not allowed direct telephone access to managed care plan members while they were admitted. The plan for embedded case management staff within the emergency room did not materialize due to the regional hospital systems reluctance to open their emergency room units to any type of personal help with members. The managed care plan tried to incorporate substance use peers from the New York State	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
implementing changes to the data collection process to improve inaccurate and inconsistent data received from health homes.				Department of Health grant to aid health plan enrollees discharged from the emergency room as a real-time, face-to-face, supporting transitional measure. The managed care plan was unable to operationalize this intervention due to the lack of real time emergency room admission and discharge information and the reluctance of health systems to allow peers to contact health plan enrollees during the admission. The managed care plan's quarterly rapid round review of readmissions identified key factors impacting readmissions, including a crucial issue: Health and Recovery Plan members with frequent readmissions who were not enrolled or engaged with case management and health home services. Outcomes from these reviews were used for process improvements in both behavioral health utilization and case management interventions. The key barriers for the implementation of a clinical bridge pilot aimed at incentivizing a large regional health system to improve their internal discharge processes were both the COVID-19 pandemic and reluctance to engage with the managed care plan as a partner rather than a strategic competitor. The interventions that included successful connections (face-to-face or telephonic) with members did affect compliance outcomes. Positive outcomes for Health and Recovery Plan members transitioning from acute behavioral health care to a lower level of care are best addressed within the discharge processes from the health systems. Health systems have face-to-face and direct impact on Health and Recovery Plan members. Addressing the fragmentation at the first point of contact - hospital or emergency level of care - is a priority. The managed care plan was unable to adequately implement the entire complement of interventions for both inpatient and emergency room movement across treatment	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				settings and linkages with behavioral health services. The managed care plan did not have direct access to members, during and at discharge, to aid and support. The COVID-19 pandemic further restricted all levels of support the Health and Recovery Plan members need to successfully transition to a lower level of care and follow treatment recommendations. The performance improvement project objectives were partially met due to the external limitations imposed on the managed care plan from the COVID-19 pandemic. Managed care plan staff resources were negatively affected in year two and parts of year three, which reduced availability to supply telephonic outreach within the prescribed timeframes. Partnerships with regional health homes yielded data which demonstrated health homes are receiving notifications of discharges from both inpatient behavioral health and emergency room services. Initially, the data demonstrated delays in this electronic medical record alerts from the regional health information systems. This barrier was investigated and improved upon within the health home. Health homes demonstrated successful follow-up with enrolled health plan members within 48-72 hours following discharge from inpatient and emergency room services.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve the health of diabetic members with schizophrenia.	X	X		The managed care plan designed a targeted program for Health and Recovery Plan members with diabetes. A member registry identified all Health and Recovery Plan members with diabetes and included key indicators of treatment compliance: medical provider visits, HbA1c compliance, and pharmacy medication refills. Outreach to all members on the registry was attempted via telephonic case management and outreach staffs. The case management program goals were to complete comprehensive diabetes assessments on successful outreach contacts. These member-focused contracts enabled the managed care plan case management staff to	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				understand where members were with their understanding of their diabetic health, as well as provide links to positive self-care, medical provider appointments, and barriers to successful diabetic self-care. Monthly reports are available to case management staff to identify members from this outreach who continue to remain at high risk due to lack of engagement in medical services and treatment compliance. The managed care plan developed and implemented comprehensive diabetic education from our medical and behavioral health staff for delivery to case management staff for uniform understanding of key aspects of diabetic self-care as well as the mental health aspects of diabetic stress on health plan members. This educational tool is made available to our health home case managers to reinforce the initial contacts from case management staff. Health home case managers are critical in the managed care plan's goal of moving members with diabetes and significant behavioral health issues closer to positive medical and behavioral health. This shift is aimed at a comprehensive approach to members with diabetes and promoting positive diabetic self-care while meeting the individual where they are and moving forward. Placing the member in the center of health plan interventions and assisting them with life issues impacting both chronic behavioral health and diabetes is the foundation for the plan to improve the health of members with diabetes and chronic mental health illness.	
The managed care plan should investigate opportunities to improve members' access to alcohol and other drug abuse treatments.	X		X	In 2020, the managed care plan established a medication assisted treatment workgroup with a focus on opioid addictions to address gaps in access-to-care, exploration of alternatives to traditional models of addiction care to close medication assisted treatment gaps and increase member-centric medication assisted treatment strategies. By creating a collaborative workgroup of behavioral	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				health and physical health clinical staff, physicians, quality, compliance, and pharmacy staff, we aim improve member access and outcomes for substance use disorder treatment. The medication assisted treatment workgroup has implemented strategies to identify the most at-risk members in our communities, partner with providers, and leverage resources in our services areas. Strategies implemented include utilization of a provider dashboard, which provided data highlighting members with an opioid use disorder diagnosis without having received opioid use disorder medications. The goals are to present this data to affected providers to investigate those members attributed to them while improving collaboration with the provider network. An additional opportunity is the Liberty Resources Peer Referral pilot program. Liberty Resources is a community provider in the managed care plan's network. This effort revolves around connecting at-risk Excellus members with certified peers. This provider is the recipient of a grant from the Office of Addiction Services and Supports that allows them to hire two full-time certified peers. Liberty Resources and the managed care plan entered into a pilot agreement in June of 2020. The managed care plan refers members meeting the appropriate criteria to Liberty Resources. The managed care plan is very supportive of peer support as an alternative treatment approach to the opioid epidemic. The goal of the relationship between Liberty Resources and the managed care plan is to develop collaborative practices in the community by aligning the Recovery-Oriented System of Care and the Continuing Care Guidance. The managed care plan has also made efforts to contact at-risk members by working with data analytics to understand the prevalence of substance use disorder diagnoses within specific zip codes in Monroe County (largest area of membership). The objective	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				is to provide education, via postcard, to members on where to access providers that render addiction services within those zip codes. Educational post cards were mailed to over 40,000 safety net members in those areas. The managed care plan reviews data on a monthly cadence that allows for a comparison of the different substance use disorder level of care admissions for four different service counties as well as understanding the facilities where members received treatment. This allows case management to understand where the outreach opportunities are, as well as building collaborative relationships with high-volume providers. The managed care plan has also identified a high-volume substance use disorder rehabilitation facility that will allow managed care plan case managers to contact Excellus members in their care prior to discharge. This will establish an introductory relationship making transitions of care for the member an easier path to navigate. Using an internal risk stratification report, members with a substance use disorder diagnosis were organized from high, medium, and low risk. Case management trialed a program to support individuals struggling with an opioid use disorder diagnosis. The goal was to increase engagement of high-risk members with an opioid use disorder diagnosis. These efforts have been monitored to determine success rates. The overall results have demonstrated increased engagement in members seeking treatment. Barriers were difficulties sharing data with affected community providers due to shared staffing shortages in a post-COVID-19 pandemic environment. Members seeking treatment may be likely in the denial or pre-contemplation stages of recovery, which results in a lower volume of engagement. The managed care plan continues to modify existing strategies and	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				redirect efforts to improve members' access to alcohol and other drug abuse treatments.	
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the Measurement Year 2019 Operational Survey conducted by the Department of Health.	X	X	X	Excellus Health Plan did not receive a full operational survey in measurement year 2019. In 2019, the managed care plan was subject to a targeted survey based on the results of the 2018 Operational Survey. The findings from the 2018 Operational Survey were all corrected, and one new area of non-compliance associated with the fair hearing form requirements was identified in 2019, for which there was an approved plan of correction that was remediated by way of system correction, training, education, and continued monitoring ahead of the 2021 Operational Survey and by the date noted in the approved plan of correction.	Partially Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 49: Excellus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Excellus's measurement year 2021 performance improvement project passed validation.	X	X	X
	Excellus exceeded target rates for six performance indicators.	X	X	X
Performance Measures	Excellus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Excellus performed significantly better than the Health and Recovery Plan program on six measures of effectiveness of care related to primary care, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	Excellus performed significantly better than the Health and Recovery Plan program on one measure of access/availability of care related to substance use.			
Compliance with Federal Managed Care Standards	During the period under review, Excellus was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Excellus did not meet target rates for five performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Excellus performed significantly worse than the Health and Recovery Plan program on one measure of effectiveness of care related to mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, Excellus was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Excellus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	Excellus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Excellus should focus on the area of care in which its rate did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	Excellus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Excellus should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

Fidelis Care

Performance Improvement Project Summary and Results

Table 50: Fidelis Care's Performance Improvement Project Summary, Measurement Year 2021

Fidelis Care's Performance Improvement Project Summary
Title: Improving Health and Recovery Plan Behavioral Health Care Transitions after Emergency Department and Inpatient Admissions Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Fidelis aims to improve the discharge process, facilitate communication between the inpatient and outpatient settings, and ensure medication adherence. Member-Focused 2021 Interventions ▪ Identified new high-risk members monthly and instructed these members on how to contact the Health and Recovery Plan case management department and educated them on the benefits of the card accompany the member card and requesting that they always carry it with them. ▪ Identified newly enrolled members with diagnoses of opioid dependence diagnosis or alcohol abuse or dependence disorder and educated them on the benefits of medication-assisted treatment and giving them the contact of their Health and Recovery Plan case management to discuss any questions. ▪ Conducted followed-up calls to high-risk members to conduct needs assessments and to provide education on the benefit package and how to access services. ▪ Implemented a member incentive initiative to improve follow-up care for emergency department visits and inpatient stays related to mental illness and substance and alcohol abuse. Provider-Focused 2021 Interventions ▪ Informed high-volume outpatient substance abuse treatment provides of the availability and benefits of medication-assisted treatment. ▪ Provided high-volume behavioral health inpatient and emergency department facilities a 6-panel pamphlet on the importance of care transition planning and how Fidelis can be used to support the transition process. ▪ Engaged with providers to identify opportunities to collaborate and to generate ideas on how to improve the care transition process. ▪ Provided health homes with real-time notifications of member emergency department visits and encouraged the provider to reach out to the member and/or to meet the member at the emergency room facility. Managed Care Plan-Focused 2021 Interventions ▪ Conducted weekly interdisciplinary rounds to review high-risk members actively admitted in a behavioral health emergency department or inpatient setting and members in a 30-day readmission. ▪ Daily reports of rejected psychotropic medication claims were utilized by the managed care plan's pharmacy team to collaborate with prescribers, pharmacists, and the members around appropriate medication treatment. ▪ Maintained the expedited process for referring members to health homes.

Table 51: Fidelis Care's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	59.87%	59.34%	58.79%	54.27%	63.87%
Follow-Up After Hospitalization for Mental Illness – 30 Days	78.54%	79.19%	78.78%	74.25%	82.54%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	64.39%	63.38%	58.89%	56.54%	67.40%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	78.89%	77.61%	74.87%	72.61%	81.90%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	34.32%	34.73%	33.61%	31.89%	36.30%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	43.03%	44.36%	42.28%	40.48%	45.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	29.10%	41.26%	43.47%	40.23%	32.10%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	58.89%	74.78%	73.43%	68.48%	61.90%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.66%	66.94%	69.32%	65.76%	68.70%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	36.22%	36.60%	44.42%	44.83%	39.20%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	17.55%	16.99%	16.20%	Not Available	17.10%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	16.74%	17.65%	26.88%	28.01%	19.70%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 52: Fidelis Care's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Fidelis Care Measurement Year 2019	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.46%	54.18%	55.58%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.44%	40.07%	41.64%	39.96%
Asthma Medication Ratio (19–64 Years)	47.77%	39.86%	35.63%	41.20%
Breast Cancer Screening	59.59%	53.85%	51.81%	54.63%
Cervical Cancer Screening	64.96%	68.13%	63.99%	63.77%
Chlamydia Screening in Women (21–24 Years)	71.93%	68.58%	68.41%	72.96%
Colorectal Cancer Screening	61.31%	51.34%	53.77%	55.13%
Comprehensive Diabetes Care – Eye Exam	60.83%	55.72%	57.42%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	41.61%	46.23%	44.04%	40.91%
Controlling High Blood Pressure	63.99%	59.12%	60.34%	63.25%
Flu Shots for Adults[2]	56.06%	56.06%	44.00%	47.31%
Advising Smokers to Quit[2]	91.53%	91.53%	83.97%	83.42%
Discussing Smoking Cessation Medications[2]	83.05%	83.05%	75.32%	68.96%
Discussing Smoking Cessation Strategies[2]	73.91%	73.91%	65.82%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	31.11%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	63.30%	63.71%	63.74%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	41.05%	30.01%	28.19%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	71.30%	68.74%	67.95%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	66.94%	69.32%	65.76%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.03%	71.61%	79.22%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	63.38%	58.89%	56.63%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	59.34%	58.79%	56.78%	57.82%

Measure	Fidelis Care Measurement Year 2019	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	16.99%	16.24%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	34.73%	33.61%	32.11%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	43.47%	42.47%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	42.39%	32.93%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	26.41%	26.71%	24.76%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	36.60%	Not Available	44.83%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	17.65%	Not Available	28.01%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 53: Fidelis Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	C	Pended	NC
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and record review, Fidelis Care and the delegate NIA failed to issue adverse determination notices for administrative denials that were factual in nature *(Contract Article 4405.10 Health maintenance organizations).*
- Based on staff interview on August 17, 2021, and review of initial adverse determination notices, Fidelis Care failed to ensure members enrolled in individual insurance plans received the correct appeal rights *(Contract Article 4405.10 Health maintenance organizations).*
- Based on staff interview on August 17, 2021, and review of the initial adverse determination notices, Fidelis Care failed to ensure the delegate Turning Point issued notices that were factual in nature to Child Health Plus members *(Contract Article 4405.10 Health maintenance organizations).*
- Based on interviews with Fidelis Care staff and document review, Fidelis Care failed to include the correct Medicaid payment information in their contract. Specifically, five of 10 Behavioral Health contracts still included "lesser of" language *(Contract Article 4405.1 Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1).*
- Based on interview held on August 17, 2021, and review of documents, Fidelis Care failed to ensure the required credentialing components were included for three out of 20 credentialing files *(New York Codes, Rules, and Regulations 98-1.12 (k)).*

Quality-of-Care Survey Results – Member Experience

Table 54: Fidelis Care's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Fidelis Care	Health and Recovery Plan Average
Getting Needed Care[1]	81.66%	78.48%
Getting Care Quickly[1]	83.69%	80.03%
How Well Doctors Communicate[1]	90.90%	90.62%
Customer Service[1]	82.52%	84.93%
Rating of All Health Care [2]	70.37%	66.87%
Rating of Personal Doctor [2]	80.17%	77.57%
Rating of Specialist Talked to Most Often[2]	79.84%	75.17%
Rating of Health Plan[2]	69.09%	71.44%
Rating of Treatment or Counseling[2]	67.32%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 55: Fidelis Care's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Validation of Performance Improvement Projects					
Regarding the Fidelis' 2019-2021 performance improvement project, the managed care plan indicated in the Health and Recovery Plan performance improvement project interim 2 report that there was a decline in performance for half of the follow-up measures. The managed care plan believes this is due to the COVID-19 pandemic, as many of the interventions were put on hold in 2020 to support members and providers through the COVID-19 pandemic. The	X			While many of the interventions Fidelis Care implemented through the Health and Recovery Plan performance improvement project in 2019 were put on hold due to the COVID-19 pandemic in 2020, many of them were restarted in 2021. Interventions that have been implemented and continue to occur are member incentives for following up within seven days of a discharge from a behavioral health-related emergency department discharge or inpatient mental health discharge, emergency department and substance use disorder inpatient provider engagement, addition of telehealth providers to network, and daily review of rejected psychotropic medications, including medication assisted treatment prescriptions. In addition to previously implemented interventions, the managed care plan is currently working with members who are interested in accessing telehealth services to ensure timely engagement following a discharge from an inpatient mental health setting. To assess effectiveness of the interventions, Fidelis Care conducts regular analysis and monitoring of the following HEDIS Measures: 1) *Follow-up after Hospitalization for Mental Illness*, 2) *Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence*, 3) *Follow-up after Emergency Department Visit for Mental Illness*, and 4) *Follow-up after High-Intensity Care for Substance Use Disorder*, including the sub-group of members receiving the interventions. The managed care plan will continue to explore additional opportunities to improve the member's overall health, which includes timely follow-up from an acute setting discharge.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
managed care plan should consider routinely investigating the barriers to members accessing behavioral health services. The managed care plan should also consider implementing changes to the performance improvement plan data collection process to improve inaccurate and inconsistent data received from providers.					
Validation of Performance Measures					
The managed care plan should continue interventions implemented to improve members accessing breast cancer screenings.	X		X	Fidelis Care has continued to conduct monthly automated calls to members, provide monthly list of members that have not had a mammogram in the last two years to providers, and member encouragement and education related to breast cancer screening. Effectiveness of the interventions will continue to be monitored regularly via the HEDIS *Breast Cancer Screening* measure. The managed care plan will continue to explore additional opportunities to increase breast cancer screenings.	Partially Addressed
The managed care plan should investigate	X		X	During the care management process, Fidelis Care Health and Recovery Plan care managers continually assess for clinical opportunities to engage members and providers in utilizing home and community-based services	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
opportunities to improve members' access to home and community-based services.				to meet the recovery needs of the Health and Recovery Plan membership. Fidelis Care actively participates in regional stakeholder meetings that provide a venue to coordinate and reduce systematic barriers that may occur. Fidelis Care also meets regularly with all health homes, who are responsible for assessing members and making referrals for home and community-based services. When members are not health home enrolled, the Health and Recovery Plan care managers work directly with recovery coordination agencies) to improve access to services.	

Strengths, Opportunities for Improvement, and Recommendations

Table 56: Fidelis Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care's measurement year 2021 performance improvement project passed validation.	X	X	X
	Fidelis Care exceeded target rates for four performance indicators.	X	X	X
Performance Measures	Fidelis Care met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Fidelis Care performed significantly better than the Health and Recovery Plan program on four measures of effectiveness of care related to primary care, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	Fidelis Care performed significantly better than the Health and Recovery Plan program on three measures of access/availability of care related to substance use.		X	X
Compliance with Federal Managed Care Standards	During the period under review, Fidelis Care was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Fidelis Care did not meet target rates for seven performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Fidelis Care performed significantly worse than the Health and Recovery Plan program on three measures of effectiveness of care related to primary care.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, Fidelis Care was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Fidelis Care should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	Fidelis Care should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Fidelis should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	Fidelis Care should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Fidelis Care should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

Healthfirst

Performance Improvement Project Summary and Results

Table 57: Healthfirst's Performance Improvement Project Summary, Measurement Year 2021

Healthfirst's Performance Improvement Project Summary
Title: Improving Care Transitions for Health and Recovery Plan Behavioral Health High Utilizers **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Healthfirst aims to enhance care coordination and discharge planning with inpatient detox and rehab facilities, increase the number of Health and Recovery Plan members enrolled in a health home after an inpatient admission or emergency room visit for behavioral health, and create an information gathering process to support member outreach initiatives. Member-Focused 2021 Interventions ▪ Conducted targeted education for members identified as non-compliant for appropriate medication management. ▪ Conducted member outreach within two business days of emergency department discharge for mental illness or substance abuse. ▪ Facilitated member health home enrollment post-discharge. Provider-Focused 2021 Interventions ▪ Conducted case shaping calls with facility staff. Managed Care Plan-Focused 2021 Interventions ▪ Case management agencies received notifications from the managed care plan when a client of the case management agency was identified as having an emergency department event or inpatient stay related to mental illness or substance abuse.

Table 58: Healthfirst's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	73.43%	69.40%	67.10%	68.86%	76.00%
Follow-Up After Hospitalization for Mental Illness – 30 Days	70.90%	84.03%	82.18%	80.66%	89.00%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	64.76%	37.61%	40.57%	40.72%	68.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	78.88%	61.41%	61.49%	59.32%	83.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	30.43%	27.03%	26.57%	27.11%	32.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	38.19%	34.61%	34.04%	36.25%	40.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	26.70%	36.74%	39.48%	32.88%	28.00%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	54.26%	69.56%	71.35%	59.82%	70.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.12%	68.07%	67.98%	65.70%	70.00%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	27.62%	27.17%	28.76%	30.18%	29.00%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	19.88%	18.65%	17.76%	Not Available	19.00%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	11.04%	13.04%	13.06%	26.09%	12.00%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 59: Healthfirst's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Healthfirst Measurement Year 2019	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.28%	51.33%	52.66%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.22%	38.07%	38.06%	39.96%
Asthma Medication Ratio (19–64 Years)	53.69%	34.78%	40.38%	41.20%
Breast Cancer Screening	68.37%	60.91%	61.88%	54.63%
Cervical Cancer Screening	72.99%	68.37%	65.21%	63.77%
Chlamydia Screening in Women (21–24 Years)	81.88%	68.93%	79.23%	72.96%
Colorectal Cancer Screening	65.16%	62.41%	62.56%	55.13%
Comprehensive Diabetes Care – Eye Exam	64.72%	53.56%	63.02%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	31.39%	48.16%	38.69%	40.91%
Controlling High Blood Pressure	66.91%	63.02%	69.27%	63.25%
Flu Shots for Adults[2]	48.44%	48.44%	48.54%	47.31%
Advising Smokers to Quit[2]	87.29%	87.29%	87.02%	83.42%
Discussing Smoking Cessation Medications[2]	76.92%	76.92%	68.99%	68.96%
Discussing Smoking Cessation Strategies[2]	71.55%	71.55%	66.41%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	31.75%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	64.73%	63.32%	66.38%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	46.95%	38.45%	27.40%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	68.74%	63.20%	63.68%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.07%	67.98%	65.70%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.97%	74.03%	81.96%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	37.61%	40.57%	40.93%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	69.40%	67.10%	71.83%	57.82%

Measure	Healthfirst Measurement Year 2019	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	18.65%	17.77%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	27.03%	26.57%	27.11%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	39.48%	38.90%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	32.02%	28.71%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	16.28%	17.76%	16.99%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	27.17%	Not Available	30.18%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	13.04%	Not Available	26.69%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 60: Healthfirst's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	C	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	NC	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2019 Results

- Based on staff interview and record review of the commercial/Child Health Plus standard utilization review appeals, Healthfirst and its delegate, DentaQuest, failed to send the member a written acknowledgment letter after filing for an appeal. This was evident in four of 10 commercial standard appeal cases reviewed. *(Contract Article 4904. 3)*
- Based on staff interview and record review, Healthfirst failed to ensure that acknowledgement notices for Medicaid complaints were sent to the members timely. This was evident in three of 22 cases. Healthfirst staff stated that they had staffing and computer systems issues. *(Contract Article 98-1.14(e), 4408.a 4)*
- Based on staff interview and record review, the Healthfirst failed to ensure that Medicaid complaints resolution notices were sent to the members timely, according to regulatory guidance. This was evident in three of 22 cases. Healthfirst staff stated they had staffing and computer system issues. *(Contract Article 4408.a 4 (iii))*
- Based on staff interview and record review, Healthfirst failed to ensure that a DentaQuest commercial complaint appeal resolution notice was sent timely, in accordance with the regulatory guidance. Specifically, on July 27, 2018, a complaint appeal was filed with the managed care plan. The "Child Health Plus Appeal of Complaint Resolution Notice" was dated November 7, 2018. This was evident in one of two cases. Healthfirst staff stated they had staffing and computer system issues. *(Contract Article 4408.a 11(ii))*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst failed to provide adequate oversight of delegated management functions (utilization review), by allowing an unregistered utilization review agent, Prest & Associates, LLC, to perform utilization review on behalf of Healthfirst. *(Contract Article 98-1.11(h))*

- Based on staff interview and record review of the final adverse determination notice, Healthfirst and its delegate, Orthonet, did not provide phone notice to the member and the provider, that additional information was needed to make a determination. This was evident in three out of 11 Medicaid expedited appeal cases. *(Contract Article 98-2.9(b))*
- Based on staff interview and record review of the Medicaid expedited appeals, Healthfirst did not issue the final adverse determination notice within 24 hours of the determination to the member. This was evident in three of 11 Medicaid expedited appeal cases. *(Contract Article 98-2.9(f))*
- Based on record review and staff interview, Healthfirst failed to ensure that a written acknowledgement notice was sent to a member. Specifically, on July 27, 2018, a complaint was filed with the managed care plan. There was no evidence of an acknowledgement notice provided. This was evident in two of two DentaQuest commercial complaint appeal cases. *(Contract Article 4408.a 9)*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst delegated the utilization review activities for behavioral health benefits to an organization identified as Prest & Associates, LLC. This organization was not a registered utilization review agent approved by the Department of Health at the time of the determination. *(Contract Article 2005-98-1.11(k)(6), 98-1.11[j](4))*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst delegated a management function (utilization review), to Prest & Associates, LLC, without submitting a management services contract to the Department of Health for prior approval. This was discussed with Healthfirst during interview on May 16, 2019, and May 17, 2019. *(Contract Article 2005-98-1.11(j)(7))*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst delegated a management function (utilization review), to Prest & Associates, LLC, without submitting a management services contract to the Department of Health for prior approval. *(Contract Article 98-1.11(k))*
- Based on staff interview and record review, the Healthfirst failed to ensure that commercial grievance resolution notices for denial of non-covered benefits were sent to the members timely, in accordance with the regulatory guidance. This was evident in five of 35 cases. *(Contract Article 4408.a 4 (iii))*

Quality-of-Care Survey Results – Member Experience

Table 61: Healthfirst's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Healthfirst	Health and Recovery Plan Average
Getting Needed Care[1]	78.98%	78.48%
Getting Care Quickly[1]	82.49%	80.03%
How Well Doctors Communicate[1]	94.16%	90.62%
Customer Service[1]	85.52%	84.93%
Rating of All Health Care [2]	67.00%	66.87%
Rating of Personal Doctor [2]	83.33%	77.57%
Rating of Specialist Talked to Most Often[2]	82.55%	75.17%
Rating of Health Plan[2]	77.69%	71.44%
Rating of Treatment or Counseling[2]	65.66%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 62: Healthfirst's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
Validation of Performance Improvement Projects					
As indicated in the managed care plan's 2019-2021 Health and Recovery Plan performance improvement project interim 2 report, the COVID-19 pandemic had a significant impact on face-to-face services in the community, which made follow-up care after a hospitalization or emergency department visit challenging. Healthfirst should consider re-evaluating its current interventions to assist with these challenges. The managed care plan should consider conducting root cause analysis to identify barriers to members accessing follow-up appointments after an	X			Healthfirst conducted a root cause analysis to identify barriers to members accessing follow-up appointments after an emergency department visit for mental illness or substance abuse. It was found that the COVID-19 pandemic had a significant impact on face-to-face services in the community that made follow-up care post-discharge from the hospital or emergency department challenging for Healthfirst members. Furthermore, it was found that long wait times for behavioral health services were also exacerbated by the COVID-19 pandemic. Therefore, in response to these challenges, Healthfirst focused on network expansion efforts to identify additional telehealth providers that offer mental health and substance use services like Valera Health, WholeView Wellness, and Brave Health. Ensuring network adequacy for telehealth providers gives members the option of quickly accessing services with a behavioral health provider in the privacy and comfort of their home and at their convenience. In addition, Healthfirst continues to maintain and monitor required network adequacy across all service regions as well as evaluates out of network providers who may be authorized for potential participation in the provider network. Importantly, Healthfirst launched the Provider Engagement Program to work with sponsor hospitals to share clinical best practices, collaborate to improve coordination of resources, member engagement, identify referral resources and promote linkages where appropriate to improve access to follow-up care. A lack of stable housing can have a negative impact on members seeking follow-up care. Therefore, Healthfirst has implemented	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
emergency department visit for mental illness or substance abuse. The managed care plan's low rate of members having a stable housing status could be directly affecting members seeking follow-up care. Therefore, implementing interventions targeting the social determinants of health would be beneficial to members during the COVID-19 pandemic.				initiatives to address members' social determinants of health issues during the COVID-19 pandemic. Healthfirst's care management department screens members for social determinants of health needs in the transitions of care assessments. If a member is identified as experiencing a condition related to social determinants of health, Healthfirst care management can utilize resources such as NowPow, an online referral platform that includes community-based resources related to items such as food, finances, transportation, and housing. Healthfirst also developed and implemented the Helping You Program that connects members to Healthfirst's community partnership network that is comprised of primary care, specialty services, and community-based organizations and provides care coordination, navigation, and coaching services. Members are assessed through the Patient Perception of Health screening tool and provided automated referral recommendations via the community partnership network digital platform. In this screening tool, (along with general perception of health and primary care provider connectivity), members are assessed for social risk factors such as transportation, food, and housing insecurity. Based on member's preferences and the outcome of their Patient Perception of Health screening tool, the digital platform can link members to the appropriate services and a Healthfirst Helping You community partner within the network.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve the health of members with asthma and chronic obstructive pulmonary disease.	X	X		Healthfirst utilizes a variety of interventions to improve the health of members with asthma and chronic obstructive pulmonary disease that incorporate both direct member outreach and provider education and support. Healthfirst's pharmacy department directly outreaches members to reinforce the importance of being on a controller medication to manage chronic, asthmatic conditions and to prevent acute exacerbations. Our pharmacists will ensure that the	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				member has been filling their controller medications, assess the member's symptoms, level of asthma control, and frequency in the usage of a rescue inhaler. Furthermore, the pharmacists will address any barrier the member may encounter and provide appropriate resources and support. Simultaneously, the Healthfirst pharmacy department also conducts outreach to the provider community. To improve the health of our members with asthma and chronic obstructive pulmonary disease, Healthfirst partnered with the American Lung Association and Asthma Educator Institute to offer continuing education unit trainings to our providers to promote adherence to the National Institute of Health, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Healthfirst performs direct outreach to providers about identified members who are only using a short-acting albuterol inhaler, and clinical guidelines from the Global Initiative for Asthma are shared. Healthfirst informs providers of non-adherent members, and if the member has been filling their rescue medications only and provide any relevant details obtained from the member outreach. Primary care providers have access to a list of their non-adherent members and their *Asthma Medication Ratio* rates through the Healthfirst Quality application, which is a web-based tool that enables them to view their quality data in a single location. This data is refreshed monthly, and primary care providers can track their performance. Providers participating in Healthfirst's Quality Incentive Program are eligible to receive a bonus payment when their "Starting Controller Medication for Members with Only Rescue Inhaler Fills" rates meet or exceed targeted rates established by Healthfirst.	
The managed care plan should investigate opportunities to improve	X	X		A variety of strategies have been implemented to connect members with mental illness and substance abuse disorders to community-based treatment and support. Transitions of care programs have	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
follow-up care for members with mental illness and substance abuse disorders.				been developed to link members to timely treatment after an emergency department visit. Healthfirst is leveraging technology to expand our outreach activities with members through texting campaigns. We have also initiated a behavioral health provider engagement program that collaborates with sponsor hospitals to improve discharge planning and care coordination activities, which includes financial incentives to support and reward performance improvement. In November of 2021, Healthfirst began utilizing the VNS Health Behavioral Health Community Transitions Program to conduct outreach and follow-up visits to Health and Recovery Plan members who have been recently discharged from an emergency department with a mental health diagnosis. The goal of the program is to provide a bridge visit between the discharge and the member's first appointment with their behavioral health community provider. This transitional visit can be provided via telehealth or face-to-face based on member preference. Additionally, the Healthfirst behavioral health care management team conducts outreach to members who recently visited the emergency department to resolve any barriers preventing the member from accessing timely follow-up care. These members are identified using the daily health information exchange report that captures emergency department visits at participating hospitals; however, successful outreach efforts are often hindered due to incomplete or out-of-date contact information. Therefore, the health information exchange report was enhanced in May 2021 to include alternate contact information for members when furnished by the discharging emergency department. To expand our member outreach efforts, Healthfirst launched a pilot in the fourth quarter of 2021 to use texting campaigns through the short message service platform. Members that were recently	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				discharged from the emergency department were texted and asked to contact a Healthfirst behavioral health care manager through a toll-free number for assistance in scheduling an outpatient follow-up appointment for mental health and/or substance use treatment. Healthfirst has launched a Behavioral Health Provider Engagement Program in 2022 that is supported by financial incentives through the Healthfirst Quality Initiative program. Participating providers are eligible to receive a bonus payment when their follow-up rates after an emergency department visit, as measured by the HEDIS *Follow-up after Emergency Department Visit for Mental Illness 7 day* or *Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence 7 day*, meet or exceed benchmarks established by Healthfirst. The behavioral health clinical leadership team uses the Provider Engagement Program to engage hospital sponsors in developing workgroups to improve care coordination, increase member engagement, share best clinical practices, and to identify effective resources that can address social determinants of health concerns.	
The managed care plan should investigate opportunities to improve members' access to alcohol and drug abuse treatments.	X		X	To improve members' access to alcohol and drug abuse treatment, Healthfirst prioritized network expansion efforts for additional telehealth providers that offer such services, including Brave Health and WholeView Wellness, virtual providers that offer alcohol and drug abuse treatment services. Telehealth services give members the option of accessing outpatient addiction treatment services virtually with behavioral health providers in the privacy and comfort of their home and at their convenience. Healthfirst has also focused efforts on the development of clinical programs to support members' access to alcohol and drug abuse treatment. The Walk with Me Program was developed and implemented in the fourth quarter of 2021 to engage members with	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				opiate and alcohol dependence, with wraparound services to promote recovery. The program provides an array of services that includes medication assisted treatment, psychiatric diagnostic evaluation, psychotherapy, medication administration, peer services, care coordination, linkages to resources to address social determinants of health, health education, and recovery-oriented socialization. Healthfirst also developed and implemented the Services for the Underserved Behavioral Health Treatment Engagement Program in the second quarter of 2022 with the goal of engaging Healthfirst members in ongoing behavioral health treatment who have a primary or co-occurring substance use disorder with a history of high emergency department utilization and non-adherence. This program aims to reduce avoidable emergency department and inpatient admissions by engaging members in intensive, outpatient behavioral health treatment and providing a combination of modalities, including group and individual therapy, medication management, and telehealth. These new programs complement the pre-existing, integrated case management programs Healthfirst already has in place through the Coordinated Behavioral Care Independent Practice Association and through VNS Health. These programs, called Pathways Home and Parachute, respectively, address the complex needs of high-risk, high-need members who have a serious mental illness, who typically have co-occurring, chronic physical health conditions. Both programs offer field-based, integrated case management using an interdisciplinary team that formulates an individualized care plan for each enrolled member to address their multifarious needs holistically. This includes in-home stabilization and crisis services, family treatment, medication management, engagement in community-based treatment for behavioral health and physical	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				health conditions, and resolution of social determinants of health matters.	
The managed care plan should investigate opportunities to improve members' access to stable housing options.	X	X		Since our Health and Recovery Plan population is comprised of low-income families who often lack health literacy and have limited supports, the Healthfirst care management department utilizes an assessment tool that routinely identifies social determinants of health needs and have established internal processes that will ensure social determinants of health-specific interventions and/or referrals are implemented in a timely manner. To identify appropriate referral sources, Healthfirst utilizes NowPow, which is an online platform that connects members with community-based resources, including housing. In response to the COVID-19 pandemic, Healthfirst expanded and updated information and services available to members in NowPow that includes food, housing, transportation, and financial support. A member can also be referred to Healthfirst's Helping You Program in which members are assessed through the Patient Perception of Health screening tool for social risk factors, including unstable housing, and provided automated referral recommendations via the community partnership network digital platform.	Partially Addressed
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the non-compliance identified during the Measurement Year 2019 Operational Survey conducted by the Department of Health.	X	X	X	During the 2019 Operational Survey, the New York State Department of Health cited three areas as deficient: Complaints and Grievances, Organization and Management, and Utilization Review. As part of Healthfirst's remediation of the noted deficiencies, we implemented an in-depth internal corrective action plan to address each citation. The corrective action plan was approved by the New York State Department of Health on December 19, 2019. The corrective action model we employ follows key elements: responsible party, date certain (the date an operational area commits to an action), monitoring and auditing, and education and	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				training, as applicable. To address and then promote sustained improvement, the steps outlined in every internal corrective action are monitored by the Healthfirst compliance team, led by the Healthfirst chief compliance officer, with the goal to both mitigate issues and to prevent repeat occurrences. Progress on all corrective actions is reported out routinely to the Healthfirst Incorporated board of directors via the Audit, Risk, and Compliance Committee. In May of 2021, the New York State Department of Health conducted a Targeted Operational Survey of Healthfirst to determine compliance with the plan of correction from the 2019 Operational Survey and Healthfirst was found in compliance with the plan of correction with no further action required.	

Strengths, Opportunities for Improvement, and Recommendations

Table 63: Healthfirst's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Healthfirst's measurement year 2021 performance improvement project passed validation.	X	X	X
	Healthfirst exceeded target rates for three performance indicators.	X	X	X
Performance Measures	Healthfirst met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Healthfirst performed significantly better than the Health and Recovery Plan program on six measures of effectiveness of care related to primary care or mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2019, Healthfirst was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*			
Quality-of-Care Survey	Healthfirst performed significantly better than the Health and Recovery Plan program on four measures of member satisfaction.	X		
Opportunities for Improvement				
Performance Improvement Project	Healthfirst did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Healthfirst performed significantly worse than the Health and Recovery Plan program on three measures of effectiveness of care related to substance use or mental health.	X	X	
Performance Measures – Access/Availability of Care	Healthfirst performed significantly worse than the Health and Recovery Plan program on two measures of access/availability of care related to substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Healthfirst was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Healthfirst should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	Healthfirst should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Healthfirst should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	Healthfirst should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the measurement year 2019 compliance findings. Healthfirst should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Healthfirst should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

HIP

Performance Improvement Project Summary and Results

Table 64: HIP's Performance Improvement Project Summary, Measurement Year 2021

HIP's Performance Improvement Project Summary
Title: Improve Performance of Care Transitions and Reducing Readmissions after an Emergency Department and/or Inpatient Hospitalization for a Psychiatric or Substance Use Related Condition. **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim HIP aims to establish robust partnerships with behavioral health vendors, Beacon Health Options and University Behavioral Associates, and high-volume provider groups including Advantage Case Physicians. HIP also aims to share data within the health home networks; provide training to health home staff, case management agencies, hospitals, community providers and members; and to connect members diagnosed with schizophrenia, cardiovascular conditions and/or diabetes to community primary care providers. Member-Focused 2021 Interventions ▪ Conducted care transitions training sessions targeted at low performing hospitals, health homes, case management agencies, community mental health providers, and substance use providers. ▪ Connected members and their families to the New York Office of Addiction Services and Supports Family Support Navigator Program and/or to an New York Office of Addiction Services and Supports peer engagement specialist. ▪ Referred members to transportation resources. ▪ Upon the event of a missed refill, education on the importance of medication adherence was conducted by telephone for the member. ▪ Members with cardiovascular diseases, diabetes, and/or schizophrenia received educational outreach upon discharge from a hospital or facility for a psychiatric or substance use disorder. ▪ Advantage Case Physicians performed LDL-C and/or HbA1c screens for members discharged from the hospital or emergency department for mental illness and/or substance abuse. Provider-Focused 2021 Interventions ▪ Partnered with health home networks to coordinate care management for members discharged from the hospital or emergency department with a psychiatric or substance use condition. ▪ Reminded providers on the importance of member compliance with appropriate medication management. ▪ Issued alerts notifying health homes of member emergency department visits, admissions, and/or discharges. Managed Care Plan-Focused 2021 Interventions ▪ Partnered with Beacon Health Options and University Behavioral Health Associates to capture percentage of supplemental data/charts submitted to the managed care plan's Quality Department. ▪ Partnered with Advantage Case Physicians to ensure members within their network, discharged from the hospital/emergency department with an opioid diagnosis receives immediate referral to outpatient medication-assisted technology.

Table 65: HIP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	48.80%	44.91%	48.00%	46.09%	52.90%
Follow-Up After Hospitalization for Mental Illness – 30 Days	72.65%	71.31%	69.00%	69.13%	74.26%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	61.42%	60.99%	52.00%	53.10%	68.18%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	76.85%	77.75%	69.00%	74.02%	81.82%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	27.58%	26.16%	26.00%	31.11%	30.89%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	36.21%	34.23%	39.00%	39.17%	38.89%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	21.72%	38.33%	35.00%	32.30%	41.90%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	49.25%	65.31%	68.00%	55.76%	67.20%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.08%	68.06%	70.96%	68.09%	70.32%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	29.86%	25.60%	35.05%	31.94%	45.67%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	16.53%	16.72%	12.17%	Not Available	12.81%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	14.99%	14.66%	15.01%	21.51%	17.04%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 66: HIP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	HIP Measurement Year 2019	HIP Measurement Year 2020	HIP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	50.77%	52.42%	53.28%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	34.23%	38.31%	40.15%	39.96%
Asthma Medication Ratio (19–64 Years)	47.62%	52.63%	46.03%	41.20%
Breast Cancer Screening	58.47%	53.43%	52.61%	54.63%
Cervical Cancer Screening	64.48%	58.16%	58.35%	63.77%
Chlamydia Screening in Women (21–24 Years)	63.16%	77.27%	62.86%	72.96%
Colorectal Cancer Screening	53.28%	48.66%	45.01%	55.13%
Comprehensive Diabetes Care – Eye Exam	54.07%	49.64%	48.42%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	47.06%	52.07%	45.99%	40.91%
Controlling High Blood Pressure	56.34%	56.69%	62.47%	63.25%
Flu Shots for Adults[2]	56.52%	56.52%	46.59%	47.31%
Advising Smokers to Quit[2]	82.86%	82.86%	77.78%	83.42%
Discussing Smoking Cessation Medications[2]	70.09%	70.09%	62.14%	68.96%
Discussing Smoking Cessation Strategies[2]	63.55%	63.55%	51.06%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	28.35%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	60.42%	65.69%	65.18%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	33.33%	29.41%	33.80%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	68.75%	63.27%	54.46%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.06%	70.96%	68.09%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.68%	68.94%	75.65%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	60.99%	51.79%	53.67%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	44.91%	47.66%	50.22%	57.82%

Measure	HIP Measurement Year 2019	HIP Measurement Year 2020	HIP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	16.72%	12.17%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	26.16%	25.50%	31.11%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	34.93%	36.46%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	34.56%	28.10%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	24.38%	22.74%	21.54%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	32.45%	Not Available	31.94%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	14.67%	Not Available	21.51%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 67: HIP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021
438.206: Availability of Services	C	C	C
438.207: Assurances of Adequate Capacity and Services	C	C	C
438.208: Coordination and Continuity of Care	C	C	C
438.210: Coverage and Authorization of Services	C	C	C
438.214: Provider Selection	C	C	C
438.224: Confidentiality	C	C	C
438.228: Grievance and Appeal System	C	C	NC
438.230: Sub-contractual Relationships and Delegation	C	C	C
438.236: Practice Guidelines	C	C	C
438.242: Health Information Systems	C	C	C
438.330: Quality Assessment and Performance Improvement Program	C	C	C

C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and record reviews, HIP failed to issue final adverse determination notices that were factual in nature. *(Contract Article 4405 Health maintenance organization)*
- Based on staff interview and record review, of expedited appeals cases for commercial and Medicaid members, HIP failed to ensure that written and/or phone notice was provided to the member and/or provider when additional information was requested. *(Contract Article 4405(10), 98-2.9(b) Responsibilities of health care plans)*
- Based on staff interview and record review of the final adverse determination notices, HIP failed to ensure members enrolled in Medicaid received the correct appeal rights. *(Contract Article 98-2.9(b) § 4405 Health maintenance organizations)*

Quality-of-Care Survey Results – Member Experience

Table 68: HIP's Adult CAHPS Results, Measurement Years 2021

Measure	Measurement Year 2021	
	HIP	Health and Recovery Plan Average
Getting Needed Care[1]	77.66%	78.48%
Getting Care Quickly[1]	75.11%	80.03%
How Well Doctors Communicate[1]	88.75%	90.62%
Customer Service[1]	78.42%	84.93%
Rating of All Health Care [2]	66.36%	66.87%
Rating of Personal Doctor [2]	78.21%	77.57%
Rating of Specialist Talked to Most Often[2]	69.23%	75.17%
Rating of Health Plan[2]	69.15%	71.44%
Rating of Treatment or Counseling[2]	63.63%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 69: HIP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
Validation of Performance Improvement Projects					
The managed care plan demonstrates an opportunity to improve members accessing follow-up care after receiving behavioral health services. The managed care plan has implemented many interventions during the 2019-2021 performance improvement project targeting these measures and should routinely evaluate if these interventions are	X	X		HIP implemented interventions during the project period from 2019-2021 that impacted the results of the performance improvement project performance indicators, which focused on improving care transitions and to improve members accessing follow-up care after receiving behavioral health services. HIP's quality department conducted educational trainings targeted to health homes and care management agencies with a high number of Health and Recovery Plan members who had a hospital discharge or emergency department visit for psychiatric or substance use-related conditions. A major part of the trainings focused on the importance of addressing the member's concrete needs such as housing and transportation. By focusing on members' more immediate needs, members may be receptive to addressing their behavioral health needs. Educational trainings were also provided to targeted community mental health and substance use providers who had a high number of Health and Recovery Plan member hospitalizations and emergency department discharges for mental health or substance use-related conditions. These trainings addressed targeting members' concrete needs. Community providers were also equipped with information on health home services and enrollment processes for Health and Recovery Plan members who were not enrolled in health homes. Claims data and Psychiatric Services and Clinical Enhancement System data was shared with Beacon Health Options, HIP's behavioral health partner, to identify patients at-risk for readmission and/or frequent emergency department visits. In addition, the collaboration with Beacon Health Options	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
effective in improving members' access to follow-up care. The managed care plan should consider implementing changes to the data collection process to improve inaccurate and inconsistent data received from other resources.				resulted in Beacon connecting members to the Office of Addiction Services and Supports Family Support Navigator Programs and the Office of Addiction Services and Supports peer engagement specialists, thereby helping to ensure successful transitions from inpatient or emergency department stay to the community. The data was also used to assist HIP case management to address members' concrete needs that may have contributed to members who had a high risk of readmissions. During the COVID-19 pandemic, thousands of calls were made to members including members in the Health and Recovery Plan, to provide information and direction regarding the COVID-19 pandemic and other needs such as medical and mental health treatment and follow-up. Barriers encountered during the start of the project included data capture/sharing issues such as receipt of incomplete information such as missing hospital location, or delayed receipt of inpatient hospital data. This resulted in delays in hospital alerts and communication between health homes and hospitals. Contacting hospitals also proved to be a barrier, resulting in difficulty communicating with inpatient hospital staff, such as not receiving return telephone calls from hospital staff. Targeted discussions with HIP's internal data team took place to discuss improvements in data sharing to secure detailed, complete inpatient hospital data to mitigate delays in hospital alerts and communication between health homes and hospitals. Additionally, capturing real-time emergency department data was a challenge throughout the project. To address this barrier, targeted discussions took place with the internal medical management team regarding capturing real-time emergency department data. Lastly, although the COVID-19 pandemic did not delay interventions, all face-to-face interventions between members and providers of care became	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				telephonic which required time and acclimation thereby delaying service. The COVID-19 pandemic impacted hospital staff ability to return calls. Moreover, trainings had to be completed via phone or webinar. Despite all the barriers, all eleven active performance improvement project indicators increased from the baseline measurement year of 2018 to the final measurement year of 2021. Eight out of the eleven active indicators focused on follow-up care for Health and Recovery Plan members. Four (*Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence* and *Follow-up After High-Intensity Care for Substance Use Disorder*) of the eight indicators focused on follow-up care increased from measurement year 2018 to measurement year 2021, as evidenced by Quality Assurance Reporting Requirements rates. The other four rates (*Follow-up After Hospitalization for Mental Illness* and *Follow-up After Emergency Department Visit for Mental Illness*) decreased from measurement year 2018. The managed care plan looks to maintain the above achievements as well as strengthening the approach with members, hospitals, providers, and health homes to continue to improve the performance of care transitions and reducing readmissions after an emergency department and/or inpatient hospitalization for a psychiatric or substance use-related condition. The project was presented at HIP's Behavioral Health Quality Management subcommittee throughout the duration of the three-year project. Progress, actions, and barriers to interventions were discussed, and key committee members were kept up to date with project successes and setbacks. HIP intends to maintain the quality improvement activities that were implemented throughout this three-year project and will continue to analyze both the successes and results that were not successful.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				▪ Collaborations with health homes and hospitals will continue, as well as continuing to educate providers and agencies on ways to better care transitions for Health and Recovery Plan members. ▪ HIP also intends to continue collaborating with health home networks that partner with HIP case management regarding care planning for Health and Recovery Plan members discharged from the hospital or emergency department with a psychiatric or substance use condition. ▪ Referrals to transportation will also remain a focus for Health and Recovery Plan members, with the HIP care management team continuing to assess the needs and barriers to care for members. HIP, along with Beacon Health Options, will continue to explore the use of peer and family support services and how they may help to drive improvement on assisting the Health and Recovery Plan membership in increasing their utilization of follow-up care. ▪ Additionally, HIP case management began working with Beacon case management on reporting for *Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence* and *Follow-up After Emergency Department Visit for Mental Illness* measures. A flag was added to *Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence* and *Follow-up After Emergency Department Visit for Mental Illness* reporting to indicate if the member is identified as an open case for Beacon case management. This performance improvement process resulted in many lessons learned in the drive to improve performance of care transitions and reducing readmissions after an emergency department and/or inpatient hospitalization for Health and Recovery Plan members with a psychiatric or substance use-related condition. HIP will utilize these results and relationships built with hospitals, health homes, medical provider groups and peers/families to enhance the care provided to Health and Recovery Plan and non-Health and Recovery Plan members.	
Validation of Performance Measures					

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
The managed care plan should investigate opportunities to improve members accessing cervical cancer screening.	X	X		HIP has made concerted efforts to improve its performance in HEDIS/Quality Assurance Reporting Requirements measures, including cervical cancer screening. HIP uses targeted processes and methodology for conducting and evaluating quality improvement activities that includes baseline measurement, root cause analysis, development and implementation of appropriate interventions, and re-measurement to determine the impact of interventions utilizing valid statistical analyses. HIP continues to monitor HEDIS/Quality Assurance Reporting Requirements rates monthly to identify lower-than-anticipated performance and implement interventions as needed. Performance, goals, and indicators are monitored through the quality committee structure and senior leadership steering committees. HEDIS/Quality Assurance Reporting Requirements reports are available to staff involved in specific performance improvement activities as well as those staff who oversee departments whose work impacts HEDIS/Quality Assurance Reporting Requirements measures. HIP continues its efforts to engage additional members, providers, and employees in the quality process. HIP provides monthly member level detailed gaps-in-care reports to all partnered health homes and care management agencies. Cancer screening measures, including *Cervical Cancer Screening,* are one of many areas of focus included in the monthly gaps-in-care reports. Health home operational conference calls are utilized to discuss gaps-in-care initiatives and quality improvement activities. Quarterly performance summary reports are assessed to highlight quality measures and areas for opportunity. Health homes and care management agencies receive training on quality measures and HEDIS/Quality Assurance Reporting Requirements measure specifications. HIP is committed to partnering with network providers to raise the quality of care for members. HIP offers an incentive to eligible providers for certain HEDIS/Quality Assurance Reporting Requirements measures, including	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				Cervical Cancer Screening, where appropriate care is administered. Measure specifications and helpful tips are given to providers. Helpful tips regarding ensuring members get screened for cervical cancer include, but are not limited to, placing a reminder in the patient's chart for when the next screening is due. Providers receive news and updates from HIP on cervical cancer awareness and prevention throughout the year via the provider newsletter, Office Visit. During Cervical Cancer Awareness Month, providers are reminded to talk to their patients about pap tests, human papillomavirus tests, and related vaccines. In addition to the awareness month activities, providers are reminded to talk to their patients and encourage them to visit the gynecologist to get regular screenings, with directions to the Quality Measure Resource Guide for measure details and helpful tips, as well as directions to the Center for Disease Control and Prevention's website for online resources. HIP examines multiple sources of data about access and availability of care to identify and determine opportunities to improve network adequacy and provide members with adequate provider networks to meet all care needs. HIP compares the number of open panel/open practice OB/GYN practitioners to the member population to determine there is an appropriate ratio of OB/GYN practitioners to members. Time and distance standards are analyzed to determine if there are enough OB/GYN practitioners within certain geographical settings. Analysis of current practitioner availability for obstetrics and gynecology reveals no issues with access and availability of obstetrics and gynecology. To engage members in their own care, HIP educates members in the importance of cervical cancer screenings through its digital Health Touch emails. Preventive health guidelines are posted on HIP's website to help members learn more about screenings and tests members and their families should get.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				Lastly, HIP implemented a Health Disparities Workgroup to identify opportunities to address health disparities focusing on race, ethnicity, and language from a global perspective, as well as through the lens of quality. From the analysis conducted, HIP developed a Women's Health Disparities Workgroup, focusing on breast cancer screening, cervical cancer screening, chlamydia screening, and prenatal and postpartum care. As identified, HIP will implement initiatives, such as fostering additional collaborations with external agencies and provider groups to support the efforts of the Women's Health Disparities Workgroup. Despite working with health homes, care management agencies, and multiple internal departments, HIP experienced a decrease in cervical cancer screening from measurement year 2019 to measurement year 2020 due to members not being able to access care due to the COVID-19 pandemic restrictions. As offices began to open, members were returning to offices to get screened. Cervical cancer screening rates improved slightly from measurement year 2020 to measurement year 2021. HIP will continue to explore industry standards and best practices, collaborate with health homes and care management agencies to reach Health and Recovery Plan members in need of cervical cancer screening, encourage providers to outreach patients to get screened and educate members on the importance of cervical cancer screenings.	
The managed care plan should investigate opportunities to improve the health of members with diabetes.	X	X		HIP continues to monitor HEDIS/Quality Assurance Reporting Requirements diabetes care rates monthly to identify lower-than-anticipated performance and implement interventions as needed. Performance, goals, and indicators are monitored through the quality committee structure and senior leadership steering committees. HEDIS/Quality Assurance Reporting Requirements reports are available to staff involved in specific performance improvement activities as well as those staff who oversee departments whose work impacts HEDIS/Quality Assurance Reporting Requirements.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				HIP recognizes that the Health and Recovery Plan diabetic population may be challenged in receiving consistent treatment which could effectively address their needs. Along with the serious nature of diabetes that Health and Recovery Plan members face, the population is also susceptible to poor health outcomes. To that end, HIP aims to address Health and Recovery Plan diabetic members' receipt of necessary care to meet their needs and to facilitate coordination and communication between physical and behavioral health teams. HIP continues its efforts to engage more members, providers, and employees in the quality process to improve the care Health and Recovery Plan diabetic members receive. To do so, HIP will continue to implement interventions to improve the care these members receive. HIP provides monthly member level detailed gaps-in-care reports to all partnered health homes and care management agencies. Diabetes care measures are one of many areas of focus included in the gaps-in-care reports which aim to improve care coordination between members and their primary care providers. Health home operational conference calls are utilized to discuss gaps-in-care initiatives and quality improvement activities. Quarterly performance summary reports are assessed to highlight quality measures and areas for opportunity. Health homes and care management agencies receive training on quality measures and HEDIS/Quality Assurance Reporting Requirements measure specifications. HIP's care management team will make at least three attempts to reach members by phone, mail, or email. Reaching members who have HbA1c-poor control can result in coordinated care for diabetes management through plans of care and/or monitoring and communication with the member and their primary care physician or specialist. Diabetic members can also enroll in HIP's diabetes self-management program to complete an	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				action plan to help the member get started on controlling their diabetes and to have discussions with their providers. HIP is committed to remaining a partner with network providers to raise the quality of care for members and to ensure Health and Recovery Plan diabetic members receive the help and support they need to manage their diabetes. Therefore, HIP offers an incentive to eligible providers for certain diabetic HEDIS/Quality Assurance Reporting Requirements measures when appropriate care is administered. Providers also receive measure specifications and helpful tips such as emphasizing the importance of medication and insulin adherence in managing blood glucose to patients, recommending follow-up visits to monitor results, and for providers to have a diabetes checklist in the electronic medical record or patient chart to monitor if patients are up to date with recommended screenings. Providers also receive news and updates from HIP on diabetes management throughout the year via the provider newsletter, Office Visit. Medical guidelines and clinical practice guidelines regarding diabetes and ways to help patients manage diabetes are provided to providers via HIP's website and provider portal. An example of a specific topic are medical guidelines regarding when nutritional counseling services are acceptable and parameters for diabetes self-management training. In addition to being a partner with network providers, HIP will be collaborating with home vendors to conduct at-home testing of diabetic members.	
The managed care plan should investigate opportunities to improve follow-up care for members after	X	X		HIP recognizes the importance of improving the follow-up care Health and Recovery Plan members receive after hospitalization for mental illness and substance use disorders. Interventions are put into place to help improve the coordination of care members receive to ensure they go for follow-up care timely after a hospitalization from a mental illness diagnosis. HIP partners with health homes and care management agencies. Gaps-in-care reports are shared with the health homes and care management	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
hospitalization for mental illness and substance use disorders.				agencies quarterly. Quarterly operational meetings are held with the health homes to discuss the gaps-in-care reports, data exchange, care coordination outreach activities, and ongoing quality improvement initiatives to address ongoing member, provider, and personnel barriers. Health home partners receive quarterly health home gaps-in-care training to review measure specifications and to discuss provider engagement strategies. Monthly, Beacon Health Options submits patient level detail reports and accompanying dashboards for quality analysis and review. Beacon Health Options receives a data exchange of daily inpatient hospital submissions reports to help identify inpatient stay and needed follow-up care. Weekly clinical/quality huddles are held by Beacon Health Options to address quality measures and to escalate at-risk members. Monthly quality/clinical meetings are held between Beacon Health Options and HIP to discuss quality improvement activities, outreach engagement strategies, barriers to care, and opportunities to improve behavioral health quality care. HIP developed a Telehealth Tip Sheet highlighting when a provider can conduct telehealth visits to allow them more flexibility to provide quality of care for patients. It will be shared with the provider groups as well as posted to the quality provider website. The continued focus on the follow-up care measures for the Health and Recovery Plan population has shown improvements in some measures as shown in the table below. Improvements in rates from measurement year 2018 were noted in *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* and *Follow-Up After High-Intensity Care for Substance Use Disorder* measures. Decreases were seen in the *Follow-up After Hospitalization for Mental Illness* and *Follow-up After Emergency Department Visit for Mental Illness* measures. HIP will continue to remain partners with health homes and care management agencies, as well as Beacon Health Options, internal	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				stakeholders, members, and providers to improve the follow-up care members receive.	

Strengths, Opportunities for Improvement, and Recommendations

Table 70: HIP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	HIP's measurement year 2021 performance improvement project passed validation.	X	X	X
	HIP exceeded target rates for three performance indicators.	X	X	X
Performance Measures	HIP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	None.			
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, HIP was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	HIP did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	HIP performed significantly worse than the Health and Recovery Plan program on eight measures of effectiveness of care related to primary care, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	HIP performed significantly worse than the Health and Recovery Plan program on two measures of effectiveness of care related to substance use.			
Compliance with Federal Managed Care Standards	During the period under review, HIP was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	HIP performed significantly worse than the Health and Recovery Plan program on two measures of member satisfaction.	X	X	X
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, HIP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	HIP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, HIP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	HIP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	HIP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

IHA

Performance Improvement Project Summary and Results

Table 71: IHA's Performance Improvement Project Summary, Measurement Year 2021

IHA's Performance Improvement Project Summary
Title: Health and Recovery Plan Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim IHA aims to improve case management interventions, identify members eligible for services, and educate and encourage providers to utilize medication-assisted technology. Member-Focused 2021 Interventions ▪ Conducted home and community-based services assessments for eligible members. ▪ Enrolled members in case management services through health homes and health home referrals. ▪ Post-discharge member outreach was conducted by the Beacon Health Options' case management team. ▪ Followed-up with members discharged from rehab or a detox facility to verify that member was aware of the available medication-assisted technology services. ▪ Members identified as non-compliant for appropriate antipsychotic medication management were outreached to by Beacon Health Options. Provider-Focused 2021 Interventions ▪ Providers were educated on available medication-assisted technology services and were encouraged to offer these services to members. ▪ Engaged with high-volume substance use disorder facilities. Managed Care Plan-Focused 2020 Interventions ▪ Evaluated barriers to executing effective case management for members identified as receiving behavioral health services.

Table 72: IHA's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	57.14%	59.22%	50.00%	50.00%	63.40%
Follow-Up After Hospitalization for Mental Illness – 30 Days	84.87%	81.89%	82.52%	77.59%	88.00%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	71.11%	51.76%	72.00%	79.17%	80.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	80.00%	64.71%	80.00%	84.72%	92.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	28.33%	23.95%	30.38%	43.42%	33.30%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	36.67%	32.34%	42.41%	51.97%	45.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	37.88%	41.41%	48.95%	46.13%	50.00%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	65.15%	77.97%	76.32%	73.24%	78.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.79%	67.43%	70.59%	65.26%	71.10%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	25.90%	29.00%	26.67%	30.23%	53.00%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	11.11%	13.79%	13.33%	10.16%	8.11%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	18.30%	17.86%	22.22%	26.45%	23.00%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Performance Measure Results

Table 73: IHA's Performance Measure Results, Measurement Years 2019 to 2021

Measure	IHA Measurement Year 2019	IHA Measurement Year 2020	IHA Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.56%	52.79%	60.96%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	42.33%	42.64%	45.45%	39.96%
Asthma Medication Ratio (19–64 Years)	58.89%	48.78%	69.77%	41.20%
Breast Cancer Screening	71.40%	62.59%	56.68%	54.63%
Cervical Cancer Screening	70.40%	64.96%	67.11%	63.77%
Chlamydia Screening in Women (21–24 Years)	Sample Size Too Small To Report	Sample Size Too Small To Report	Sample Size Too Small To Report	72.96%
Colorectal Cancer Screening	62.28%	56.33%	60.69%	55.13%
Comprehensive Diabetes Care – Eye Exam	67.88%	63.40%	63.01%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	23.84%	29.12%	25.00%	40.91%
Controlling High Blood Pressure	71.75%	66.18%	67.39%	63.25%
Flu Shots for Adults[2]	60.26%	60.26%	50.14%	47.31%
Advising Smokers to Quit[2]	85.44%	85.44%	86.19%	83.42%
Discussing Smoking Cessation Medications[2]	73.58%	73.58%	71.35%	68.96%
Discussing Smoking Cessation Strategies[2]	55.24%	55.24%	54.70%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	34.87%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	58.73%	69.74%	70.42%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	38.46%	23.33%	26.92%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	76.79%	82.81%	83.08%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.20%	71.02%	65.26%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.12%	73.56%	76.63%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	73.75%	76.06%	79.17%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	56.69%	63.30%	54.13%	57.82%

Measure	IHA Measurement Year 2019	IHA Measurement Year 2020	IHA Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	13.79%	13.79%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	33.99%	34.25%	43.42%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	59.11%	49.65%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	36.14%	35.37%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	26.38%	28.21%	24.46%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	28.24%	Not Available	30.23%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	17.39%	Not Available	26.45%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 74: IHA's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	C	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	C	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery plan is in compliance with all standard requirements.

Quality-of-Care Survey Results – Member Experience

Table 75: IHA's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	IHA	Health and Recovery Plan Average
Getting Needed Care[1]	79.90%	78.48%
Getting Care Quickly[1]	83.47%	80.03%
How Well Doctors Communicate[1]	91.42%	90.62%
Customer Service[1]	91.93%	84.93%
Rating of All Health Care [2]	69.08%	66.87%
Rating of Personal Doctor [2]	80.96%	77.57%
Rating of Specialist Talked to Most Often[2]	72.53%	75.17%
Rating of Health Plan[2]	81.85%	71.44%
Rating of Treatment or Counseling[2]	71.35%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."
[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."
Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 76: IHA's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
Validation of Performance Improvement Projects					
Regarding the managed care plan's 2019-2021 Health and Recovery Plan performance improvement project interim 2 results, the managed care plan had identified challenges with data collection, member participation with medication assisted treatment, and member engagement (both telephonically and face-to-face communications). IPRO recommends that the managed care plan continues with its current interventions put in place to address these challenges. While the managed care plan's rates have not reached its goal rates in measurement year 2020, most of the performance improvement project	X	X		IHA has recently completed the Health and Recovery Plan performance improvement project 2019-2021 final report. The report notes that we successfully mitigated all data collection issues identified in the Health and Recovery Plan performance improvement project 2019-2021 interim 2 report, regarding member participation in medication assisted treatment. In the interim report, we initiated a new intervention in which Beacon Health Options held recurring meetings with high-volume substance use disorder facilities to increase collaborative communications and to identify strategies to address member resistance to medication assisted treatment. We continue to monitor this intervention, and Beacon Health Options has held quarterly meetings with all the identified facilities quarterly in 2022. In addition, we have restarted or implemented several interventions to improve telephonic and face-to-face member engagement: for example, Beacon Health Options recently restarted face-to-face engagement for members hospitalized for mental health in the local hospital with the highest volume of mental health admission, Erie County Medical Center. We are also working with Beacon Health Options to obtain access and training to HealtheLink (Western New York regional health information organization) for the Beacon Health Options team to obtain additional member contact information. With the continued tracking of performance rates and interventions, we expect to see continued improvement in the	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
indicators are trending upwards. The managed care plan should also consider implementing changes to the data collection process to improve inaccurate and inconsistent data received from other resources.				member connection with medication assisted treatment and telephonic and face-to-face engagement. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve member health outcomes. Performance measures and interventions will continue to be assessed through Plan-Do-Study-Act cycles: interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly, as applicable, looking at both process and outcome results, by IHA's Value Governance and Quality committees, as applicable.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve the health of members who are smokers.	X	X		IHA acknowledges the importance of improving the health of members who are smokers. As a result, we have performed above the statewide and national averages in several smoking cessation-related measures such as advising smokers to quit, (IHA 86, statewide average 79, national 77), discussing smoking cessation medications (IHA 70, statewide average 62, national 54), and discussing smoking cessation strategies (IHA 72, statewide average 56, national 49) as published in the *2020 Health Plan Comparison in New York State* report. To continue improving the health of smokers, we have multiple interventions, either active or planned, for providers and members. Provider interventions include creating and distributing a provider tip sheet to highlight the formulary coverage for Medicaid cessation aids. Education regarding best practices for tobacco cessation and resources for cessation aids are sent to mental health and primary care providers through HIP's web-based educational platform, *Outcomes Matter*. Smoking cessation clinical	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				practice guidelines were updated and distributed through our provider newsletter, *SCOPE*. IHA partnered with Health Systems Change to provide training to three large mental health provider groups to establish workflows and systems that support cessation in office settings. We are also partnering with Roswell Park Cancer Institute to provide educational resources and referrals to primary care providers and behavioral health providers in 2023. We have an incentive with an independent physician association that holds much of IHA's Health and Recovery Plan membership to develop a process to identify Health and Recovery Plan members with diabetes and tobacco use to provide member education and cessation options. We plan to have an incentive in 2023 with this independent physician association to improve the smoking cessation treatment or referrals for this membership. Additionally, we have partnered with Erie County Medical Center to follow up on all members referred and linked to tobacco cessation services upon inpatient hospital discharge to ensure linkage to services post-discharge. This process began in the third quarter of 2022. Member interventions include resources for members to quit smoking on our website (i.e., flyers for members with smoking cessation resources and highlighting smoking cessation counseling and smoking cessation intervention pharmacotherapy as $0 preventive services). Additionally, we are partnering with Roswell Park Cancer Institute and the New York State Quitline to provide member education about smoking cessation at Good for the Neighborhood events held by the IHA Foundation. The Good for the Neighborhood events empower families in underserved neighborhoods to eat right, be active, see their doctor and live a smoke-free lifestyle by connecting them with the tools and resources needed to be healthy.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				With the continued tracking of performance rates and interventions, we expect to see continued engagement in smoking cessation among our Health and Recovery Plan members. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve member health outcomes to increase the number of members connected to smoking cessation strategies. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles: interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly, as applicable, looking at both process and outcome results, by IHA's Value Governance and Quality committees, as applicable.	
The managed care plan should investigate opportunities to improve members' access to home and community-based services.	X	X		IHA recognizes the benefits of enrolling members in home and community-based services. We have several current and planned interventions to improve members' access to home and community-based services. In the Health and Recovery Plan performance improvement project 2019-2021, we had an intervention to track the percentage of Health and Recovery Plan members with a home and community-based services assessment. We will continue monitoring this rate. Additionally, we will add this discussion topic to the quarterly meetings we hold with the health home agencies to improve the rates of Health and Recovery Plan members with a home and community-based services assessment, discuss barriers that impact assessment completion, and strategies to improve home and community-based services assessment rates. IHA is working to improve health home enrollment of our Health and Recovery Plan population. We are updating member materials related to health homes and identifying high-risk Health and Recovery Plan members for telephonic outreach and education about the benefits and	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				services available through health homes and home and community-based services. With the continued tracking of performance rates and interventions, we expect to see a continued increase in the number of Health and Recovery Plan members enrolled in health homes and utilizing home and community-based services. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve members' health outcomes to increase the number of members engaged with home and community-based services. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles; interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly, as applicable, looking at both process and outcome results, by IHA's Value Governance and Quality committees, as applicable.	

Strengths, Opportunities for Improvement, and Recommendations

Table 77: IHA's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	IHA's measurement year 2021 performance improvement project passed validation.	X	X	X
	IHA exceeded target rates for four performance indicators.	X	X	X
Performance Measures	IHA met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	IHA performed significantly better than the Health and Recovery Plan program on seven measures of effectiveness of care related to primary care, HIV, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2019, IHA was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	IHA performed significantly better than the Health and Recovery Plan program on three measures of member satisfaction.	X		
Opportunities for Improvement				
Performance Improvement Project	IHA did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	None.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, IHA should continue to	X	X	X

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
	facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.			
Performance Measures	IHA should continue to utilize the results of the HEDIS/ Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, IHA should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	IHA should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	IHA should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

MetroPlus

Performance Improvement Project Summary and Results

Table 78: MetroPlus's Performance Improvement Project Summary, Measurement Year 2021

MetroPlus's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim MetroPlus aims to increase the number of member referrals to home-based therapy; increase health home enrollment; obtain timely member emergency room admission information to facilitate coordination of aftercare; increase the number of members visited while in an inpatient facility by a field-based case manager who facilitates continuity of care post-discharge; increase the number of members who receive medication-assisted technology services; improve member adherence to pharmacotherapy; and obtain consent from substance use disorder members to provide enhanced care coordination. Member-Focused 2021 Interventions ▪ Conducted onsite discharge planning visits to members during inpatient stays. Members were educated on available services, social supports, and community resources during the visit. ▪ Connected members to health homes. ▪ Facilitated coordination between the member and the health home of enrollment at the time of admission. ▪ Members identified with housing insecurities received a housing assessment referral. ▪ Connected members to peer support specialists to prior to discharge. ▪ Educated members on the importance of aftercare treatment and available home-based therapy services. Provider-Focused 2021 Interventions ▪ Coordinated with facilities during the discharge planning process to member needs were effectively addressed and to encourage integration of medication-assisted technology services into the discharge plan when appropriate. ▪ Conducted quarterly provider education sessions on appropriate case coordination and the importance of obtaining member consent for care coordination services. Managed Care Plan-Focused 2021 Interventions ▪ Notifications of member inpatient admission were sent to the health home of enrollment to trigger the initiation of care coordination. ▪ Established access to regional health information organizations to obtain real-time information on member emergency department use. ▪ The process for identifying members with high-utilization rates and reporting these members to case managers and health homes was established.

Table 79: MetroPlus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	43.83%	42.68%	42.11%	35.51%	46.83%
Follow-Up After Hospitalization for Mental Illness – 30 Days	69.72%	69.28%	69.00%	60.31%	72.72%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	66.09%	42.54%	45.21%	40.89%	69.09%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	81.03%	64.65%	65.00%	60.59%	84.03%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	29.60%	34.81%	33.61%	26.83%	32.60%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	36.73%	43.04%	41.32%	35.51%	39.73%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	28.86%	38.40%	47.04%	39.46%	31.90%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	60.09%	71.69%	76.26%	63.11%	63.10%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.66%	63.35%	70.21%	65.50%	67.66%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	37.56%	37.80%	45.05%	35.96%	40.56%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	21.03%	19.25%	17.48%	Not Available	24.03%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	10.03%	12.59%	28.45%	27.89%	13.03%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 80: MetroPlus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	MetroPlus Measurement Year 2019	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	50.34%	51.13%	47.49%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.47%	38.22%	35.26%	39.96%
Asthma Medication Ratio (19–64 Years)	46.05%	32.70%	32.78%	41.20%
Breast Cancer Screening	55.50%	49.37%	48.82%	54.63%
Cervical Cancer Screening	65.94%	63.02%	57.91%	63.77%
Chlamydia Screening in Women (21–24 Years)	77.66%	81.93%	77.11%	72.96%
Colorectal Cancer Screening	52.31%	45.74%	46.72%	55.13%
Comprehensive Diabetes Care – Eye Exam	53.28%	47.45%	45.74%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	27.74%	36.25%	39.66%	40.91%
Controlling High Blood Pressure	69.59%	69.34%	65.21%	63.25%
Flu Shots for Adults[2]	50.22%	50.22%	48.38%	47.31%
Advising Smokers to Quit[2]	88.10%	88.10%	81.12%	83.42%
Discussing Smoking Cessation Medications[2]	72.58%	72.58%	67.61%	68.96%
Discussing Smoking Cessation Strategies[2]	66.67%	66.67%	59.44%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	22.75%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	66.53%	66.41%	64.86%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	39.77%	26.82%	24.66%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	58.41%	55.19%	52.42%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.35%	70.21%	65.50%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	87.87%	75.07%	83.51%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	42.54%	45.40%	40.92%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	42.68%	42.11%	40.39%	57.82%

Measure	MetroPlus Measurement Year 2019	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	19.25%	17.48%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	34.81%	33.67%	26.94%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	47.04%	43.92%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	35.47%	26.08%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	17.61%	22.23%	20.37%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	37.80%	Not Available	35.96%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	12.59%	Not Available	27.89%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 81: MetroPlus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	NC	Pended	C
438.214: Provider Selection	C	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	C
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements.

Quality-of-Care Survey Results – Member Experience

Table 82: MetroPlus's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	MetroPlus	Health and Recovery Plan Average
Getting Needed Care[1]	72.99%	78.48%
Getting Care Quickly[1]	77.51%	80.03%
How Well Doctors Communicate[1]	89.03%	90.62%
Customer Service[1]	80.24%	84.93%
Rating of All Health Care [2]	64.60%	66.87%
Rating of Personal Doctor [2]	71.19%	77.57%
Rating of Specialist Talked to Most Often[2]	73.94%	75.17%
Rating of Health Plan[2]	65.82%	71.44%
Rating of Treatment or Counseling[2]	60.57%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."
[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 83: MetroPlus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
Validation of Performance Improvement Projects					
Regarding the managed care plan's 2019-2020 Health and Recovery Plan performance improvement project interim 2 results, MetroPlus identified challenges with improving members' access to follow-up behavioral health care such as the COVID-19 pandemic affecting field-based case management interventions, reduction in case management staff, and data collection. The managed care plan should be continuously re-evaluating the interventions to determine its effectiveness. The managed care plan should also consider implementing changes to	X	X		▪ The 2019-2021 performance improvement project was titled, "Care Transitions after Emergency Department and Inpatient Admissions." The goal of this performance improvement project focused on improving transition to the community for members who had inpatient mental health and inpatient substance use disorder admissions, as well as emergency department encounters. Interventions consisted of field-based, on-site, and telephonic case managers educating members on available community services, linkage to peer support specialists, and coordinating with members' health homes and assertive community treatment teams. Additional interventions aimed to assist providers in coordinating appointments during discharge planning, facilitating signed member consent for members receiving inpatient substance use disorder treatment, and texting members who had an emergency department visit. ▪ The behavioral health program was transitioned from MetroPlus's vendor, Beacon Health Options, to MetroPlus as of October 1, 2021. Comprehensive behavioral health services were in-sourced to internal MetroPlus departments. The transition enables MetroPlus to directly implement member and provider interventions, and work toward improving project indicators on an ongoing basis. Software development specific to utilization management, case management functions and analytics, and reporting configuration were essential components to the behavioral health carve-in.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
the data collection process to improve inaccurate and inconsistent data received from other resources.				▪ The fully staffed behavioral health program incorporates case managers, peer support specialists, medical doctor consults, utilization management review, and coordination for discharge planning. Staff seek to engage members and providers to improve members' transition to the community upon discharge from an inpatient or emergency department encounter. Emphasis is placed on increasing member access to community resources and addressing essential needs, such as transportation to medical appointments and housing. ▪ As field-based operations resume throughout 2022, case managers will return to the field and be embedded in facilities for on-site case management. Specialized appointment reminders and regular attempts to engage the member to facilitate member follow-up post-discharge from an inpatient or emergency department encounter has been put in place. For optimized care coordination, the behavioral health team makes referrals to and communicates with community care providers, such as health homes, assertive community treatment teams, home and community-based services or community-oriented recovery and empowerment services, and residential treatment programs, where appropriate. ▪ Since the behavioral health program carve-in, MetroPlus has increased visibility into members' behavioral health utilization, case management interventions and outcomes. Data collection processes are internal to MetroPlus, allowing for prompt and streamlined tracking and oversight. Case management interventions and calls for behavioral health follow-up are audited by the behavioral health case management team leads. Additionally, MetroPlus converted an existing clinical role to "case management quality examiner" as of June 2022. The case management quality examiner provides clinical and quality	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				oversight to behavioral health case management on an ongoing basis.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve breast cancer screenings.	X	X		Due to comorbidities of both medical and mental health conditions, the Health and Recovery Plan population has barriers to completing breast cancer screenings as they have competing health and psychosocial priorities. Barriers for members may include not understanding the importance of mammograms, not knowing a mammogram is due, past painful experience during a mammogram, fear and paranoia preventing members from completing breast cancer screening, and members may not be going in for routine care. Provider barriers may include not being aware that members are due for a mammogram and not having staff or an automated system to outreach members who are missing mammograms. The COVID-19 pandemic caused significant disruption in healthcare, creating delays in access and availability. The following interventions are in place to improve breast cancer screening rates: ▪ Monthly provider report cards and gaps-in-care reports are distributed to providers and health homes. ▪ Pay for Performance Provider Incentive program incentivizes providers to focus on and improve breast cancer screening rates. ▪ Member Rewards program incentivizes members to complete breast cancer screenings. ▪ Text/interactive voice response campaigns educating members on the importance of breast cancer screenings and reminding members to complete mammograms. ▪ One-time text to members with breast cancer screening gap with patient portal link and phone number to a radiology provider so members can self-schedule a mammogram appointment.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Providers who have members with upcoming appointments who are missing a breast cancer screening are sent an email as a reminder to assist members to close the gap. ▪ Health and Recovery Plan care management team addresses breast cancer screening with members when there is a breast cancer screening gap alert in the internal care management documentation system. Breast cancer screening rate is monitored via a monthly dashboard and at the interdepartmental Health Status Improvement Team meeting. Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership also include breast cancer screening reporting. Breast cancer screening rates for Health and Recovery Plan are 56% for calendar year 2019, 51% for calendar year 2020, and 49% for calendar year 2021.	
The managed care plan should investigate opportunities to improve the health of members with asthma, diabetes, and HIV.	X	X		Asthma Medication Ratio Managing asthma for Health and Recovery Plan members may be challenging due to comorbid chronic and mental health conditions. Member barriers may include not knowing they have asthma, not understanding the asthma condition, and not understanding the purpose of asthma controller medications or how to take them. A provider barrier might be not prescribing asthma controller medications. The following ongoing interventions aim to address these barriers: ▪ Share monthly provider report cards and gaps-in-care data with providers and health homes. ▪ Health and Recovery Plan care management team discuss asthma controller adherence when managing care for members with asthma medication ratio gap. ▪ Share with the care management team a weekly list of members who have open Health and Recovery Plan care management	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				cases, who are close to the 50% *Asthma Medication Ratio* (45% to 49.99%) to educate those members in the importance of continued controller use, for outreach. ▪ Asthma medication ratio text campaign to educate members regarding asthma management; text/interactive voice response asthma medication ratio controller medication refill reminders. ▪ Promote Member Rewards and Pay for Performance in all asthma medication ratio member/provider communications. ▪ Pharmacy department outreaches members who have been non-compliant for the past two years to educate and address barriers to filling asthma controller medications. ▪ Pharmacy department outreaches providers with high volume of non-compliant members via phone call and follow-up with fax with member level detail. ▪ List of members who are stable on 30-day supply of asthma controller medications are sent to providers to convert script to 90-day supply. ▪ Post current Global Initiative for Asthma clinical practice guidelines on the provider portal. Asthma medication ratio is included in the Quality Matrix Action Plan 2021. *Asthma Medication Ratio* measure rates are monitored on a monthly dashboard and at the Health Status Improvement Team meeting, as well as reported at Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership. *Asthma Medication Ratio* measure rates for Health and Recovery Plan are 46% for calendar year 2019, 33% for calendar year 2020, and 33% for calendar year 2021. Eye Exam for Patients with Diabetes For diabetes care in the Health and Recovery Plan population, the *Comprehensive Diabetes Care – Eye Exam* rate (47%) performed	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				below the statewide average (54%) in 2020. Member barriers to the diabetic retinal eye exam may include members not realizing the importance of a diabetic retinal eye exam, not prioritizing routine diabetic retinal eye exam, and not knowing that a diabetic retinal eye exam is due. Provider barriers may include not reminding members to get their diabetic retinal eye exam or not realizing that the member is due for a diabetic retinal eye exam. The COVID-19 pandemic has also caused disruption in accessing healthcare and caused delays in getting appointments. To increase the rate of diabetic eye exams, the following interventions are ongoing: ▪ Diabetes management text/interactive voice response campaign which includes education regarding diabetes retinal eye exam. ▪ Monthly provider report cards and gaps-in-care data are shared with providers and health homes. ▪ Letter/panel report to eye care providers who have seen members, but members still have diabetic retinal eye exam gaps to encourage providers to call members back in for diabetic retinal eye exam. ▪ Health and Recovery Plan care management team discuss diabetic retinal eye exams when managing care for members with diabetic retinal eye exam gap. ▪ Promote member rewards/pay for performance (diabetic retinal eye exam) in all member and provider communications. Diabetic retinal eye exam rates are monitored via a monthly dashboard and at the Health Status Improvement Team meeting. Rates are also included in the report presented at the Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership. the *Comprehensive Diabetes Care – Eye Exam* rate is 53% for calendar	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				year 2019, 47% for calendar year 2020, and 46% for calendar year 2021. HIV *Viral Load Suppression* performed below the statewide average in 2020. *Viral Load Suppression* was selected as an area for improvement with an action plan in place for 2022. The goal of the plan is to increase the rate of *Viral Load Suppression* for Health and Recovery Plan members living with HIV to the statewide average: 55% to 66% for Health and Recovery Plan. Barriers to improving the *Viral Load Suppression* rate include the lack of viral load test result data from community providers, difficulty outreaching and engaging members who are lost to care, members' difficulty adhering to HIV care and treatment, and members' lack of knowledge about HIV/medication adherence/services. Several interventions are being implemented and monitored to address these barriers: ▪ Partnership in Care leadership is meeting with community providers and lab vendors to explore solutions to enhance data collection of viral load test results. ▪ Members who are out of care for over 12 months are outreached by MetroPlus's Ending the Epidemic staff using a focused return-to-care intervention with the goal of addressing the member's barriers to engaging in HIV primary care. If unsuccessful, out-of-care members are referred to a vendor for street outreach. ▪ Members with poor adherence or unsuppressed viral loads are outreached by health and wellness advisors using an adherence coaching intervention to help identify and overcome barriers to adherence.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Members with HIV are enrolled into several text message campaigns as needed or by member preference: HIV medication refill reminders if they are more than 14 days late picking up medications, adherence education for members with unsuppressed viral loads, and daily medication reminders for members who opt in. The interventions outlined above are monitored and evaluated through the action plan. Results are reported to the Department of Health. A proxy of viral load suppression performance is also reported quarterly at the Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership.	
The managed care plan should investigate opportunities to improve follow-up care for members after an emergency department visit or hospitalization for mental illness. Additionally, the managed care plan should investigate opportunities to reduce members' risk of continued opioid use.	X	X		Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Room Visit for Mental Illness MetroPlus recognizes the importance of follow-up, post-inpatient mental health care. In response to 2020 performance, the managed care plan conducted an in-depth barrier analysis to identify member barriers to aftercare and implemented the following interventions to support members in their recovery journey. ▪ MetroPlus attempts to outreach every member discharged from an inpatient stay or emergency room visit for mental health by telephone to confirm that the member has and understands their aftercare plan. We also assist members with making doctor appointments as needed. This outreach is continued from the previous year. The managed care plan uses advanced methods to locate the best phone number to reach the member. ▪ MetroPlus recently placed field-based case managers in high-volume facilities to assist members in securing aftercare services.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Members with multiple admissions are offered case management services and assistance with social determinants of health. ▪ MetroPlus makes use of peers to better engage members in aftercare services. ▪ MetroPlus engaged a large inpatient provider in a value-based performance arrangement to support members in obtaining aftercare services post-discharge. MetroPlus has observed a decrease in year-over-year performance in the *Follow-Up After Hospitalization for Mental Illness/Follow-Up After Emergency Room Visit for Mental Illness – 7 Days* and *30 Days* measures for the Health and Recovery Plan. Rates are noted below: *Follow-Up After Hospitalization for Mental Illness* ▪ *7 Days* measure: ▫ Calendar year 2019 39.18% ▫ Calendar year 2020 39.56% ▫ Calendar year 2021 34.82% ▪ *30 Days* measure: ▫ Calendar year 2019 64.81% ▫ Calendar year 2020 65.02% ▫ Calendar year 2021 58.45% *Follow-Up After Emergency Room Visit for Mental Illness* ▪ *7 Days* measure: ▫ Calendar year 2019 42% ▫ Calendar year 2020 45% ▫ Calendar year 2021 28% ▪ *30 Days* measure: ▫ Calendar year 2019 64% ▫ Calendar year 2020 65%	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▫ Calendar year 2021 50% Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence MetroPlus recognizes the importance of medication assisted treatment for members diagnosed with an opioid use disorder. In response to 2020 performance, the managed care plan conducted an in-depth barrier analysis to identify member barriers to medication assisted treatment and implemented the following interventions to support members in their recovery journey. ▪ On a weekly basis, the MetroPlus runs data on members who were diagnosed with opioid use disorder in the preceding seven days. MetroPlus outreaches these members to support their recovery and assists them in securing medication assisted treatment. ▪ Members with opioid diagnosis who were seen and discharged from an emergency room or inpatient substance use care are outreached telephonically to support engagement in medication assisted treatment. ▪ Quarterly meetings are held with high-volume inpatient substance treatment facilities to discuss better identification of members appropriate for medication assisted treatment, as well as monitoring of facility performance in this measure. ▪ MetroPlus makes use of weekly collaboration meetings with our internal behavioral health department to address member and provider barriers to medication assisted treatment. ▪ MetroPlus has developed a provider assessment to support annual screening for substance use disorders as well as resources for treatment and referral for these disorders. The managed care plan has observed a decrease in year-over-year performance in the *Initiation of Pharmacotherapy upon New Episode*	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				of Opioid Dependence measure for the Health and Recovery Plan. Rates are: ▪ Calendar year 2019 37.80% ▪ Calendar year 2020 45.05% ▪ Calendar year 2021 35.96% MetroPlus uses member demographics to determine if disparities exist based on gender, age, race and ethnicity, language spoken, and geography. If poor performance is noted, the managed care plan will alter actions or implement new interventions to prioritize members as needed to address and reduce these disparities. MetroPlus's process for monitoring actions is to: ▪ Track measure rate performance by utilizing internal monthly dashboards and year-over-year trend reports. ▪ Monitor process data and the effectiveness of each intervention on Quality Improvement Activity tools. ▪ Report outcomes to the Quality Management Committee and Quality Assurance Performance Improvement Committee.	
The managed care plan should investigate opportunities to improve members' access to stable housing.	X	X		To address the housing needs of our members, MetroPlus invested in the implementation of a housing taskforce. The taskforce is made up of care managers and housing specialists who assist members in making smooth and healthy transitions from homeless shelters to permanent housing. Services include linkage to medical and behavioral health providers, benefits coordination, assistance with navigating all aspects of low-income housing subsidies, etc. MetroPlus collaborates with the Department of Housing Services to obtain a monthly list of members who are living in shelters. In addition, along with New York City Health and Hospitals, MetroPlus collaborates with the Human Resources Administration, the HIV/AIDS Services Administration, Housing Preservation and Development, and other housing providers. As housing	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				opportunities are identified, the housing taskforce works with members who meet the criteria, to complete applications for the housing offer. Since the inception of the housing taskforce, MetroPlus Health has stably housed over 350 members. To evaluate this work, we are tracking the following: ▪ Number of members housed ▪ Number of members housed to specific housing opportunities ▪ Number of members housed who remain enrolled with the MetroPlus The following data is currently being analyzed: ▪ Number of hospitalizations ▪ Number of emergency department visits	
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the non-compliance identified during the Measurement Year 2019 Operational Survey conducted by the Department of Health.	X	X	X	MetroPlus underwent a full operational survey between 11/29/21 and 12/7/2021. The survey reviewed key areas and the managed care plan received one deficiency related to a contracted vendor utilization review initial adverse determination notice for three Child Health Plus cases in which the vendor failed to ensure the notice included a complete statement of clinical rationale. Upon investigation, the vendor discovered this was an error made by a staff nurse. The template was updated to ensure that this error does not occur again. The managed care plan continues to monitor compliance with Medicaid standards by addressing the non-compliance identified during the survey and by conducting quarterly random samples of cases to ensure that this error has been resolved and is not reoccurring. To date, no issues have been identified.	Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 84: MetroPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus's measurement year 2021 performance improvement project passed validation.	X	X	X
	MetroPlus exceeded target rates for three performance indicators.	X	X	X
Performance Measures	MetroPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	MetroPlus performed significantly better than the Health and Recovery Plan program on one measure of effectiveness of care related to mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, MetroPlus was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	MetroPlus did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	MetroPlus performed significantly worse than the Health and Recovery Plan program on 10 measures of effectiveness of care related to primary care, HIV, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	MetroPlus performed significantly worse than the Health and Recovery Plan program on one measure of access/availability of care related to substance use.			
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	MetroPlus performed significantly worse than the Health and Recovery Plan program on three measures of member satisfaction.	X		

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, MetroPlus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	MetroPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MetroPlus should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	MetroPlus should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	MetroPlus should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

Molina

Performance Improvement Project Summary and Results

Table 85: Molina's Performance Improvement Project Summary, Measurement Year 2021

Molina's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Molina aims to improve transition of care after emergency department visits or hospital admissions among members diagnosed with mental illness and substance use disorder. Member-Focused 2021 Interventions ▪ Case managers outreached monthly to members with schizophrenia who are non-adherent with their medication treatment plan based on the monthly non-adherent report. ▪ Case managers worked with members to remove barriers, ensure primary care provider appointment attendance, engage in case management and medication adherence. ▪ A discharge action score card was completed for every member discharged from an inpatient mental health or substance abuse admission. This assessed aftercare needs and referrals for appointments and social determinants of health, such as housing, primary care provider appointments, specialist appointments, food, and housing insecurities, and prompted providers to include these referrals in their discharge planning process. ▪ Members were offered a $25 gift card incentive for a wellness visit. Requests for gift cards were tracked. ▪ Contacted members to encourage primary care provider follow-up, discuss their last visit, and updated the member's primary care provider assignment in their internal system as needed. Provider-Focused 2021 Interventions ▪ Educated Molina's high-volume integrated mental health and substance abuse provider on the need to ensure scheduled appointments with a therapist and ensure appointments are provided. ▪ Case managers called members to confirm knowledge of their appointments and quality department staff called the providers to verify appointments. This outreach was tracked and reviewed monthly. A behavioral health provider relations representative also made monthly provider visits to educate and provide feedback. ▪ Quality specialists and case managers followed up with members discharged from the emergency department and/or inpatient hospital admissions due to mental illness/substance use disorder to ensure continuity of case was occurring and to offer telehealth option for follow-up appointments. ▪ Nurse practitioners conducted home visits to provide follow-up visits and additional services as needed among members discharged from emergency department and/or inpatient hospital admissions due to substance use disorder. Managed Care Plan-Focused 2021 Interventions ▪ Partnered with and educated Molina's health homes and community partners on the need to ensure scheduled appointments with a therapist are held following inpatient and emergency department visits for substance use or mental health. ▪ Implemented process improvement for documentation and discharge plans by creating a SharePoint with a single point of access for multiple internal staff and their case manager vendor, Monroe Plan, utilizing information from external inpatient collaborators such as State University of New York Upstate Medical University, Kaleida, Erie County Medical Center, St Joseph's and Crouse hospitals.

Table 86: Molina's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	48.84%	59.32%	40.31%	40.00%	52.00%
Follow-Up After Hospitalization for Mental Illness – 30 Days	80.23%	79.66%	68.37%	69.09%	68.00%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	75.22%	22.46%	44.20%	34.11%	52.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	85.84%	47.83%	65.63%	56.59%	68.50%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	26.77%	23.44%	26.62%	26.87%	31.43%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	33.86%	35.94%	39.93%	37.07%	43.52%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	31.90%	47.62%	50.52%	41.62%	51.10%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	54.20%	69.05%	73.70%	65.90%	80.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.14%	68.51%	72.56%	65.30%	70.92%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	45.10%	47.97%	51.52%	53.00%	48.00%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	19.05%	24.56%	11.02%	Not Available	No Target Established
Use of Pharmacotherapy for Alcohol Abuse or Dependence	7.49%	9.15%	20.95%	22.71%	18.00%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 87: Molina's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Molina Measurement Year 2019	Molina Measurement Year 2020	Molina Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	44.29%	57.85%	47.17%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	30.71%	43.08%	31.45%	39.96%
Asthma Medication Ratio (19–64 Years)	47.92%	57.48%	56.52%	41.20%
Breast Cancer Screening	65.11%	58.75%	52.70%	54.63%
Cervical Cancer Screening	73.72%	65.35%	65.69%	63.77%
Chlamydia Screening in Women (21–24 Years)	*SS*	71.43%	72.97%	72.96%
Colorectal Cancer Screening	58.88%	58.39%	54.35%	55.13%
Comprehensive Diabetes Care – Eye Exam	67.48%	62.29%	58.64%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	25.87%	44.04%	43.55%	40.91%
Controlling High Blood Pressure	64.88%	63.99%	63.02%	63.25%
Flu Shots for Adults[2]	49.72%	49.72%	54.00%	47.31%
Advising Smokers to Quit[2]	85.00%	85.00%	80.93%	83.42%
Discussing Smoking Cessation Medications[2]	73.74%	73.74%	72.02%	68.96%
Discussing Smoking Cessation Strategies[2]	67.01%	67.01%	63.02%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	31.92%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	44.44%	68.42%	63.53%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	34.21%	30.34%	21.98%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	96.67%	80.00%	86.44%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.51%	72.56%	65.30%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.00%	66.43%	74.62%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	22.46%	44.20%	34.11%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	59.32%	47.40%	40.00%	57.82%

Measure	Molina Measurement Year 2019	Molina Measurement Year 2020	Molina Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	24.56%	11.02%	Not Available	Not Available
Effectiveness of Care – Substance Use Measures				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	23.44%	26.62%	26.87%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	51.90%	41.62%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	36.72%	30.86%	30.44%
Access/Availability of Care – Substance Use Measures				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	15.92%	17.39%	18.09%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	47.97%	Not Available	53.00%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	9.15%	Not Available	22.71%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 88: Molina's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	NC	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	C	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2019 Results

- Based on staff interview and review of the Molina Provider Manual and associated materials, Molina failed to update the Provider Manual and associated materials to include/communicate required information to the managed care plan's providers. *(Contract Article 98-1.12(o))*
- Based on staff interview and review of the provider network submission, Molina failed to submit and/or report an accurate 2nd quarter 2019 provider network. *(Contract Article 98-1.16 (i) (j))*
- Based on staff interview and review of approval notices, Molina failed to ensure its delegate, HealthPlex, made the determination and issued the written and the phone notice within three business days of receipt of the necessary information. This was evident in two of 10 Medicaid approval utilization review cases. *(Contract Article 4903(2)(a))*

Quality-of-Care Survey Results – Member Experience

Table 89: Molina's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	Molina	Health and Recovery Plan Average
Getting Needed Care[1]	76.85%	78.48%
Getting Care Quickly[1]	81.52%	80.03%
How Well Doctors Communicate[1]	90.30%	90.62%
Customer Service[1]	80.88%	84.93%
Rating of All Health Care [2]	54.17%	66.87%
Rating of Personal Doctor [2]	76.47%	77.57%
Rating of Specialist Talked to Most Often[2]	73.86%	75.17%
Rating of Health Plan[2]	62.50%	71.44%
Rating of Treatment or Counseling[2]	68.49%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 90: Molina's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
Validation of Performance Improvement Projects					
Molina demonstrates an opportunity for improvement with some 2020 performance improvement project indicators. As indicated in the managed care plan's 2019-2021 Health and Recovery Plan performance improvement project Interim 2 report, the plan identified the COVID-19 pandemic and the acquisition of YourCare members as some of the challenges affecting the performance rates. The managed care plan should routinely evaluate its current interventions to determine its effectiveness and adjust as needed to improve members access to	X	X		Since the conclusion of the 2019-2021 Health and Recovery Plan performance improvement project, the managed care plan continues regular outreach to members post-emergency department visits and post-inpatient stays for behavioral health related care. Molina also continues to outreach schizophrenia members on antipsychotics to ensure medication adherence. Molina has partnered with value-based payment providers and health homes to exchange data to facilitate ongoing improvement in behavioral health related care to our members. Molina is also in the process of implementing a text messaging campaign for the behavioral health population to combat reluctancy to answer calls from unknown numbers.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
follow-up behavioral health care.					
Validation of Performance Measures					
The managed care plan should investigate opportunities to reduce members use of opioids and improve diabetes screenings for members on antipsychotic medications.	X			Molina's root causes and resulting interventions for reducing members use of opioids and improving diabetes screenings for members on antipsychotic medications are indicated below. **Diabetes Screenings** Obtaining lab results data and knowing if diabetic members require intervention to maintain A1c control has been the main obstacle for ensuring appropriate levels of care and care management is delivered. In addition to generating monthly reports of members requiring A1c tests and sharing with the members' attributed primary care providers and assigned health homes when applicable, we have engaged with several large standalone lab vendors to receive monthly data feeds of lab results. Also, Molina is receiving lab results data as part of supplemental data feeds from two regional health information exchanges. These data feeds have resulted in a more complete and accurate view of our diabetic members needs and numbers, so we can target the right members are the right time. Additionally, Molina expects to engage a national lab vendor in an in-home lab testing program to address potential provider capacity/access/availability issues and to meet the members "where they are" if they experience challenges/barriers in keeping up with office visits. **Opioid Use** Identifying newly diagnosed opioid users in a way that allows for timely intervention has been a challenge, especially those identified in acute care settings. To that end, Molina implemented the process of receiving hospital admission/discharge/transfer	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				alerts from three regional health information organizations within our catchment area, covering members across both upstate and downstate regions. The daily alerts allow case managers to commence member outreach within a couple business days of notification when they can make several attempts to successfully contact the members for coordination of medical, behavioral health, and social services required to safely transition and stabilize the member in the community. However, because some diagnostic information around substance use is protected, the behavioral health and case management departments are exploring the possibility of embedding staff in specific high-volume substance treatment facilities to allow engagement with members prior to discharge to potentially increase the likelihood of connecting members to appropriate, ongoing outpatient services and medication-assisted treatment while the members' location and whereabouts are still known to the managed care plan (and reducing the potential for members getting lost to care).	
The managed care plan should investigate opportunities to improve members' access to alcohol and drug abuse treatments.	X		X	Molina is now receiving hospital admission/discharge/transfer alerts from three regional health information organization within our catchment area, covering members across both Upstate and Downstate regions. These alerts are updated in Molina's case management system and queued up for immediate action to be taken by the behavioral health case management team. The purpose of the frequent alert updates is to facilitate timely identification of members diagnosed with substance use disorders so that timely initiation of treatment can be facilitated during the case manager's contact with the members. The behavioral health and case management departments are also exploring the possibility of embedding staff in specific high-volume facilities that will allow engagement with members prior to discharge.	Addressed
Compliance with Medicaid Standards					

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the compliance review conducted by the Department of Health.	X	X	X	Molina submitted a plan of correction to address identified deficiencies on 01/31/2020, and received Department of Health approval on 07/22/2020. The plan of correction included immediate updates to the provider directory to accurately reflect primary care physicians, updates to the Molina's provider manual along with quarterly audits to ensure compliance with regulatory requirements, and immediate action by the dental benefit manager to correct processes to respond to prior authorization requests in a timely fashion. All corrective actions and future monitoring activities are monitored by Molina's compliance committee on a quarterly basis. Molina was reaudited in December 2020 for the previously identified areas and found to be fully compliant as of 1/15/2021.	Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 91: Molina's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Molina's measurement year 2021 performance improvement project passed validation.	X	X	X
	Molina exceeded target rates for three performance indicators.	X	X	X
Performance Measures	Molina met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Molina performed significantly better than the Health and Recovery Plan program on three measures of effectiveness of care related to primary care, HIV, or substance use.	X	X	
Performance Measures – Access/Availability of Care	Molina performed significantly better than the Health and Recovery Plan program on one measure of access/availability of care related to substance use.			
Compliance with Federal Managed Care Standards	During measurement year 2019, Molina was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Molina did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	Molina performed significantly worse than the Health and Recovery Plan program on four measures of effectiveness of care related to primary care or mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2019, Molina was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	Molina performed significantly worse than the Health and Recovery Plan program on two measures of member satisfaction.	X		
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Molina should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	Molina should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Molina should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	Molina should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the measurement year 2019 compliance findings. Molina should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Molina should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

MVP

Performance Improvement Project Summary and Results

Table 92: MVP's Performance Improvement Project Summary, Measurement Year 2021

MVP's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions for Health and Recovery Plan Members with Mental Illness and Substance Use Disorder **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim MVP aims to improve discharge plans to be comprehensive and patient-centered; and to include needed post-discharge follow-up, community supports, and medication reconciliation. MVP also aims to facilitate communication and coordination between inpatient providers, community providers, members, health homes and managed care plan case management. Member-Focused 2021 Interventions ▪ Ensured a follow-up visit for alcohol and other drug treatment was in place prior to discharge and scheduled to occur within 14 days of the discharge. ▪ Members not enrolled in a health home with an emergency department visit for substance abuse or mental illness received post-discharge received outreached for follow-up care coordination; education on health homes, case management and home and community-based services; and to provide care coordination. ▪ Members identified as non-compliant with appropriate mediation management for two or more months were engaged by telephone to identify and address barriers to appropriate medication management. ▪ Promoted the managed care plan's telehealth program which offers behavioral health services with licensed mental health professionals on an urgent and/or continuous basis. ▪ Educated members on the importance of consent for coordination of care between the managed care plan and the health home. Targeted outreach to members who declined to consent care coordination between the managed care plan and the health home was conducted, and included education on the benefits of care coordination, available home and community-based services, and the need to schedule follow-up care within seven days of discharge. Provider-Focused 2021 Interventions ▪ Discharge planning and confirmation of member involvement were conducted during medical necessity reviews between the managed care plan and the facility. ▪ Provided the member's primary care provider and/or behavioral health provider with information from the member's aftercare plan. ▪ Discharge medication lists were sent to primary care providers and/or behavioral health providers by the inpatient facility. ▪ Coordinated the reporting of emergency room census logs with two days of admission by the top five to ten facilities for high-volume emergency department admissions. ▪ Daily reporting to health homes of members discharged from inpatient hospitalization. ▪ Provided health homes a daily report of members enrolled in a health home who were discharged from an inpatient hospitalization or had an emergency department alert in HIXNY for substance use disorder or serious mental illness. ▪ Issued discharge logs, Public Health Law reporting obligations and follow-up requirements to birthing facilities with the highest number of missing results in the Ealy Hearing Detection and Intervention system.

MVP's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions for Health and Recovery Plan Members with Mental Illness and Substance Use Disorder Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
▪ MVP's pharmacy team identified members prescribed an anti-psychotic that did not fill their last prescription in 30 or more days and notified their prescribing physicians via letter advising the member has been non-adherent. ▪ Ran a monthly report to identify members eligible for health home and home and community-based services and send referrals to the health home for member outreach. Managed Care Plan-Focused 2021 Interventions ▪ Implemented process of conducting medication reconciliation at the time of admission and upon discharge. ▪ Designed literature to promote health home enrollment and home and community-based services. ▪ Directly contacted members who had five or more emergency department visits within 60 days and are being prescribed medication-assisted technology to assist with coordination of case and to determine the need for intensive case management.

Table 93: MVP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	55.90%	49.59%	47.67%	50.11%	60.00%
Follow-Up After Hospitalization for Mental Illness – 30 Days	75.90%	68.70%	62.97%	65.01%	80.00%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	54.02%	82.38%	46.56%	38.73%	74.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	73.79%	88.98%	69.72%	56.94%	80.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	24.47%	40.43%	28.06%	23.49%	40.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	30.26%	48.68%	37.19%	31.38%	50.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	24.31%	40.90%	42.77%	42.16%	42.00%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	57.64%	66.44%	76.52%	69.41%	70.00%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.23%	66.36%	65.24%	66.54%	74.00%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	32.00%	42.99%	57.60%	48.95%	52.00%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	18.56%	21.39%	22.52%	20.89%	15.00%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	12.46%	14.48%	26.71%	27.51%	17.00%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Performance Measure Results

Table 94: MVP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	MVP Measurement Year 2019	MVP Measurement Year 2020	MVP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.94%	47.83%	50.60%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.63%	37.99%	41.65%	39.96%
Asthma Medication Ratio (19–64 Years)	50.46%	38.86%	37.33%	41.20%
Breast Cancer Screening	57.86%	52.26%	47.77%	54.63%
Cervical Cancer Screening	66.67%	63.02%	63.75%	63.77%
Chlamydia Screening in Women (21–24 Years)	78.26%	66.27%	72.41%	72.96%
Colorectal Cancer Screening	58.15%	54.01%	53.15%	55.13%
Comprehensive Diabetes Care – Eye Exam	55.72%	48.66%	49.88%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	43.80%	58.88%	48.91%	40.91%
Controlling High Blood Pressure	63.26%	42.34%	56.20%	63.25%
Flu Shots for Adults[2]	58.95%	58.95%	46.95%	47.31%
Advising Smokers to Quit[2]	88.24%	88.24%	80.41%	83.42%
Discussing Smoking Cessation Medications[2]	79.21%	79.21%	62.76%	68.96%
Discussing Smoking Cessation Strategies[2]	70.10%	70.10%	52.38%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	31.33%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	53.68%	59.21%	58.76%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	33.33%	30.40%	21.38%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	78.26%	75.00%	79.41%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	66.36%	65.24%	66.54%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.75%	63.68%	79.50%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	82.38%	46.56%	38.84%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	49.59%	47.67%	53.61%	57.82%

Measure	MVP Measurement Year 2019	MVP Measurement Year 2020	MVP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	16.94%	19.21%	Not Available	Not Available
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	40.43%	28.06%	23.49%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	42.77%	44.35%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	40.23%	33.26%	30.44%
Access/Availability of Care – Substance Use Measure				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	23.33%	24.21%	21.75%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	42.99%	Not Available	48.95%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	14.48%	Not Available	27.51%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 95: MVP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	NC	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	NC	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	C	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Based on staff interview and review of sampled hospital contracts, MVP failed to notify the Department of Health 45 days in advance of three of 65 contracts that were set to expire. *(Contract Article 2005-98-1.13(c)(2))*
- Based on staff interview and review of the external appeal instructions and application, MVP failed to issue current external appeal instructions and application forms to enrollees in four of 16 Medicaid standard and expedited appeals, and four of 15 commercial/Child Health Plus standard and expedited appeals. *(Contract Article 98-2.9(h)(1))*
- Based on staff interview and review of the final adverse determination notices, MVP failed to ensure its delegate, EviCore, issued notices to enrollees that included the utilization review agent's contact person or department name in two of eight Medicaid expedited appeal utilization review cases. *(Contract Article 98-2.9(e)(1), 4904. (3)(a))*
- Based on staff interview and review of the Adverse Determination Notices, MVP failed to ensure its delegate, HealthPlex, issued written notices that were factual and accurate in nature for three of 13 Child Health Plus pre-authorizations and for two of eight Child Health Plus standard appeal utilization review cases. *(Contract Article 4405(10))*
- Based on staff interview and review of the sampled provider credentialing files, MVP failed to credential two of 16 providers every three years as required. *(Contract Article 2005-98-1.12(k))*
- Based on staff interview and review of the sampled provider contracts, MVP failed to provide evidence that 15 of 65 providers were sent an amendment that included the 2017 New York State Department of Health

Standard Clauses for Managed Care Provider/Independent Physician Association/Accountable Care Organization Contracts Incorporation Language. *(Contract Article 2005-98-1.13(a))*

Quality-of-Care Survey Results – Member Experience

Table 96: MVP's Adult CAHPS Results, Measurement Year 2021

Measure	Measurement Year 2021	
	MVP	Health and Recovery Plan Average
Getting Needed Care[1]	81.18%	78.48%
Getting Care Quickly[1]	82.58%	80.03%
How Well Doctors Communicate[1]	90.69%	90.62%
Customer Service[1]	91.21%	84.93%
Rating of All Health Care [2]	69.56%	66.87%
Rating of Personal Doctor [2]	81.39%	77.57%
Rating of Specialist Talked to Most Often[2]	71.96%	75.17%
Rating of Health Plan[2]	72.88%	71.44%
Rating of Treatment or Counseling[2]	67.78%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the Health and Recovery Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 97: MVP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
Validation of Performance Improvement Projects					
MVP demonstrates opportunities for improvement with the interventions implemented under the performance improvement project as these indicators have not met target goals.	X			MVP acknowledges that several indicators did not meet their target goals. After completing the 2019-2021 Health and Recovery Plan performance improvement project, MVP reflected on the performance improvement project interventions' varying levels of success and determined that several interventions relied heavily upon the assistance of onsite performance improvement project partners. When a key performance improvement project partnership was dissolved midway through the performance improvement project timeline, several member outreach and education interventions became unsustainable and were either terminated or limited to telephonic outreach, which proved to be less effective than MVP anticipated. In response to this lesson learned, MVP's new 2022-2023 Health and Recovery Plan performance improvement project, *Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus*, emphasizes MVP-led member outreach and education initiatives and includes a new partnership with a vendor that supports in-home lab services. The interventions in this new Health and Recovery Plan performance improvement project are tracked, monitored, and reviewed each quarter, and the effectiveness of these MVP-led interventions and home-based lab services will be assessed at the time of the interim and final performance improvement project reports.	Partially Addressed
Validation of Performance Measures					
The managed care plan should investigate	X			Interventions included in the 2022-2023 Health and Recovery Plan performance improvement project, *Improving*	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
opportunities to improve the health of members with diabetes and hypertension.				*Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus*, address opportunities to improve the health of members with diabetes and hypertension. Activities include mailed and telephonic outreach to members with diabetes care gaps to educate them about the importance of managing diabetes, the availability of at-home labs and screenings, and the option to enroll in the MVP Diabetes Care Management Program. Various educational opportunities are also advertised throughout the year through member newsletters and social media campaigns. The interventions in this new Health and Recovery Plan performance improvement project are tracked, monitored, and reviewed each quarter. The effect that these interventions have on the health of members with diabetes and hypertension, will be assessed at the interim and final reporting periods via performance indicator three, *Controlling Blood Pressure (<140/90 mmHg)*; the target goal is to improve blood pressure control among Health and Recovery Plan members by five percent by 2023.	
The managed care plan should investigate opportunities to improve follow-up care after hospitalization for mental illness and members' use of opioids.	X	X		MVP has conducted a root cause analysis of factors that contributed to poor performance on the *Follow-Up After Hospitalization for Mental Illness – 7 Days* quality measure and is currently implementing a quality performance matrix action plan to address identified barriers to improve our performance. MVP began implementing this plan in the first quarter of 2022 and continues to monitor and evaluate our progress and the effectiveness of the interventions. To improve follow-up care for members experiencing mental health and or opioid misuse issues, MVP has partnered with two different organizations to provide MVP members with access to	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
				immediate community-based outreach and support from licensed practitioners when members are discharged from inpatient psychiatric, and substance use units. Furthermore, MVP's Opioid Taskforce meets regularly to discuss decreasing opioid use, substance use disorder readmission rates, and improve member access to medication-assisted treatment. More broadly, between 2020 and 2022, the Opioid Task Force raised awareness within the health plan about the support, treatment, and access needs of members with substance use disorder/opioid use disorder and incorporated MVP's response to these needs into the routine operational work of the health plan.	
The managed care plan should investigate opportunities to improve members' access to home and community-based services.	X		X	MVP has participated in the New York State Infrastructure programs in order to improve capacity, connectivity, and access to home and community-based services and community-oriented recovery and empowerment services. MVP routinely engages health homes in monthly meetings to discuss home and community-based services and community-oriented recovery and empowerment services, identify new developments with the Health and Recovery Plan, discuss enhanced benefits, and problem solve for any access issues that may be occurring. Additionally, MVP publishes a Health and Recovery Plan-specific newsletter that lets members know about their benefits, available services, and encourages them to discuss their care needs with their provider(s).	Partially Addressed
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the	X	X	X	MVP recognizes that complying with Medicaid standards is an integral part of providing a high-quality health plan and creating a positive experience for MVP's customers. Compliance with these standards is an enterprise-wide effort, and MVP teams remain committed to improving our internal collaboration and communication to ensure compliance with Medicaid standards.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
Measurement Year 2020 Operational Survey conducted by the Department of Health.					

Strengths, Opportunities for Improvement, and Recommendations

Table 98: MVP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MVP's measurement year 2021 performance improvement project passed validation.	X	X	X
	MVP exceeded target rates for three performance indicators.	X	X	X
Performance Measures	MVP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	MVP performed significantly better than the Health and Recovery Plan program on one measure of effectiveness of care related to HIV or substance use.	X	X	
Performance Measures – Access/Availability of Care	MVP performed significantly better than the Health and Recovery Plan program on one measure of access/availability of care related to substance use.			
Compliance with Federal Managed Care Standards	During measurement year 2020, MVP was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	MVP performed significantly better than the Health and Recovery Plan program on one measure of member satisfaction.	X		
Opportunities for Improvement				
Performance Improvement Project	MVP did not meet target rates for nine performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	MVP performed significantly worse than the Health and Recovery Plan program on seven measures of effectiveness of care related to primary care, mental health, or substance use.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During measurement year 2020, MVP was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, MVP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	MVP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MVP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	MVP should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the measurement year 2020 compliance findings. MVP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	MVP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

UHCCP

Performance Improvement Project Summary and Results

Table 99: UHCCP's Performance Improvement Project Summary, Measurement Year 2021

UHCCP's Performance Improvement Project Summary
Title: Care Transitions after Emergency Department and Inpatient Admissions **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP aims to implement timely clinical case management interventions and improve education, communication, and discharge planning. Member-Focused 2021 Interventions ▪ Developed and implemented a member incentive program for inpatient mental health and substance use disorder follow-up post discharge. ▪ Referred members to transitional providers upon inpatient mental health admission. Provider-Focused 2021 Interventions ▪ Met with high-volume health homes to identify and address barriers to member enrollment. Managed Care Plan-Focused 2021 Interventions ▪ Obtained timely information on members present in the emergency department through their regional health information organization, Healthix. ▪ Reviewed allocation of staffing to support expansion of the "against medical advice" project to the top five high-volume detox facilities with high against medical advice rates. ▪ Added additional providers to the UHCCP's Transitional/Home Visit program.

Table 100: UHCCP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021[1]	Target/Goal
Follow-Up After Hospitalization for Mental Illness – 7 Days	55.45%	51.17%	50.29%	58.46%	60.00%
Follow-Up After Hospitalization for Mental Illness – 30 Days	72.21%	67.16%	68.55%	75.60%	78.00%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days	44.76%	44.38%	40.27%	36.56%	52.00%
Follow-Up After Emergency Department Visit for Mental Illness – 30 Days	66.05%	44.38%	56.35%	56.53%	73.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days	19.66%	25.56%	26.85%	27.15%	30.00%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Days	26.69%	31.22%	33.84%	35.65%	40.00%
Follow-Up After High-Intensity Care for Substance Use Disorder –7 Days	26.60%	37.87%	42.10%	42.10%	28.28%
Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days	52.10%	60.63%	66.52%	66.52%	58.85%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	52.69%	61.44%	60.71%	64.56%	67.00%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	29.78%	35.85%	35.35%	28.77%	40.00%
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	Not Available	19.10%	15.23%	Not Available	No Target Established
Use of Pharmacotherapy for Alcohol Abuse or Dependence	16.54%	17.47%	17.57%	25.78%	18.20%

[1] The measurement year 2021 rates presented in this table are unenhanced, and may differ from the measurement year 2021 rates presented in the managed care plan-specific performance measure results table. Enhanced rates are inclusive of out-of-plan services received by a managed care enrollee that the managed care plan is unaware of. Enhanced rates are calculated by the Office of Quality and Patient Safety and shared with the managed care plans as they become available.

Not available means that an enhanced rate was not made available by the Department of Health and the managed care plan chose not to report the unenhanced rate.

Performance Measure Results

Table 101: UHCCP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	UHCCP Measurement Year 2019	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.63%	51.74%	55.18%	53.62%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.55%	40.45%	43.84%	39.96%
Asthma Medication Ratio (19–64 Years)	44.92%	45.89%	50.99%	41.20%
Breast Cancer Screening	53.69%	49.69%	48.10%	54.63%
Cervical Cancer Screening	61.31%	59.85%	59.37%	63.77%
Chlamydia Screening in Women (21–24 Years)	71.82%	65.66%	69.57%	72.96%
Colorectal Cancer Screening	49.64%	55.23%	44.77%	55.13%
Comprehensive Diabetes Care – Eye Exam	52.31%	45.01%	49.88%	56.74%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	38.20%	45.01%	41.61%	40.91%
Controlling High Blood Pressure	60.58%	53.28%	61.07%	63.25%
Flu Shots for Adults[2]	40.94%	40.94%	40.41%	47.31%
Advising Smokers to Quit[2]	85.29%	85.29%	88.03%	83.42%
Discussing Smoking Cessation Medications[2]	66.67%	66.67%	74.13%	68.96%
Discussing Smoking Cessation Strategies[2]	58.00%	58.00%	61.54%	59.37%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[3]	22.78%	31.97%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	58.71%	54.70%	61.83%	64.47%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	38.04%	29.50%	26.58%	27.71%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	63.58%	62.35%	61.62%	65.59%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62.13%	63.47%	65.06%	65.95%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.54%	74.50%	79.39%	79.90%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	44.28%	38.42%	36.33%	49.11%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	57.87%	56.42%	59.82%	57.82%

Measure	UHCCP Measurement Year 2019	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	Health and Recovery Plan Measurement Year 2021
Potentially Preventable Mental Health Related Readmission Rate – 30 Days	15.23%	18.48%	Not Available	Not Available
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	24.97%	26.48%	26.96%	29.41%
Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days	First Year Measure[3]	40.87%	40.52%	42.87%
Pharmacotherapy for Opioid Use Disorder	First Year Measure[3]	32.01%	28.52%	30.44%
Access/Availability of Care – Substance Use Measure				
Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (Total)	24.06%	21.59%	19.85%	20.73%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	43.74%	Not Available	45.62%	41.05%
Use of Pharmacotherapy for Alcohol Abuse or Dependence	17.02%	Not Available	25.61%	26.88%

[1] Lower rate indicates better performance.

[2] Measure derives from adult CAHPS. Measurement year 2019 CAHPS results are reported for measurement year 2020 because the adult CAHPS survey is administered every other year.

[3] First year measures are not publicly reported.

Green shading indicates that the managed care plan's performance for the measurement year is statistically significantly better than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates that the managed care plan's performance for the measurement year is statistically significantly worse than the Health and Recovery Plan statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 102: UHCCP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	NC	Pended	NC
438.207: Assurances of adequate capacity and services	C	Pended	C
438.208: Coordination and continuity of care	C	Pended	C
438.210: Coverage and authorization of services	NC	Pended	C
438.214: Provider selection	C	Pended	NC
438.224: Confidentiality	C	Pended	C
438.228: Grievance and appeal system	NC	Pended	C
438.230: Sub-contractual relationships and delegation	C	Pended	C
438.236: Practice guidelines	C	Pended	C
438.242: Health information systems	C	Pended	C
438.330: Quality assessment and performance improvement program	NC	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Health and Recovery Plan is in compliance with all standard requirements; NC: Health and Recovery Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- UHCCP failed to ensure that four of the 27 contracts reviewed included required components. Specifically, the contracts did not include the 21st Century Cures Act Amendment and/or the 2017 Standard Clause incorporation language or attachment. *(New York Codes, Rules, and Regulations 98-1.13(a))*
- Based on an interview held on June 16, 2021, and a review of documents, UHCCP failed to ensure that credential files included the required components for four of 16 credential files reviewed. *(Contract Article 2005-98-1.13(a))*
- Based on an interview held on June 16, 2021, and a review of documents, UHCCP failed to notify the New York State Department of Health, of the departure of former board member. *(Contract Article 2005-98-1.12(k))*

Quality-of-Care Survey Results – Member Experience

Table 103: UHCCP's Adult CAHPS Results, Measurement Years 2021

Measure	Measurement Year 2021	
	UHCCP	Health and Recovery Plan Average
Getting Needed Care[1]	76.02%	78.48%
Getting Care Quickly[1]	77.11%	80.03%
How Well Doctors Communicate[1]	90.01%	90.62%
Customer Service[1]	86.95%	84.93%
Rating of All Health Care [2]	65.93%	66.87%
Rating of Personal Doctor [2]	72.14%	77.57%
Rating of Specialist Talked to Most Often[2]	71.76%	75.17%
Rating of Health Plan[2]	69.33%	71.44%
Rating of Treatment or Counseling[2]	57.92%	64.51%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 104: UHCCP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
Validation of Performance Improvement Projects					
The managed care plan demonstrates opportunities to improve the performance rates for HEDIS/Quality Assurance Reporting Requirements behavioral health measures. The managed care plan should conduct routine root cause analysis to determine barriers to Health and Recovery Plan members accessing follow-up appointments after an emergency department visit for mental illness or substance abuse. As indicated in UHC's Health and Recovery Plan Performance Improvement Plan Interim 2 report, there were multiple challenges identified associated with data collection. UHC	X	X	X	The aim of the Care Transitions after Emergency Department and Inpatient Admissions 2019-2020 performance improvement project was to facilitate successful transition for Health and Recovery Plan members from emergency department visits and inpatient mental health care to community care, from inpatient substance use disorder detoxification or inpatient substance use disorder rehabilitation to a lower level of care, and to reduce subsequent emergency department visits and inpatient readmissions. The interventions included obtaining alternate member phone numbers for case managers and health home agency case managers to facilitate their transition in care. The second intervention focused on increasing member geographic accessibility to specialized transitional supports/home visits from contracted providers. The third intervention addressed receiving timely notification of member emergency room episodes of care. Since emergency room care does not require managed care plan notification or prior authorization, the managed care plan accessed regional health information organization emergency department service reports within one to two days of the episode of care. The regional health information organization emergency room episode report notified case managers, health homes, and assertive community treatment teams so that they may intervene to support a member's transition in care. Allocation and redistribution of staff was implemented to expand the UHCCP	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
should continue with its current interventions that were created to address these issues such as removal of a transitional provider, resubmission of claims, creation of a daily report of emergency room admission triggered by data received from a regional health information organization and increasing member engagement.				case manager on-site presence at high-volume inpatient detox facilities. Goals for the *Follow Up After Hospitalization for Mental Illness – 7 Days* and *30 Days* measures were improved but did not meet the target. Improvements were attributed to referrals to transitional providers who outreached members within seven days of discharge and facilitated engagement in aftercare. During the project, a low-performing provider agency was replaced with a new provider agency who could also provide services telephonically. Going forward, we have contracted with an additional transitional provider. This agency can also become the ongoing aftercare provider for those who do not have a recent mental health community provider. Promoting member access to substance abuse treatment can be challenging but an important effort towards long-term sobriety. The NCQA measure *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* assesses emergency department visits for members 13 years of age and older, with a principle diagnosis of alcohol or other drug dependence, who had a follow-up visit for alcohol or other drug abuse. From 2019-2021, UHCCP participated in a performance improvement project to improve access to care for members who followed up after emergency room visits for alcohol and other drug abuse treatment. Improvement was attributed to case management outreach and this opportunity shall continue. Case managers and peers are embedded at high-volume, inpatient substance use treatment facilities to support engagement in follow-up care. A COVID-19 pandemic-related suspension of onsite services did interfere in 2020-2021. However, the "in-field" case manager and peer assignments have resumed in the second quarter of 2022	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				and shall continue. Measurement of success is the Quality Assurance Reporting Requirements *Follow-Up After High Intensity Care for Substance Use Disorder* data and a reduction in the against-medical-advice discharges from the facilities where UHCCP has embedded staff. The *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* rate was improved but the goal was not met. Improvement was attributed to telephonic outreach to assertive community treatment and personal recovery-oriented services providers and a member-specific mailing to prescribers. Going forward, we plan to expand telephonic outreach to include prescribers at clinics, group practices, and private practices. Health home enrollment and UHCCP case management enrollment goals were not met. Going forward, we plan for members with behavioral health Quality Assurance Reporting Requirements gaps-in-care to have that need assessed in recommending referral to a health home or UHCCP case management. UHCCP shall continue with health home joint operating committee meetings that include behavioral health Quality Assurance Reporting Requirements data, and continue with the UHCCP case manager's workflow that includes addressing Quality Assurance Reporting Requirements gaps-in-care with members. For the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* measure, the goal was met. Improvement was attributed to case management outreach. *Initiation of Pharmacotherapy upon New Episode of Opioid Dependence* was improved over baseline in 2019 and into 2020 but deceased in 2021. The change is attributed to a COVID-19	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				pandemic-related suspension of embedded UHCCP case management and peers at high-volume, inpatient substance use treatment facilities. The "in-field" case manager and peer assignments have resumed in the second quarter of 2022 and shall continue.	
Validation of Performance Measures					
The managed care plan should continue interventions implemented to improve members' access to cancer screenings and flu immunizations.	X		X	UHCCP has continued interventions implemented to improve members' access to cancer screenings and flu immunization. There are annual flu season campaigns which provide the member with information regarding the flu vaccine and encourages members to obtain the vaccine at no cost. The website "healthtalkexam.myuhc.com" will help members find locations for flu shots on the "myuhc.com/find flu shot" page. Member newsletters include information about the importance of flu vaccines. Member direct outreach is facilitated using the auto-dialer by which the plan outreach coordinators call members to help close gaps-in-care. This includes educating members on screening and helping schedule appointments. In 2021, there were almost 77,000 interactive voice response calls regarding colorectal cancer screenings, breast cancer screenings, and cervical cancer screenings. Data is monitored monthly by UHCCP's member outreach manager. Members who attended preventative care appointments received a gift card after UHCCP received a signed form by their doctor confirming an appointment took place for a particular screening. Additional follow-up is conducted by comparing claims received for each measure. Home-based programs are an identified opportunity for member engagement and compliance in cancer screening. UHCCP has implemented a program which provides an immunochemical	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				fecal occult blood home testing kit. Providers and members receive results. Member newsletters include prevention and screening topics. There are articles on breast, cervical, and colorectal cancer screenings, as well as articles on vaccines and dental visits for adults. Newsletters include information on getting the appropriate care and how to prevent chronic conditions, to help members understand the importance of preventative care. There are articles that focus on where and when to go for treatment such as your primary care provider, urgent care, or emergency room; getting appropriate care, knowing which provider to see, and where to go; and information regarding smoking cessation, influenza vaccines and ways to prepare to see your providers.	
The managed care plan should investigate opportunities to improve the health of members with hypertension and diabetes.	X			UHCCP continues to act on initiatives to improve the health of members with hypertension and diabetes. UHCCP analyzed opportunities to improve the health of members with hypertension and diabetes by launching direct member and provider-based initiatives. UHCCP will continue to analyze opportunities to improve. UHCCP is looking closely at how health disparities might affect member compliance with these rates. The following programs include components related to improving the health of members with high blood pressure and diabetics are new and on-going projects and programs: UHCCP's performance improvement project objective was to improve cardiometabolic monitoring and outcomes for Health and Recovery Plan members with diabetes mellitus. UHCCP analyzed barriers and developed interventions to increase the rates of members with diabetes whose most recent HbA1c results (< 8%) demonstrate adequate control as well as those individuals for blood pressure control or for smoking cessation during	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				measurement years 2022-2023. Improving cardiometabolic monitoring and outcomes for members with diabetes mellitus will: ▪ Increase the rate of diabetic members with HbA1c adequate control, defined as members with HbA1c <8%, increase the rate of diabetic members who have blood pressure control, defined as members with <140/90 mmHg, and increasing the number of members utilizing smoking cessation options of pharmacotherapy for smoking cessation, smoking cessation counseling or both. ▪ The study indicators measure facilitation, coordination, and communication between physical and behavioral health teams through care management staff. Case management staff ensure members are connected with the care and services they need in a timely fashion. UnitedHealthcare is not using data sampling: all data are reported and the remeasurement period is quarterly. Data collection includes sources from PSYCKES, HEDIS software, and internal data bases such as physical health/behavioral health/pharmacy claims and membership data. The patient care opportunity report is a comprehensive report which allows providers to get details about preventive care opportunities for their UHCCP patients. Providers will receive monthly patient care opportunity report lists with member level details. On a monthly basis, clinical practice consultants will reinforce the patient care opportunity reports by engaging with providers and communicating the importance of educating their patients regarding scheduling preventative care appointments. Medication adherence emails go out to members aged 18 years and older with diabetes, asthma, and heart disease to provide	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				educational information to help members remember to take medication as prescribed to stay healthy and discuss medication adherence with their primary care provider. The email has links to the landing page (myuhc.com/Community plan), find a provider, and 24/7 online access. Members who fall into scope for at least one of the following HEDIS measures will be eligible for the campaign: *Controlling High Blood Pressure* and *Asthma Medication Ratio*. Identified members receive an automated interactive voice recording sent to their home phone number. The identified members may be chosen for inclusion based on past lack of compliance or current noncompliance to a specific measure. The voice recording will be a call to action to have a necessary visit, screening, or improved adherence to therapy. The calls implemented based on 10 groupings designed to limit duplicative calls to members. An email campaign providing education and resources to manage blood pressure and "improve your health by checking your numbers and talking to a provider" was sent regularly to members. The email contains three tips to help reach blood pressure goals. Find-a-doctor is included as a resource as well as a landing page (containing frequently asked questions).	
The managed care plan should investigate opportunities to improve women's access to prenatal care.	X		X	Improving access to prenatal care begins with promoting the importance and benefits of prenatal care. Opportunities encompass interactive voice response recordings designed to encourage and engage members to schedule prenatal appointments. One of the most successful programs is the Upstate Summer Program, supporting the large Hasidic community population living in Brooklyn, New York. For several years, UHCCP supported an obstetrics and gynecology office set	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				up in the Catskills area of New York where families vacation every summer from mid-June to mid-August. On a yearly average, between 500 and 700 pregnant women are seen there for prenatal visits. Engaging providers in routine prenatal visits was another important factor in engaging our members in prenatal care. Providers can notify UHCCP immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. Providers can call the Healthy First Steps program directly or complete the digital obstetrical risk assessment form and submit within five days of a woman's first prenatal care visit. Participating providers will receive an incentive bonus which is paid on a quarterly basis.	
Compliance with Medicaid Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the compliance review conducted by the Department of Health.	X	X	X	Based on record review and staff interview, UHCCP and its delegate, United Behavioral Health, failed to provide a written notice to the enrollee within one business day. The initial adverse benefit notice to the member was issued late. This was evident in three of nine Medicaid concurrent cases. On 1/14/2020, a reminder was sent to staff on the importance of meeting compliance of state required turnaround time. On 1/16/2020, Optum/United Behavioral Health provided additional staff coaching via email to the team. A daily dashboard is currently in use on a manual basis and will be automated to optimize performance tracking of Optum/United Behavioral Health inventory. This reporting will allow the inventory to be reviewed daily by leadership. The report will be used to manage and identify cases that require immediate review to ensure turnaround time compliance at least twice a day by leadership. This is in addition to the individual coordinators running their own inventory report to review cases that have been assigned to them. Leadership holds a daily inventory call to review overall	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				turnaround time compliance for all types of denials. The Regulatory Adherence Advisory will be issued to reinforce expectations as to New York State requirements regarding turnaround times, including the issuing of the notice of verbal and written notification by the end of April 2020. The Department of Health's Division of Health Plan Contracting and Oversight accepted the plan of correction on 3/9/2020. Based on record review and staff interview, UHCCP failed to include required components in contract files. UHCCP completed a review of all contracts to ensure that both the 2017 standard clause incorporation language as well as the *21st Century Cures Act Amendment* are included. A provider amendment via mailing went out to the entire provider network with an amendment replacing the *New York State Regulatory Appendix* and *New York State Standard Clauses* with an updated version as required by the state in October 2021. This version addresses previous concerns with discrepancies with language as well as addressing *21st Century Cures Act Amendment* requirements. To ensure the submission and management of any business segment contractual changes to include regulatory or health plan changes are appropriately submitted, the *Health Plan Contract Change Management Policy & Procedure* has been created and implemented. Education was provided to all applicable submitters by March 2022. The associate director of network programs and associate director of provider operations maintain oversight of this process. Once a quarter, a statistical sample of new provider contracts will be pulled across all functional areas to be reconciled utilizing quarterly quality checks of all contractual requirements. Contracts not containing the correct language will be corrected and resubmitted to the	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				provider. Monitoring results, remediation, and process improvements will be reviewed and discussed at the appropriate monthly or quarterly joint operating committees. The Department of Health's Division of Health Plan Contracting and Oversight accepted the plan of correction on 05/14/2020. Based on record review and staff interview, UHCCP failed to include required credential components for two of 20 files. UHCCP worked with the National Credentialing Center team to complete an entire audit of our provider network credentialing files to ensure all applicable components include the Office of Professional Medical Conduct verifications were completed by March 2022. The National Credentialing Center utilized their internal Audit Process for Credentialing Policy and Procedure, to ensure that an audit includes verification that credentialing findings are based on criteria as specified by the current UHCCP credentialing and recredentialing plan and are conducted in a non-discriminatory manner. Quality analysts selected random records, for audit from daily inventory across functional areas. If during the audit process errors were identified, they were submitted for remediation. Moving forward, once a quarter, the associate director of provider operations will utilize the Credentialing and Recredentialing File Preparation Guidelines Submission process which specifies the process and procedures in which the National Credentialing Center shall accept requests from health plans for file preparation for the purpose of regulatory and accreditation audits. This will be utilized to review credentialing/recredentialing files to determine whether the provider record needs to be updated and/or terminated based on a list of reasons through the National Credentialing Center checklist. The credentialing analyst will work with the network	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				data analyst of the provider network data system submission file to continuously monitor and reconcile any provider changes prior to the next quarterly provider network data system submission. The Department of Health's Division of Health Plan Contracting and Oversight accepted the plan of correction on 05/14/2020. Based on record review and staff interview, UHCCP failed to ensure that its delegate, United Behavioral Health, included member-specific information in its denial of services letter. Specifically, the initial adverse benefit notices did not include enrollee-specific clinical/social detail to show how the enrollee did not meet the criteria. This was evident in eight of 20 Medicaid prior-authorization and concurrent cases reviewed. In October 2019, the denial letter template was updated to include member-specific rationale. Additionally, all New York medical directors were educated on the internal guidance related to the updated denial letter template. Lastly, denial letter reviews were added to the monthly internal audits to monitor, ensure compliance, and identify any additional training needed, if necessary. A regulatory adherence validation audit was be conducted in the second quarter of 2020 to determine commitments were met and efforts for regulatory adherence were sustained post the commitment date. Monthly auditing is being conducted of denial letters, specifically that the initial adverse benefit notices include enrollee specific clinical/social detail to show how the enrollee did not meet criteria. The Department of Health's Division of Health Plan Contracting and Oversight accepted the plan of correction on 5/12/2020.	

Strengths, Opportunities for Improvement, and Recommendations

Table 105: UHCCP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	UHCCP's measurement year 2021 performance improvement project passed validation.	X	X	X
	UHCCP exceeded the target rate for three performance indicator.	X	X	X
Performance Measures	UHCCP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	UHCCP performed significantly better than the Health and Recovery Plan program on one measures of effectiveness of care related to primary care.	X	X	
Performance Measures – Access/Availability of Care	UHCCP performed significantly better than the Health and Recovery Plan program on one measure of access/availability of care related to substance use.			
Compliance with Federal Managed Care Standards	During the period under review, UHCCP was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	UHCCP did not meet target rates for eight performance indicators.	X	X	X
Performance Measures – Effectiveness of Care	UHCCP performed significantly worse than the Health and Recovery Plan program on six measures of effectiveness of care related to primary care or mental health.	X	X	
Performance Measures – Access/Availability of Care	None.			
Compliance with Federal Managed Care Standards	During the period under review, UHCCP was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.	X		
Recommendations				

External Quality Review Activity	External Quality Review Organization's Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, UHCCP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	X	X	X
Performance Measures	UHCCP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	X	X	
Compliance with Federal Managed Care Standards	UHCCP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	UHCCP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	X	X	X

Attachment A – Quality Assurance Reporting Requirements for Measurement Year 2021

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Administrative	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	Required	Required	Required	HEDIS 2020-2021
Administrative	Antidepressant Medication Management	AMM	Required	Required	Required	HEDIS 2020-2021
Administrative	Appropriate Testing for Pharyngitis	CWP	Required	Required	Required	HEDIS 2020-2021
Administrative	Appropriate Treatment for Upper Respiratory Infection	URI	Required	Required	Required	HEDIS 2020-2021
Administrative	Asthma Medication Ratio	AMR	Required	Required	Required	HEDIS 2020-2021
Administrative	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	AAB	Required	Not Required	Required	HEDIS 2020-2021
Administrative	Breast Cancer Screening	BCS	Required	Required	Required	HEDIS 2020-2021
Administrative	Cardiac Rehabilitation	CRE	Required	Required	Required	HEDIS 2020-2021
Administrative	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	SMC	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Cervical Cancer Screening	CCS	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Childhood Immunization Status	CIS	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Chlamydia Screening in Women	CHL	Required	Required	Required	HEDIS 2020-2021
Administrative/	Colorectal Cancer Screening	COL	Required	Required	Required	HEDIS

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Hybrid						2020-2021
Administrative/ Hybrid	Comprehensive Diabetes Care	CDC	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Controlling High Blood Pressure	CBP	Required	Required	Required	HEDIS 2020-2021
Administrative	Diabetes Monitoring for People With Diabetes and Schizophrenia	SMD	Required	Required	Required	HEDIS 2020-2021
Administrative	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Required	Required	Required	HEDIS 2020-2021
Survey	Flu Vaccinations for Adults Ages 18 - 64	FVA	Required	Required	Required	CAHPS 5.0H
Administrative	Follow-Up After High Intensity Care for Substance Use Disorder	FUI	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Hospitalization for Mental Illness	FUH	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up Care for Children Prescribed ADHD Medication	ADD	Required	Required	Not Required	HEDIS 2020-2021
Administrative/ Hybrid	Immunizations for Adolescents	IMA	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Kidney Health Evaluation for Patients With Diabetes	KED	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Lead Screening in Children	LSC	Required	Required	Not Required	HEDIS 2020-2021

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Survey	Medical Assistance With Smoking and Tobacco Use Cessation	MSC	Required	Required	Required	CAHPS 5.0H
Administrative	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Non-Recommended Cervical Cancer Screening in Adolescent Females	NCS	Required	Not Required	Not Required	HEDIS 2020-2021
Administrative	Persistence of Beta-Blocker Treatment After a Heart Attack	PBH	Required	Required	Required	HEDIS 2020-2021
Administrative	Pharmacotherapy for Opioid Use Disorder	POD	Required	Required	Required	HEDIS 2020-2021
Administrative	Pharmacotherapy Management of COPD Exacerbation	PCE	Required	Required	Required	HEDIS 2020-2021
Administrative	Risk of Continued Opioid Use	COU	Required	Required	Required	HEDIS 2020-2021
Administrative	Statin Therapy for Patients With Cardiovascular Disease	SPC	Required	Required	Required	HEDIS 2020-2021
Administrative	Statin Therapy for Patients With Diabetes	SPD	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Imaging Studies for Low Back Pain	LBP	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Opioids at High Dosage	HDO	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Opioids from Multiple Providers	UOP	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	Required	Required	Required	HEDIS 2020-2021
Administrative	Viral Load Suppression	VLS	Required	Required	Required	New York State 2020-2021

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Administrative/ Hybrid	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	WCC	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Adults' Access to Preventive/Ambulatory Health Services	AAP	Required	Required	Required	HEDIS 2020-2021
Administrative	Annual Dental Visit	ADV	Required	Not Required	Not Required	HEDIS 2020-2021
Administrative	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET	Required	Required	Required	HEDIS 2020-2021
Administrative	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	POD-N	Required	Required	Required	New York State 2020-2021
Administrative/ Hybrid	Prenatal and Postpartum Care	PPC	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Use of Pharmacotherapy for Alcohol Abuse or Dependence	POA	Required	Required	Required	New York State 2020-2021