# New York State

# Medicaid Managed Care

# HIV Special Needs Plans

# 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 HIV Special Needs Plans that are part of New York's 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: HIV Special Needs 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 HIV Special Needs Plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects. | Conducted performance improvement projects on topics related to mental illness and substance use, or diabetes disease management. | Evaluated how the HIV Special Needs Plans conducted performance improvement projects. |
| Required all HIV Special Needs 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 HIV Special Needs Plans to calculate performance measures rates. |
| Required all HIV Special Needs Plans to comply with federal and state Medicaid standards; and conducted an evaluation to determine HIV Special Needs Plan compliance with these standards. | Presented evidence of compliance with Medicaid standards to the Department of Health. | Reviewed the results of an evaluation of HIV Special Needs Plans compliance with Medicaid standards. |
| Sponsored a quality-of-care survey for all HIV Special Needs 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 HIV Special Needs 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 HIV Special Needs Plans that are part of New York's Medicaid managed care program.

## 2021 External Quality Review

This external quality review technical report focuses on 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.

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[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 | Applicable External Quality Review Protocol | Activity Description |
|---|---|---|
| Activity 1. Validation of Performance Improvement Projects (Required) | Protocol 1 | IPRO reviewed HIV Special Needs 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 HIV Special Needs 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 HIV Special Needs Plans. |

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.

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[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).

# New York State Medicaid Managed Care Program and Medicaid Quality Strategy

## 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.

# HIV Special Needs Plan Profiles

Table 4 displays an overview of each HIV Special Needs Plan profile. For each HIV Special Needs Plan, the table displays the product lines carried and the total HIV Special Needs Plan enrollment for calendar year 2021.

Table 4: Managed Care Plan Corporate Profiles

| Managed Care Plan | HIV Special Needs Program Name | Product Line(s) | Medicaid/Child Health Plus Enrollment as of 12/2021[1] |
|---|---|---|---|
| Amida Care, Inc. (Amida Care) | Medicaid Live Life Plus Plan | Medicaid Managed Care | 7,990 |
| MetroPlus Health Plan, Inc. Special Needs Plan (MetroPlus SNP) | Partnership in Care | Medicaid Managed Care | 4,624 |
| VNS Health, New York (VNS Health) | SelectHealth | Medicaid Managed Care | 2,978 |
| **Statewide HIV Special Needs Plan Enrollment** | | | **15,592** |

[1] Data Source: New York State Office of Health Insurance Programs Medicaid DataMart.

# 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 managed care plans had different performance improvement project topics. Amida Care's project focused on screenings for mental health and substance use disorders. MetroPlus SNP's project focused on transitions of care for mental illness and substance use. VNS Health's project focused on diabetes disease management.

## 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**

- Amida Care exceeded 1 of 7 performance improvement targets.
- MetroPlus SNP exceeded 3 of 11 performance improvement targets.
- VNS Health exceeded 1 of 5 performance improvement targets.

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.

*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 HIV Special Needs Plans' performance improvement projects.

Amida Care aimed to increase screenings and timely follow-up for mental health and substance use disorders in the primary care setting. MetroPlus SNP aimed to improve the quality of transitions of care from the emergency department or inpatient stay to the community for conditions of mental illness and substance use. VNS Health aimed to decrease the number of members with uncontrolled diabetes and the number of inpatient admissions among members with diabetes.

## 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.

Amida Care performance indicator rates are in Table 6; MetroPlus SNP indicator rates are in Table 7; and VNS Health indicator rates are in Table 8.

Details of each managed care plan’s performance improvement project activities are described in the HIV Special Needs 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] |
| Amida Care | Met | Met | Met | Met | Not Applicable | Met | Met | Met | Met | Met |
| MetroPlus SNP | Met | Met | Met | Met | Not Applicable | Met | Met | Met | Met | Met |
| VNS Health | 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: Amida Care's Performance Improvement Project Indicator Rates, Measurement Year 2021

| Indicator | Final Measurement Year 2021 |
|---|---|
| Members Living with HIV Screened Annually for Mental Health – Depression and Anxiety[1] | 5.80% |
| Members Living with HIV Screened Annually for Substance Use – Alcohol or Substance Use Disorder | 5.54% |
| Members Living with HIV Screened at a High-Volume Primary Care Site for Depression | 3.87% |
| Members Living with HIV Screened at a High-Volume Primary Care Site for Alcohol Use or Substance Use | 4.89% |
| Members with a Positive Depression Screen and an Antidepressant Medication Dispensing Event Within 30 Days | 35.29% |
| Members with a Positive Depression Screen and a Follow-Up Visit with a Primary Care Provider Within 30 Days | 100.00% |
| Members with a Positive Depression Screen and a Follow-Up Visit with a Mental Health Provider Within 30 Days | 0.00% |

[1] Anxiety was removed from the measure specifications starting with measurement year 2021.

Table 7: MetroPlus SNP's Performance Improvement Project Indicator Rates, Measurement Year 2021

| Indicator | Final Measurement Year 2021 |
|---|---|
| HEDIS Follow-up After Hospitalization for Mental Illness – 7 Days | 31.03% |
| HEDIS Follow-up After Hospitalization for Mental Illness – 30 Days | 41.38% |
| HEDIS Follow-up After Emergency Department Visit for Mental Illness – 7 Days | 15.79% |
| HEDIS Follow-up After Emergency Department Visit for Mental Illness – 30 Days | 30.26% |
| HEDIS Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence – 7 Days | 25.17% |
| HEDIS Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence – 30 Days | 30.07% |
| HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 65.52% |
| HEDIS Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | 35.34% |
| HEDIS Use of Pharmacotherapy for Alcohol Abuse or Dependence | 20.14% |
| HEDIS Follow-up After High-Intensity Care for Substance Use Disorder – 7 Days | 36.54% |
| HEDIS Follow-up After High-Intensity Care for Substance Use Disorder – 30 Days | 54.81% |

Table 8: VNS Health's Performance Improvement Project Indicator Rates, Measurement Year 2021

| Indicator | Final Measurement Year 2021 |
|---|---|
| Diabetic Members with an Inpatient Hospitalization[1] | 27.40% |
| Diabetic Members Who Received All Tests | 64.56% |
| HEDIS Comprehensive Diabetes Care – HbA1c Test | 94.88% |
| HEDIS Comprehensive Diabetes Care – HbA1c Control <8% | 63.07% |
| HEDIS Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1] | 29.38% |

[1]Lower rate indicates better performance.

# 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 3 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 2021 managed care plan performance measure rates included in this report:
  - 21.3% performed significantly better than statewide HIV Special Needs Plan performance
  - 17.3% performed significantly worse than statewide HIV Special Needs Plan performance
  - 61.3% did not differ in performance from statewide HIV Special Needs Plan performance

Note: Percentages do not total 100% due to rounding.

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 HIV Special Needs 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 9** displays vendors and compliance auditors by managed care plan.

Table 9: HEDIS Vendors and Compliance Auditors

| Managed Care Plan | NCQA-Certified HEDIS Vendor | NCQA-Certified HEDIS Compliance Auditor |
|---|---|---|
| Amida Care | Cotiviti, Inc. | Aqurate Health Data Management, Inc. |
| MetroPlus SNP | Inovalon, Inc. | Aqurate Health Data Management, Inc. |
| VNS Health | Cotiviti, Inc. | Advent Advisory Group, LLC |

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.

### 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 10** displays these standards as well as the elements audited for the standard.

[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.

Table 10: 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 11 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 11: 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.<br>a. For Effectiveness of Care and Effectiveness of Care-like measures when the denominator is fewer than 30.<br>b. For utilization measures that count member months when the denominator is fewer than 360 member months.<br>c. For all risk-adjusted utilization measures when the denominator is fewer than 150.<br>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 11).

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 HIV Special Needs 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 HIV Special Needs Plan 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 12 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 HIV Special Needs 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-five (25) measures from the 2021 Quality Assurance Reporting Requirements program were selected by the Department of Health for inclusion in its evaluation of HIV Special Needs Plan performance under the 2021–2022 Quality Incentive Program. These measures cover primary care, HIV, substance use, and mental health care 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 HIV Special Needs Plans, rates for these measures are presented in this report.

Table 13 through Table 17 display managed care plan rates, statewide averages, and national Medicaid benchmarks for measurement year 2021.

Table 12: 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 |
| Amida Care | Met | Met | Met | Met | Met | Met | Met |
| MetroPlus SNP | Met | Met | Met | Met | Met | Met | Met |
| VNS Health | Met | Met | Met | Met | Met | Met | Met |

NCQA: National Committee for Quality Assurance.

Table 13: 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 | Colorectal Cancer Screening |
| Statewide HIV Special Needs Plan | 55.20% | 40.04% | 32.06% | 65.97% | 75.87% | 64.88% |
| National 2021 Medicaid Mean | 60.80% | 44.06% | Not Available | 51.00% | 56.26% | Not Available |
| National 2021 Medicaid 90th Percentile | 71.26% | 56.24% | Not Available | 61.27% | 66.88% | Not Available |
| Amida Care | 52.92% | 37.43% | 36.01% | 58.94% | 68.13% | 62.77% |
| MetroPlus SNP | 55.64% | 40.60% | 27.10% | 69.35% | 82.73% | 68.37% |
| VNS Health | 63.04% | 48.91% | 30.15% | 72.65% | 81.25% | 64.30% |

**Green shading** indicates managed care plan's 2021 performance is statistically significantly better than the HIV Special Needs 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 HIV Special Needs 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, 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 |
| Statewide HIV Special Needs Plan | 53.18% | 25.08% | 63.78% | 70.19% | 88.55% | 77.78% | 72.97% |
| National 2021 Medicaid Mean | 50.81% | 42.26% | 58.63% | 40.13% | 72.45% | 50.83% | 42.25% |
| National 2021 Medicaid 90th Percentile | 63.75% | 30.90% | 69.19% | 50.70% | 78.70% | 60.10% | 52.69% |
| Amida Care | 38.69% | 26.76% | 58.88% | 64.54% | 88.24% | 76.30% | 73.13% |
| MetroPlus SNP | 62.04% | 19.22% | 75.67% | 69.95% | 87.58% | 82.89% | 75.66% |
| VNS Health | 68.73% | 29.38% | 58.54% | 73.59% | 89.47% | 75.00% | 70.87% |

[1]Lower rate indicates better performance.

**Green shading** indicates managed care plan's 2021 performance is statistically significantly better than the HIV Special Needs 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 HIV Special Needs 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) – Primary Care and HIV Care, Measurement Year 2021

| | Effectiveness of Care – Primary Care Measures (Continued) | | | Effectiveness of Care – HIV Care 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 |
| Statewide HIV Special Needs Plan | 28.85% | 78.45% | 17.67% | 77.56% |
| 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 |
| Amida Care | 35.72% | 77.78% | 16.83% | 73.53% |
| MetroPlus SNP | 16.21% | 78.26% | 14.75% | 81.65% |
| VNS Health | 32.76% | 79.55% | 22.64% | 81.14% |

**Green shading** indicates managed care plan's 2021 performance is statistically significantly better than the HIV Special Needs 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 HIV Special Needs 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 Performance Measures (Continued) – Substance Use and Mental Health, Measurement Year 2021

| | Effectiveness of Care – Substance Use Measure | Effectiveness of Care – Mental Health Measures | | | |
|---|---|---|---|---|---|
| Benchmark/Managed Care Plan | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days | 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) |
| Statewide HIV Special Needs Plan | 26.75% | 59.43% | 98.07% | 38.78% | 37.04% |
| National 2021 Medicaid Mean | 13.35% | 59.65% | Not Available | 40.08% | 38.44% |
| National 2021 Medicaid 90th Percentile | 21.97% | 72.94% | Not Available | 60.58% | 54.55% |
| Amida Care | 28.61% | 51.36% | 97.76% | 48.33% | 37.50% |
| MetroPlus SNP | 25.17% | 65.52% | 99.37% | 15.79% | 34.48% |
| VNS Health | 21.33% | 75.00% | 97.48% | 21.28% | 38.89% |

**Green shading** indicates managed care plan's 2021 performance is statistically significantly better than the HIV Special Needs 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 HIV Special Needs 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 17: Access/Availability of Care Performance Measures – Primary Care and Substance Use, Measurement Year 2021

| | Access/Availability of Care – Primary Care Measures | | Access/Availability of Care – Substance Use Measure |
|---|---|---|---|
| Benchmark/Managed Care Plan | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total) | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total) | Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence |
| Statewide HIV Special Needs Plan | 47.56% | 11.06% | 32.24% |
| National 2021 Medicaid Mean | 44.16% | 13.87% | Not Available |
| National 2021 Medicaid 90th Percentile | 52.81% | 22.12% | Not Available |
| Amida Care | 34.42% | 9.15% | 33.21% |
| MetroPlus SNP | 73.70% | 14.39% | 35.34% |
| VNS Health | 61.11% | 13.58% | 26.42% |

**Green shading** indicates managed care plan’s 2021 performance is statistically significantly better than the HIV Special Needs 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.

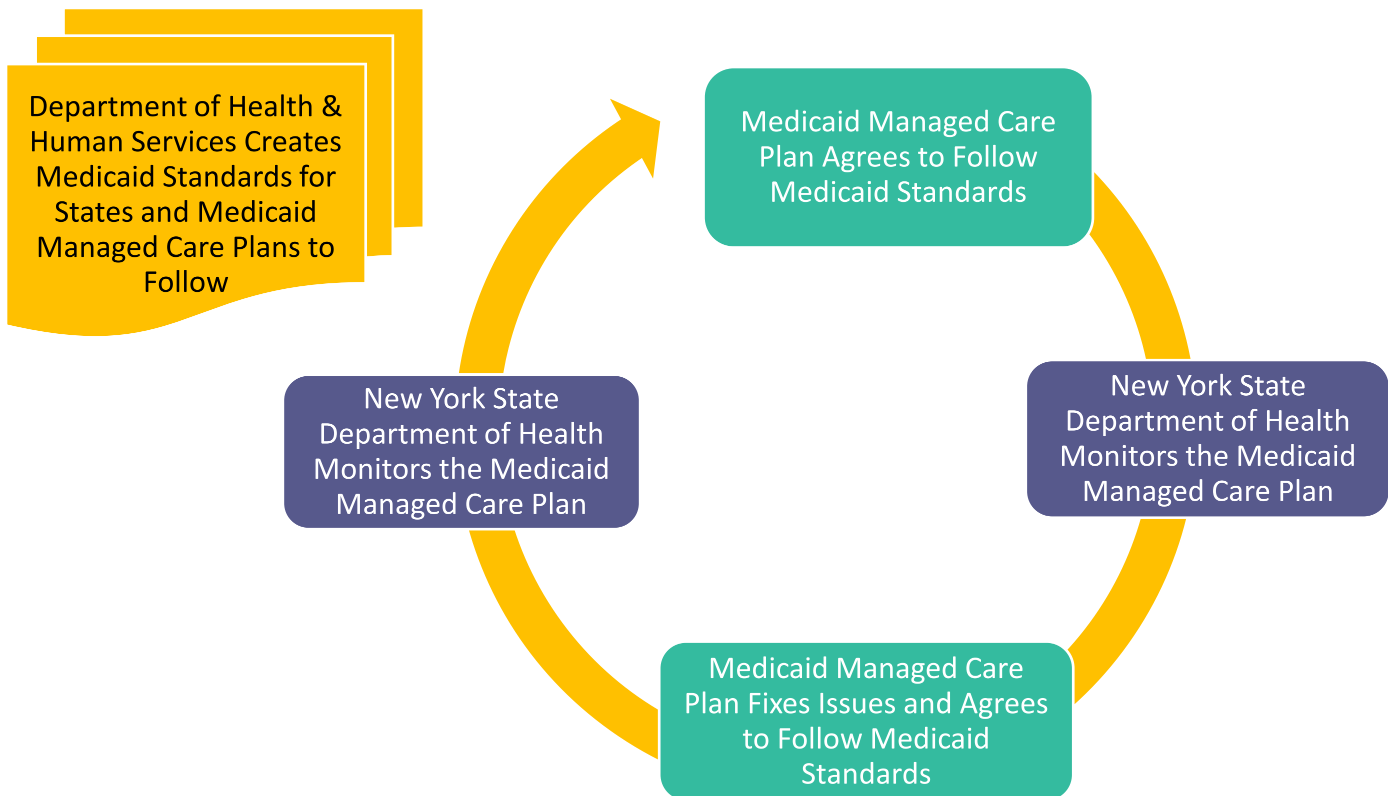
**Red shading** indicates managed care plan's 2021 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically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

The results of the most recent compliance activities conducted for the HIV Special Needs 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 18. In Table 18, 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 HIV Special Needs Plan-Level Reporting section of this report.

Table 18: 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Amida Care | 2019 Activity | C | C | C | C | C | C | C | C | C | C | C |
| | 2020 Pended[1] | | | | | | | | | | | |
| | 2021 Activity | C | C | C | C | C | C | NC | NC | C | C | C |
| MetroPlus SNP | 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 |
| VNS Health | 2019 Activity | NC | C | C | C | C | C | NC | C | C | C | C |
| | 2020 Pended[1] | | | | | | | | | | | |
| | 2021 Activity | C | C | C | C | C | 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: HIV Special Needs Plan is in compliance with all standard requirements; NC: HIV Special Needs 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 HIV Special Needs 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 HIV Special Needs Plan and provider performance. The HIV Special Needs Plan 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 an HIV Special Needs 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 CAHPS 5.1H Adult Medicaid Health Plan Survey* on behalf of all Medicaid managed care 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 *CAHPS 5.0H Adult Medicaid Health Plan 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 19** provides more detail on how the 69 survey questions are categorized.

Table 19: CAHPS Categories and Response Options

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

Adults who were current members of a New York State Medicaid managed care plan, ages 18 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 26,000 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 20 provides a summary of the technical methods of data collection.

Table 20: 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 | 3 |
| Type of Medicaid Managed Care Plan | HIV Special Needs Plans |
| Survey Timeframe | 10/14/21 to 1/13/22 |
| Method of Collection | Mail only, three waves |
| Sample Size | 6,000 |
| Number of Completed Surveys | 1,401 |
| Response Rate | 23.5% |

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.

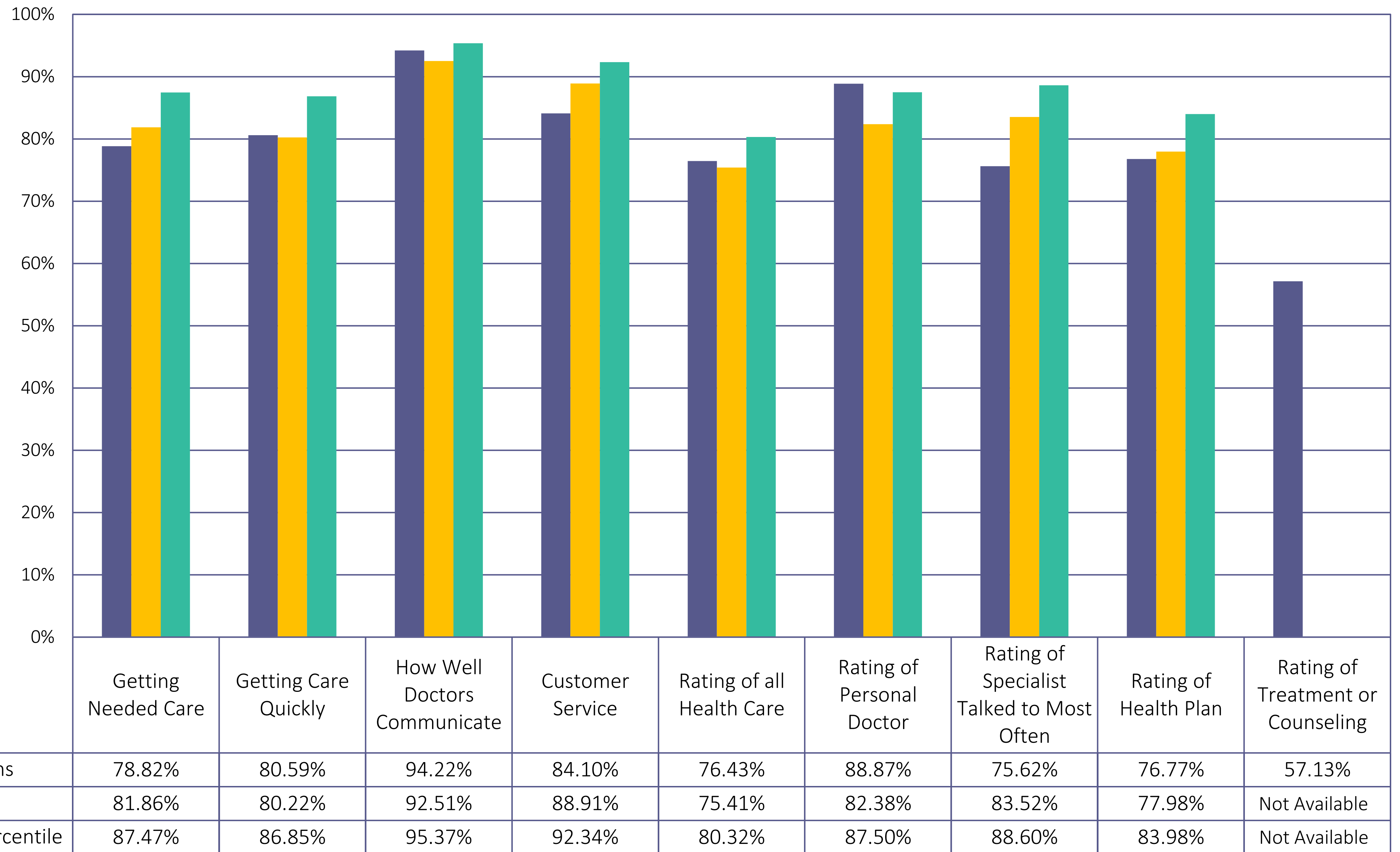
Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

## Description of Data Obtained

IPRO received a copy of the *New York State HIV Special Needs Plans (SNP) 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 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 21.




| | 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 HIV Special Needs Plans | 78.82% | 80.59% | 94.22% | 84.10% | 76.43% | 88.87% | 75.62% | 76.77% | 57.13% |
| 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 HIV Special Needs Plans statewide (dark blue), National Medicaid Mean for (yellow) and National Medicaid 90th Percentile (green) for 2021.

Table 21: CAHPS Achievement Scores by Region and 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 HIV Special Needs Plans | 78.82% | 80.59% | 94.22% | 84.10% | 76.43% | 88.87% | 75.62% | 76.77% | 57.13% |
| 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 |
| Amida Care | 74.46% | 78.62% | 93.98% | 80.01% | 76.58% | 86.30% | 75.70% | 75.55% | 48.37% |
| MetroPlus SNP | 79.91% | 81.14% | 93.88% | 86.55% | 76.73% | 90.06% | 71.09% | 76.05% | 62.64% |
| VNS Health | 82.10% | 81.99% | 94.79% | 85.75% | 75.99% | 90.25% | 80.08% | 78.72% | 60.38% |

[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 HIV Special Needs 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 HIV Special Needs 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.

# HIV Special Needs 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 HIV Special Needs 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 HIV Special Needs Plan-level HEDIS/Quality Assurance Reporting Requirements 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 as 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 HIV Special Needs 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 required standard was considered an opportunity for improvement.

## Quality-of-Care Survey Results – Member Experience

This section displays the HIV Special Needs 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 years 2017, 2019, and 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 scoring 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 22 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the 2020 external quality review recommendations.

Table 22: 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 HIV Special Needs 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.

# Amida Care

## Performance Improvement Project Summary and Results

Table 23: Amida Care's Performance Improvement Project Summary, Measurement Year 2021

| Amida Care's Performance Improvement Project Summary |
|---|
| Title: Improving Screening Rates for Mental Health Disorders and Substance Use by Primary Care Providers for HIV SNP Enrollees<br>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. |
| Aim<br>Amida Care aims to effectively track and evaluate the behavioral health screening rates of its membership in the primary care setting, and in turn, to address any concerns or deficiencies with providers.<br><br>Member-Focused 2021 Interventions<br>▪ Outreached to members identified by positive depression screening to encourage completing appointments and to facilitate the office visit if needed.<br><br>Provider-Focused 2021 Interventions<br>▪ Collaborated with providers to understand the process of how members were screened for behavioral health concerns and how the process was monitored.<br>▪ Distributed quarterly data to providers, including screening rates and members identified as needing a screening.<br>▪ Requested that providers share with Amida Care a monthly listing of members with a positive depression screening and who require a behavioral health contact.<br>▪ Provided feedback to provider clinical groups on assessment findings, and discussed improvements to mental health and substance abuse screening and management practices.<br><br>Managed Care Plan-Focused 2021 Interventions<br>▪ Developed a supplemental data submission process for providers. |

Table 24: Amida 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 | Target/Goal |
|---|---|---|---|---|---|
| Members Living with HIV Screened Annually for Mental Health – Depression and Anxiety[1] | 4.96% | 14.37% | 13.19% | 5.80% | 20.00% |
| Members Living with HIV Screened Annually for Substance Use – Alcohol or Substance Use Disorder | 10.55% | 11.51% | 9.67% | 5.54% | 16.00% |
| Members Living with HIV Screened at a High-Volume Primary Care Site for Depression[2] | 87.93% | See Table Note 2 | 34.53% | 3.87% | 70.00% |
| Members Living with HIV Screened at a High-Volume Primary Care Site for Alcohol Use or Substance Use | New Measure in 2020 | New Measure in 2020 | 18.70% | 4.89% | 64.00% |
| Members with a Positive Depression Screen and an Antidepressant Medication Dispensing Event Within 30 Days | New Measure in 2020 | New Measure in 2020 | 42.79% | 35.29% | 85.00% |
| Members with a Positive Depression Screen and a Follow-Up Visit with a Primary Care Provider Within 30 Days | New Measure in 2020 | New Measure in 2020 | 82.98% | 100.00% | 85.00% |
| Members with a Positive Depression Screen and a Follow-Up Visit with a Mental Health Provider Within 30 Days | New Measure in 2020 | New Measure in 2020 | 78.72% | 0.00% | 85.00% |

[1] Anxiety was removed from the measure specifications starting with measurement year 2021.

[2] The measurement year 2018 baseline rate was established in 2019, and Amida Care did not report a measurement year 2019 rate. The measurement year 2018 rate was calculated using medical record documentation, while the measurement year 2020 rate was calculated using administrative data.

## Performance Measure Results

Table 25: Amida Care's Performance Measure Results, Measurement Years 2019 to 2021

| Measure | Amida Care Measurement Year 2019 | Amida Care Measurement Year 2020 | Amida Care Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| **Effectiveness of Care - Primary Care Measures** | | | | |
| Antidepressant Medication Management – Effective Acute Phase Treatment | 47.65% | 52.57% | 52.92% | 55.20% |
| Antidepressant Medication Management – Effective Continuation Phase Treatment | 33.86% | 36.25% | 37.43% | 40.04% |
| Asthma Medication Ratio (19–64 Years) | 31.37% | 34.93% | 36.01% | 32.06% |
| Breast Cancer Screening | 65.39% | 59.36% | 58.94% | 65.97% |
| Cervical Cancer Screening | 74.91% | 73.97% | 68.13% | 75.87% |
| Colorectal Cancer Screening | 59.35% | 55.47% | 62.77% | 64.88% |
| Comprehensive Diabetes Care – Eye Exam | 55.23% | 50.12% | 38.69% | 53.18% |
| Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1] | 31.39% | 32.36% | 26.76% | 25.08% |
| Controlling High Blood Pressure | 51.82% | 54.26% | 58.88% | 63.78% |
| Flu Shots for Adults[2] | 73.02% | 73.02% | 64.54% | 70.19% |
| Advising Smokers to and Tobacco Users to Quit[2] | 94.04% | 94.04% | 88.24% | 88.55% |
| Discussing Cessation Medications[2] | 87.33% | 87.33% | 76.30% | 77.78% |
| Discussing Cessation Strategies[2] | 76.97% | 76.97% | 73.13% | 72.97% |
| Kidney Health Evaluation for Patients with Diabetes (Total) | New Measure in 2020 | First Year Measure[3] | 35.72% | 28.85% |
| Statin Therapy for Patients with Cardiovascular Disease – Adherence 80% | 76.84% | 78.33% | 77.78% | 78.45% |
| Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease | 20.51% | 16.38% | 16.83% | 17.67% |
| **Effectiveness of Care - HIV Care Measure** | | | | |
| Viral Load Suppression | 76.38% | 74.03% | 73.53% | 77.56% |
| **Effectiveness of Care - Substance Use Measures** | | | | |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days | 28.91% | 33.43% | 28.61% | 26.75% |
| **Effectiveness of Care - Mental Health Issues Measures** | | | | |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 47.77% | 51.78% | 51.36% | 59.43% |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | 99.34% | 96.60% | 97.76% | 98.07% |
| Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total) | 62.95% | 48.21% | 48.33% | 38.78% |

| Measure | Amida Care Measurement Year 2019 | Amida Care Measurement Year 2020 | Amida Care Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| Follow-Up After Hospitalization for Mental Illness – 7 Days (Total) | 43.79% | 35.47% | 37.50% | 37.04% |
| **Access/Availability of Care - Primary Care Measures** | | | | |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total) | 55.15% | 49.11% | 34.42% | 47.56% |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total) | 15.74% | 12.04% | 9.15% | 11.06% |
| **Access/Availability of Care - Substance Use Measures** | | | | |
| Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | 23.65% | Not Available | 33.21% | 32.24% |

[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 managed care plan’s performance for the measurement year is statistically significantly better than the HIV Special Needs 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 managed care plan's performance for the measurement year is statistically significantly worse than the HIV Special Needs 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 26: Amida Care's Compliance with Federal Medicaid Standards Results

| Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards | 2019 | 2020[1] | 2021 |
|---|---|---|---|
| 438.206: Availability of Services | C | Activity Pended | C |
| 438.207: Assurances of Adequate Capacity and Services | C | Activity Pended | C |
| 438.208: Coordination and Continuity of Care | C | Activity Pended | C |
| 438.210: Coverage and Authorization of Services | C | Activity Pended | C |
| 438.214: Provider Selection | C | Activity Pended | C |
| 438.224: Confidentiality | C | Activity Pended | C |
| 438.228: Grievance and Appeal System | C | Activity Pended | NC |
| 438.230: Sub-contractual Relationships and Delegation | C | Activity Pended | NC |
| 438.236: Practice Guidelines | C | Activity Pended | C |
| 438.242: Health Information Systems | C | Activity Pended | C |
| 438.330: Quality Assessment and Performance Improvement Program | C | Activity 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: HIV Special Needs Plan is in compliance with all standard requirements; NC: HIV Special Needs Plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on the interview and documentation during the contract review of the full operational survey between 7/12/2021 and 7/23/2021, it was identified that Amida Care had failed to submit three one-year renewals to the Department of Health for review and approval. The term for the Productive Processing, Inc. Agreement was for five years effective 2/1/17. The Agreement stated at the end of the initial two year-term, the contract would automatically renew for successive three one-year terms. Amida Care failed to submit the contract renewals for years three, four and five for review and approval on 2/1/2019, 2/1/2020, and 2/1/2021. The contract term ends 1/31/2022. *(Contract Article 2005-98-1.11[k], 2005-98-1.11[s])*
- Based on record review and staff interview, it was determined that Amida Care and its delegates Beacon and Monroe, failed to provide verbal and/or written notice to the enrollee and/or the enrollee's health care provider of the approved services within three business days of the initial adverse determination. This was evident in five of 32 Medicaid approvals. Specifically, cases #1 and #5 had no evidence of verbal notification; Monroe cases #58 and #59 had no evidence of verbal and written notification; and Beacon case #31 had no evidence of written notification to member. *(Contract Article 4903.)*
- Based on interview and documentation reviewed Amida Care failed to submit two management services agreements to the Department of Health for review prior to expiration. Specifically, the management services agreement between Amida Care and Davis Vision, Inc. was set to expire on 3/31/2021 and as of the date of this operational survey, this agreement has not been submitted for review and approval by the Department of Health; and during the fraud waste and abuse interview on 7/19/2021, it was discovered Amida Care failed to submit to the Department of Health for review and approval a management services agreement between Amida Care and T&M Protection Resources, LLC. T&M Protection Resources, LLC operates Amida Care's full time special investigation unit and, Amida failed to submit the management services agreement 90 days prior to the 3/29/2017 effective date. *(Contract Article 2005-98-1.11[k])*

## Quality-of-Care Survey Results – Member Experience

Table 27: Amida Care's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

| Measure | Measurement Year 2017 | | Measurement Year 2019 | | Measurement Year 2021 | |
|---|---|---|---|---|---|---|
| | Amida Care | HIV Special Needs Average | Amida Care | HIV Special Needs Average | Amida Care | HIV Special Needs Average |
| Getting Needed Care[1] | 81.05% | 80.41% | 82.72% | 82.83% | 74.46% | 78.82% |
| Getting Care Quickly[1] | 88.69% | 85.71% | 84.07% | 85.90% | 78.62% | 80.59% |
| How Well Doctors Communicate[1] | 93.10% | 93.25% | 95.29% | 95.09% | 93.98% | 94.22% |
| Customer Service[1] | 91.87% | 90.36% | 92.06% | 89.89% | 80.01% | 84.10% |
| Rating of All Health Care[2] | 77.18% | 79.16% | 78.16% | 78.50% | 76.58% | 76.43% |
| Rating of Personal Doctor[2] | 87.39% | 88.40% | 86.22% | 88.45% | 86.30% | 88.87% |
| Rating of Specialist Talked to Most Often[2] | 77.25% | 78.70% | 76.53% | 79.49% | 75.70% | 75.62% |
| Rating of Health Plan[2] | 80.14% | 79.43% | 83.77% | 82.17% | 75.55% | 76.77% |
| Rating of Treatment or Counseling[2] | 62.84% | 64.24% | 56.95% | 64.62% | 48.37% | 57.13% |

[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 performance for the measurement year is statistically significantly better than the corresponding HIV Special Needs Plan statewide measurement year 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 performance for the measurement year is statistically significantly worse than the corresponding HIV Special Needs Plan statewide measurement year 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 28: Amida Care's Response to the Previous Year's Recommendations

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| **Validation of Performance Improvement Projects** | | | | | |
| The managed care plan should investigate additional interventions as these indicators did not meet the target goals. | X | X | | The COVID pandemic may have impacted access to care resulting in a low baseline and remeasurement rate in the study. Certain screenings occur typically during annual visits which were limited in 2020, when most visits were rendered via telehealth.<br>Amida Care has taken the following steps to improve screening rates and capture data for depression and substance use disorder over the next 12-18 months:<br>▪ Screening rates for depression and substance use are included as quality measures in the current/future value-base payment contracts<br>▪ Obtain data extracts on screening from electronic medical records from high-volume provider partners on a regular basis<br>▪ Educate providers on submitting appropriate codes via claims for depression and substance use screening services<br>▪ Collect data on depression and substance use screening from low-volume providers through chart review<br>▪ Amida Care will monitor the progress on above projects via updated screening rates at the provider level. Feedback on coding practices and opportunity for data submission will be shared at the quarterly meetings with the high-volume/value-based contact providers. | Partially Addressed |
| **Validation of Performance Measures** | | | | | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| The managed care plan should investigate interventions to improve members accessing cancer screenings. | X | | | In 2022, Amida Care implemented the following initiatives to improve cancer screening rates (colorectal, breast and cervical) and capture service data:<br>▪ Include above quality measures in the value-based contracts with providers<br>▪ Additional activities to improve uptake of member incentive program (Healthy Rewards) to motivate members to get screened<br>▪ Implement targeted campaigns – e.g., FOBT kit mailing to members via lab partner, member outreach to schedule mammograms<br>▪ Sharing of regular gaps in care report with providers<br>▪ Ongoing collection of historical screening data via data exchange with value-based payment sites<br>▪ Chart abstraction for screening information at non-value-based payment sites<br>▪ Member education by Member Services Representative during incoming calls or via targeted outreach<br>▪ Performance incentives for non-value-based payment and/or low-volume providers (Effective date 2023)<br><br>Success of above initiatives is measured by updating the measure rates every other month. The overall goal of these initiatives is to exceed the New York statewide average as the primary goal and the New York State 75th percentile benchmark as a stretch goal for measurement year 2022/2023. Progress and success on these initiatives is evaluated at least quarterly and the activities modified, if necessary, to meet the project objectives. | Partially Addressed |
| The managed care plan should investigate opportunities to improve | X | X | | As part of its quality improvement activities, Amida Care launched the following initiatives to improve viral load | Partially Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| the health of members with diabetes, HIV, and cardiovascular disease. | | | | suppression rates and management of chronic conditions including diabetes and cardiovascular disease:<br>▪ Include above quality measures in the value-based contracts with providers<br>▪ Cross-functional initiative (VLS Project) to improve monitoring, data collection, promote intensive case management and increase member/provider outreach<br>▪ Increase uptake of member incentive program (Live Your Life-Undetectable) to engage members in timely monitoring and follow up activities<br>▪ Sharing of regular gaps in care report with providers<br>▪ Treatment adherence program -field based workers educate members on disease mgmt., and antiretroviral medication adherence<br>▪ Academic detailing of providers by pharmacists – addressing member barriers, and exploring various ways Amida Care can provide support to providers to help improve patient's adherence, such as treatment adherence program, directly observed therapy, restriction, case management and referral to Health Homes/Adult Day Health Care.<br>▪ Ongoing collection of lab and clinical data via data exchange with value-based payment sites<br>▪ Chart abstraction for lab results at non-value-based payment/low-volume sites<br>▪ Ongoing receipt of lab results data from lab partners, regional health information organizations and New York State Department of Health<br>▪ Member education by member services Representative during incoming calls or via targeted outreach | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| | | | | ▪ Performance incentives for non-value-based payment and/or low-volume providers (Effective date 2023)<br><br>Performance on above initiatives is tracked and discussed regularly among the cross-functional team members, and activities modified, as needed. The measure performance is also discussed with the high-volume sites at the quarterly value-based payment meeting. The overall goal of these initiatives is to exceed the New York statewide average as the primary goal and the New York State 75th percentile benchmark as a stretch goal for measurement year 2022/2023. | |
| The managed care plan should investigate opportunities to improve follow-up care for members with a substance use disorder and improve access to medication management for members with depression or schizophrenia. | X | X | | Of note, certain substance use disorder services may not necessarily be captured via claims, as they are provided by harm reduction and ADHC programs.<br><br>Following initiatives were implemented to improve medication adherence, access, and follow up care for behavioral health/substance use disorders:<br>▪ Sharing regional health information organization alerts with managed behavioral health organization vendor informing of members presenting to hospital with a behavioral health/substance use disorder diagnosis to ensure timely follow up and connection to services<br>▪ Partnering with behavioral health vendor to improve access to medication assisted treatment:<br>    ▫ Promote MATTERS program that aims to connect members with opioid use disorder to medication assisted treatment providers and substance use disorder programs. Amida Care will be able to provide referrals to connect members to those services. | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| | | | | ▫ Promote Changing Pathways program that uses medication assisted treatment during detox/rehab.<br>▪ Improving screening at primary care provider sites and appropriate referrals would improve medication management for depression or schizophrenia.<br>▪ Pharmacy initiative in collaboration with behavioral health vendor promoting long-acting injectable drugs for schizophrenia, as well as managed behavioral health organization's medical director's consultation with behavioral health providers of members receiving anti-psychotics who are at risk of failing the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure.<br>▪ Campaigns – M-Pulse, texting campaign promoting adherence to medications, targeting members receiving anti-depressants<br>▪ Focus on transition of care of hospitalized members by Amida Care's care coordinators team, to ensure medication reconciliation and proper follow-up | |
| The managed care plan should investigate opportunities to improve members access to preventive/ambulatory services and alcohol and drug abuse treatments. | X | X | X | Amida Care has implemented several quality improvement projects in collaboration with its stakeholders; these projects should improve access to medical care across the Amida Care membership:<br>▪ Gaps in care data shared with providers to outreach and engage members in care<br>▪ Member outreach to educate on preventive services and facilitate scheduling provider visits<br>▪ Vendor outreach programs to promote necessary services i.e. annual eye exam, preventive dental visit, etc. | Partially Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| | | | | ▪ Member outreach programs to re-engage members who are lost to care<br>▪ Provider incentives (value-based payment and direct programs) to improve preventive screening and management of chronic conditions<br><br>The NCQA HEDIS *Adults Access to Preventive/Ambulatory Health Services* measure is tracked and updated on a regular basis. The goal is to exceed the New York statewide average as the primary goal and the New York State 75th percentile benchmark as a stretch goal for measurement year 2022/2023. Progress and success on these initiatives is evaluated at least quarterly and the activities modified, if necessary, to meet the project objectives.<br><br>Amida Care is closely working with its behavioral health vendor to improve access to care as outlined in the projects below:<br>▪ Partnering with behavioral health vendor to improve access to medication assisted treatment:<br>  ▫ Promote MATTERS program that aims to connect members with opioid use disorder to medication assisted treatment providers and substance use disorder programs. Amida Care will be able to provide referrals to connect members to those services<br>  ▫ Promote Changing Pathways program that uses medication assisted treatment in the course of detox/rehab.<br>▪ Working with behavioral health organization to evaluate/analyze access and availability by geography to better understand barriers to access and formulate solutions | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | Amida Care's Response | IPRO's Assessment of Amida Care's Response |
|---|---|---|---|---|---|
| | | | | ▪ Sharing regional health information organization alerts with behavioral health vendor informing of members presenting to hospital with a behavioral health/substance use disorder diagnosis to ensure timely follow up and connection to services<br><br>Amida Care reviews utilization and access and availability metrics with the behavioral health vendor at the quarterly delegated vendor oversight meeting. Also, performance on the HEDIS access to care measure is tracked on a regular basis. | |
| Review of Compliance with Medicaid and Children's Health Insurance Program Standards | | | | | |
| None. | | | | No response required. | Not Applicable |

## Strengths, Opportunities for Improvement, and Recommendations

Table 29: Amida Care's Strengths, Opportunities, and Recommendations

| External Quality Review Activity | External Quality Review Organization's Assessment/Recommendation | Quality | Timeliness | Access |
|---|---|---|---|---|
| **Strengths** | | | | |
| Performance Improvement Project | Amida Care's measurement year 2021 performance improvement project passed validation. | X | X | X |
| | Amida Care exceeded the target rate for one performance indicator related to follow-up care following a positive depression screen. | X | X | X |
| Performance Measures | Amida 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 | Amida Care performed significantly better than the HIV Special Needs Plan program on three measures of effectiveness of care related to primary care or mental health issues. | X | X | X |
| Compliance with Federal Managed Care Standards | During the period under review, Amida 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 | Amida Care did not meet target rates for six performance indicators related to screenings for mental health and substance use and timely follow-up for positive screens. | X | X | X |
| Performance Measures – Effectiveness of Care | Amida Care performed significantly worse than the HIV Special Needs Plan program on seven measures of effectiveness of care related to primary care, HIV care, or mental health issues. | X | X | X |
| Performance Measures – Access/Availability of Care | Amida Care performed significantly worse than the HIV Special Needs Plan program on two measures of access/availability of care related to primary care. | | X | X |
| Compliance with Federal Managed Care Standards | During the period under review, Amida 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 | Amida Care performed significantly worse than the HIV Special Needs Plan program on three measures of member satisfaction. | X | X | X |
| **Recommendations** | | | | |
| Performance Improvement Project | As the performance improvement project focused on care at select high-volume practices, Amida Care should evaluate mental health and substance use screens across its entire membership. This will allow Amida Care to determine if the performance improvement outcomes are global or specific to the high-volume sites. | X | X | X |
| Performance Measures | Amida 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, Amida Care should focus on the areas of care in which its rates did not meet HIV Special Needs program performance. | X | X | X |
| Compliance with Federal Managed Care Standards | Amida 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 | Amida Care should work to improve its performance on measures of member satisfaction, for which it did not meet the HIV Special Needs Plan program average. | X | X | X |

## MetroPlus SNP

### Performance Improvement Project Summary and Results

Table 30: MetroPlus SNP's Performance Improvement Project Summary, Measurement Year 2021

| MetroPlus SNP's Performance Improvement Project Summary |
| --- |
| Title: Care Transitions after Emergency Department and Inpatient Admissions<br>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. |
| Aim<br>MetroPlus SNP aims to reduce subsequent emergency department visits and inpatient readmissions by improving care transitions after initial emergency department treatment and initial inpatient admissions.<br><br>Member-Focused 2021 Interventions<br>▪ Enhanced inpatient discharge planning process to include member education on available services, social supports, and community resources; member connection to a peer-support specialist; and telephonic case management by Beacon that included education on medication-assisted treatment options.<br>▪ MetroPlus SNP field-based case managers educated members on the importance of aftercare treatment engagement, medication adherence, and the availability of home-based therapy services.<br>▪ Reconnected members with health home of enrollment and provided health home referrals to unlinked members.<br>▪ MetroPlus SNP field-based case managers referred homeless members and members with unstable housing to the MetroPlus internal housing specialist for housing assessments.<br>▪ Follow-up outreach regarding aftercare was conducted via text messaging for members identified as receiving emergency room department care.<br><br>Provider-Focused 2021 Interventions<br>▪ Beacon medical directors collaborated with attending physicians to integrate medication-assisted treatment into the discharge planning process.<br>▪ Conducted quarterly trainings on the topics of care coordination and member consent.<br><br>Managed Care Plan-Focused 2021 Interventions<br>▪ Notified health homes of inpatient admissions to coordinate care and promote communication between the inpatient discharge team and the health home staff.<br>▪ MetroPlus SNP utilization management and case management staff worked with facility staff to address member needs during the discharge planning process.<br>▪ Monitored trends to determine the need for facility-specific interventions.<br>▪ Outreached to assertive community treatment teams managing member care with admission notifications and care consultation.<br>▪ Utilization management and care management staff rounded inpatient admissions for substance use disorder with Beacon to determine the appropriateness of medication-assisted treatment.<br>▪ Case managers obtained executed member consent forms for inpatient substance use disorder and for care coordination that includes treating providers and community and family support.<br>▪ Developed and issued a tip sheet that highlighted the importance of member consent to care coordination to all substance use disorder facilities.<br>▪ MetroPlus SNP requested regional health information organization connectivity with New York Care Information Gateway to access emergency room data for plan members. |

Table 31: MetroPlus SNP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

| Indicator | Baseline Measurement Year 2018 | Interim Measurement Year 2019 | Interim Measurement Year 2020[1] | Final Measurement Year 2021 | Target/Goal |
|---|---|---|---|---|---|
| HEDIS Follow-up After Hospitalization for Mental Illness – 7 Days | 35.63% | 35.29% | 38.18% | 31.03% | 38.63% |
| HEDIS Follow-up After Hospitalization for Mental Illness – 30 Days | 57.47% | 55.88% | 49.09% | 41.38% | 60.47% |
| HEDIS Follow-up After Emergency Department Visit for Mental Illness – 7 Days | 68.12% | 36.78% | 43.04% | 15.79% | 71.12% |
| HEDIS Follow-up After Emergency Department Visit for Mental Illness – 30 Days | 73.91% | 52.87% | 54.43% | 30.26% | 76.91% |
| HEDIS Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence – 7 Days | 25.66% | 36.91% | 28.69% | 25.17% | 28.66% |
| HEDIS Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence – 30 Days | 30.09% | 48.99% | 35.25% | 30.07% | 33.09% |
| HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 52.34% | 57.00% | 63.64% | 65.52% | 55.34% |
| HEDIS Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | 33.33% | 33.10% | 47.37% | 35.34% | 36.33% |
| HEDIS Use of Pharmacotherapy for Alcohol Abuse or Dependence | 5.93% | 9.51% | 24.72% | 20.14% | 8.93% |
| HEDIS Follow-up After High-Intensity Care for Substance Use Disorder – 7 Days | 22.52% | 49.74% | 50.98% | 36.54% | 25.50% |
| HEDIS Follow-up After High-Intensity Care for Substance Use Disorder – 30 Days | 48.20% | 82.01% | 97.06% | 54.81% | 51.20% |

[1] Measurement year 2020 data has been revised since the publication of the *New York State Medicaid Managed Care HIV Special Needs Plans 2020 External Quality Review Annual Technical Report*.

## Performance Measure Results

Table 32: MetroPlus SNP's Performance Measure Results, Measurement Years 2019 to 2021

| Measure | MetroPlus SNP Measurement Year 2019 | MetroPlus SNP Measurement Year 2020 | MetroPlus SNP Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| Effectiveness of Care - Primary Care Measures | | | | |
| Antidepressant Medication Management – Effective Acute Phase Treatment | 60.28% | 63.04% | 55.64% | 55.20% |
| Antidepressant Medication Management – Effective Continuation Phase Treatment | 41.84% | 49.28% | 40.60% | 40.04% |
| Asthma Medication Ratio (19–64 Years) | 30.50% | 26.27% | 27.10% | 32.06% |
| Breast Cancer Screening | 77.14% | 69.54% | 69.35% | 65.97% |
| Cervical Cancer Screening | 90.75% | 82.48% | 82.73% | 75.87% |
| Colorectal Cancer Screening | 71.53% | 65.21% | 68.37% | 64.88% |
| Comprehensive Diabetes Care – Eye Exam | 61.80% | 51.34% | 62.04% | 53.18% |
| Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1] | 21.65% | 25.30% | 19.22% | 25.08% |
| Controlling High Blood Pressure | 85.40% | 74.94% | 75.67% | 63.78% |
| Flu Shots for Adults[2] | 74.38% | 74.38% | 69.95% | 70.19% |
| Advising Smokers to and Tobacco Users to Quit[2] | 91.95% | 91.95% | 87.58% | 88.55% |
| Discussing Cessation Medications[2] | 84.46% | 84.46% | 82.89% | 77.78% |
| Discussing Cessation Strategies[2] | 79.05% | 79.05% | 75.66% | 72.97% |
| Kidney Health Evaluation for Patients with Diabetes (Total) | New Measure in 2020 | First Year Measure[3] | 16.21% | 28.85% |
| Statin Therapy for Patients with Cardiovascular Disease – Adherence 80% | 79.07% | 95.24% | 78.26% | 78.45% |
| Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease | 26.47% | 16.67% | 14.75% | 17.67% |
| Effectiveness of Care - HIV Care Measures | | | | |
| Viral Load Suppression | 81.70% | 79.74% | 81.65% | 77.56% |
| Effectiveness of Care - Substance Use Measures | | | | |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days | 36.91% | 28.69% | 25.17% | 26.75% |
| Effectiveness of Care - Mental Health Issues Measures | | | | |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 57.00% | 63.64% | 65.52% | 59.43% |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | 100.00% | 96.39% | 99.37% | 98.07% |
| Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total) | 36.78% | 43.04% | 15.79% | 38.78% |
| Follow-Up After Hospitalization for Mental Illness – 7 Days (Total) | 35.29% | 38.18% | 34.48% | 37.04% |

| Measure | MetroPlus SNP Measurement Year 2019 | MetroPlus SNP Measurement Year 2020 | MetroPlus SNP Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| **Access/Availability of Care - Primary Care Measures** | | | | |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total) | 60.04% | 64.72% | 73.70% | 47.56% |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total) | 16.11% | 15.74% | 14.39% | 11.06% |
| **Access/Availability of Care - Substance Use Measures** | | | | |
| Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | 33.10% | Not Available | 35.34% | 32.24% |

[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 managed care plan's performance for the measurement year is statistically significantly better than the HIV Special Needs 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 managed care plan's performance for the measurement year is statistically significantly worse than the HIV Special Needs 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 33: MetroPlus SNP's Compliance with Federal Medicaid Standards Results

| Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards | 2019 | 2020[1] | 2021 |
|---|---|---|---|
| 438.206: Availability of Services | C | Activity Pended | C |
| 438.207: Assurances of Adequate Capacity and Services | C | Activity Pended | C |
| 438.208: Coordination and Continuity of Care | C | Activity Pended | C |
| 438.210: Coverage and Authorization of Services | NC | Activity Pended | C |
| 438.214: Provider Selection | C | Activity Pended | C |
| 438.224: Confidentiality | C | Activity Pended | C |
| 438.228: Grievance and Appeal System | C | Activity Pended | C |
| 438.230: Sub-contractual Relationships and Delegation | C | Activity Pended | C |
| 438.236: Practice Guidelines | C | Activity Pended | C |
| 438.242: Health Information Systems | C | Activity Pended | C |
| 438.330: Quality Assessment and Performance Improvement Program | C | Activity 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: HIV Special Needs Plan is in compliance with all standard requirements; NC: HIV Special Needs Plan is not in compliance with at least one standard requirement.

## Quality-of-Care Survey Results – Member Experience

Table 34: MetroPlus SNP's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

| Measure | Measurement Year 2017 | | Measurement Year 2019 | | Measurement Year 2021 | |
|---|---|---|---|---|---|---|
| | MetroPlus SNP | HIV Special Needs Average | MetroPlus SNP | HIV Special Needs Average | MetroPlus SNP | HIV Special Needs Average |
| Getting Needed Care[1] | 78.54% | 80.41% | 83.05% | 82.83% | 79.91% | 78.82% |
| Getting Care Quickly[1] | 82.24% | 85.71% | 87.18% | 85.90% | 81.14% | 80.59% |
| How Well Doctors Communicate[1] | 92.67% | 93.25% | 95.35% | 95.09% | 93.88% | 94.22% |
| Customer Service[1] | 87.58% | 90.36% | 86.66% | 89.89% | 86.55% | 84.10% |
| Rating of All Health Care[2] | 82.45% | 79.16% | 77.46% | 78.50% | 76.73% | 76.43% |
| Rating of Personal Doctor[2] | 87.45% | 88.40% | 88.99% | 88.45% | 90.06% | 88.87% |
| Rating of Specialist Talked to Most Often[2] | 81.07% | 78.70% | 80.25% | 79.49% | 71.09% | 75.62% |
| Rating of Health Plan[2] | 79.55% | 79.43% | 80.41% | 82.17% | 76.05% | 76.77% |
| Rating of Treatment or Counseling[2] | 66.81% | 64.24% | 69.54% | 64.62% | 62.64% | 57.13% |

[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 performance for the measurement year is statistically significantly worse than the corresponding HIV Special Needs Plan statewide measurement year 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 35: MetroPlus SNP's Response to the Previous Year's Recommendations

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | MetroPlus SNP's Response | IPRO's Assessment of MetroPlus SNP's Response |
|---|---|---|---|---|---|
| **Validation of Performance Improvement Projects** | | | | | |
| The managed care plan should continue interventions implemented under the performance improvement project as these indicators have demonstrated performance improvement. | 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, onsite and telephonic case managers educating members on available community services, linkage to peer support specialists, and coordinating with member's Health Homes and Assertive Community Treatment teams. Additional interventions aimed to assist providers in coordinating appointments during discharge planning, facilitating signed member consents for members receiving inpatient substance use disorder treatment, and texting members who had an emergency department visit.<br>▪ The behavioral health program was transitioned from MetroPlus SNP's vendor, Beacon Health Options, to MetroPlus SNP as of October 1, 2021. Comprehensive behavioral health services were in-sourced to internal MetroPlus SNP departments. The transition enables MetroPlus SNP to directly implement member and provider interventions and work toward improving project indicators on an ongoing basis. | Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | MetroPlus SNP's Response | IPRO's Assessment of MetroPlus SNP's Response |
|---|---|---|---|---|---|
| | | | | ▪ The behavioral health program module incorporates case managers, peer support specialists, medical director consults, utilization management review and coordination for discharge planning. Staff continue efforts to engage members and providers to improve member's transition to the community upon discharge from an inpatient/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.<br>▪ Since the behavioral health program carve-in, MetroPlus SNP has increased visibility into members' behavioral health utilization, case management interventions and outcomes. Data collection processes are internal to MetroPlus SNP, allowing for prompt and streamlined tracking and oversight. The behavioral health team closely collaborates with MetroPlus SNP's department for comprehensive medical and behavioral health case management for members of MetroPlus SNP.<br>▪ Case management interventions and calls for behavioral health follow up are audited by the behavioral health case management team leads. Additionally, MetroPlus SNP converted an existing clinical role to "case manager quality examiner" as of June 2022. The case manager quality examiner provides clinical and quality oversight to behavioral health case management on an ongoing basis. | |
| Validation of Performance Measures | | | | | |
| The managed care plan should continue its current | X | X | | Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | MetroPlus SNP's Response | IPRO's Assessment of MetroPlus SNP's Response |
|---|---|---|---|---|---|
| interventions to improve members accessing quality healthcare services, as most rates performed well in measurement year 2020. Additionally, the managed care plan should consider implementing interventions that will reduce members risk of continued opioid use as these rates were significantly worse than the statewide average for two consecutive years. | | | | MetroPlus SNP recognizes the importance of medication assisted treatment for members diagnosed with an opioid use disorder. In response to 2020 performance MetroPlus SNP 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.<br>▪ On a weekly basis MetroPlus SNP runs data on members who were diagnosed with opioid use disorder in the preceding seven days. MetroPlus SNP outreaches these members to support their recovery and assist them in securing medication assisted therapy.<br>▪ Members with opioid diagnosis who were seen and discharged from emergency room/inpatient substance use care are outreached telephonically for a "Bridge Visit" to support engagement in medication assisted treatment.<br>▪ 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.<br>▪ MetroPlus SNP makes use of weekly collaboration meetings with our internal Behavioral Health Department to address member and provider barriers to medication assisted treatment.<br>▪ MetroPlus SNP has developed a provider assessment tool to support annual screening for substance use disorders as well as resources for treatment and referral for these disorders. | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | MetroPlus SNP's Response | IPRO's Assessment of MetroPlus SNP's Response |
|---|---|---|---|---|---|
| | | | | MetroPlus SNP has observed a decrease in year-over-year performance in the *Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence* measure for SNP. Rates are noted below:<br>▪ calendar year 2019 - 33%<br>▪ calendar year 2020 - 47%<br>▪ calendar year 2021 - 35%<br><br>MetroPlus SNP uses member demographics to determine if disparities exist based on gender, age, race and ethnicity, language spoken, and geography. If poor performance is noted, MetroPlus SNP will alter actions or implement new interventions to prioritize members as needed to address and reduce these disparities. MetroPlus SNP's process for monitoring actions is to:<br><br>▪ Track measure rate performance by utilizing internal monthly dashboards and year over year trend reports.<br>▪ Monitor process data and the effectiveness of each intervention on Quality Improvement Activity tools.<br>▪ Report outcomes to the Quality Management Committee and Quality Assurance Performance Improvement Committee. | |
| **Review of Compliance with Medicaid and Children's Health Insurance Program Standards** | | | | | |
| The managed care plan should investigate opportunities to address the noncompliance identified received during the measurement year 2019 operational survey conducted by the Department of Health. | X | X | X | MetroPlus SNP underwent a full operational survey between 11/29/2021 and 12/7/2021. The survey reviewed key areas and MetroPlus SNP received only one deficiency related to one of our contracted vendors related to a 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 | Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | MetroPlus SNP's Response | IPRO's Assessment of MetroPlus SNP's Response |
|---|---|---|---|---|---|
| | | | | 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. MetroPlus SNP continues to monitor compliance with Medicaid standards by addressing the noncompliance identified during the survey and by conducting quarterly random samples of cases to ensure that this error has been resolved and is not re-occurring. To date, no issues have been identified. | |

## Strengths, Opportunities for Improvement, and Recommendations

Table 36: MetroPlus SNP's Strengths, Opportunities, and Recommendations

| External Quality Review Activity | External Quality Review Organization's Assessment/Recommendation | Quality | Timeliness | Access |
|---|---|---|---|---|
| Strengths | | | | |
| Performance Improvement Project | MetroPlus SNP's measurement year 2021 performance improvement project passed validation. | X | X | X |
| | MetroPlus SNP exceeded target rates for four performance indicators related to medication management, treatment of alcohol abuse, and timely follow-up after high-intensity care for substance use disorder. | X | X | |
| Performance Measures | MetroPlus SNP 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 SNP performed significantly better than the HIV Special Needs Plan program on five measures of effectiveness of care related to primary care or HIV care. | X | X | X |
| Performance Measures – Access/Availability of Care | MetroPlus SNP performed significantly better than the HIV Special Needs Plan program on two measures of access/availability of care related to primary care. | | X | X |
| Compliance with Federal Managed Care Standards | During the period under review, MetroPlus SNP 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 SNP did not meet target rates for seven performance indicators related to timely follow-up care for mental illness, timely follow-up after emergency department care for alcohol and substance use, and treatment for opioid use. | X | X | |
| Performance Measures – Effectiveness of Care | MetroPlus SNP performed significantly worse than the HIV Special Needs Plan program on two measures of effectiveness of care related to primary care or mental health issues. | X | X | X |
| Compliance with Federal Managed Care Standards | None. | | | |
| Quality-of-Care Survey | None. | | | |

| External Quality Review Activity | External Quality Review Organization's Assessment/Recommendation | Quality | Timeliness | Access |
|---|---|---|---|---|
| **Recommendations** | | | | |
| Performance Improvement Project | MetroPlus SNP should continue its efforts to improve the quality of care available to members living with mental illness or substance abuse disease. MetroPlus SNP should also evaluate the adequacy of its health care delivery system to effectively manage the health of these members. | X | X | X |
| Performance Measures | MetroPlus SNP 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 SNP should focus on the areas of care in which its rates did not meet HIV Special Needs program performance. | X | X | X |
| Compliance with Federal Managed Care Standards | MetroPlus SNP 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 meet the HIV Special Needs Plan program average. | X | X | X |

# VNS Health

## Performance Improvement Project Summary and Results

Table 37: VNS Health's Performance Improvement Project Summary, Measurement Year 2021

| VNS Health's Performance Improvement Project Summary |
| --- |
| Title: Disease Management in the Diabetic Population<br>Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. |
| Aim<br>VNS Health aims to decrease the number of members with uncontrolled diabetes and the number of inpatient admissions among members with diabetes by improving disease management.<br><br>Member-Focused 2021 Interventions<br>▪ Diabetic members identified as "complex case" received telephonic outreach and referral to an endocrinologist.<br>▪ Implemented the STEPS incentive program which provided members with $25 for completing routine diabetic screenings.<br>▪ Developed materials to educate members on diabetes self-management, diabetes control, annual screenings, nutrition and exercise, and blood pressure control.<br>▪ Member outreach on medication adherence was conducted telephonically.<br>▪ The VNS Health medical management team conducted member assessments and issued glucometers to encourage self-monitoring.<br>▪ Conducted education on screenings during managed care plan baby shower events.<br><br>Provider-Focused 2021 Interventions<br>▪ Notified providers of members who were non-compliant with prescribed medications.<br>▪ Collaborated with high-volume provider sites to close gaps in care through member referrals to nutrition counseling and referrals to diabetes self-management education.<br>▪ Conducted onsite education for designated AIDS centers and VNS Health providers on performance improvement project objectives and interventions.<br><br>Managed Care Plan-Focused 2021 Interventions<br>▪ Utilized claims data to monitor the number of members with diabetes who attended nutrition classes, the number of members with diabetes who completed a visit with an endocrinologist, and the number of members who received diabetes self-management education. |

Table 38: VNS Health's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

| Indicator | Baseline Measurement Year 2018 | Interim Measurement Year 2019 | Interim Measurement Year 2020[1] | Final Measurement Year 2021 | Target/Goal |
|---|---|---|---|---|---|
| Diabetic Members with an Inpatient Hospitalization[2] | 25.23% | 28.07% | 26.26% | 27.40% | 20.00% |
| Diabetic Members Who Received All Tests | 51.09% | 52.07% | 65.45% | 64.56% | 56.00% |
| HEDIS Comprehensive Diabetes Care – HbA1c Test | 95.86% | 95.62% | 96.59% | 94.88% | 97.00% |
| HEDIS Comprehensive Diabetes Care – HbA1c Control <8% | 55.47% | 51.58% | 69.10% | 63.07% | 65.00% |
| HEDIS Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1] | 35.04% | 41.36% | 23.60% | 29.38% | 28.00% |

[1] Measurement year 2020 data has been revised since the publication of the *New York State Medicaid Managed Care HIV Special Needs Plans 2020 External Quality Review Annual Technical Report*.

[2] Lower rate indicates better performance.

## Performance Measure Results

Table 39: VNS Health's Performance Measure Results, Measurement Years 2019 to 2021

| Measure | VNS Health Measurement Year 2019 | VNS Health Measurement Year 2020 | VNS Health Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| Effectiveness of Care - Primary Care Measures | | | | |
| Antidepressant Medication Management – Effective Acute Phase Treatment | 67.86% | 67.00% | 63.04% | 55.20% |
| Antidepressant Medication Management – Effective Continuation Phase Treatment | 58.04% | 48.00% | 48.91% | 40.04% |
| Asthma Medication Ratio (19–64 Years) | 25.50% | 29.14% | 30.15% | 32.06% |
| Breast Cancer Screening | 64.83% | 68.45% | 72.65% | 65.97% |
| Cervical Cancer Screening | 85.19% | 78.08% | 81.25% | 75.87% |
| Colorectal Cancer Screening | 65.82% | 63.28% | 64.30% | 64.88% |
| Comprehensive Diabetes Care – Eye Exam | 57.42% | 67.64% | 68.73% | 53.18% |
| Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1] | 35.04% | 23.60% | 29.38% | 25.08% |
| Controlling High Blood Pressure | 61.18% | 59.37% | 58.54% | 63.78% |
| Flu Shots for Adults[2] | 75.40% | 75.40% | 73.59% | 70.19% |
| Advising Smokers to and Tobacco Users to Quit[2] | 95.57% | 95.57% | 89.47% | 88.55% |
| Discussing Cessation Medications[2] | 86.27% | 86.27% | 75.00% | 77.78% |
| Discussing Cessation Strategies[2] | 78.22% | 78.22% | 70.87% | 72.97% |
| Kidney Health Evaluation for Patients with Diabetes (Total) | New Measure in 2020 | First Year Measure[3] | 32.76% | 28.85% |
| Statin Therapy for Patients with Cardiovascular Disease – Adherence 80% | 89.71% | 84.81% | 79.55% | 78.45% |
| Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease | 18.57% | 21.15% | 22.64% | 17.67% |
| Effectiveness of Care - HIV Care Measures | | | | |
| Viral Load Suppression | 84.46% | 81.57% | 81.14% | 77.56% |
| Effectiveness of Care - Substance Use Measures | | | | |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days | 19.75% | 31.51% | 21.33% | 26.75% |
| Effectiveness of Care - Mental Health Issues Measures | | | | |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 72.73% | 73.08% | 75.00% | 59.43% |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications | 100.00% | 95.24% | 97.48% | 98.07% |
| Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total) | 22.86% | 43.33% | 21.28% | 38.78% |
| Follow-Up After Hospitalization for Mental Illness – 7 Days (Total) | 36.36% | 40.48% | 38.89% | 37.04% |

| Measure | VNS Health Measurement Year 2019 | VNS Health Measurement Year 2020 | VNS Health Measurement Year 2021 | HIV Special Needs Plan Measurement Year 2021 |
|---|---|---|---|---|
| **Access/Availability of Care - Primary Care Measures** | | | | |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total) | 51.79% | 56.81% | 61.11% | 47.56% |
| Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total) | 11.88% | 10.30% | 13.58% | 11.06% |
| **Access/Availability of Care - Substance Use Measures** | | | | |
| Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence | 25.00% | Not Available | 26.42% | 32.24% |

[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 managed care plan's performance for the measurement year is statistically significantly better than the HIV Special Needs 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 managed care plan's performance for the measurement year is statistically significantly worse than the HIV Special Needs 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 40: VNS Health's Compliance with Federal Medicaid Standards Results

| Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards | 2019 | 2020[1] | 2021 |
|---|---|---|---|
| 438.206: Availability of Services | NC | Activity Pended | C |
| 438.207: Assurances of Adequate Capacity and Services | C | Activity Pended | C |
| 438.208: Coordination and Continuity of Care | C | Activity Pended | C |
| 438.210: Coverage and Authorization of Services | C | Activity Pended | C |
| 438.214: Provider Selection | C | Activity Pended | C |
| 438.224: Confidentiality | C | Activity Pended | C |
| 438.228: Grievance and Appeal System | NC | Activity Pended | C |
| 438.230: Sub-contractual Relationships and Delegation | C | Activity Pended | C |
| 438.236: Practice Guidelines | C | Activity Pended | C |
| 438.242: Health Information Systems | C | Activity Pended | C |
| 438.330: Quality Assessment and Performance Improvement Program | C | Activity 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: HIV Special Needs Plan is in compliance with all standard requirements; NC: HIV Special Needs Plan is not in compliance with at least one standard requirement.

## Quality-of-Care Survey Results – Member Experience

Table 41: VNS Health's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

| Measure | Measurement Year 2017 | | Measurement Year 2019 | | Measurement Year 2021 | |
|---|---|---|---|---|---|---|
| | VNS Health | HIV Special Needs Average | VNS Health | HIV Special Needs Average | VNS Health | HIV Special Needs Average |
| Getting Needed Care[1] | 81.63% | 80.41% | 82.71% | 82.83% | 82.10% | 78.82% |
| Getting Care Quickly[1] | 86.22% | 85.71% | 86.43% | 85.90% | 81.99% | 80.59% |
| How Well Doctors Communicate[1] | 93.97% | 93.25% | 94.64% | 95.09% | 94.79% | 94.22% |
| Customer Service[1] | 91.63% | 90.36% | 90.93% | 89.89% | 85.75% | 84.10% |
| Rating of All Health Care[2] | 77.85% | 79.16% | 79.87% | 78.50% | 75.99% | 76.43% |
| Rating of Personal Doctor[2] | 90.37% | 88.40% | 90.14% | 88.45% | 90.25% | 88.87% |
| Rating of Specialist Talked to Most Often[2] | 77.79% | 78.70% | 81.67% | 79.49% | 80.08% | 75.62% |
| Rating of Health Plan[2] | 78.61% | 79.43% | 82.32% | 82.17% | 78.72% | 76.77% |
| Rating of Treatment or Counseling[2] | 63.08% | 64.24% | 67.38% | 64.62% | 60.38% | 57.13% |

[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 performance for the measurement year is statistically significantly better than the corresponding HIV Special Needs Plan statewide measurement year 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 42: VNS Health's Response to the Previous Year's Recommendations

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| **Validation of Performance Improvement Projects** | | | | | |
| The managed care plan should investigate additional interventions as three of the five performance improvement project indicators have not met the target goals. | X | X | | VNS Health has implemented several initiatives aimed towards the continued improvement in diabetes self-management and reducing HbA1c levels amongst the diabetic membership, these initiatives include:<br>▪ VNS Health Care Team in collaboration with vendor partners, conduct counseling with members on leading a healthy life through diabetes self-management education, providing nutritional guidance, and assisting with barriers to medication adherence.<br>▪ VNS Health collaborated with providers through bi-directional data sharing programs whereby diabetic pharmacy fill and HbA1c testing data are shared with providers to inform member outreach, education, and treatment needs.<br>▪ VNS Health has implemented a provider education online seminar series and created reference materials that outline evidenced-based clinical best practices for diabetes management for distribution with in-network providers.<br>▪ VNS Health will continue to incorporate member-level gaps in care indicators for the HEDIS/Quality Assurance Reporting Requirements diabetes measure in the case management platform. This allows for medical management and outreach teams to identify members with diabetes care gaps and assist with coordinating primary care provider/specialist appointments, reinforcing best practices for diabetes management including | Partially Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| | | | | regular HbA1c testing, retinal eye examinations, nutrition, and other lifestyle changes. On a monthly basis VNS Health will refresh the case management platform gap indicators to ensure that members with an HbA1c > 9% are appropriately flagged for follow-up.<br>▪ VNS Health will also continue to expand provider and lab vendor data sharing initiatives to improve plan access to member-level HbA1c results and reduce data gaps to focus on members with true clinical gaps in care. To ensure complete and comprehensive lab data, VNS Health has instituted a quarterly process to reconcile lab claims billed against lab results received. Instances of missing lab results are communicated back to the lab and missing labs are submitted for integration into the VNS Health's lab data tables.<br>▪ VNS Health will continue to collaborate with primary care physicians and contracted lab vendors to coordinate mobile HbA1c testing in the community for diabetic members.<br>▪ Gaps in care reports are generated and distributed monthly to internal stakeholders, and targeted designated AIDS centers/HIV primary care specialists to monitor HEDIS diabetes care performance. VNS Health also maintains a regular meeting cadence with the high-volume AIDS centers/HIV primary care specialists to review care gaps, assess barriers and make recommendations/linkage to additional services, as necessary. | |
| Validation of Performance Measures | | | | | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| The managed care plan should investigate opportunities to improve the health of members who use opioids at high dosages. | X | X | | As a plan, the following are currently performed to address opportunities to improve the health of members who use opioids at high dosages:<br>▪ Opioid Cumulative Dosing at Point of Sale – At the point of sale an intervention is in place that will identify and deny incoming opioid claim(s) when an eligible member's daily morphine milligram equivalent is greater than or equal to a hard threshold (e.g., ≥ 200 milligrams) across a single or multiple opioid-containing claim(s). The intervention also allows a soft stop on incoming opioid claim(s) with daily cumulative morphine milligram equivalent greater than or equal to a soft threshold (e.g., ≥ 90 milligrams). The interventions can be overridden by clinical prior authorization or professional pharmacy services codes submitted by the participating pharmacy.<br>▪ Opioid-Benzodiazepine Concurrent Use at Point of Sale – At the point of sale an intervention that will identify and deny concurrent use of opioids and benzodiazepines when there is an overlap in days' supply. The intervention is non-overridable except by clinical prior authorization or professional pharmacy services codes submitted by the participating pharmacy.<br>▪ Opioid Overutilization Intervention – A monthly report that identifies eligible members with an average daily morphine milligram equivalent greater than or equal to 90 milligrams for any duration (monthly rolling six-month look-back) from either: (i) three or more prescribers and three or more participating pharmacies, or (ii) five | Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| | | | | or more prescribers. The report is used to send prescriber letters monthly to determine if the opioid medications and current dosage of opioid medications are being prescribed appropriately. eligible members who have claims for an oncology drug and/or have a hospice identifier are excluded from this program.<br>▪ Opioid Overutilization-Benzodiazepine/ Potentiators Retrospective – Of those eligible members identified with opioid overutilization intervention, the plan will also identify eligible members with concurrent use of opioids and benzodiazepines, gabapentin (>2400 milligrams per day), and/or pregabalin. Letters are generated monthly for notifications to prescribers to verify prescribed medications. Eligible members who have claims for an oncology drug and/or have a hospice identifier are excluded from this program.<br>▪ Naloxone for High-Risk Opioid Use Retrospective Intervention – A monthly prescriber outreach program which identifies eligible members 18 years of age or older who received an opioid over the previous three-month time period without a history of a Naloxone claim in the prior 12 months. In addition, at least one of the following criteria must be met: (i) eligible member has a history of opioid addiction, (ii) eligible member obtained an average daily morphine milligram equivalent greater than or equal to 50 milligrams, or (iii) eligible member has been taking an opioid in combination with a benzodiazepine for at least 30 days. Eligible members who have claims for an | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| | | | | oncology drug and/or have a hospice identifier are excluded from this program. Letters are generated monthly for notifications to prescribers to verify prescribed medications.<br><br>All these programs are currently in place. Point of sale interventions are done daily thru the pharmacy systems. Monthly letters are sent to prescribers to address opioid overutilization, opioid overutilization-benzodiazepine potentiators and Naloxone for high-risk opioid use members.<br><br>On a monthly basis, once letters are sent out to prescribers, the VNS Health Pharmacy Services team monitors for prescriber responses and if the regimen does not seem appropriate, they reach out to the prescriber to get a diagnosis. The Pharmacy Team performs evaluation and determines if any cases need to be referred further to the care management team for member outreach and/or pain management services referral (where appropriate).<br><br>After outreach, Pharmacy Services team monitors for any provider feedback and/or response. Additionally, monitor subsequent monthly reports to see if the same members are still on the reports, evaluate for any trends, and if any new members identified. Outcomes from the unique members identified for opioid overutilization program and the unique members identified for the opioid potentiator program are presented quarterly at the utilization management subcommittee meetings. | |
| Review of Compliance with Medicaid and Children's Health Insurance Program Standards | | | | | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| The managed care plan should investigate opportunities to improve the areas which received a deficiency and routinely monitor the effectiveness of the interventions to ensure full compliance achieved during the next compliance review. | X | X | X | During the VNS Health Operational Survey conducted between 11/18/2019 and 11/21/2919 statements of deficiency were issued for the VNS Health's failure to ensure that the initial adverse determination decisions were reviewed by a physician in six out of 10 Medicaid pre-authorization and concurrent cases reviewed and failure to ensure that the initial and the final adverse determination decisions were reviewed by a physician in four out of eight Medicaid expedited appeal cases reviewed. These deficiencies were not reissued from 2018 or any other previous recommendation.<br><br>The initial adverse determinations were made by a member of the "VNS Health Utilization Management Team" in the Utilization Management Department. VNS Health acknowledged a misinterpretation of the *Model Contract (Appendix F-3)* and *Public Health Law §4900(2)(a)* definition of a medical necessity determination led to policies and processes in which requests with no clinical information to make determinations based on medically necessity were decisioned by the Utilization Management Team rather than the VNS Health's medical director. The rationale was that the medical director had no information to make a determination based on medical necessity. VNS Health revised policies and procedures to comply with the *Model Contract (Appendix F-3)* and *Public Health Law §4900(2)(a)*. VNS Health's Director of Care Management implemented a plan of correction which included the revision of the service request review process, providing staff training, and updating the VNS Health's Care and Utilization Management department's written policies | Addressed |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| | | | | and procedures. The staff was trained on the new process, requiring all inpatient, outpatient, skilled nursing facility, durable medical equipment, and out-of-network requests are sent to a licensed physician for a determination when the registered nurse is unable to make a determination regardless of the presence of clinical criteria on 1/3/2020, with an effective date of 1/6/2020. The revised written policies and procedures were approved by VNS Health's Policy and Procedure Committee in March 2020. Monthly auditing of adverse determinations was completed to ensure adverse determinations were made by the licensed physicians.<br><br>The initial and final adverse determination decisions were made by "registered nurse utilization review reviewers," and "registered nurse specialist appeals reviewers," in the VNS Health Utilization Management and Grievance and Appeals Departments. VNS Health challenged the statement of deficiency citing its interpretation of *Public Health Law 4900 (2)* definition of "clinical peer reviewer" as either (1) "a physician who possesses a current and valid non-restricted license to practice medicine" or (2) "a health care professional other than a licensed physician who, where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession and is in the same profession and same or similar specialty as the health care provider who typically manages the medical condition or disease or provides the health care | |

| 2020 External Quality Review Recommendation | Quality | Timeliness | Access | VNS Health's Response | IPRO's Assessment of VNS Health's Response |
|---|---|---|---|---|---|
| | | | | service or treatment under review." VNS Health asserted registered nurses are commonly responsible determining the appropriateness and level of personal care services required by a member, as well as monitoring the effectiveness of those services on an ongoing basis, and therefore are qualified to act a clinical peer reviewer for personal care services. On 6/3/2020, the Department of Health notified VNS Heath its challenge was without merit and unacceptable.<br><br>On 6/10/2020 and 6/24/2020 VNS Health staff received additional guidance and training those adverse determinations for all services including personal care services must be made by a licensed physician effective 8/1/2020. Written policies for the care and utilization management and the grievance and appeals departments were revised on 6/24/2020 to include adverse determinations for personal care services must be determined by a licensed clinician. Monthly auditing of adverse determinations was completed to ensure adverse determinations were made by the licensed physicians.<br><br>VNS Health successfully participated in a Targeted Operational Survey between 9/13/2021 and 9/16/2021. Areas with identified deficiencies in the 2019 Full Operational Survey were reviewed with no findings. | |

## Strengths, Opportunities for Improvement, and Recommendations

Table 43: VNS Health's Strengths, Opportunities, and Recommendations

| External Quality Review Activity | External Quality Review Organization's Assessment/Recommendation | Quality | Timeliness | Access |
|---|---|---|---|---|
| Strengths | | | | |
| Performance Improvement Project | VNS Health's measurement year 2021 performance improvement project passed validation. | X | X | X |
| | VNS Health exceeded the target rate for one performance indicator related to diabetes-related tests. | X | X | X |
| Performance Measures | VNS Health 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 | VNS Health performed significantly better than the HIV Special Needs Plan program on five measures of effectiveness of care related to primary care, HIV care, or mental health issues. | X | X | X |
| Performance Measures – Access/Availability of Care | VNS Health performed significantly better than the HIV Special Needs Plan program on one measure of access/availability of care related to treatment for alcohol and substance use. | | X | X |
| Compliance with Federal Managed Care Standards | During the period under review, VNS Health 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 | VNS Health performed significantly better than the HIV Special Needs Plan program on two measures of member satisfaction. | X | X | X |
| Opportunities for Improvement | | | | |
| Performance Improvement Project | VNS Health did not meet target rates for four performance indicators related to the hospitalization of members with diabetes, and HbA1c testing and control. | X | X | X |
| Performance Measures – Effectiveness of Care | VNS Health performed significantly worse than the HIV Special Needs Plan program on two measures of effectiveness of care related to primary care or mental health issues. | X | X | X |
| Compliance with Federal Managed Care Standards | None. | | | |
| Quality-of-Care Survey | None. | | | |

| External Quality Review Activity | External Quality Review Organization's Assessment/Recommendation | Quality | Timeliness | Access |
|---|---|---|---|---|
| **Recommendations** | | | | |
| Performance Improvement Project | VNS Health should continue its efforts to improve the health outcomes of its members living with diabetes. | X | | |
| Performance Measures | VNS Health 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, VNS Health should focus on the areas of care in which its rates did not meet HIV Special Needs program performance. | X | X | X |
| Compliance with Federal Managed Care Standards | VNS Health 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 | VNS Health should work to improve its performance on measures of member satisfaction for which it did not meet the HIV Special Needs Plan program average. | X | X | X |

# Appendix 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/ Hybrid | Colorectal Cancer Screening | COL | Required | Required | Required | HEDIS 2020-2021 |
| Administrative/ | Comprehensive Diabetes Care | CDC | 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 | 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 |
| 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 |

| Data Collection Method | Measure | Measure Abbreviation | Medicaid Managed Care Plan Types | | | Technical Specifications |
|---|---|---|---|---|---|---|
| | | | Mainstream | HIV Special Needs | Health And Recovery Plan | |
| 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 | NYS 2020-2021 |
| 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 |

| Data Collection Method | Measure | Measure Abbreviation | Medicaid Managed Care Plan Types | | | Technical Specifications |
|---|---|---|---|---|---|---|
| | | | Mainstream | HIV Special Needs | Health And Recovery Plan | |
| 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 |