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New York State Medicaid Managed Care and Child Health Plus Programs

2022 External Quality Review Annual Technical Report

Mainstream Medicaid Plans
Child Health Plus Plans
HIV Special Needs Plans
Health and Recovery Plans

April 2024

Prepared on behalf of:
The New York State Department of Health

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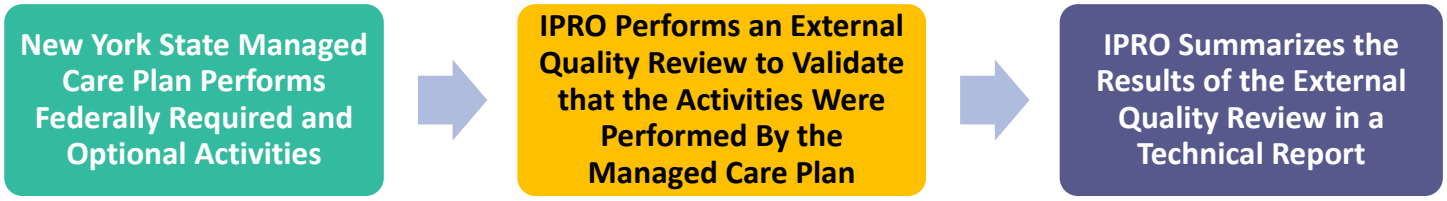
About This Report

The Balanced Budget Act of 1997 requires that state agencies contracting with Medicaid managed care and Children's Health Insurance Program 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 2022 external quality review of the managed care plans that comprised New York's Medicaid managed care and Child Health Plus programs. Review results for three of New York's Medicaid products (Mainstream Medicaid, HIV Special Needs Plan, and Health and Recovery Plan) and New York's Child Health Plus program are summarized in this report, while results of the Medicaid Managed Long-Term Care plans are summarized in a separate report.



This external quality review technical report focuses on three federally required activities (performance improvement projects, performance measures, and review of compliance with Medicaid and Children's Health Insurance Program standards) and one optional activity (quality-of-care survey) that were conducted between January 1, 2022, and December 31, 2022, or measurement year 2022.

Table 1: Medicaid Managed Care and Child Health Plus External Quality Review Activities Performed for 2022

What Did the Department of Health Do?	What Did the Managed Care Plans Do?	What Did IPRO Do?
Required all managed care plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on adult preventive dental care or diabetes-related health monitoring and outcomes.	Evaluated how the managed care plans conducted performance improvement projects.
Required all managed care 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 managed care plans to calculate performance measures rates.
Required all managed care plans to comply with applicable federal and state standards and conducted an evaluation to determine managed care plan compliance with these standards.	Presented evidence of compliance with Medicaid and Child Health Plus standards to the Department of Health.	Reviewed the results of an evaluation of managed care plan compliance with Medicaid and Child Health Plus standards.
Sponsored a quality-of-care survey for New York's Mainstream Medicaid managed care and Child Health Plus plans.	Used these findings in planning future activities to address or enhance member experience.	Reviewed data collection and analysis methods and results of the survey on member experience with Mainstream Medicaid managed care and Child Health Plus plans.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care and Children's Health Insurance Program 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 Medicaid standards at *Title 42 Code of Federal Regulations Section 438.350 External quality review* and Child Health Insurance Program standards at *Title* 42 *Code of Federal Regulations Section 457.1250 External quality review* set forth the requirements for the annual external quality review of contracted managed care plans[1]. *(Hereafter, only Medicaid standards are referenced.)* States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care and Children's Health Insurance Program 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 & Medicaid Services.[2] 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[3], PAHP[4], or PCCM[5] 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 and Children's Health Insurance Program 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 2022 external quality review of the managed care plans that are part of New York's Medicaid and Child Health Plus programs.

2022 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 and Children's Health Insurance Program standards) and one optional activity (quality-of-care survey) that were conducted for measurement year 2022. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in February 2023. The external quality review activities and corresponding protocols are described in Table 2.

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[1] Child Health Insurance Program standards at *Title* 42 *Code of Federal Regulations* 457.1250 cross-reference to the Medicaid managed care external quality review requirements at *Title* 42 *Code of Federal Regulations* 438.356.

[2] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.

[3] prepaid inpatient health plan.

[4] prepaid ambulatory health plan.

[5] primary care case management.

[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/sites/default/files/2023-03/2023-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 managed care 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®[7]) 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 managed care plan compliance with Medicaid and Children's Health Insurance Program standards. Specifically, this review assessed compliance with *Title 42 Code of Federal Regulations Part 438 Managed Care Subpart B 438.56, Subpart C 438.100 and 438.114, Subpart D, Subpart E 438.330,* the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, the *Child Health Plus Model Contract*, *New York State Public Health Law*[8] *Article 44* and *Article 49*, and *New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*.[9]
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO subcontracted with DataStat, an NCQA-certified survey vendor, to administer the 2022-2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS®[10]) survey to evaluate member experience with New York's Mainstream Medicaid and Child Health Plus programs.

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

While the *CMS External Quality Review (EQR) Protocols* published in February 2023 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 2022.

[7] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[8] New York State Legislature Website: http://public.leginfo.state.ny.us/navigate.cgi?NVMUO.
[9] 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.
[10] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

History of New York State's Managed Care Programs

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.[11] 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's Title XXI program, Child Health Plus is a "combination program" comprising both a Medicaid expansion and a separate state program. The program began as state-funded initiative in 1990, to provide preventive, primary, and outpatient care to children. In 1997, with the passage of the Balanced Budget Act and the creation of the State Children's Health Insurance Program, New York's program was "grandfathered" into Title XXI.

Today, Child Health Plus offers free or low-cost health insurance to uninsured children from birth until their 19th birthday. To qualify, families must have incomes below 400% of the federal poverty level, be ineligible for Medicaid, and be a resident of New York State. There are no resource requirements and no immigration criteria. There are no deductibles, co-payments, or co-insurance, but families with incomes above 222% federal poverty level are required to pay a monthly premium. All Child Health Plus health services in New York State are provided through managed care plans. Application and renewal for Child Health Plus is through the New York State of Health Marketplace, where consumers are able to apply for and renew Child Health Plus coverage, as well as enroll in a health plan.

New York State's Medicaid and Child Health Plus 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 New York State's Medicaid and Child Health Plus programs and participating managed care plans. The Department of Health performs periodic reviews of its Medicaid and Child Health Plus 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

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

monitoring and ongoing quality improvement. The Department of Health updates the Medicaid and Child Health Plus quality strategy as needed, but no less than once every three years.

New York State's 2020–2022 Medicaid and Child Health Plus Quality Strategy[12] 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 and Child Health Plus quality strategy aims and corresponding goals are:

- Triple Aim 1: Improved Population Health
  Goal 1: Improve maternal health
  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 quality strategy measurement plan, including metric names, 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 remeasurement rates are from measurement year 2020 (January 1, 2020 through December 31, 2020), year 2 remeasurement rates are from measurement year 2021 (January 1, 2021 through December 31, 2021), and year 3 remeasurement rates are from measurement year 2022 (January 1, 2022 through December 31, 2022).

[12] 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.

Table 3: New York State's Medicaid and Child Health Plus Quality Strategy Metrics and Performance Rates

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	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%	82.44%	84%
	Maternal mortality rate per 100,000 live births[7] (All New York State)	18.9[1]	18.1[3]	19.3[4]	19.3[5]	16.0
Goal 2: Ensure a healthy start	Lead screening in children (Mainstream Medicaid, Child Health Plus)	89%	87%	81.18%	80.66%	90%
	Members receiving oral health services by a non-dentist provider (Mainstream Medicaid)	0.8%	1.25%	1.38%	1.18%	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%	Retired Measure	94%
	Asthma medication ratio, 5-18 years (Mainstream Medicaid, Child Health Plus)	66%	68%	65.47%	64.84%	67%
	Asthma medication ratio, 19-64 years (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	55%	49%	49.59%	58.12%	56%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
	Controlling high blood pressure (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan)	67%	56%	64.82%	66.63%	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%	66.09%	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	First Year Rate Not Publicly Reported	To Be Determined
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[7] (Subset of high school students in New York State)	26.4%	Non-Survey Year	20.0%	Non-Survey Year	23.6%
	High school students reporting binge drinking on at least one day during the past 30 days[7] (Subset of high school students in New York State)	12.7%	Non-Survey Year	10.2%	Non-Survey Year	10.8%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
	High school students reporting current use of marijuana on at least one day during the past 30 days[7] (Subset of high school students in New York State)	19.1%	Non-Survey Year	14.2%	Non-Survey Year	17.1%
	Adult alcohol binge drinking[7] (All New York State)	25.48%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	24.0%
	Adult use of marijuana[7] (All New York State)	10.05%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	9.14%
	Adult use of cocaine[7] (All New York State)	2.82%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	2.37%
	Adult use of heroin[7] (All New York State)	0.3%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	0.17%
	Adult use of illicit drug use other than marijuana[7] (All New York State)	3.42%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	Data Not Yet Available	2.94%
	Medicaid smoking prevalence[7] (Mainstream Medicaid, Fee-For-Service)	23%	22.9%	19.1%	17.5%	21.4%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
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%	44.63%	38%
	Initiation of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)[6]	50%	50%	48.99%	New Specifications for Measure	51%
	Engagement of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)[6]	20%	20%	18.68%	New Specifications for Measure	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%	66%	70%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
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[7] (Managed Long-Term Care)	2.76	No data due to COVID-19	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%	Non-Survey Year	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%	95.17%	95%
	Appropriate treatment for upper respiratory infection, 18-64 Years (Mainstream Medicaid, Health and Recovery Plan, HIV Special Needs Plan)	72%	75%	81.18%	79.48%	73%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Remeasurement Measurement Year 2020	Year 2 Remeasurement Measurement Year 2021	Year 3 Remeasurement Measurement Year 2022	Target by 2022
Triple Aim 3: Lower Per Capita Cost						
Goal 10: Pay for High-Value Care	Potentially preventable admissions per 100,000 members[7] (Mainstream Medicaid)	1,153	847	916.84	886.71	1,124-1,181
	Potentially preventable admission expenditures/ Total inpatient expenditures[7] (Mainstream Medicaid)	9.97	8.29	8.55	9.17	7.47-12.47
	Potentially preventable admissions per 100,000 members[7] (Mainstream Medicaid, Fee-For-Service)	1,097	820	834.95	798.36	1,069-1,124
	Potentially preventable admission expenditures/ Total inpatient expenditures[7] (Mainstream Medicaid, Fee-for-Service)	10.33	8.95	9.07	9.80	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.
[5] Year 3 Remeasurement rate is from measurement year 2018-measurement year 2020.
[6] Trending is not available for this measure. The 2022 technical specifications for this measure are different than the technical specifications used in prior years.
[7] A lower rate indicates better performance.

To achieve the overall objectives of the New York State managed care programs and to ensure New York Medicaid and Child Health Plus recipients have access to the highest quality of health care, New York State's 2020-2022 Medicaid and Child Health Plus 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 2020-2022 Medicaid and Child Health Plus 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 and Child Health Plus cover services delivered by telehealth.
- The Department of Health requires 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. The Delivery System Reform Incentive Payment program ended on March 31, 2020.

IPRO's Assessment of New York State's Medicaid and Child Health Plus Quality Strategy

The New York State Medicaid and Child Health Plus Quality Strategy for 2020-2022 generally aligns with the requirements of *42 Code of Federal Regulations 438.340 Managed Care State Quality Strategy*. It serves as a guiding framework for managed care plans, aiming to enhance the quality, timeliness, and accessibility of care. Clearly defined goals are supported by well-designed interventions, incorporating methods to measure and monitor progress through external quality review activities.

The strategy encompasses various quality improvement activities to establish an innovative, well-coordinated care system addressing both medical and non-medical determinants of health. These activities include performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

From the baseline period (measurement year 2020) to Year 3 (measurement year 2022), statewide performance related to five goals either met or exceeded targets. This success was observed in areas such as asthma medication management in adults, smoking prevalence, pharmacotherapy treatment for substance abuse, appropriate treatment for upper respiratory infections in children and adults, and potentially preventable admissions and cost. Notably, increased access to oral health services in alternative settings was also demonstrated.

Despite positive outcomes, opportunities for enhancing health outcomes exist statewide. As evidenced by the performance in measurement year 2022, continued attention to population health and quality of care is warranted.

Moreover, there are opportunities to strengthen the effectiveness of the quality strategy. The Department of Health faces challenges in trending its performance from baseline for twelve quality strategy metrics due to data collection limitations. These limitations include the absence of data collection during the COVID-19 public health emergency, unavailability of data at the time of report production, measurement year 2022 not being a survey year, suppression of first-year measures from public reporting, and measure retirement.

Recommendations to the New York State Department of Health

Per *42 Code of Federal Regulations 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 and Child Health Plus enrollees. As such, IPRO recommends the following to the Department of Health:

- 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 consider including the results of its *Consumer Guide Star Rating* as a component of the annual external quality review report.

Mainstream Medicaid Covers:

- Children
- Pregnant Women
- Single Individuals
- Families
- Certified Blind Individuals
- Certified Disabled Individuals

Child Health Plus Covers:

- Uninsured Children, Ages 0 through 18 Years Who Are Not Eligible For Medicaid

HIV Special Needs Plan Covers:

- HIV/AIDS Positive Individuals Who Are Eligible For Medicaid
- Children Of Enrolled HIV/AIDS Positive Individuals
- Homeless Individuals Who Are Eligible For Medicaid
- Transgender Individuals Who Are Eligible For Medicaid

Health and Recovery Plan Covers:

- Adults 21 Years Or Older Who Are Insured By Medicaid Only And Have A Chronic Mental Illness or Substance Use Issue And Eligible For Medicaid Managed Care

In 2022, 12 New York State managed care plans provided Mainstream Medicaid and Child Health Plus coverage, three managed care plans provided HIV Special Needs Plan coverage, and 11 managed care plans provided Health and Recovery Plan coverage.

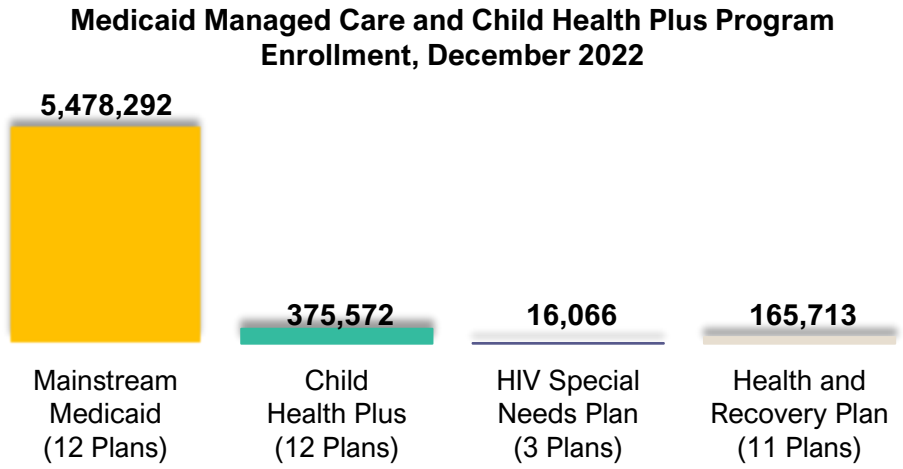


Table 4 displays an overview of each managed care plan's profile. For each managed care plan, the table displays the product lines carried, Medicaid and Child Health Plus program enrollment totals for calendar year 2022, and the NCQA accreditation rating achieved for the Medicaid product line, where available. The New York State Department of Health does not require NCQA accreditation; managed care plans voluntarily decide to seek accreditation. The NCQA accreditation survey includes an assessment of managed care plan systems and processes, and an evaluation of key dimensions of care and services provided by the managed care plan. NCQA awards health plans a rating based on these survey results.

Table 4: Managed Care Plan Corporate Profiles

Managed Care Plan (Abbreviated Name)	Product Line(s)	Mainstream Medicaid Enrollment as of 12/2022[1]	Child Health Plus Enrollment as of 12/2022[2]	HIV Special Needs Plan Enrollment as of 12/2022[1]	Health and Recovery Plan Enrollment as of 12/2022[1]	NCQA Accreditation Status For Medicaid[3]
Amida Care, Inc. (Amida Care)	HIV Special Needs Plan	No Enrollment	No Enrollment	8,393	No Enrollment	Not Accredited
Capital District Physicians' Health Plan Inc. (CDPHP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	114,798	13,293	No Enrollment	5,006	Accredited
Excellus Health Plan Inc. (Excellus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	234,386	29,607	No Enrollment	12,139	Accredited
Healthfirst PHSP, Inc. (Healthfirst)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	1,260,951	67,572	No Enrollment	32,801	Not Accredited
HealthPlus HP, LLC (Empire BCBS HealthPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	401,645	34,877	No Enrollment	8,041	Accredited
Health Insurance Plan of Greater New York, Inc. (HIP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	167,577	9,487	No Enrollment	5,717	Not Accredited
Highmark Western and Northeastern New York, Inc. (Highmark BCBS WNY)	Mainstream Medicaid, Child Health Plus, Commercial	57,578	3,676	No Enrollment	No Enrollment	Not Accredited
Independent Health Association, Inc. (IHA)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	71,077	5,311	No Enrollment	2,946	Not Accredited
MetroPlus Health Plan, Inc. (MetroPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan, Commercial	486,531	27,839	4,521	13,592	Not Accredited
Molina Healthcare of New York, Inc. (Molina)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	313,270	16,150	No Enrollment	10,094	Not Accredited

Managed Care Plan (Abbreviated Name)	Product Line(s)	Mainstream Medicaid Enrollment as of 12/2022[1]	Child Health Plus Enrollment as of 12/2022[2]	HIV Special Needs Plan Enrollment as of 12/2022[1]	Health and Recovery Plan Enrollment as of 12/2022[1]	NCQA Accreditation Status For Medicaid[3]
MVP Health Plan, Inc. (MVP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	213,838	19,062	No Enrollment	8,058	Not Accredited
New York Quality Healthcare Cooperation (Fidelis Care)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	1,782,982	126,078	No Enrollment	56,258	Accredited
UnitedHealthcare of New York, Inc. (UHCCP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	373,659	22,620	No Enrollment	11,061	Accredited
VNS Health, New York (VNS Health)	HIV Special Needs Plan	No Enrollment	No Enrollment	3,152	No Enrollment	Not Accredited
	Total Program Enrollment:	5,478,292	375,572	16,066	165,713	

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

[2] Data Source: New York State Office of Health Insurance Programs Knowledge Information and Data System (KIDS).

[3] Status is as of 09/15/2023. For more detail on the managed care plans' accreditation status and ratings, please see the NCQA website: https://reportcards.ncqa.org/health-plans.

NCQA: National Committee for Quality Assurance.

Accredited: Service and quality meet or exceed rigorous requirements for consumer protection and quality improvement.

External Quality Report Activity 1. Validation of Performance Improvement Projects

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

Managed care plans do projects to improve the value or quality of health care for New Yorkers. These types of projects are called performance improvement projects. New York's 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 topics for performance improvement projects.

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.

In 2022, all Mainstream Medicaid plans and HIV Special Needs Plans conducted a performance improvement project on adult preventive dental care. All Health and Recovery Plans conducted a performance improvement project on diabetes-related health monitoring and outcomes.

2022 Performance Improvement Projects Summary

Validation Process	▪ Does the report have a topic, identify a population, have a clear and meaningful focus? ▪ Are the managed care plan's sampling methods, data collection steps, and results reliable? ▪ Are the improvement strategies appropriate? Was there an improvement?
Validation Results	▪ All performance improvement projects passed validation.
Performance Improvement Project Results	▪ Of the 12 Mainstream Medicaid plans: ▫ 1 increased the percentage of members with a preventive dental visit ▫ 9 decreased the rate of emergency department visits for non-traumatic dental conditions ▪ Of the 3 HIV Special Needs Plans: ▫ 1 increased the percentage of members with a preventive dental visit ▫ 1 decreased the rate of emergency department visits for non-traumatic dental conditions ▪ Of the 11 Health and Recovery Plans: ▫ 9 increased the percentage of diabetic members with a HbA1c rate under 8% ▫ 9 decreased the percentage of diabetic members with a HbA1c rate above 9% ▫ 9 increased the percentage of diabetic members with controlled blood pressure ▫ 2 increased the percentage of diabetic members with a pharmacotherapy prescription for smoking cessation ▫ 1 increased the percentage of diabetic members with outpatient counseling for smoking cessation ▫ 3 increased the percentage of diabetic members with both a pharmacotherapy prescription and outpatient counseling for smoking cessation

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 Quality assessment and performance improvement program (d) Performance improvement projects establishes that the state must require contracted Medicaid managed care and Children's Health Insurance Program 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* and *Section 19* of the *Child Health Plus Contract*, New York State managed care plans must conduct at least one performance improvement project in a priority topic area of its choosing with the mutual agreement of the Department of Health and the external quality review organization, and consistent with federal requirements. Beginning in 2022, New York's managed care plans were required to conduct a state-developed performance improvement project and identify a health disparity within the study population for targeted improvement.

Healthcare disparities are differences in access to or availability of medical facilities and services and variation in rates of disease occurrence and disabilities between population groups defined by socioeconomic characteristics such as age, ethnicity, economic resources, or gender and populations identified geographically.

Source: Agency for Healthcare Research and Quality

For each performance improvement project, the existence of health disparity within the study population was determined by the managed care plan. Calculations of indices of disproportionate over- and under-representation informed the managed care plan's identification of health disparity as well as the impacted subpopulation. (Subpopulations were studied by age, gender, race/ethnicity, residential region, Social Security income status, and cash assistance status.)

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 Mainstream Medicaid and HIV Special Needs Plans' *Improving Rates of Preventive Dental Care in Adult Members Ages 21 Through 64 Years* performance improvement projects and Health and Recovery Plans' *Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus* performance improvement projects that were initiated on January 1, 2022 and scheduled to end on December 31, 2023.

The Mainstream Medicaid and HIV Special Needs Plans' *Improving Rates of Preventive Dental Care in Adult Members Ages 21 Through 64 Years* performance improvement projects aim to address preventive dental care, emergency department utilization for non-traumatic dental conditions, and at least one disparity in care.

The Health and Recovery Plans' *Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus* performance improvement projects aim to address blood pressure and blood sugar control, HbA1c screenings, communication between physical and behavioral health teams, smoking prevalence, and at least one disparity in care.

Table 5 displays performance improvement project topics by plan by managed care program.

Table 5: Performance Improvement Project Topics, 2022

Managed Care Plan	Mainstream Medicaid Topic	HIV Special Needs Plan Topic	Health and Recovery Plan Topic
Amida Care	Not Applicable	Improving Rates of Preventive Dental Care	Not Applicable
CDPHP	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Empire BCBS HealthPlus	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Excellus	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Fidelis Care	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Healthfirst	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Highmark BCBS WNY	Improving Rates of Preventive Dental Care	Not Applicable	Not Applicable
HIP	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
IHA	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
MetroPlus	Improving Rates of Preventive Dental Care	Improving Rates of Preventive Dental Care	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
Molina	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
MVP	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus

Managed Care Plan	Mainstream Medicaid Topic	HIV Special Needs Plan Topic	Health and Recovery Plan Topic
UHCCP	Improving Rates of Preventive Dental Care	Not Applicable	Improving Cardiometabolic Monitoring and Outcomes for Members with Diabetes Mellitus
VNS Health	Not Applicable	Improving Rates of Preventive Dental Care	Not Applicable

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." While elements 1-8 are reviewed each year that the performance improvement project is in progress, elements 9 and 10 are included in the review the year that the performance improvement project concludes. IPRO did not review elements 9 and 10 as part of the validation activity for measurement year 2022, as the performance improvement projects continued into measurement year 2023.

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 2022 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 and interim), 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. Summaries of the Mainstream Medicaid, HIV Special Needs Plan, and Health and Recovery Plan validation assessments are in Table 6, Table 7, and Table 8, respectively.

Mainstream Medicaid performance indicator rates related to adult dental care are in Table 9; HIV Special Needs Plan rates related to adult dental care are in Table 10; and Health and Recovery Plan rates related to diabetes-related health monitoring and outcomes are in Table 11.

The managed care plans' Health and Recovery Plan performance improvement project rates that are HEDIS measures were calculated using technical specifications that are different than the technical specifications used in the calculation of rates for performance measure activity.

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

Table 6: Mainstream Medicaid Performance Improvement Project Validation Findings, Measurement Year 2022

Mainstream Medicaid Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods[1]	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[2]	Achieved Sustained Improvement[2]
CDPHP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Excellus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Healthfirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Highmark BCBS WNY	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
HIP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
IHA	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
Molina	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
MVP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
UHCCP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable

[1] **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

[2] **Achieved Real Improvement** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 7: HIV Special Needs Plan Performance Improvement Project Validation Findings, Measurement Year 2022

HIV Special Needs Plan Performance Improvement Project Validation Elements										
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods[1]	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[2]	Achieved Sustained Improvement[2]
Amida Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable
VNS Health	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Not Applicable	Not Applicable

[1] **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

[2] **Achieved Real Improvement** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 8: Health and Recovery Plan Performance Improvement Project Validation Findings, Measurement Year 2022

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

[1] **Sampling Methods** were not applied by the managed care plan (the study population includes all eligible members) and therefore the element was not included in the validation review.

[2] **Achieved Real Improvement** and **Achieved Sustained Improvement** are included in the validation review the year that the performance improvement project concludes.

Table 9: Mainstream Medicaid Performance Improvement Project Dental Rates, Measurement Year 2022

Mainstream Medicaid Performance Improvement Project Indicator Rates				
	Members Who Had at Least One Preventive Dental Visit During the Measurement Year (21-64 Years)		Adult Emergency Department Visits for Ambulatory Care Sensitive Non-Traumatic Dental Conditions per 100,000 Member Months[1]	
Managed Care Plan	Rate	Target	Rate	Target
CDPHP	14.23%	26.00%	196.47	71.68
Empire BCBS HealthPlus	17.73%	29.31%	97.90	92.89
Excellus	14.28%	25.40%	135.51	129.93
Fidelis Care	23.52%	29.45%	5.71	4.67
Healthfirst	24.54%	29.00%	97.37	91.00
Highmark	50.20%	31.00%	171.27	200.00
HIP	13.13%	25.00%	93.55	97.00
IHA	21.12%	34.00%	148.37	117.00
MetroPlus	15.76%	21.43%	115.57	107.89
Molina	14.95%	21.45%	98.85	89.82
MVP	15.79%	26.00%	131.43	115.00
UHCCP	19.29%	32.00%	92.86	94.00

[1] A lower rate indicates better performance.

Table 10: HIV Special Needs Plan Performance Improvement Project Dental Rates, Measurement Year 2022

HIV Special Needs Plan Performance Improvement Project Indicator Rates				
	Members Who Had at Least One Preventive Dental Visit During the Measurement Year (21-64 Years)		Adult Emergency Department Visits for Ambulatory Care Sensitive Non-Traumatic Dental Conditions per 100,000 Member Months[1]	
Managed Care Plan	Rate	Target	Rate	Target
Amida Care	16.63%	29.40%	267.40	<10.00
MetroPlus	16.03%	21.36%	207.66	165.10
VNS Health	14.24%	24.00%	209.80	90.00

[1] A lower rate indicates better performance.

Table 11: Health and Recovery Plan Performance Improvement Project Diabetes Health Monitoring and Outcomes Rates, Measurement Year 2022

Health and Recovery Plan Performance Improvement Project Indicator Rates												
Managed Care Plan	HEDIS HbA1c Control Less Than 8%[2]		HEDIS HbA1c Poor Control Greater Than 9%[1, 2]		HEDIS Blood Pressure Control Less Than 140/90 mm Hg[2]		Individuals With At Least One Prescription For Tobacco Cessation Pharmacotherapy		Individuals With At Least One Outpatient Visit That Included Tobacco Cessation Counseling		Individuals With At Least One Prescription For Tobacco Cessation Pharmacotherapy and At Least One Outpatient Visit That Included Tobacco Cessation Counseling	
	Rate	Target	Rate	Target	Rate	Target	Rate	Target	Rate	Target	Rate	Target
CDPHP[3]	45.74%	38.67%	47.34%	57.81%	62.77%	59.74%	18.09%	28.66%	18.22%	24.19%	7.58%	14.16%
Empire BCBS HealthPlus[3]	35.05%	38.70%	60.48%	56.35%	40.52%	36.18%	10.55%	15.09%	10.55%	18.30%	3.08%	4.44%
Excellus[4]	23.97%	32.00%	72.24%	63.00%	31.55%	30.00%	17.82%	29.00%	8.83%	20.00%	4.21%	15.00%
Fidelis Care[4]	24.21%	20.90%	72.96%	76.20%	26.07%	22.70%	15.23%	18.00%	13.49%	16.60%	4.82%	6.50%
Healthfirst[3]	43.60%	44.42%	49.24%	49.88%	42.92%	47.08%	7.79%	19.16%	6.63%	16.79%	1.83%	9.30%
HIP[3]	34.60%	46.01%	60.10%	52.31%	34.85%	45.36%	10.23%	20.00%	8.59%	20.00%	3.16%	13.20%
IHA[3]	59.73%	63.00%	32.06%	29.30%	60.11%	72.80%	13.00%	21.10%	12.62%	28.40%	4.02%	12.60%
MetroPlus[3]	44.73%	42.64%	49.56%	37.21%	39.28%	39.98%	13.87%	19.50%	11.37%	17.28%	3.67%	9.08%
Molina[4]	30.71%	45.94%	65.73%	46.73%	28.49%	58.96%	16.40%	19.80%	10.28%	13.80%	3.56%	5.25%
MVP[3]	31.13%	32.95%	64.76%	63.92%	24.68%	24.29%	16.77%	22.14%	1.37%	6.15%	0.73%	5.49%
UHCCP[3]	30.57%	48.00%	65.75%	60.00%	33.78%	30.00%	13.69%	15.00%	11.48%	14.00%	4.07%	6.00%

[1] A lower rate indicates better performance.

[2] The HEDIS measure rates reported by the managed care plans in this table are different than the rates reported by the managed care plans in the performance measure sections of this report. Rate differences within managed care plan reporting are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Managed care plan rates for all measures were calculated using the administrative methodology.

[4] Managed care plan rates for HEDIS measures were calculated using the hybrid methodology, and managed care plan rates for tobacco cessation measures were calculated using the administrative methodology.

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 enrolled in Medicaid or Child Health Plus 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.

2022 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 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 **Mainstream Medicaid and Child Health Plus** rates included in this report, **24% were significantly better** than the statewide Mainstream Medicaid/Child Health Plus average; **31% were significantly worse** than the statewide Mainstream Medicaid/Child Health Plus average; and **45% did not differ** from the statewide Mainstream Medicaid/Child Health Plus average.
- Of the **HIV Special Needs Plan** rates included in this report, **19% were significantly better** than the statewide HIV Special Needs Plan average; **18% were significantly worse** than the statewide HIV Special Needs Plan average; and **63% did not differ** from statewide HIV Special Needs Plan average.
- Of the **Health and Recovery Plan** rates included in this report, **16% were significantly better** than the statewide Health and Recovery Plan average; **17% were significantly worse** than the statewide Health and Recovery Plan average; and **68% did not differ** from the statewide Health and Recovery Plan average.

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* and *Section 16* of the *Child Health Plus Model Contract*, New York's Medicaid managed care and Child Health Plus 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.[13]

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 2022.

Technical Methods for Data Collection and Analysis

The 2022 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 2022 Quality Assurance Reporting Requirements program are available in Appendix A of this report. The major domains of performance included in the 2022 Quality Assurance Reporting Requirements program for the Medicaid managed care and Child Health Plus 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.

For measurement year 2022, the New York State managed care plans were required to submit performance measure data to the Department of Health based on the *2022 Quality Assurance Reporting Requirements Technical Specifications Manual.*[14] These specifications require managed care plans that participate in both

[13] 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.

[14] New York State Department of Health 2022 Quality Assurance Reporting Requirements Technical Specifications Manual (2022 QARR/HEDIS 2022) Website: https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2022/docs/technical_specifications.pdf.

Medicaid and Child Health Plus to combine eligible members from these two programs for measure calculation and reporting when applicable.

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 12 displays vendors and compliance auditors by managed care plan.

Table 12: 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.
CDPHP	Cotiviti, Inc.	Aqurate Health Data Management, Inc.
Empire BCBS HealthPlus	Inovalon, Inc. and Cotiviti Inc.	DTS Group
Excellus	Cotiviti, Inc.	Advent Advisory Group
Fidelis Care	Cotiviti, Inc.	Aqurate Health Data Management, Inc.
Healthfirst	Cotiviti, Inc.	Aqurate Health Data Management, Inc.
Highmark BCBS WNY	Inovalon, Inc. and Cotiviti, Inc.	DTS Group
HIP	Cognizant	Aqurate Health Data Management, Inc.
IHA	SPH Analytics	Attest Health Care Advisors
MetroPlus	Inovalon, Inc.	Aqurate Health Data Management, Inc.
Molina	Cognizant TriZetto Software Group, Inc.	Advent Advisory Group
MVP	Inovalon, Inc.	Aqurate Health Data Management, Inc.
UHCCP	SPH Analytics	Attest Health Care Advisors
VNS Health	Cotiviti, Inc.	Advent Advisory Group

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 2022. The HEDIS vendor calculated rates using NCQA's HEDIS Measurement Year 2022 Volume 2 Technical Specifications for Health Plans and the Department of Health's 2022 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 13** displays these standards as well as the elements audited for the standard.

Table 13: 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 2022 and New York State 2022 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 14** 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 14: Performance Measure Outcome Designations

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

NCQA: National Committee for Quality Assurance.

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

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

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

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

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

Description of Data Received

For the 2022 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 14).

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 Medicaid managed care and Child Health Plus 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 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 2022 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 15 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 managed care 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.

Rates for 41 measures from the 2022 Quality Assurance Reporting Requirements program were selected by the Department of Health for inclusion in its evaluation of Mainstream Medicaid managed care and Child Health Plus plan performance under the 2022–2023 Quality Incentive Program. These measures cover primary care, children's health, mental health, substance use, maternity care, and HIV care.

The managed care plans that participate in both Mainstream Medicaid and Child Health Plus reported a single rate, inclusive of eligible members from both populations, for each measure that includes members under the age of 19 years.

Rates for 29 measures from the 2022 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 2022–2023 Quality Incentive Program. These measures cover primary care, mental health, substance use, and HIV care.

Rates for 28 measures from the 2022 Quality Assurance Reporting Requirements program were selected by the Department of Health for inclusion in its evaluation of Health and Recovery Plan performance under the 2022–2023 Quality Incentive Program. These measures cover primary care, HIV care, mental health, and substance use.

The 2022–2023 Quality Incentive Program measures fall into one of the following major domains:

- Effectiveness of Care,
- Access/Availability of Care, or
- Utilization and Risk Adjusted Utilization.

As the 2022 Quality Assurance Reporting Requirements measures included in the 2022–2023 Quality Incentive Program represent high-priority areas of care for New York's Medicaid managed care and Child Health Plus plans, rates for these measures are presented in this report.

Table 16 through Table 22 display Mainstream Medicaid and Child Health Plus managed care plan rates, statewide Mainstream Medicaid and Child Health Plus averages, and national Medicaid benchmarks for measurement year 2022.

Table 23 through Table 27 display HIV Special Needs Plan managed care plan rates, statewide HIV Special Needs Plan averages, and national Medicaid benchmarks for measurement year 2022.

Table 28 through Table 31 display Health and Recovery Plan managed care plan rates, statewide Health and Recovery Plan averages, and national Medicaid benchmarks for measurement year 2022.

Table 15: 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
CDPHP	Met	Met	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Met	Met	Met
Excellus	Met	Met	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Met	Met	Met
Healthfirst	Met	Met	Met	Met	Met	Met	Met
Highmark BCBS WNY	Met	Met	Met	Met	Met	Met	Met
HIP	Met	Met	Met	Met	Met	Met	Met
IHA	Met	Met	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Met	Met	Met
MVP	Met	Met	Met	Met	Met	Met	Met
UHCCP	Met	Met	Met	Met	Met	Met	Met
VNS Health	Met	Met	Met	Met	Met	Met	Met

NCQA: National Committee for Quality Assurance.

Table 16: Mainstream Medicaid/Child Health Plus Effectiveness of Care Measures – Primary Care, Measurement Year 2022

Effectiveness of Care – Primary Care Measures									
		Antidepressant Medication Management					Chlamydia Screening in Women		
Benchmark/Managed Care Plan	Adult Immunization Status – Influenza	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Asthma Medication Ratio (5–64 Years)	Breast Cancer Screening[1]	Cervical Cancer Screening[1]	16–20 Years	21–24 Years[1]	Colorectal Cancer Screening (50–75 Years)[1]
Statewide Mainstream Medicaid/Child Health Plus Mean	17.19%	57.69%	41.45%	61.20%	65.60%	69.95%	71.89%	73.49%	52.96%
National 2022 Medicaid Mean	14.19%	60.91%	43.90%	65.53%	52.43%	55.92%	52.15%	61.18%	Not Available
National 2022 Medicaid 90th Percentile	48.80%	74.16%	58.06%	75.92%	63.37%	66.48%	66.44%	70.64%	Not Available
CDPHP	19.68%	60.21%	43.49%	72.45%	60.42%	63.20%	62.95%	69.16%	53.84%
Empire BCBS HealthPlus	19.39%	57.43%	41.43%	65.87%	66.47%	66.17%	76.32%	74.31%	54.13%
Excellus	20.05%	56.91%	42.50%	61.89%	62.41%	68.71%	52.19%	65.09%	48.64%
Fidelis Care	12.97%	58.74%	42.12%	55.26%	63.39%	67.40%	66.56%	69.62%	48.85%
Healthfirst	21.00%	55.90%	40.01%	69.41%	71.32%	77.57%	80.85%	79.56%	62.58%
Highmark BCBS WNY	13.39%	52.45%	38.04%	63.05%	57.12%	59.00%	63.27%	68.11%	40.10%
HIP	18.27%	60.10%	44.95%	70.13%	67.00%	68.88%	73.13%	74.78%	53.35%
IHA	24.25%	64.90%	43.76%	71.92%	63.37%	71.47%	72.39%	71.60%	52.00%
MetroPlus	21.03%	55.04%	37.23%	45.51%	67.31%	70.26%	81.19%	78.58%	52.77%
Molina	14.62%	57.41%	41.93%	57.77%	64.93%	69.10%	74.80%	77.22%	48.46%
MVP	17.20%	55.96%	39.78%	60.65%	60.33%	68.37%	64.77%	70.47%	51.65%
UHCCP	15.89%	58.77%	43.11%	58.00%	59.25%	64.23%	66.45%	69.91%	46.85%

[1] Rate reflects Mainstream Medicaid performance only.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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: Mainstream Medicaid/Child Health Plus Effectiveness of Care Measures (Continued) – Primary Care (Continued), Measurement Year 2022

Effectiveness of Care – Primary Care Measures						
Benchmark/Managed Care Plan	Controlling High Blood Pressure	Diabetes – Eye Exam for Patients With Diabetes	Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Kidney Health Evaluation for Patients With Diabetes (Total)	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]
Statewide Mainstream Medicaid/Child Health Plus Mean	66.70%	62.01%	34.84%	78.48%	42.18%	35.47%
National 2022 Medicaid Mean	60.86%	51.47%	40.34%	79.00%	34.54%	22.93%
National 2022 Medicaid 90th Percentile	72.22%	63.33%	29.44%	85.52%	47.55%	30.83%
CDPHP	73.13%	64.79%	30.32%	76.94%	40.99%	28.21%
Empire BCBS HealthPlus	60.83%	59.85%	33.82%	80.85%	41.55%	39.79%
Excellus	62.24%	60.99%	33.58%	74.10%	41.31%	27.01%
Fidelis Care	64.48%	59.61%	38.93%	77.85%	39.81%	37.72%
Healthfirst	70.45%	65.63%	29.52%	81.30%	44.77%	38.33%
Highmark BCBS WNY	68.37%	62.77%	30.17%	76.32%	37.39%	21.08%
HIP	72.24%	60.64%	32.76%	76.29%	39.10%	33.73%
IHA	68.61%	63.54%	24.48%	73.06%	43.73%	29.91%
MetroPlus	74.32%	67.33%	27.93%	83.35%	50.28%	35.51%
Molina	53.77%	60.83%	52.31%	76.64%	42.16%	27.49%
MVP	64.72%	49.86%	45.01%	76.08%	36.27%	32.22%
UHCCP	66.91%	60.34%	35.04%	77.22%	36.88%	34.77%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 18: Mainstream Medicaid/Child Health Plus Effectiveness of Care Measures (Continued) – Children's Health and Mental Health, Measurement Year 2022

	Effectiveness of Care – Children's Health Measures					Effectiveness of Care – Mental Health Measures	
			Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			Depression Screening and Follow-Up for Adolescents and Adults	
Benchmark/Managed Care Plan	Childhood Immunization Status – Combination 3	Immunizations for Adolescents – Combination 2	Counseling for Nutrition	Counseling for Physical Activity	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Depression Screening	Follow-Up on a Positive Screen
Statewide Mainstream Medicaid/Child Health Plus Mean	68.59%	43.33%	82.28%	78.24%	61.79%	1.39%	82.65%
National 2022 Medicaid Mean	63.16%	35.55%	68.12%	64.75%	59.83%	Not Available	Not Available
National 2022 Medicaid 90th Percentile	73.97%	48.80%	83.46%	81.54%	72.61%	Not Available	Not Available
CDPHP	75.18%	33.33%	83.11%	80.37%	62.61%	24.89%	83.03%
Empire BCBS HealthPlus	61.31%	38.93%	85.16%	81.75%	61.07%	0.08%	75.00%
Excellus	76.40%	44.53%	80.60%	76.72%	60.74%	0.89%	58.21%
Fidelis Care	64.48%	38.20%	80.29%	76.16%	63.24%	0.00%	Small Sample
Healthfirst	75.18%	53.41%	86.13%	81.51%	64.86%	2.83%	83.46%
Highmark BCBS WNY	81.02%	43.07%	81.51%	79.81%	58.70%	0.00%	Small Sample
HIP	68.61%	38.93%	83.46%	81.54%	60.69%	0.47%	68.48%
IHA	76.06%	46.22%	91.16%	87.76%	61.98%	13.19%	88.24%
MetroPlus	74.33%	57.49%	85.71%	82.14%	56.90%	0.00%	Small Sample
Molina	72.02%	45.26%	75.91%	72.51%	54.05%	0.74%	97.44%
MVP	67.83%	42.09%	80.29%	75.43%	58.00%	0.00%	Small Sample
UHCCP	53.28%	25.48%	76.40%	71.78%	61.50%	0.22%	58.06%

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 19: Mainstream Medicaid/Child Health Plus Effectiveness of Care Measures (Continued) – Mental Health (Continued), Measurement Year 2022

	Effectiveness of Care – Mental Health Measures				
			Follow-Up Care for Children Prescribed Attention – Deficit/Hyperactivity Disorder Medication		
Benchmark/Managed Care Plan	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	Initiation Phase	Continuation and Maintenance Phase	Metabolic Monitoring for Children and Adolescents on Antipsychotics
Statewide Mainstream Medicaid/Child Health Plus Mean	53.50%	64.42%	57.66%	64.25%	41.57%
National 2022 Medicaid Mean	41.53%	36.61%	43.62%	54.25%	36.29%
National 2022 Medicaid 90th Percentile	61.68%	52.90%	53.14%	63.92%	50.95%
CDPHP	48.88%	63.25%	46.46%	50.41%	42.01%
Empire BCBS HealthPlus	61.81%	62.57%	57.22%	62.73%	49.77%
Excellus	54.80%	62.30%	43.87%	52.38%	28.98%
Fidelis Care	57.37%	62.95%	58.51%	66.58%	40.79%
Healthfirst	50.81%	73.69%	64.41%	73.16%	51.12%
Highmark BCBS WNY	75.36%	58.37%	53.96%	60.56%	37.56%
HIP	58.87%	52.42%	63.42%	73.61%	37.70%
IHA	79.02%	60.90%	50.53%	60.82%	34.69%
MetroPlus	53.91%	60.55%	63.43%	79.28%	55.94%
Molina	38.04%	50.99%	95.47%	61.32%	39.70%
MVP	50.09%	73.95%	49.03%	53.78%	35.02%
UHCCP	42.24%	63.75%	59.60%	71.81%	37.70%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 20: Mainstream Medicaid/Child Health Plus Effectiveness of Care Measures (Continued) – Substance Use, HIV Care, and Maternity, Measurement Year 2022

	Effectiveness of Care – Substance Use Measures				Effectiveness of Care – HIV Care Measures	Effectiveness of Care – Maternity Measures
Benchmark/Managed Care Plan	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Pharmacotherapy for Opioid Use Disorder	Viral Load Suppression	Prenatal Immunization Status
Statewide Mainstream Medicaid/Child Health Plus Mean	27.90%	41.50%	45.93%	33.31%	74.19%	24.44%
National 2022 Medicaid Mean	25.00%	31.01%	Not Available	27.48%	Not Available	21.66%
National 2022 Medicaid 90th Percentile	38.15%	49.55%	Not Available	40.34%	Not Available	37.75%
CDPHP	31.89%	32.69%	53.22%	35.68%	77.90%	28.78%
Empire BCBS HealthPlus	26.92%	43.66%	40.55%	23.84%	72.28%	20.91%
Excellus	29.72%	47.26%	55.55%	37.14%	76.00%	31.53%
Fidelis Care	30.36%	41.77%	49.56%	34.89%	73.82%	17.85%
Healthfirst	28.97%	39.48%	32.49%	30.58%	76.16%	29.26%
Highmark BCBS WNY	40.61%	47.25%	56.64%	36.44%	79.80%	19.13%
HIP	28.30%	35.77%	35.08%	32.11%	72.25%	18.85%
IHA	26.96%	45.07%	42.12%	33.85%	83.80%	29.51%
MetroPlus	26.00%	47.35%	40.85%	28.12%	71.59%	41.17%
Molina	20.27%	38.91%	43.65%	39.16%	72.31%	25.84%
MVP	22.98%	45.63%	48.38%	29.48%	79.91%	24.37%
UHCCP	21.82%	36.03%	45.05%	31.81%	70.04%	15.07%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 21: Mainstream Medicaid/Child Health Plus Access/Availability of Care Measures – Primary Care, Children's Health, and Maternity, Measurement Year 2022

	Access/Availability of Care – Primary Care Measures		Access/Availability of Care – Children's Health Measures	Access/Availability of Care – Maternity Measures	
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment			Prenatal and Postpartum Care	
Benchmark/Managed Care Plan	Initiation of Treatment (Total)	Engagement of Treatment (Total)	Annual Dental Visit (2–18 Years)	Timeliness of Prenatal Care	Postpartum Care
Statewide Mainstream Medicaid/Child Health Plus Mean	46.54%	18.06%	54.16%	86.75%	82.71%
National 2022 Medicaid Mean	45.01%	14.91%	Not Available	82.95%	76.96%
National 2022 Medicaid 90th Percentile	55.24%	24.37%	Not Available	91.07%	84.59%
CDPHP	45.49%	16.63%	61.23%	92.83%	84.23%
Empire BCBS HealthPlus	43.45%	15.12%	57.19%	86.02%	82.08%
Excellus	42.91%	18.73%	49.42%	89.96%	84.59%
Fidelis Care	51.53%	21.70%	56.74%	88.08%	81.75%
Healthfirst	42.77%	14.90%	52.47%	85.00%	84.17%
Highmark BCBS WNY	40.89%	13.91%	55.82%	86.49%	83.78%
HIP	56.53%	23.69%	43.79%	87.10%	83.87%
IHA	38.77%	14.52%	60.93%	90.38%	85.00%
MetroPlus	43.40%	13.77%	51.29%	89.85%	85.84%
Molina	43.23%	14.79%	46.58%	82.97%	79.81%
MVP	44.71%	20.13%	57.17%	87.83%	80.05%
UHCCP	44.41%	16.35%	53.64%	79.08%	79.56%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 22: Mainstream Medicaid/Child Health Plus Utilization Measures – Children's Health, Measurement Year 2022

	Utilization – Children's Health Measures		
Benchmark/Managed Care Plan	Child and Adolescent Well-Care Visits (Total)	Well-Child Visits in the First 30 Months of Life – First 15 Months	Well-Child Visits in the First 30 Months of Life – 15–30 Months
Statewide Mainstream Medicaid/Child Health Plus Mean	68.47%	67.34%	77.84%
National 2022 Medicaid Mean	48.61%	56.76%	66.74%
National 2022 Medicaid 90th Percentile	61.15%	68.09%	77.78%
CDPHP	66.70%	74.43%	79.11%
Empire BCBS HealthPlus	70.69%	63.32%	78.25%
Excellus	68.36%	74.61%	82.92%
Fidelis Care	66.28%	63.42%	75.91%
Healthfirst	73.81%	72.78%	81.82%
Highmark BCBS WNY	70.93%	69.28%	83.79%
HIP	67.92%	67.31%	73.57%
IHA	72.83%	73.41%	82.07%
MetroPlus	68.13%	71.90%	76.93%
Molina	62.72%	63.86%	75.09%
MVP	71.13%	72.90%	78.47%
UHCCP	61.79%	56.13%	70.90%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 23: HIV Special Needs Plan Effectiveness of Care Measures – Primary Care, Measurement Year 2022

Effectiveness of Care – Primary Care Measures									
		Antidepressant Medication Management					Chlamydia Screening in Women		
Benchmark/Managed Care Plan	Adult Immunization Status – Influenza	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Asthma Medication Ratio (19–64 Years)	Breast Cancer Screening	Cervical Cancer Screening	16–20 Years	21–24 Years	Colorectal Cancer Screening (50–75 Years)
Statewide HIV Special Needs Plan Mean	22.79%	61.98%	46.31%	40.27%	68.00%	75.27%	85.11%	78.72%	60.41%
National 2022 Medicaid Mean	14.19%	60.91%	43.90%	Not Available	52.43%	55.92%	52.15%	61.18%	Not Available
National 2022 Medicaid 90th Percentile	48.80%	74.16%	58.06%	Not Available	63.37%	66.48%	66.44%	70.64%	Not Available
Amida Care	24.12%	60.69%	45.38%	59.35%	61.61%	68.33%	Small Sample	79.71%	56.09%
MetroPlus	15.56%	58.06%	38.71%	22.41%	72.11%	83.20%	Small Sample	Small Sample	66.42%
VNS Health	12.05%	72.94%	61.18%	31.82%	72.98%	76.92%	Small Sample	Small Sample	60.25%

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 24: HIV Special Needs Plan Effectiveness of Care Measures (Continued) – Primary Care (Continued), Measurement Year 2022

Effectiveness of Care – Primary Care Measures							
					Medical Assistance with Tobacco Cessation		
Benchmark/Managed Care Plan	Controlling High Blood Pressure	Diabetes – Eye Exam for Patients With Diabetes	Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)	Kidney Health Evaluation for Patients With Diabetes (Total)	Advising Smokers and Tobacco Users to Quit	Discussing Smoking Cessation Medications	Discussing Smoking Cessation Strategies
Statewide HIV Special Needs Plan Mean	61.61%	61.01%	21.05%	39.64%	88.55%	77.78%	72.97%
National 2022 Medicaid Mean	60.86%	51.47%	40.34%	34.54%	72.78%	51.16%	45.43%
National 2022 Medicaid 90th Percentile	72.22%	63.33%	29.44%	47.55%	80.39%	61.38%	53.97%
Amida Care	51.26%	48.42%	21.65%	40.97%	88.24%	76.30%	73.13%
MetroPlus	75.72%	71.05%	18.73%	41.67%	87.58%	82.89%	75.66%
VNS Health	62.34%	71.50%	23.10%	34.06%	89.47%	75.00%	70.87%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 25: HIV Special Needs Plan Effectiveness of Care Measures (Continued) – Primary Care (Continued) and Mental Health, Measurement Year 2022

	Effectiveness of Care – Primary Care Measures		Effectiveness of Care – Mental Health			
				Depression Screening and Follow-Up for Adolescents and Adults		Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Benchmark/Managed Care Plan	Statin Therapy for Patients With Cardiovascular Disease – Statin Adherence 80%	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Depression Screening	Follow-Up on a Positive Screen	
Statewide HIV Special Needs Plan Mean	82.13%	14.51%	59.47%	4.02%	Small Sample	96.70%
National 2022 Medicaid Mean	69.94%	22.93%	59.83%	Not Available	Not Available	79.00%
National 2022 Medicaid 90th Percentile	80.95%	30.83%	72.61%	Not Available	Not Available	85.52%
Amida Care	78.63%	13.19%	56.02%	7.93%	Small Sample	97.07%
MetroPlus	87.50%	12.50%	61.22%	0.00%	Small Sample	95.04%
VNS Health	82.95%	18.52%	67.95%	0.00%	Small Sample	97.41%

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 26: HIV Special Needs Plan Effectiveness of Care Measures (Continued) –Substance Use and HIV Care, Measurement Year 2022

	Effectiveness of Care – Substance Use				Effectiveness of Care – HIV Care
Benchmark/Managed Care Plan	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Viral Load Suppression
Statewide HIV Special Needs Plan Mean	51.45%	36.82%	37.19%	31.33%	80.13%
National 2022 Medicaid Mean	41.53%	36.61%	25.00%	Not Available	Not Available
National 2022 Medicaid 90th Percentile	61.68%	52.90%	38.15%	Not Available	Not Available
Amida Care	55.81%	34.76%	41.44%	31.39%	76.76%
MetroPlus	41.38%	46.15%	29.13%	28.44%	82.48%
VNS Health	46.81%	33.33%	34.31%	34.34%	84.52%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 27: HIV Special Needs Plan Availability of Care Measures – Substance Use, Measurement Year 2022

	Access/Availability of Care – Substance Use Measures	
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	
Benchmark/Managed Care Plan	Initiation of Treatment (Total)	Engagement of Treatment (Total)
Statewide HIV Special Needs Plan Mean	45.09%	11.08%
National 2022 Medicaid Mean	45.01%	14.91%
National 2022 Medicaid 90th Percentile	55.24%	24.37%
Amida Care	42.40%	10.20%
MetroPlus	45.17%	13.08%
VNS Health	54.52%	12.04%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 28: Health and Recovery Plan Effectiveness of Care Measures – Primary Care, Measurement Year 2022

Effectiveness of Care – Primary Care Measures								
		Antidepressant Medication Management						
Benchmark/Managed Care Plan	Flu Shots for Adults (CAHPS)	Effective Acute Phase Treatment	Effective Continuation Phase Treatment	Asthma Medication Ratio (19–64 Years)	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women (21–24 Years)	Colorectal Cancer Screening (50–75 Years)
Statewide Health and Recovery Plan Mean	47.31%	52.60%	38.03%	52.89%	54.68%	63.33%	72.23%	47.33%
National 2022 Medicaid Mean	40.34%	60.91%	43.90%	Not Available	52.43%	55.92%	61.18%	Not Available
National 2022 Medicaid 90th Percentile	52.11%	74.16%	58.06%	Not Available	63.37%	66.48%	70.64%	Not Available
CDPHP	49.24%	49.40%	33.33%	67.29%	51.17%	67.60%	71.43%	55.33%
Empire BCBS HealthPlus	45.60%	49.36%	35.29%	50.00%	51.76%	63.59%	80.52%	45.69%
Excellus	51.87%	47.97%	35.66%	58.20%	57.19%	67.22%	63.85%	50.83%
Fidelis Care	44.00%	54.72%	40.01%	42.57%	52.26%	58.88%	67.32%	44.89%
Healthfirst	48.54%	51.05%	34.93%	66.52%	62.07%	70.07%	82.88%	54.77%
HIP	46.59%	57.56%	44.54%	57.30%	52.38%	56.61%	Small Sample	43.79%
IHA	50.14%	57.08%	42.47%	65.22%	60.70%	70.22%	Small Sample	54.24%
MetroPlus	48.38%	53.89%	37.20%	34.07%	47.87%	62.28%	70.59%	41.51%
Molina	54.00%	50.78%	39.47%	53.09%	54.84%	67.88%	67.47%	43.93%
MVP	46.95%	52.70%	41.51%	37.30%	47.95%	63.75%	75.38%	48.05%
UHCCP	40.41%	50.38%	36.01%	45.67%	49.75%	55.96%	74.76%	36.15%

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 29: Health and Recovery Plan Effectiveness of Care Measures (Continued) – Primary Care (Continued), Measurement Year 2022

Effectiveness of Care – Primary Care Measures									
					Medical Assistance with Tobacco (CAHPS)				
Benchmark/Managed Care Plan	Controlling High Blood Pressure	Diabetes – Eye Exam for Patients With Diabetes	Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	Kidney Health Evaluation for Patients With Diabetes	Advising Smokers and Tobacco User to Quit	Discussing Cessation Medications	Discussing Cessation Strategies	Statin Therapy for Patients With Cardiovascular Disease – Statin Adherence 80%	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease
Statewide Health and Recovery Plan Mean	66.27%	55.13%	37.57%	32.93%	83.42%	68.96%	59.37%	63.88%	26.23%
National 2022 Medicaid Mean	60.86%	51.47%	40.34%	34.54%	72.78%	51.16%	45.43%	69.94%	22.93%
National 2022 Medicaid 90th Percentile	72.22%	63.33%	29.44%	47.55%	80.39%	61.38%	53.97%	80.95%	30.83%
CDPHP	77.13%	55.99%	29.10%	38.74%	86.93%	68.83%	61.04%	69.29%	21.21%
Empire BCBS HealthPlus	60.34%	50.12%	46.72%	29.46%	78.91%	64.06%	56.69%	58.80%	30.00%
Excellus	65.82%	59.17%	34.72%	38.33%	82.89%	71.52%	60.13%	70.98%	21.69%
Fidelis Care	63.99%	55.47%	40.15%	32.43%	83.97%	75.32%	65.82%	62.77%	28.26%
Healthfirst	73.16%	56.25%	33.67%	32.12%	87.02%	68.99%	66.41%	64.21%	27.55%
HIP	64.95%	50.61%	41.61%	31.26%	77.78%	62.14%	51.06%	63.37%	26.04%
IHA	68.58%	61.72%	23.70%	37.16%	86.19%	71.35%	54.70%	70.59%	19.72%
MetroPlus	67.82%	56.20%	27.98%	38.31%	81.12%	67.61%	59.44%	63.14%	26.64%
Molina	54.50%	54.99%	53.77%	32.65%	80.93%	72.02%	63.02%	64.81%	20.11%
MVP	63.50%	47.93%	40.63%	31.66%	80.41%	62.76%	52.38%	62.13%	22.61%
UHCCP	61.80%	51.82%	40.63%	24.18%	88.03%	74.13%	61.54%	62.90%	27.22%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 30: Health and Recovery Plan Effectiveness of Care Measures (Continued) –Mental Health and HIV Care, Measurement Year 2022

	Effectiveness of Care – Mental Health Measures				Effectiveness of Care – HIV Care
Benchmark/Managed Care Plan	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	Viral Load Suppression
Statewide Health and Recovery Plan Mean	66.20%	80.22%	49.48%	56.83%	66.01%
National 2022 Medicaid Mean	59.83%	79.00%	41.53%	36.61%	Not Available
National 2022 Medicaid 90th Percentile	72.61%	85.52%	61.68%	52.90%	Not Available
CDPHP	67.82%	80.42%	39.93%	54.95%	77.00%
Empire BCBS HealthPlus	66.55%	82.27%	66.10%	56.13%	65.49%
Excellus	68.48%	76.96%	56.05%	52.02%	71.61%
Fidelis Care	67.66%	80.04%	54.88%	57.15%	68.70%
Healthfirst	67.04%	82.73%	51.91%	71.92%	64.89%
HIP	67.46%	74.94%	56.63%	40.99%	64.91%
IHA	63.89%	72.47%	69.64%	50.31%	79.31%
MetroPlus	62.07%	82.71%	40.39%	44.14%	54.47%
Molina	65.93%	77.34%	32.79%	36.16%	71.25%
MVP	68.01%	78.77%	40.30%	63.70%	76.73%
UHCCP	60.42%	79.14%	32.69%	54.79%	56.32%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 31: Health and Recovery Plan Effectiveness of Care Measures (Continued) – Substance Use and Access/Availability of Care Measure – Substance Use, Measurement Year 2022

	Effectiveness of Care – Substance Use Measures					Access/Availability of Care – Substance Use Measures
Benchmark/Managed Care Plan	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Pharmacotherapy for Opioid Use Disorder	Use of Pharmacotherapy for Alcohol Abuse or Dependence	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment
Statewide Health and Recovery Plan Mean	39.88%	42.33%	42.80%	33.73%	27.52%	20.42%
National 2022 Medicaid Mean	25.00%	31.01%	Not Available	27.48%	Not Available	14.91%
National 2022 Medicaid 90th Percentile	38.15%	49.55%	Not Available	40.34%	Not Available	24.37%
CDPHP	43.76%	39.41%	50.98%	32.08%	27.88%	19.85%
Empire BCBS HealthPlus	39.29%	44.56%	34.33%	29.28%	23.92%	18.03%
Excellus	42.49%	50.46%	53.78%	34.90%	30.83%	21.84%
Fidelis Care	44.32%	42.81%	47.52%	36.30%	27.81%	23.59%
Healthfirst	40.09%	37.69%	28.22%	29.40%	28.22%	15.00%
HIP	36.45%	34.82%	34.20%	31.34%	24.12%	25.72%
IHA	52.31%	46.15%	37.42%	45.08%	23.37%	17.76%
MetroPlus	36.60%	46.53%	39.87%	32.39%	29.02%	18.29%
Molina	29.17%	40.45%	39.17%	40.00%	23.30%	20.95%
MVP	35.28%	46.47%	50.82%	32.14%	30.71%	23.71%
UHCCP	33.91%	40.91%	46.19%	28.98%	25.02%	21.86%

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

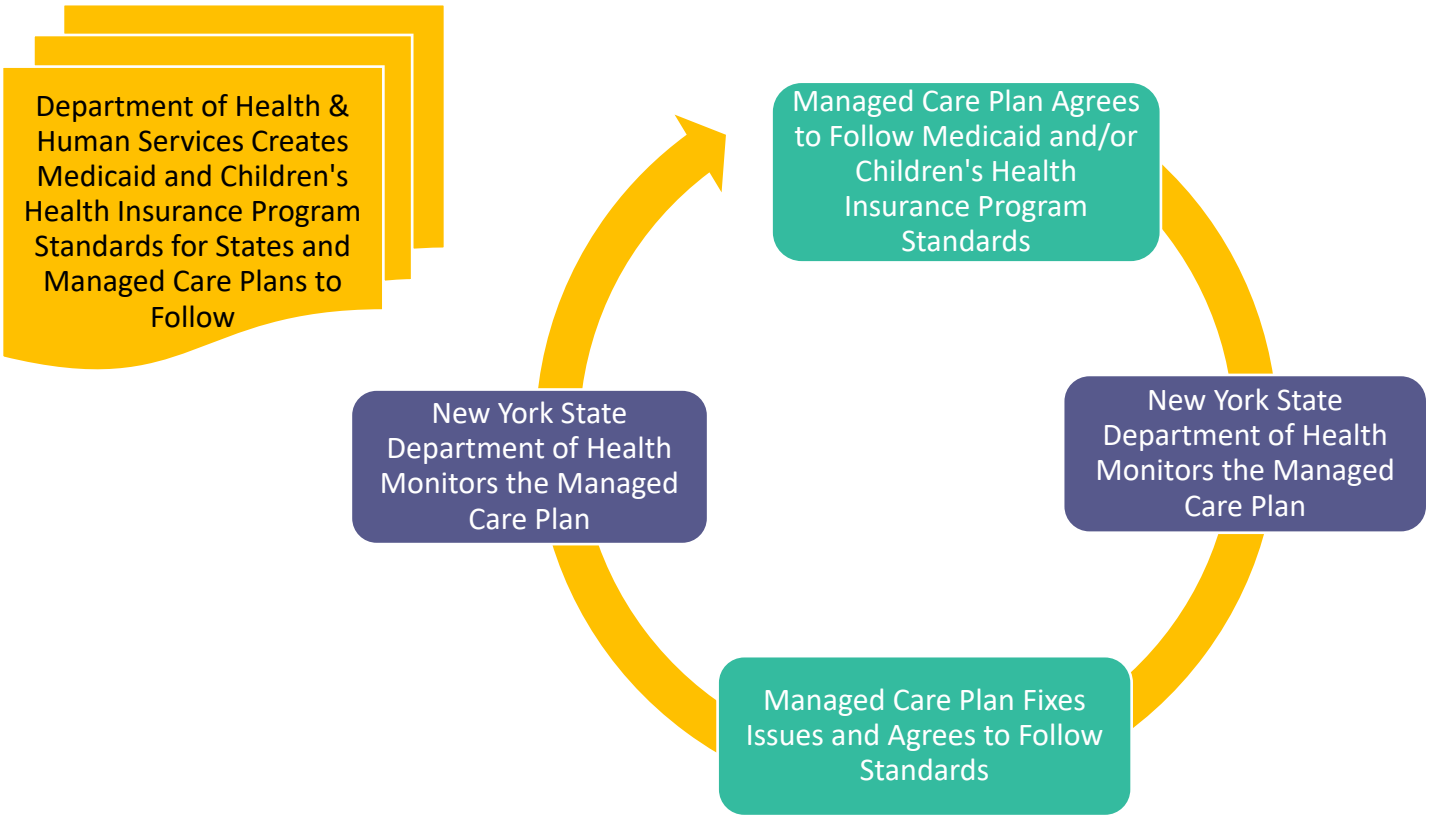
Red shading indicates managed care plan's 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically 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 and Children's Health Insurance Program should work. The Department of Health & Human Services created a set of rules for states and managed care plans to follow. These rules are called Medicaid and Children's Health Insurance Program standards. These standards protect people who receive health care through state managed care programs. All Medicaid and Children's Health Insurance Program 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 and Child Health Plus plans follow the required standards. The Department of Health continuously monitors the Medicaid managed care and Child Health Plus plans. The main way that the managed care plans are monitored is through the Managed Care Operational Survey. During the survey, the Department of Health reviews managed care plan documents and interviews staff. The 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 set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards*, the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56*, the enrollee rights requirements described in *42 Code of Federal Regulations 438.100*, the emergency and post-stabilization services requirements described in *42 Code of Federal Regulations 438.114*, and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330* is a mandatory external quality review 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 requirements and the applicable standards of *Title 42 Code of Federal Regulations Part 438 Managed Care and Part 457 State Children's Health Insurance Programs*, the *Medicaid Managed Care/HIV-Special Needs Plan/Health and Recovery Plan Model Contract*, the *Child Health Plus Model Contract*, *New York State Public Health Law Article 44* and *Article 49*, and *Title 10 of the 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 services and is conducted for New York's Medicaid managed care and Child Health Plus plans.

The Department of Health monitors Child Health Plus plan compliance with requirements for disenrollment outside of the Managed Care Operational Survey. Medicaid managed care plans and Child Health Plus plans follow different state requirements for disenrollment. The Department of Health grants Child Health Plus plans the authority to disenroll members while Medicaid managed care plans are not permitted to disenroll members. The Department of Health monitors Child Health Plus plan compliance with state and federal disenrollment requirements as part of the assessment for the federally mandated Children's Health Insurance Program Annual Report. Child Health Plus plan compliance with other state and federal requirements is monitored through the Managed Care Operational Survey.

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 and Children's Health Insurance Program standards. To meet this federal regulation, the Department of Health provided IPRO with the results of the Managed Care Operational Survey conducted for New York's Medicaid managed care and Child Health Plus plans in 2020, 2021, and 2022, and the results of the 2022 Child Health Plus Annual 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 managed care plans.

The results of the most recent compliance activities conducted for New York's Medicaid managed care and Child Health Plus plans by the Department of Health for 2020, 2021, and 2022 are presented in this report.

Technical Methods of Data Collection and Analysis

Managed Care Operational Survey

The Department of Health's primary method for managed care plan assessment and determination of compliance with federal and state 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. Survey team members include staff from across the Department of Health as well as other state agencies such as the Office of Mental Health and Office of Addiction Services and Supports.

The Comprehensive Operational Survey is a full review of state and federal Medicaid and Children's Health Insurance Program requirements which covers the following:

- Organization and Management
- Service Delivery
- Fraud, Waste, Abuse, and Program Integrity
- Management Information Systems
- Medicaid Contract
- Child Health Plus 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 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, and 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 implemented the plan of correction developed in response to the Comprehensive Operational Survey results and determined that the noncompliance has been corrected.
- An evaluation of the implementation of plan(s) of correction developed in response to other to noncompliant results issued secondary to complaints, or other monitoring areas, if applicable.

Each 2020, 2021, and 2022 Comprehensive Operational Survey and Target Operational Survey was conducted over an 8-week period in three phases:

Phase 1 - Pre-virtual 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 standards under review. The requested documents included, but were not limited to, organizational 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's survey team members reviewed the documentation for evidence of managed care plan compliance and to identify areas needing further review during the Department of Health's virtual 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 - Virtual Visit

During the virtual visit, the Department of Health's survey team members 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-virtual Visit

Six to eight weeks following the virtual 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 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* and *Child Health Plus 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.

Children's Health Insurance Program Annual Review

Under section 2108(a) of the Social Security Act, states must assess the operation of their separate Children's Health Insurance Program and Medicaid expansion programs and the progress made in reducing the number of uncovered, low-income children[15]. As part of the annual assessment, the Department of Health reviews the Child Health Plus plans' policies and procedures to determine compliance with standards for disenrollment notices and transactions. Results of the Department of Health's 2022 review of Child Health Plus plan compliance with disenrollment requirements are shared in this report.

IPRO cross-walked the results of the operational activities to federal standards contained in *42 Code of Federal Regulations Part 438*. The scope of these standards included in IPRO's crosswalk and in this report are:

- 438.56 Disenrollment requirements and limitations,
- 438.100 Enrollee rights requirements,
- 438.114 Emergency and poststabilization services,
- 438.206 Availability of services,
- 438.207 Assurances of adequate capacity and services,
- 438.208 Coordination and continuity of care,
- 438.210 Coverage and authorization of services,
- 438.214 Provider selection,
- 438.224 Confidentiality,
- 438.228 Grievance and appeal systems,
- 438.230 Subcontractual relationships and delegation,
- 438.236 Practice guidelines,
- 438.242 Health information systems, and
- 438.330 Quality assessment and performance improvement program.

[15] The results of the assessment are reported to the Secretary of Health and Human Services by January 1 following the end of the fiscal year in the Children's Health Insurance Program Annual Report Template System.

Description of Data Received

To evaluate managed care plan compliance with federal and state standards, IPRO reviewed the Department of Health-produced *Operational Deficiencies by Plan/Category Report* and the *Operational Plan Deficiencies Report* and *2022 Child Health Plus Findings Summary*. 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. The *2022 Child Health Plus Findings Summary* included descriptions of finding categories and the total number of findings issued by Child Health Plus plan.

Comparative Results

Managed care plan results for the Operational Survey activities conducted for 2020, 2021, and 2022 are presented by federal Medicaid and Children's Health Insurance Program standards in Table 32, except for UHCCP. UHCCP is actively contesting the outcomes of the 2022 compliance activity, consequently, the results are not available for public disclosure.

Managed care plan results for the Children's Health Insurance Program Report activity for 2022 are presented for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations* in Table 33.

In Table 32 and Table 33, 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 Managed Care Plan-Level Reporting section of this report.

Table 32: Managed Care Plan Operational Survey Results, 2020, 2021, and 2022

Managed Care Plan	Compliance Activity	Medicaid Compliance	Medicaid and Children's Health Insurance Program Compliance												
		438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Amida Care	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	C	C	C	NC	NC	C	C	C
	2022 Targeted										C	C			
CDPHP	2020 Comprehensive	C	C	C	NC	C	C	C	C	C	NC	NC	C	C	C
	2021 Pended[1]														
	2022 Targeted				C						C	NC			
Empire BCBS HealthPlus	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	NC	C	C	NC	C	C	NC	C
	2022 Open Period														
Excellus	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	C	C	C	NC	C	C	C	C
	2022 Targeted										C				
Fidelis	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	C	NC	C	NC	C	C	C	C
	2022 Open Period														
Healthfirst	2020 Pended[1]														
	2021 Pended[1]														
	2022 Comprehensive	C	C	C	C	C	C	C	C	C	NC	NC	C	C	C
Highmark BCBS WNY	2020 Pended[1]														
	2021 Pended[1]														
	2022 Comprehensive	C	C	C	C	C	C	C	C	C	NC	C	C	C	C
HIP	2020 Comprehensive	C	C	C	C	C	C	C	C	C	C	C	C	C	C
	2021 Comprehensive	C	C	C	C	C	C	C	C	C	NC	C	C	C	C
	2022 Open Period														
IHA	2020 Pended[1]														
	2021 Pended[1]														
	2022 Comprehensive	C	C	C	C	C	C	C	C	C	NC	NC	C	C	C
MetroPlus	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	C	C	C	C	C	C	C	C
	2022 Open Period														
Molina	2020 Pended[1]														
	2021 Pended[1]														

Managed Care Plan	Compliance Activity	Medicaid Compliance	Medicaid and Children's Health Insurance Program Compliance												
		438.56	438.100	438.114	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
	2022 Comprehensive	C	C	C	C	C	C	NC	C	C	NC	C	C	NC	C
MVP	2020 Comprehensive	C	C	C	NC	C	C	C	NC	C	NC	C	C	C	C
	2021 Pended[1]														
	2022 Targeted				NC				C		C				
UHCCP	2020 Pended[1]														
	2021 Comprehensive	C	C	C	NC	C	C	C	NC	C	C	C	C	C	C
	2022 Comprehensive	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available	Not Yet Available
VNS Health	2020 Pended[1]														
	2021 Comprehensive	C	C	C	C	C	C	C	C	C	C	C	C	C	C
	2022 Comprehensive	C	C	C	NC	C	NC	NC	C	C	NC	NC	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement; Comprehensive: a full review of state and federal Medicaid and Children's Health Insurance Program requirements; Targeted: a follow-up review to the Comprehensive Operational Survey and includes standard reporting and review in addition to a follow-up of all areas and issues identified to be noncompliant during the Comprehensive Operational Survey; Open Period: the timeline between the accepted plan of correction and the date certain for implementation.

Table 33: Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Compliance Activity	Managed Care Plan	Children's Health Insurance Program Compliance
		438.56
2022 Children's Health Insurance Program Annual Report	CDPHP	C
	Empire BCBS HealthPlus	C
	Excellus	C
	Fidelis	NC
	Highmark BCBS WNY	C
	Healthfirst	C
	HIP	C
	IHA	NC
	MetroPlus	NC
	Molina	NC
	MVP	C
	UHCCP	NC

C: Managed care plan is in compliance with all standard requirements; NC: Managed care 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 and Child Health Plus programs 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 children. 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.

Between October 2022 and January 2023, IPRO surveyed parents/guardians of New Yorkers under the age of 18 who received care in 2022 through a Mainstream Medicaid or Child Health Plus plan. IPRO asked these New Yorkers to rate their experiences with the managed care plans, health care services, personal doctors, and specialists.

The results of the 2022 survey were used by the Department of Health as a tool to monitor Mainstream Medicaid and Child Health Plus plans and provider performance. The Mainstream Medicaid and Child Health Plus plans used the survey results to understand the experience of New Yorkers enrolled with their managed care plan.

For more information about the 2022 survey, please read the Technical Summary – Administration of Quality-of-Care Surveys section.

Technical Summary – Administration of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations Section 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 Section 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 children enrolled in a Mainstream Medicaid or Child Health Plus 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 Section 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 2022, IPRO subcontracted with DataStat, an NCQA-certified CAHPS vendor, to administer the *CAHPS 5.1H Child Medicaid Survey* on behalf of the 12 managed care plans with enrollees under 18 years of age.

This external quality review report presents the 2023 CAHPS results for measurement year 2022.

Technical Methods for Data Collection and Analysis

The standardized survey instrument administered for 2022 was the *CAHPS 5.1H Child Medicaid Survey* including *Children with Chronic Conditions* supplemental questions. The majority of questions addressed parent's/caretaker's experience with their child's health care, such as getting care quickly, communication with doctors, overall satisfaction with health care, and screening questions to identify children with chronic conditions. The questionnaire was further expanded to include five items from the CAHPS Health Information Technology Item Set and an additional six 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 87 questions.

The CAHPS survey yields two primary result types for reporting:

1. composite measures
2. global rating measures

There are five global rating measures and five composite measures. Composites group individual questions related to the same broad domain of performance. In the case of the standard *CAHPS Child Medicaid Survey*, composites aggregate responses into four key care areas: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. The achievement score for each composite is the average of the scores for individual items within that composite.

To enhance clarity and provide a user-friendly presentation of the survey's key findings, the Department of Health publicly reports CAHPS results by composite measure and global rating measure. Table 34 displays measures presented in this report along with response options.

Table 34: CAHPS Reporting Categories and Response Options

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

Children who were current members of a New York State Mainstream Medicaid or Child Health Plus plan, ages 17 years and younger as of July 31, 2022, and who had been enrolled in a Mainstream Medicaid or Child Health Plus managed care plan for five out of the six months in the period of January 1, 2022 through June 30, 2022, were eligible to be randomly selected for the survey. A stratified random sample of 1,750 children ages 0 to 17 years was drawn for each managed care plan, resulting in a statewide sample size of 21,000 members.

Respondents were parents or caretakers of the selected children. The survey was administered over a 13-week period using a mixed-mode (mail and web) five wave protocol. The protocol consisted of a first questionnaire packet and first reminder postcard to a parent/caretaker of all selected child members, followed by a second questionnaire packet and second postcard to non-responders to the first mailing, and a third questionnaire packet to non-responders to prior mailings. Each cover letter included a member-specific link and a quick response code with password for members who preferred to complete the survey online.

Table 35 provides a summary of the technical methods of data collection.

Table 35: CAHPS Technical Methods of Data Collection Summary

Category	Data Collection Information
Survey Vendor	DataStat, Inc.
Survey Tool	*CAHPS 5.1H Child Medicaid Survey*
Number of Managed Care Plans	12
Type of Managed Care Plan	Mainstream Medicaid and Child Health Plus
Survey Period	10/21/2022–1/20/2023
Method of Collection	Mail and Web in Five Waves
Sample Size	21,000 (1,750 Per Managed Care Plan)
Number of Completed Surveys	2,467
Response Rate	13.1%

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

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.

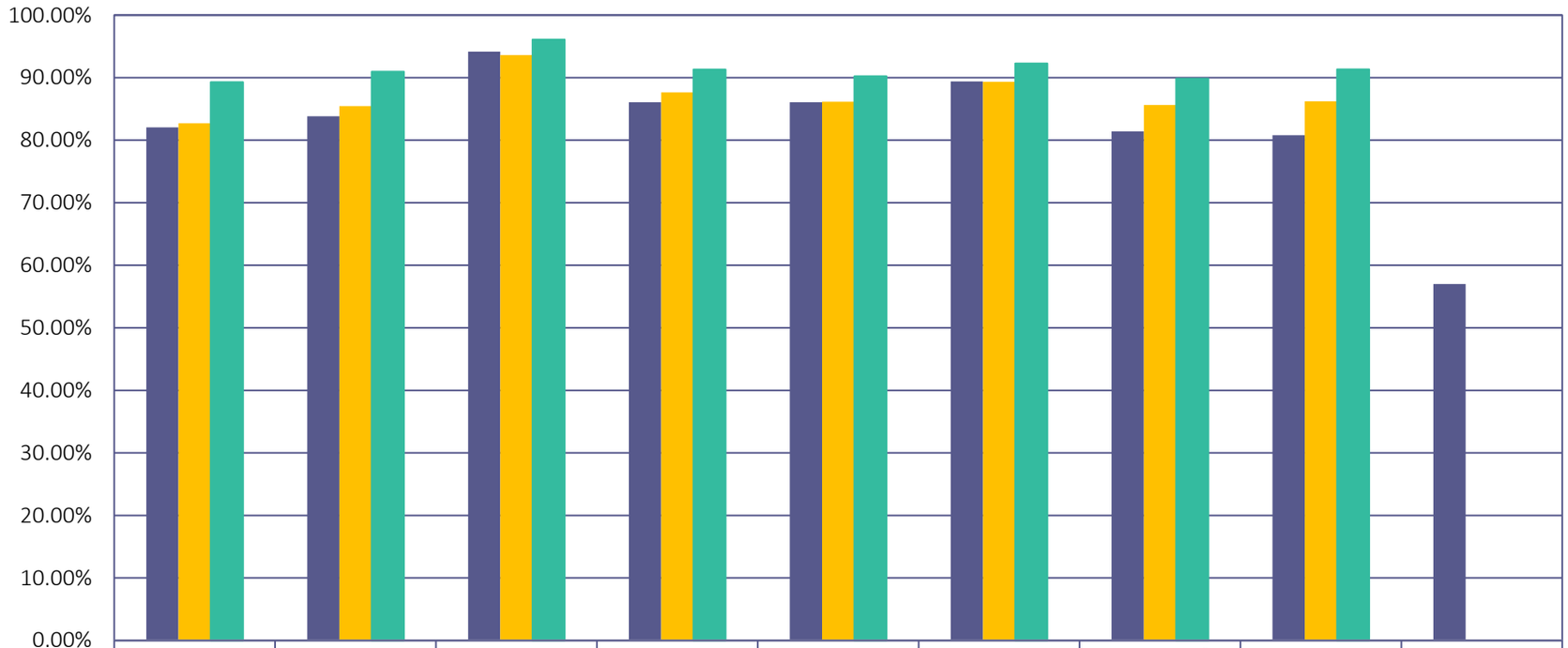
Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Description of Data Obtained

IPRO received a copy of the *New York State Medicaid and Child Health Plus CAHPS 5.1H Child CCC Survey* report that was produced by DataStat, Inc. in February 2023. 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 Medicaid benchmarks for measurement year 2022 are presented in Figure 1. Achievement scores for the managed care plans are presented in Table 36.



	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan	Rating of Treatment or Counseling
Statewide 2022 Mainstream Medicaid and Child Health Plus	82.04%	83.82%	94.17%	86.07%	86.07%	89.41%	81.40%	80.80%	57.00%
National 2022 Medicaid Mean	82.71%	85.46%	93.62%	87.64%	86.16%	89.33%	85.63%	86.21%	Not Available
National 2022 Medicaid 90th Percentile	89.28%	90.95%	96.10%	91.32%	90.24%	92.27%	89.84%	91.33%	Not Available

Figure 1: 2022 Member Satisfaction Achievement Scores. Achievement scores for Statewide Mainstream Medicaid and Child Health Plus (dark purple), National Medicaid Mean (yellow) and National Medicaid 90th Percentile (green) for 2022.

Table 36: Mainstream Medicaid and Child Health Plus CAHPS Achievement Scores by Managed Care Plan, Measurement Year 2022

	Mainstream Medicaid and Child Health Plus Enrollee Satisfaction								
Benchmark/Managed Care Plan	Getting Needed Care[1]	Getting Care Quickly[1]	How Well Doctors Communicate[1]	Customer Service[1]	Rating of Personal Doctor[2]	Rating of Specialist Seen Most Often[2]	Rating of All Health Care[2]	Rating of Health Plan[2]	Rating of Treatment or Counseling[2]
Statewide 2022 Mainstream Medicaid Managed Care and Child Health Plus	82.04%	83.82%	94.17%	86.07%	86.07%	89.41%	81.40%	80.80%	57.00%
National 2022 Medicaid Mean	82.71%	85.46%	93.62%	87.64%	86.16%	89.33%	85.63%	86.21%	Not Available
National 2022 Medicaid 90th Percentile	89.28%	90.95%	96.10%	91.32%	90.24%	92.27%	89.84%	91.33%	Not Available
CDPHP	80.62%	90.95%	96.56%	Small Sample	89.09%	91.61%	88.34%	89.27%	60.30%
Empire BCBS HealthPlus	84.06%	84.33%	94.65%	81.58%	89.50%	79.26%	83.82%	79.28%	Small Sample
Excellus	85.22%	86.32%	94.47%	Small Sample	92.86%	82.64%	91.05%	86.80%	56.32%
Fidelis Care	82.74%	80.35%	93.88%	83.95%	89.24%	82.98%	83.60%	77.98%	Small Sample
Healthfirst	85.23%	81.71%	91.03%	88.57%	86.70%	87.99%	87.40%	83.46%	Small Sample
Highmark BCBS WNY	87.08%	90.21%	94.30%	93.45%	87.57%	82.55%	89.46%	83.88%	60.08%
HIP	75.89%	82.67%	93.36%	84.52%	92.39%	85.69%	84.27%	72.48%	58.51%
IHA	87.81%	88.66%	96.09%	86.79%	91.35%	82.02%	89.01%	85.68%	57.73%
MetroPlus	76.58%	76.97%	91.88%	81.51%	89.58%	60.77%	83.12%	77.69%	Small Sample
Molina	73.03%	79.78%	94.53%	85.40%	85.34%	82.14%	83.40%	78.78%	Small Sample
MVP	86.42%	82.34%	94.81%	89.47%	90.55%	86.36%	84.73%	83.52%	63.82%
UHCCP	79.84%	81.55%	94.49%	88.01%	88.72%	72.85%	84.58%	70.77%	Small Sample

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

To assess the impact of Medicaid managed care and Child Health Plus on the quality of, timeliness of, and access to health care services, IPRO considered managed care plan responses to the 2021 external quality review recommendations, as well as plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2022 external quality review:

- Managed Care Plan Follow-Up on 2021 External Quality Review Recommendations
- External Quality Review Mandatory Activity 1: Performance Improvement Projects (2022)
- External Quality Review Mandatory Activity 2: Performance Measures (2022)
- External Quality Review Mandatory Activity 3: Compliance with Medicaid and Children's Health Insurance Program Standards (2020-2022)
- External Quality Review Optional Activity 6: Quality-of-Care Survey on Member Experience (2022)

Assessment of Managed Care Plan Follow-up on the 2021 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 *2021 External Quality Review Technical Report*. Managed care plan responses are reported in this section of the report.

Table 37 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the 2021 external quality review recommendations.

Table 37: 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, more time is needed to observe for performance improvement.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; or performance declined.

Performance Improvement Project Summary and Results

This section displays a comprehensive summary of the managed care plans' performance improvement projects that were in place in 2022. Each summary includes the project topic, the external quality review organization's validation statement, study populations, aims, a description of key interventions, and results achieved. Within every summary, the populations being studied are categorized into one of two groups, global or subgroup. The global group represents all managed care plan members meeting the study criteria, while the subgroup represents members identified by the managed care plan as meeting the study criteria and experiencing a health disparity. Aim statements for these two groups are independent and are presented under "Global Aim" or

"Disparity Reduction Aim." The corresponding tables display performance indicators, baseline rates, interim rates, and targets/goals. Performance indicators and rates representing the subgroup are identified by the following table footnote "subpopulation targeted for health disparity reduction." A managed care plan's performance indicator showing improvement from the baseline or meeting/exceeding the established target were considered strengths, while opportunities for improvement were noted when an indicator demonstrated performance decline from the baseline or did not meet the established target.

Performance Measure Results

This section displays the managed care plan-level HEDIS/Quality Assurance Report Requirements performance rates for measurement years 2020, 2021, and 2022, as well as the statewide average rates for measurement year 2022. The corresponding tables indicate whether the managed care plan's rate was statistically better than the statewide average rate (indicated by green shading) or whether the managed care plan's rate was statistically worse than the statewide average rate (indicated by red shading). A managed care plan statistically exceeding the statewide average rate for a measure was considered a strength during this evaluation, while a managed care plan rate reported statistically below the statewide average rate was considered an opportunity for improvement.

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

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

Quality-of-Care Survey Results – Member Experience

This section displays the managed care plan-level Child CAHPS performance for 2018, 2020, and 2022. The corresponding tables display the satisfaction domains, individual supplemental questions, managed care plan scores, and the statewide average scores for measurement years 2018, 2020, and 2022. 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.

The 2022 CAHPS was administered for Mainstream Medicaid and Child Health Plus only. There are no CAHPS data for managed care plans that do not participate in either of these two programs.

Strengths, Opportunities for Improvement, and Recommendations

The managed care 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.

The strengths and opportunities for improvement based on the managed care plans' 2022 performance, as well as recommendations for improving quality, timeliness, and access to care are presented in this section (in table format). In these tables, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 38: Amida Care's Response to 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Amida Care's Response	IPRO's Assessment of Amida Care's Response
Validation of Performance Improvement Projects			
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.	HIV Special Needs Plan	Amida Care shares monthly gaps-in-care reports with all primary care providers which includes mental health and substance use screenings. Supplemental data is encouraged to close care gaps. Amida Care collaborates with regional health information organizations to maximize all data reporting opportunity.	Addressed.
Validation of 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.	HIV Special Needs Plan	Amida Care's Quality Management Department informs decisions for improving quality, providing quality improvement initiatives, improving patient safety, and leveraging our clinical informatics team to support the development of high quality and timely analyses and reports. Performance improvement initiatives are focused on monitoring and improving health care delivery and health outcomes; addressing metrics as highlighted in the HEDIS and Quality Assurance Reporting Requirements performance results. Measures are analyzed and trended monthly.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Amida Care should execute the approved corrective action plan	HIV Special Needs Plan	Barrier analysis and interventions are monitored	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	Amida Care's Response	IPRO's Assessment of Amida Care's Response
and conduct routine monitoring to ensure compliance is achieved and maintained.		monthly with all key stakeholders. Performance results and outcomes are tracked and reviewed as outlined in the corrective action plan. If performance metrics are not achieving the desired projected results, interventions will be revaluated using the 'plan-do-study-act' methodology. Corrective action plans are shared with Amida Care's Quality Management Committee, value-base payment provider groups and supporting vendors.	
Administration of Quality-of-Care Surveys – Member Experience			
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.	HIV Special Needs Plan	Amida Care implemented technological improvements of a Zoom channel and cloud-based platform allows for first call resolution and reduction in abandoned calls. Adoption of new platform increased call routing efficiency and the implementation of a virtual receptionist significantly improved call handling efficiency. Daily huddles conducted each day monitoring call center stats and new member orientation, identifying areas of improvement, and reviewing established action plans.	Partially addressed.

Table 39: Amida Care's HIV Special Needs Plan Performance Improvement Project Summary, 2022

Amida Care's HIV Special Needs Plan Performance Improvement Project Summary
Title: Improving the Adult Preventive Dental Access Rate **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** HIV Special Needs Plan **Subpopulations With Health Disparity:** Black/African American Members Ages 21-64 Years; Members Ages 21-64 Years Residing in Brooklyn, New York
Global Aim ▪ Amida Care aims to maintain the rate of emergency department visits for non-traumatic dental conditions for all age groups at less than 10 visits per 100,000 member months. Disparity Reduction Aims ▪ Amida Care aims to increase preventive dental care visits among Black/African American members ages 21–64 years. ▪ Amida Care aims to increase preventive dental care visits among members ages 21–64 years residing in Brooklyn, New York. Member-Focused 2022 Interventions ▪ Mailed the Amida Care SMILE brochure to members identified as not having a dental claim within the last 18 months. ▪ HealthPlex conducted quarterly member outreach calls to members overdue for preventive dental care. Provider-Focused 2022 Interventions ▪ Distributed reports of members missing a preventive dental visit to providers who participate in the value-based program and to primary care providers. ▪ Discussed dental measures and performance rates during the quarterly value-based program provider meetings. Managed Care Plan-Focused 2022 Interventions ▪ Established a process to identify annual dental visit claims reported to HealthPlex as part of the Healthy Reward program but that are unknown to Amida Care.

Table 40: Amida Care's HIV Special Needs Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of HIV Special Needs Plan members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	14.36%	16.63%	29.40%
Black/African American, ages 21–64 years[1]	12.85%	14.79%	Not Applicable
Brooklyn, New York resident, ages 21–64 years[1]	13.05%	15.29%	Not Applicable
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 HIV Special Needs Plan member months[2]			
Ages 21–64 years	273.35	267.40	<10.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Performance Measure Results

Table 41: Amida Care's HIV Special Needs Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Amida Care Measurement Year 2020	Amida Care Measurement Year 2021	Amida Care Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	24.12%	22.79%
Antidepressant Medication Management – Effective Acute Phase Treatment	52.57%	52.92%	60.69%	61.98%
Antidepressant Medication Management – Effective Continuation Phase Treatment	36.25%	37.43%	45.38%	46.31%
Asthma Medication Ratio (19-64 Years)	34.93%	36.01%	59.35%	40.27%
Breast Cancer Screening	59.36%	58.94%	61.61%	68.00%
Cervical Cancer Screening	73.97%	68.13%	68.33%	75.27%
Chlamydia Screening in Women (16–20 Years)	Small Sample	Small Sample	Small Sample	85.11%
Chlamydia Screening in Women (21–24 Years)	76.00%	77.42%	79.71%	78.72%
Colorectal Cancer Screening (50–75 Years)	55.47%	62.77%	56.09%	60.41%
Controlling High Blood Pressure	54.26%	58.88%	51.26%	61.61%
Diabetes – Eye Exam for Patients With Diabetes	50.12%	38.69%	48.42%	61.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)	32.36%	26.76%	21.65%	21.05%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	35.72%	40.97%	39.64%
Advising Smokers to Quit[1]	94.04%	88.24%	88.24%	88.55%
Discussing Smoking Cessation Medications[1]	87.33%	76.30%	76.30%	77.78%
Discussing Smoking Cessation Strategies[1]	76.97%	73.13%	73.13%	72.97%
Statin Therapy for Patients With Cardiovascular Disease – Adherence 80%	78.33%	77.78%	78.63%	82.13%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	16.38%	16.83%	13.19%	14.51%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	51.78%	51.36%	56.02%	59.47%

Measure Description	Amida Care Measurement Year 2020	Amida Care Measurement Year 2021	Amida Care Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	7.93%	4.02%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	Small Sample
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	96.60%	97.76%	97.07%	96.70%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	48.21%	48.33%	55.81%	51.45%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	35.47%	37.50%	34.76%	36.82%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	33.43%	28.61%	41.44%	37.19%
Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder	Not Available	33.21%	31.39%	31.33%
Viral Load Suppression	74.03%	73.53%	76.76%	80.13%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	49.11%	34.42%	42.40%	45.09%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	9.15%	10.20%	11.08%

[1] Measure derives from adult CAHPS. Measurement year 2020 CAHPS results are reported for measurement year 2021 because the adult CAHPS survey is administered every other year.

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. 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 42: Amida Care's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Not Reviewed
438.100 Enrollee Rights (Medicaid)	Pended	C	Not Reviewed
438.114 Emergency and Poststabilization Services (Medicaid)	Pended	C	Not Reviewed
438.206 Availability of Services (Medicaid)	Pended	C	Not Reviewed
438.207 Assurances of Adequate Capacity and Services (Medicaid)	Pended	C	Not Reviewed
438.208 Coordination and Continuity of Care (Medicaid)	Pended	C	Not Reviewed
438.210 Coverage and Authorization of Services (Medicaid)	Pended	C	Not Reviewed
438.214 Provider Selection (Medicaid)	Pended	C	Not Reviewed
438.224 Confidentiality (Medicaid)	Pended	C	Not Reviewed
438.228 Grievance and Appeal System (Medicaid)	Pended	NC	C
438.230 Subcontractual Relationships and Delegation (Medicaid)	Pended	NC	C
438.236 Practice Guidelines (Medicaid)	Pended	C	Not Reviewed
438.242 Health Information Systems (Medicaid)	Pended	C	Not Reviewed
438.330 Quality Assessment and Performance Improvement Program (Medicaid)	Pended	C	Not Reviewed

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 43: Amida Care's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	HIV Special Needs Plan	Amida Care's performance improvement project for the HIV Special Needs Plan population passed validation for measurement year 2022.			
		All four performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	HIV Special Needs Plan	Amida Care met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	HIV Special Needs Plan	Four performance measure rates reported by Amida Care for measurement year 2022 performed statistically significantly better than the statewide HIV Special Needs Plan mean.	X	X	X
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	During measurement year 2022, Amida Care was in compliance with the two standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement					
Performance Improvement Projects	HIV Special Needs Plan	Amida Care did not meet goal rates for the two indicators with established targets.	X	X	X
Performance Measures – Effectiveness of Care	HIV Special Needs Plan	Six performance measure rates reported by Amida Care for measurement year 2022 performed statistically significantly worse than the statewide HIV Special Needs Plan mean.	X	X	X
Performance Measures – Access/ Availability of Care	HIV Special Needs Plan	One performance measure rate reported by Amida Care for measurement year 2022 performed statistically significantly worse than the statewide HIV Special Needs Plan mean.	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	None.			
Recommendations					
Performance Improvement Projects	HIV Special Needs Plan	Amida Care should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	HIV Special Needs Plan	Amida Care should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Amida Care should concentrate on improving areas of care where its rates fall below HIV Special Needs Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	Amida Care should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. Amida Care should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 44: CDPHP's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	CDPHP's Response	IPRO's Assessment of CDPHP's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, CDPHP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	CDPHP is committed to addressing and supporting lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening and follow-up. Ongoing activities include care coordination services for identified gaps in care, transportation assistance, member education, gaps-in-care list dissemination to provider practices, provider engagement and collaboration to address care delivery barriers, inclusion in value-based payment programs, and financial support of the Parenting Support Program.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, CDPHP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	CDPHP identified that physical office locations are often not able to schedule timely patient appointments. In January 2023, CDPHP contracted with a telehealth vendor to expand access for patients who have been discharged. Members are guided to the platform by care managers and care navigators. Monitoring will include reviewing the rate of members who are discharged from inpatient psychiatry who had a visit from the telehealth vendor. This is reported monthly.	Addressed.
Validation of Performance Measures			
CDPHP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in	Mainstream Medicaid and Child Health Plus	CDPHP has developed quality pillars in which workgroups engage providers, members, internal and external resources to	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	CDPHP's Response	IPRO's Assessment of CDPHP's Response
the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, CDPHP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.		improve performance metrics. Any area in which our rates do not exceed mainstream Medicaid performance is assigned to a pillar. Rates are monitored on a monthly basis to ensure that improvement efforts are succeeding, and to identify any new areas where performance is no longer on target.	
CDPHP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, CDPHP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	CDPHP has developed quality pillars in which workgroups engage providers, members, internal and external resources to improve performance metrics. Any area in which our rates do not exceed Health and Recovery Plan performance is assigned to a pillar. Rates are monitored on a monthly basis to ensure that improvement efforts are succeeding, and to identify any new areas where performance is no longer on target.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
CDPHP should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2020 compliance findings. CDPHP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	CDPHP maintains active quality oversight checks of this vendor and all mentioned elements are included in these checks involving Medicaid enrollees. In addition, CDPHP performed a specific audit on the improved process in May 2021 to verify the correction has had the intended effect. CDPHP has a dedicated staff member responsible for ensuring the internal audits are completed.	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	CDPHP's Response	IPRO's Assessment of CDPHP's Response
Administration of Quality-of-Care Surveys – Member Experience			
CDPHP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	CDPHP's CAHPS Drive To 5 Team meets monthly to analyze CAHPS survey results. This team evaluates all categories that either fell below benchmark or came in lower than previous years. Opportunities are identified for improvement based on the findings. Customer Service, Rating of All Health Care and Rating of Specialist are categories that we have historically found opportunities to improve upon.	Partially addressed.
CDPHP should work to improve its performance on measures of member satisfaction for which it did not meet the Health and Recovery Plan average.	Health and Recovery Plan	CDPHP's CAHPS Drive To 5 Team meets monthly to analyze CAHPS survey results. This team evaluates any category that fell below benchmark or came in lower than previous years. Opportunities are identified based on the findings. Getting needed care and Getting care quickly are two common categories that we have found opportunities to improve upon. Past improvement strategies have included newsletter publications, in office signage and email blasts to help with providing education when needed.	Partially addressed.

Table 45: CDPHP's Mainstream Medicaid Performance Improvement Project Summary, 2022

CDPHP's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Adult Members **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Male Members Ages 21-64 Years
Global Aims ▪ CDPHP aims to increase annual preventive dental visits among members ages 21–64 years. ▪ CDPHP aims to decrease ambulatory emergency department visits for non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aim ▪ CDPHP aims to increase annual preventive dental visits among male members ages 21–64 years. Member-Focused 2022 Interventions ▪ Educated members with no claims in the past 12 months on the importance of oral hygiene and preventive dental care. ▪ Conducted direct telephone outreach to members identified as not having a preventive dental visit and having one or more emergency department visits related to a non-traumatic dental condition. Assistance with locating a dentist and/or scheduling a preventive dental appointment was offered to the member during the call. ▪ Mailed educational materials to members identified as having at least one emergency department visit related to a non-traumatic dental condition. ▪ Educated members on transportation services available for dental appointments. ▪ Targeted male members with a mixed media educational campaign on the importance of oral hygiene and preventive dental care. Provider-Focused 2022 Interventions ▪ Published an article in the provider newsletter on promoting oral health in the primary care setting. Managed Care Plan-Focused 2022 Interventions ▪ CDPHP's dental vendor conducted recruitment activities in counties with network deficiencies.

Table 46: CDPHP's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	14.38%	14.23%	26.00%
Males, ages 21–64 years[1]	11.33%	10.95%	19.30%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	180.65	196.47	71.68

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 47: CDPHP's Health and Recovery Plan Performance Improvement Project Summary, 2022

CDPHP's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Black/African American Members Ages 21–64 Years With Diabetes
Global Aims ▪ CDPHP aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ CDPHP aims to increase the rate of smoking cessation pharmacotherapy engagement among members ages 21–64 with diabetes. ▪ CDPHP aims to increase the rate of smoking cessation counseling among members 21–64 years with diabetes. ▪ CDPHP aims to increase the rate of smoking cessation pharmacotherapy engagement and smoking cessation counseling among members ages 21–64 years with diabetes. Disparity Reduction Aim ▪ CDPHP aims to increase the rate of blood pressure control among Black/African American members ages 21–64 years with diabetes. Member-Focused 2022 Interventions ▪ Conducted targeted outreach to members with gaps in diabetes care. ▪ Mailed diabetes disease management education materials to members. ▪ Educated members who self-identify as smokers on the importance of smoking cessation and the Pivot program. The Pivot program addresses tobacco use and leverages features such as smart phone technology, carbon monoxide sensors, tools to combat cravings, and quit coaches to support members in their smoking cessation. ▪ Referred members to a health home.

Table 48: CDPHP's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	30.67%	45.74%	38.67%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	63.81%	47.34%	57.81%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	51.74%	62.77%	59.74%
Black/African Americans, ages 21–64 years[4]	48.43%	58.90%	59.43%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	21.66%	18.09%	28.66%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	19.19%	18.22%	24.19%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	9.16%	7.58%	14.16%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 49: CDPHP's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	CDPHP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	19.68%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	58.81%	58.02%	60.21%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	42.68%	42.08%	43.49%	41.45%
Asthma Medication Ratio (5–64 Years)	66.03%	68.79%	72.45%	61.20%
Breast Cancer Screening	60.76%	57.82%	60.42%	65.60%
Cervical Cancer Screening[1]	67.99%	64.75%	63.20%	69.95%
Chlamydia Screening in Women (16–20 Years)	65.21%	63.70%	62.95%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	71.75%	68.95%	69.16%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	57.61%	62.72%	53.84%	52.96%
Controlling High Blood Pressure	71.78%	72.81%	73.13%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	58.97%	54.68%	64.79%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	35.14%	30.96%	30.32%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.94%	77.24%	76.94%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	40.25%	40.99%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	30.80%	27.96%	28.21%	35.47%
Childhood Immunization Status – Combination 3	82.48%	75.67%	75.18%	68.59%

Measure Description	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	CDPHP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	34.91%	33.39%	33.33%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	84.00%	88.75%	83.11%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	83.60%	85.00%	80.37%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.92%	63.96%	62.61%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	24.89%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	83.03%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	43.74%	47.68%	48.88%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	68.24%	64.81%	63.25%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	47.65%	41.02%	46.46%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	55.07%	51.42%	50.41%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.37%	39.19%	42.01%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	23.03%	16.38%	31.89%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	First Year Measure, Not Publicly Reported	29.55%	32.69%	41.50%

Measure Description	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	CDPHP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	49.35%	53.22%	45.93%
Pharmacotherapy for Opioid Use Disorder	First Year Measure, Not Publicly Reported	37.56%	35.68%	33.31%
Viral Load Suppression	78.66%	78.06%	77.90%	74.19%
Prenatal Immunization Status	40.64%	31.97%	28.78%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	41.94%	42.62%	45.49%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	17.02%	16.63%	18.06%
Annual Dental Visit (2–18 Years)	53.87%	58.98%	61.23%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	94.65%	93.46%	92.83%	86.75%
Prenatal and Postpartum Care – Postpartum Care	81.75%	79.23%	84.23%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	67.51%	67.62%	66.70%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	74.57%	74.35%	74.43%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	85.67%	81.58%	79.11%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 50: CDPHP's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	CDPHP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	53.72%	61.16%	49.40%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.53%	44.90%	33.33%	38.03%
Asthma Medication Ratio (19-64 Years)	51.91%	60.90%	67.29%	52.89%
Breast Cancer Screening	55.68%	52.03%	51.17%	54.68%
Cervical Cancer Screening	70.34%	61.78%	67.60%	63.33%
Chlamydia Screening in Women (21–24 Years)	64.29%	81.67%	71.43%	72.23%
Colorectal Cancer Screening (50–75 Years)	58.76%	61.04%	55.33%	47.33%
Controlling High Blood Pressure	72.51%	73.43%	77.13%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	55.06%	55.53%	55.99%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	36.54%	34.40%	29.10%	37.57%
Flu Vaccination for Adults Ages 18-64	50.85%	49.24%	49.24%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	39.24%	38.74%	32.93%
Advising Smokers to Quit (CAHPS)	88.64%	86.93%	86.93%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	72.73%	68.83%	68.83%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	65.52%	61.04%	61.04%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	64.22%	61.21%	69.29%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	22.99%	41.49%	21.21%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.97%	65.07%	67.82%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.28%	76.16%	80.42%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	63.14%	49.17%	54.95%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	48.17%	42.61%	39.93%	49.48%

Measure Description	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	CDPHP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	84.21%	81.20%	77.00%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	25.77%	29.51%	43.76%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	40.17%	34.66%	39.41%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	49.31%	50.98%	42.80%
Pharmacotherapy for Opioid Use Disorder	34.21%	32.78%	32.08%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	26.15%	27.88%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	19.25	19.85	20.42

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 51: CDPHP's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	C	Pended	Not Reviewed
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	NC	Pended	C
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	NC	Pended	C
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	NC	Pended	NC
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 52: CDPHP's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on interview and review of submitted documentation, CDPHP failed to submit one renewal amendment and four amendments to the *Management Services Agreement* with Caremark PCS Health, LLC to the New York State Department of Health for review and approval. Specifically, the following one renewal amendment was not submitted: A renewal amendment dated 01/01/2021. The contract expired on 12/31/2020. Specifically, the following four amendments were not submitted: an amendment dated 03/05/2018, an amendment dated 08/01/2019, an amendment dated 08/15/2020, and an amendment dated 12/15/2020. These issues were discovered after a review of the Caremark *Management Services Agreement* and additional documentation submitted on 01/21/2022 and discussion with CDPHP staff on 01/18/22 and 01/20/2022.	Contract Article 98-1.11(j)	438.230
Based on interview and review of submitted documentation, CDPHP failed to submit one renewal amendment and four amendments to the *Management Services Agreement* with Caremark PCS Health, LLC to the New York State Department of Health for review and approval. Specifically, the following one renewal amendment was not submitted: A renewal amendment dated 01/01/2021. The contract expired on 12/31/2020. Specifically, the following four amendments were not submitted: an amendment dated 03/05/2018, an amendment dated 08/01/2019, an amendment dated 08/15/2020, and an amendment dated 12/15/2020. These issues were discovered after a review of the Caremark *Management Services Agreement* and additional documentation submitted on 01/21/2022 and discussion with CDPHP staff on 01/18/22 and 01/20/2022.	Contract Article 98-1.11(m)	438.230
Based on interview and review of submitted documentation, CDPHP failed to submit one renewal amendment and four amendments to the *Management Services Agreement* with Caremark PCS Health, LLC to the New York State Department of Health for review and approval. Specifically, the following one renewal amendment was not submitted: A renewal amendment dated 01/01/2021. The contract expired on 12/31/2020. Specifically, the following four amendments were not submitted: an amendment dated 03/05/2018, an amendment dated 08/01/2019, an amendment dated 08/15/2020, and an amendment dated 12/15/2020. These issues were discovered after a review of the Caremark *Management Services Agreement* and additional documentation submitted on 01/21/2022 and discussion with CDPHP staff on 01/18/22 and 01/20/2022.	Contract Article 98-1.11[k]	438.230

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 53: CDPHP's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	CDPHP	Mainstream Medicaid and Child Health Plus Average	CDPHP	Mainstream Medicaid and Child Health Plus Average	CDPHP	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	88.14%	83.75%	82.47%	84.31%	80.62%	82.04%
Getting Care Quickly[1]	92.46%	88.14%	94.09%	87.84%	90.95%	83.82%
How Well Doctors Communicate[1]	96.73%	93.44%	95.74%	93.35%	96.56%	94.17%
Customer Service[1]	92.70%	85.84%	88.91%	86.53%	Small Sample	86.07%
Rating of All Health Care[2]	90.04%	87.48%	92.83%	89.77%	88.34%	86.07%
Rating of Personal Doctor[2]	91.42%	90.40%	92.39%	90.08%	89.09%	89.41%
Rating of Specialist Talked to Most Often[2]	82.33%	83.58%	88.85%	87.11%	91.61%	81.40%
Rating of Health Plan[2]	88.40%	85.18%	88.32%	86.02%	89.27%	80.80%
Rating of Treatment or Counseling[2]	78.24%	68.99%	58.89%	65.85%	60.30%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 54: CDPHP's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	CDPHP's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		None.	X	X	X
	Health and Recovery Plan	CDPHP's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Four of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	CDPHP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Eight performance measure rates reported by CDPHP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
	Health and Recovery Plan	Six performance measure rates reported by CDPHP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by CDPHP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by CDPHP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, CDPHP was in compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, CDPHP was in compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	Four member satisfaction scores achieved by CDPHP for measurement year 2022 performed statistically significantly better than the Mainstream Medicaid and Child Health Plus program average.	X	X	X
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	All three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Nine performance measure rates reported by CDPHP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	One performance measure rate reported by CDPHP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by CDPHP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, CDPHP was not in full compliance with one of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	CDPHP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	CDPHP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	CDPHP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, CDPHP should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	CDPHP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, CDPHP should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	CDPHP should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. CDPHP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 55: Empire BCBS HealthPlus's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Empire BCBS HealthPlus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Empire BCBS HealthPlus continues the execution of member outreach and engagement interventions: Multi-lingual text campaigns on hearing, lead and developmental delay screenings targeting members 0-3 years. Early, Periodic, Screenings and Diagnostic Treatment member outreach (mailing, text, phone) and Early, Periodic, Screenings and Diagnostic Treatment Provider Toolkit. Whole Health-Access to Care Work Group focused on increasing adherence to wellness visits. Provider webinars on coding and measures offering continuing education unit credits.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Empire BCBS HealthPlus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Empire BCBS HealthPlus continues to track aftercare appointments that are shared with the managed care plan prior to member discharge. Empire BCBS HealthPlus continues to request that providers discuss signing a 1515 form with members. Empire BCBS HealthPlus continues to call members that have a gap in refiling their antipsychotic medication. Empire BCBS HealthPlus continues outreach to every member that is admitted for inpatient or residential. Empire BCBS HealthPlus continues outreach to all members identified timely that have accessed the emergency room. Empire BCBS HealthPlus meets quarterly with high volume facilities to share with them their follow-up rates.	Addressed.
Validation of Performance Measures			

2021 External Quality Review Recommendation	Managed Care Program	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Empire BCBS HealthPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Empire BCBS HealthPlus should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	Executing 2023 Quality Improvement Plan, and Whole Health cross-functional work groups focusing on low performance HEDIS measures: Diabetes HbA1c, Controlling High Blood Pressure, Colorectal Cancer Screening, Prenatal/Postpartum Care, Well-Visits/Immunizations. Targeted member and provider focused interventions, geo mapping, digital platforms to address disparities. Leveraging data and analytics. Expanded value-based payment contracts, Pay for Quality and Provider Incentive for CPT II CAT Codes.	Partially addressed.
Empire BCBS HealthPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Empire BCBS HealthPlus should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	Executing our 2023 Quality Improvement Plan and Whole Health Work Groups focusing on low performance HEDIS measures (Health and Recovery Plan): Diabetes HbA1c, Adherence to Antipsychotics, Viral load suppression, and Engagement of Alcohol & other drug use. Targeted member and provider focused interventions, digital platforms to address disparities and improve health equity. Leveraging data and analytics. Expanded Value-Based Payment Contracts, Pay for Quality and Provider Incentive for CPT II CAT Codes.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			

2021 External Quality Review Recommendation	Managed Care Program	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Empire BCBS HealthPlus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	The Department of Health conducted an Article 44/49 Operational Survey between September 2021 and October 2021. Plans of correction included utilization review letters and processes, behavioral health member services, and behavioral health network claim denials. The Department of Health conducted a Targeted Survey in January 2023 to review the status of prior deficiency areas. No findings report has been received to date. Oversight on all areas continues, including status updates to Compliance Committee, Board of Managers, and Quarterly Quality Management Committee.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience			
Empire BCBS HealthPlus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Executing monthly, cross-functional CAHPS Improvement Strategy and Work Group. Member and provider outreach and engagement activities. Digital platforms to improve access to care and Plan benefits. Associate CAHPS Awareness Trainings. Latest CAHPS results show improvement in satisfaction measures among the child and adult populations which previously did not meet the Medicaid average: Getting Needed Care, How Well Doctors Communicate, Customer Service, Rating of Plan.	Partially addressed.
Empire BCBS HealthPlus should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	Executing monthly, cross-functional CAHPS Improvement Strategy and Work Group. Member and provider outreach and engagement activities. Digital platforms to improve access to care and plan benefits. Associate CAHPS Awareness Trainings. Executed flu strategy to include flu shot compliance rates. Focus area in workgroup continues to be on customer service as we were below the statewide average for Health and Recovery Plan plans.	Partially addressed.

Table 56: Empire BCBS HealthPlus's Mainstream Medicaid Performance Improvement Project Summary, 2022

Empire BCBS HealthPlus's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Medicaid Managed Care Members **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulations With Health Disparity:** Male Members Ages 21-64 Years; Black/African American Members; Hispanic Members
Global Aims ▪ Empire BCBS HealthPlus aims to increase annual preventive dental visits among members ages 21–64 years. ▪ Empire BCBS HealthPlus aims to decrease emergency department visits among members ages 21–64 years. Disparity Reduction Aims ▪ Empire BCBS HealthPlus aims to increase annual preventive dental visits among male members ages 21–64 years. ▪ Empire BCBS HealthPlus aims to decrease non-traumatic dental conditions emergency department visits among Black/African American members. ▪ Empire BCBS HealthPlus Plus aims to decrease non-traumatic dental conditions emergency department visits among Hispanic members. Member-Focused 2022 Interventions ▪ Hosted quarterly community dental education events targeting members who identify as Black, African American, or Hispanic. ▪ Targeted text messaging educational outreach to members with reminders about the importance of preventive dental care and to see a dental provider for routine dental care. ▪ Educated members on the availability of teledentistry services. Provider-Focused 2022 Interventions ▪ Published articles in the provider newsletter related to disparity in care, available educational websites, webinars, and resources. ▪ Provided gaps in care reports of members needing a preventive dental visit to large practice groups. ▪ Conducted in-person educational sessions with providers from the 25 largest practice groups.

Table 57: Empire BCBS HealthPlus's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	24.32%	17.73%	29.31%
Males, ages 21–64 years[1]	20.85%	14.71%	25.85%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	134.93	97.90	92.89
Black/African American, ages 21–64 years[1]	251.39	200.53	180.52
Hispanic, ages 21–64 years[1]	188.13	125.69	105.69

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 58: Empire BCBS HealthPlus's Health and Recovery Plan Performance Improvement Project Summary, 2022

Empire BCBS HealthPlus's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Black/African American Members Ages 21–64 Years With Diabetes
Global Aims ▪ Empire BCBS HealthPlus aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ Empire BCBS HealthPlus aims to decrease the rate of hemoglobin A1c poor control among members ages 21–64 years with diabetes. ▪ Empire BCBS HealthPlus aims to increase the rate of blood pressure control among members ages 21–64 years with diabetes. ▪ Empire BCBS HealthPlus aims to increase the rate of smoking cessation engagement among members ages 21–64 years with diabetes who use tobacco or vaping products. Disparity Reduction Aim ▪ Empire BCBS HealthPlus aims to increase the rate of blood pressure control among Black/African American members ages 21–64 years with diabetes. Member-Focused 2022 Interventions ▪ Referred members to outpatient diabetes educators. ▪ Provided information on nicotine replacement therapy or referral to smoking cessation counseling for members who reported using tobacco products. ▪ Addressed and supported gaps in refilling medications during member outreach. ▪ Encouraged members to visit their primary care provider to address hypertension. ▪ Conducted targeted outreach to Black/African American members to make an appointment with their primary care provider to discuss blood pressure control, with follow-up calls to ensure the appointment was kept. Provider-Focused 2022 Interventions ▪ Engaged providers with 10 or more members who reported using tobacco products to discuss the importance of screening patients for nicotine and substance use, offering smoking cessation and Screening, Brief Intervention, and Referral to Treatment trainings. Managed Care Plan-Focused 2022 Interventions ▪ Created a system flow for notifying hospitals when an inpatient member has diabetes for a referral to a diabetes educator (or another hospital staff member if a diabetes educator is not available) before the member is discharged, with follow-up to ensure the diabetes education was received; for members who were not able to receive diabetes education before discharge, an outpatient diabetes education referral was provided. ▪ Established a new prompt for case managers to ask members if they use tobacco products during outreach calls.

Table 59: Empire BCBS HealthPlus's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	28.70%	35.05%	38.70%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	66.35%	60.48%	56.35%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	26.18%	40.52%	36.18%
Black/African Americans, ages 21–64 years[4]	24.27%	33.90%	34.27%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	10.06%	10.55%	15.09%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	12.20%	10.55%	18.30%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	2.96%	3.08%	4.44%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 60: Empire BCBS HealthPlus's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Empire BCBS Health Plus Measurement Year 2020	Empire BCBS Health Plus Measurement Year 2021	Empire BCBS Health Plus Measurement Year 2022	Mainstream Medicaid/Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	19.39%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	51.29%	57.17%	57.43%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	36.02%	41.81%	41.43%	41.45%
Asthma Medication Ratio (5–64 Years)	65.11%	63.83%	65.87%	61.20%
Breast Cancer Screening	67.64%	65.42%	66.47%	65.60%
Cervical Cancer Screening[1]	70.49%	71.78%	66.17%	69.95%
Chlamydia Screening in Women (16–20 Years)	77.10%	74.76%	76.32%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	74.98%	75.51%	74.31%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	55.72%	56.93%	54.13%	52.96%
Controlling High Blood Pressure	51.09%	54.26%	60.83%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	54.01%	58.88%	59.85%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	39.42%	36.25%	33.82%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.20%	79.79%	80.85%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	42.47%	41.55%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	47.92%	46.15%	39.79%	35.47%
Childhood Immunization Status – Combination 3	64.48%	59.61%	61.31%	68.59%

Measure Description	Empire BCBS Health Plus Measurement Year 2020	Empire BCBS Health Plus Measurement Year 2021	Empire BCBS Health Plus Measurement Year 2022	Mainstream Medicaid/Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	41.61%	38.67%	38.93%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	82.48%	81.27%	85.16%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	79.56%	78.59%	81.75%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.16%	61.77%	61.07%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.08%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	75.00%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	65.87%	61.98%	61.81%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	61.16%	60.41%	62.57%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	60.99%	53.75%	57.22%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	72.63%	66.67%	62.73%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	44.11%	49.74%	49.77%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	17.85%	17.47%	26.92%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	40.14%	41.07%	43.66%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	38.46%	40.55%	45.93%
Pharmacotherapy for Opioid Use Disorder	30.42%	26.37%	23.84%	33.31%

Measure Description	Empire BCBS Health Plus Measurement Year 2020	Empire BCBS Health Plus Measurement Year 2021	Empire BCBS Health Plus Measurement Year 2022	Mainstream Medicaid/Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	71.64%	72.27%	72.28%	74.19%
Prenatal Immunization Status	21.29%	19.27%	20.91%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	46.14%	45.23%	43.45%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	15.05%	15.12%	18.06%
Annual Dental Visit (2–18 Years)	52.82%	58.08%	57.19%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	85.89%	80.29%	86.02%	86.75%
Prenatal and Postpartum Care – Postpartum Care	76.89%	79.56%	82.08%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	67.92%	70.74%	70.69%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	63.21%	63.29%	63.32%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	82.28%	78.07%	78.25%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 61: Empire BCBS HealthPlus's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Empire BCBS HealthPlus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	47.65%	52.08%	49.36%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.04%	37.50%	35.29%	38.03%
Asthma Medication Ratio (19-64 Years)	41.62%	43.05%	50.00%	52.89%
Breast Cancer Screening	54.84%	51.19%	51.76%	54.68%
Cervical Cancer Screening	62.02%	58.76%	63.59%	63.33%
Chlamydia Screening in Women (21–24 Years)	78.46%	86.59%	80.52%	72.23%
Colorectal Cancer Screening (50–75 Years)	54.99%	52.07%	45.69%	47.33%
Controlling High Blood Pressure	47.20%	49.64%	60.34%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	46.72%	46.72%	50.12%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	50.85%	47.45%	46.72%	37.57%
Flu Vaccination for Adults Ages 18-64	44.80%	45.60%	45.60%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	29.29%	29.46%	32.93%
Advising Smokers to Quit (CAHPS)	87.62%	78.91%	78.91%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	70.19%	64.06%	64.06%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	67.65%	56.69%	56.69%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	56.02%	60.93%	58.80%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	45.10%	30.53%	30.00%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.93%	67.08%	66.55%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.70%	80.92%	82.27%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	56.61%	55.67%	56.13%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	68.46%	63.84%	66.10%	49.48%

Measure Description	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Empire BCBS HealthPlus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	63.31%	61.57%	65.49%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	23.53%	28.51%	39.29%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	47.08%	50.56%	44.56%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	34.62%	34.33%	42.80%
Pharmacotherapy for Opioid Use Disorder	35.08%	29.97%	29.28%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	24.86%	23.92%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	16.81%	18.03%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 62: Empire BCBS HealthPlus's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Open Period
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	NC	Open Period
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	NC	Open Period
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	NC	Open Period
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement; Open Period: the timeline between the accepted plan of correction and the date certain for implementation.

Table 63: Empire BCBS HealthPlus's Compliance Review Summary of Results, 2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus's delegate failed to ensure required enrollee information was included in the notices.	Contract Article 98-2.9(e)(3)	438.228
Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus failed to ensure enrollees were provided the correct appeal documents.	Contract Article 98-2.9(h)(1)	438.228
Based on staff interview and review of initial adverse determination notices, Empire BCBS HealthPlus and its delegates failed to ensure the notices included the required appeal language.	Contract Article 4903.2 § 4405	438.228
Based on staff interview and review of the prior authorization and approval case notes, Empire BCBS HealthPlus and its delegates failed to ensure the enrollee, or designee, and/or the health care provider were notified of the determination by telephone within three business days. Specifically, telephone notification was not provided to the member and/or provider.	Contract Article 4903(2)(a)	438.210
Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus and its delegate failed to ensure members enrolled in individual insurance plans received the correct appeal rights.	Contract Article 4903.2 § 4405	438.228
Based on staff interview and review of case notes, Empire BCBS HealthPlus and its delegate failed to ensure requests for additional information were conducted by telephone and in writing to both the member and the provider.	Contract Article 98-2.9(b)	438.228
Based on staff interview and review of the final adverse determination notices, Empire BCBS HealthPlus and its delegate, failed to ensure required enrollee information was included in the notices.	Contract Article 98-2.9(e)(4)	438.228
Based on interviews with Empire BCBS HealthPlus's network and claims staff on 09/30/2021, review of claims denial documents, and follow up responses, Empire BCBS HealthPlus failed to appropriately process and pay claims.	Contract Article 98-2.9(e)(4), Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1	438.242

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 64: Empire BCBS HealthPlus's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Empire BCBS HealthPlus	Mainstream Medicaid and Child Health Plus Average	Empire BCBS HealthPlus	Mainstream Medicaid and Child Health Plus Average	Empire BCBS HealthPlus	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	81.14%	83.75%	79.21%	84.31%	84.06%	82.04%
Getting Care Quickly[1]	81.64%	88.14%	85.87%	87.84%	84.33%	83.82%
How Well Doctors Communicate[1]	92.59%	93.44%	91.69%	93.35%	94.65%	94.17%
Customer Service[1]	82.35%	85.84%	83.74%	86.53%	81.58%	86.07%
Rating of All Health Care[2]	86.16%	87.48%	88.19%	89.77%	83.82%	86.07%
Rating of Personal Doctor[2]	89.46%	90.40%	88.78%	90.08%	89.50%	89.41%
Rating of Specialist Talked to Most Often[2]	74.90%	83.58%	87.37%	87.11%	79.26%	81.40%
Rating of Health Plan[2]	83.85%	85.18%	88.10%	86.02%	79.28%	80.80%
Rating of Treatment or Counseling[2]	63.28%	68.99%	Small Sample	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Table 65: Empire BCBS HealthPlus's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Empire BCBS HealthPlus's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		Three of five performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Empire BCBS HealthPlus's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Six of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Empire BCBS HealthPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Seven performance measure rates reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	One performance measure rate reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		statewide managed care program mean.			
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, Empire HealthPlus was in compliance with 11 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, Empire HealthPlus was in compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Two of five performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	One of seven performance improvement project indicator rates demonstrated performance	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		decline between measurement years 2021 and 2022.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Seven performance measure rates reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Five performance measure rates reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by Empire BCBS HealthPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
	Health and Recovery Plan	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, Empire BCBS HealthPlus was not in full compliance with three of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	Empire BCBS HealthPlus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	Empire BCBS HealthPlus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	Empire BCBS HealthPlus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Empire BCBS HealthPlus should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.	X	X	X
	Health and Recovery Plan	Empire BCBS HealthPlus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		health outcomes. To address this, Empire BCBS HealthPlus should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Empire BCBS HealthPlus should regularly monitor the effectiveness of the implemented corrective action plan to ensure that achieved compliance is sustained.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 66: Excellus's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Excellus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Excellus continues to educate its child members that are non-compliant with lead screenings. The member outreach specific to elevated lead levels ended with the 2021 measurement period as access to the data was no longer available. The elevated lead data pulled from the New York State Immunization Information System was provided to Excellus from the Department of Health. The New York State Immunization Information System report was no longer provided to Excellus after the 2021 measurement year. Attempts to reinstate this report were unsuccessful.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Excellus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Excellus continues to monitor mental health discharges and transitions of care through a daily emergency room report. The report is reviewed by leadership and follow-up is performed through our Case Management teams. Once case management is referred, they will outreach to the provider and member to participate in discharge planning and assist in closing any gaps-in-care when the member steps down to a lower level of care. The Case	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		Managers follow the same process for inpatient mental health and substance admissions and discharges.	
Validation of Performance Measures			
Excellus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Excellus should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	Excellus has an annual performance improvement program that utilizes multiple strategies to address low performance measures and the barriers that drive low performance. The Health Care Improvement Department leads dynamic, cross-functional improvement teams related to adult, women's, children's, and behavioral health specific measures and use data to drive interventions with members, providers, and community. Using both past performance and predictive analytics, priority improvement measures are identified for additional and enhanced interventions. As interventions are proven effective through the 'plan-do-study-act' methodology, they are incorporated into ongoing workflows as a best practice for continued member care and maintaining performance. Additionally, all intervention efforts are relayed through quality governance committees for extended corporate awareness, input, and collaboration. The measures below were identified in the *2021 External Quality Review Annual Technical Report* as performing statistically lower than the	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		mainstream Medicaid performance. Chlamydia Screening in Women, Ages 16-20 Years, and 21-24 Years Member behavior barriers limit our ability to improve. Specifically, parental involvement in the age group for 16–20-year-olds, and birth control not being equivalent to being sexually active in both age groups. We continue to explore data options and provider partnerships and are expecting minimal improvement at this time. Spirometry Testing As the measure is now being retired, no current or future interventions are planned. Weight Assessment and Counseling for Children/Adolescents Nutrition & Physical Activity Well-child visits have been an ongoing priority measure that incorporates well-child care components, and is showing success with targeted telephonic outreach, calendar appointment member tool, broad member newsletter campaigns. Diabetes Screening for People With Schizophrenia & Metabolic Monitoring for Children and Adolescents on Antipsychotics New collateral for metabolic monitoring education was designed in 2022 and distributed in 2023 to	

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		members and providers, along with new quarterly member targeted telephonic outreach that started in the second quarter of 2023. Excellus is also exploring sharing demographic contact information with health homes and value-based payment partners. All activities are expected to help improve the measurement rate compared to prior years. <u>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication - Initiation & Continuation</u> Enhancements to the current targeted outreach workflow started in 2022 with increasing the number of contact attempts and expanding conversation skills. The measurement rate has been improving as a result and is expected to continue to improve. <u>Initiation of Alcohol or Drug Dependence Treatment</u> Utilization management provides inpatient and discharge alerts to our care management department for targeted outreach. This measure continues to be difficult to influence due to multiple barriers such as claim/alert timing, member behavior, and access/availability. Excellus continues to expand hospital data sources to enhance identification and outreach.	

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		Annual Dental Visit Partnership with dental vendor developed additional awareness/notification to members for dental visits needed and assistance with finding a dental provider. Rates have been improving. Excellus is preparing for retirement of this measure and transition to new dental measure for future interventions.	
Excellus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Excellus should focus on the area of care in which its rate did not meet Health and Recovery Plan performance.	Health and Recovery Plan	Excellus enacts an annual performance improvement program that utilizes multiple strategies to address low performance measures and the barriers that drive low performance. The Health Care Improvement Department leads dynamic, cross functional improvement teams related to adult, women's, children's, and behavioral health specific measures and use data to drive interventions with members, providers, and community. Using both past performance and predictive analytics, priority improvement measures are identified for additional and enhanced interventions. As interventions are proven effective through the 'plan-do-study-act' methodology, they are incorporated into ongoing workflows as a best practice for continued member care and maintaining performance. Additionally, all intervention efforts are relayed through quality governance committees for extended	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		corporate awareness, input, and collaboration. The measure below was identified in the *2021 External Quality Review Annual Technical Report* as performing statistically lower than the mainstream Medicaid performance. <u>Diabetes Screening for People With Schizophrenia</u> New collateral for metabolic monitoring education was designed in 2022 and distributed in 2023 to members and providers, along with new quarterly member targeted telephonic outreach that started in the second quarter of 2023. Additionally exploring sharing of demographic contact information with health home and value-based payment partners. All activities are expected to help improve the measure rate compared to prior years.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Excellus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	The approved corrective action plan was executed, and compliance was achieved. Routine monitoring is performed by the business area to ensure compliance is maintained.	Addressed.
Administration of Quality-of-Care Surveys – Member Experience			
Excellus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	A strategy refresh was completed in 2023. New predictive analytics were incorporated into the risk-based engagement model for targeted outreach. Additional internal partnership teams	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Excellus's Response	IPRO's Assessment of Excellus's Response
		were added to the targeted outreach effort. Pulse surveys were updated with new sub-questions to continue to assess ongoing member needs outside of the official surveys, and the closed-loop feedback to survey responses continues. The VBP Incentive Program CAHPS measures that started in 2022 continue in 2023. Targeted HEDIS gaps-in-care outreach also includes CAHPS satisfaction support for access to care as of 2023. Per the *Mainstream Medicaid Managed Care 2021 External Quality Review Annual Technical Report*, Excellus did not perform statistically lower than the mainstream Medicaid performance. Per the *Health and Recover Plan 2021 External Quality Review Annual Technical Report*, Excellus did not perform statistically lower than the mainstream HARP performance.	

Table 67: Excellus's Mainstream Medicaid Performance Improvement Project Summary, 2022

Excellus's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Adult Dental Preventive Care in a Medicaid Managed Care Organization **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Native American Members Ages 21-64 Years Residing in Central New York State
Global Aims ▪ Excellus aims to increase annual preventive dental care among members ages 21–64 years. ▪ Excellus aims to decrease non-traumatic emergency department dental visits among members ages 21–64 years. Disparity Reduction Aim ▪ Excellus aims to increase annual preventive care services among Native American members ages 21–64 years living in the central region of New York State. Member-Focused 2022 Interventions ▪ Sent targeted educational and motivational mailing to members without preventive dental services in the preceding year. ▪ Conducted telephonic outreach to members to assist in scheduling appointments and provide resources to facilitate compliance with dental preventive services. ▪ Distributed enhanced member guidebooks to members over 19 years of age. ▪ Educated new enrollees regarding dental preventive services with network dental vendor. ▪ Provided dental preventive care and benefit resources to members during facilitated enrollment and health risk assessments. ▪ Targeted educational mailing to Native American members living in central New York without dental preventive service use. Provider-Focused 2022 Interventions ▪ Established partnership with primary care providers currently scheduling appointments for Medicaid managed care members to provide up-to-date directories of dental providers. ▪ Distributed gap reports to members with no preventive care services claims.

Table 68: Excellus's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	15.42%	14.28%	25.40%
Native American residents of central New York State, ages 21–64 years[1]	15.10%	17.99%	25.60%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	152.86	135.51	129.93

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 69: Excellus's Health and Recovery Plan Performance Improvement Project Summary, 2022

Excellus's Health and Recovery Plan Performance Improvement Project Summary
Title: Health and Recovery Plan Diabetes Performance Improvement Project **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Members Ages 21–64 Years With Diabetes Who Reside in the Central Region of New York State
Global Aims • Excellus aims to improve the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. • Excellus aims to decrease the rate of hemoglobin A1c poor control among members ages 21–64 years with diabetes. • Excellus aims to increase the rate of blood pressure control among members ages 21–64 years with diabetes. • Excellus aims to increase smoking cessation utilization among members ages 21–64 years with diabetes. Disparity Reduction Aim ▪ Excellus aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes who live in the central region of New York States. Member-Focused 2022 Interventions ▪ Conducted telephone outreach to members enrolled in health homes to provide education focusing on diabetic self-control and blood pressure management. ▪ Identified high-risk members with diabetes to receive care management outreach following hospitalization discharge. ▪ Called members enrolled in medical or pregnancy case management services to assist with diabetes self-care, blood pressure management, and linkage to physical services. ▪ Referred members not enrolled in clinical operations case management or health homes to case management services. ▪ Linked any members who reported using tobacco products during outreach calls to the New York State Smokers' Quitline. Managed Care Plan-Focused 2022 Interventions ▪ Created a process to identify high-risk members with diabetes.

Table 70: Excellus's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes (types 1 and 2) whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	22.33%	23.97%	32.00%
Central New York State residents, ages 21–64 years[3]	2.83%	11.84%	13.00%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 4]			
Ages 21–64 years	73.17%	72.24%	63.00%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	20.05%	31.55%	30.00%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	19.89%	17.82%	29.00%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	11.00%	8.83%	20.00%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	5.91%	4.21%	15.00%

[1] Managed care plan rates for HEDIS measures were calculated using the hybrid methodology, and Managed care plan rates for tobacco cessation measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Subpopulation targeted for health disparity reduction.

[4] A lower rate indicates better performance.

Performance Measure Results

Table 71: Excellus's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Excellus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	20.05%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	53.95%	56.29%	56.91%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.23%	42.29%	42.50%	41.45%
Asthma Medication Ratio (5–64 Years)	59.05%	57.33%	61.89%	61.20%
Breast Cancer Screening	64.45%	63.42%	62.41%	65.60%
Cervical Cancer Screening[1]	70.98%	71.26%	68.71%	69.95%
Chlamydia Screening in Women (16–20 Years)	51.20%	52.00%	52.19%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	65.73%	67.26%	65.09%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	59.55%	56.53%	48.64%	52.96%
Controlling High Blood Pressure	58.64%	61.10%	62.24%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	58.27%	56.93%	60.99%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	39.26%	31.63%	33.58%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	72.83%	73.97%	74.10%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	42.00%	41.31%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	29.47%	27.94%	27.01%	35.47%
Childhood Immunization Status – Combination 3	82.16%	75.06%	76.40%	68.59%

Measure Description	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Excellus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	42.09%	40.15%	44.53%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	81.64%	75.35%	80.60%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	78.69%	72.57%	76.72%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.98%	64.29%	60.74%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.89%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	58.21%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	50.66%	54.37%	54.80%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	63.99%	65.40%	62.30%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	42.18%	39.78%	43.87%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	48.27%	44.57%	52.38%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	25.24%	28.04%	28.98%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	21.93%	21.75%	29.72%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	55.37%	49.44%	47.26%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	52.32%	55.55%	45.93%
Pharmacotherapy for Opioid Use Disorder	42.14%	36.27%	37.14%	33.31%

Measure Description	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Excellus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	80.44%	78.80%	76.00%	74.19%
Prenatal Immunization Status	40.50%	33.50%	31.53%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	42.38%	43.83%	42.91%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	19.23%	18.73%	18.06%
Annual Dental Visit (2–18 Years)	47.86%	49.72%	49.42%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.21%	89.25%	89.96%	86.75%
Prenatal and Postpartum Care – Postpartum Care	79.32%	79.57%	84.59%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	66.73%	69.57%	68.36%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	74.00%	74.42%	74.61%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	87.15%	83.10%	82.92%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 72: Excellus's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Excellus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	49.68%	52.87%	47.97%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.36%	38.57%	35.66%	38.03%
Asthma Medication Ratio (19-64 Years)	48.72%	48.54%	58.20%	52.89%
Breast Cancer Screening	57.74%	57.56%	57.19%	54.68%
Cervical Cancer Screening	65.03%	68.35%	67.22%	63.33%
Chlamydia Screening in Women (21–24 Years)	61.26%	67.46%	63.85%	72.23%
Colorectal Cancer Screening (50–75 Years)	57.04%	58.77%	50.83%	47.33%
Controlling High Blood Pressure	56.45%	60.74%	65.82%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	64.07%	63.26%	59.17%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	37.19%	36.25%	34.72%	37.57%
Flu Vaccination for Adults Ages 18-64	51.94%	51.87%	51.87%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	40.83%	38.33%	32.93%
Advising Smokers to Quit (CAHPS)	88.79%	82.89%	82.89%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	82.61%	71.52%	71.52%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	70.69%	60.13%	60.13%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	72.64%	73.50%	70.98%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	22.40%	22.16%	21.69%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.74%	66.04%	68.48%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.62%	76.01%	76.96%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	60.87%	57.66%	52.02%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	53.39%	57.31%	56.05%	49.48%

Measure Description	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Excellus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	76.92%	75.64%	71.61%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	35.39%	32.93%	42.49%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	57.26%	53.93%	50.46%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	50.25%	53.78%	42.80%
Pharmacotherapy for Opioid Use Disorder	40.08%	31.44%	34.90%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	28.63%	30.83%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	20.16%	21.84%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 73: Excellus's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Not Reviewed
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	NC	C
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	C	Not Reviewed

[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, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.

C: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 74: Excellus's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Excellus	Mainstream Medicaid and Child Health Plus Average	Excellus	Mainstream Medicaid and Child Health Plus Average	Excellus	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	86.74%	83.75%	85.06%	84.31%	85.22%	82.04%
Getting Care Quickly[1]	90.94%	88.14%	86.40%	87.84%	86.32%	83.82%
How Well Doctors Communicate[1]	95.80%	93.44%	95.34%	93.35%	94.47%	94.17%
Customer Service[1]	84.16%	85.84%	90.37%	86.53%	Small Sample	86.07%
Rating of All Health Care[2]	89.59%	87.48%	89.15%	89.77%	91.05%	86.07%
Rating of Personal Doctor[2]	89.89%	90.40%	88.25%	90.08%	92.86%	89.41%
Rating of Specialist Talked to Most Often[2]	85.98%	83.58%	88.42%	87.11%	82.64%	81.40%
Rating of Health Plan[2]	87.52%	85.18%	88.61%	86.02%	86.80%	80.80%
Rating of Treatment or Counseling[2]	65.70%	68.99%	59.79%	65.85%	56.32%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 75: Excellus's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Excellus's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		Two of three performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Excellus's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Four of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Excellus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Five performance measure rates reported by Excellus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Six performance measure rates reported by Excellus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/	Mainstream Medicaid and Child Health Plus	None.			

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Availability of Care	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by Excellus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, Excellus was in compliance with the one standard reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, Excellus was in compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	Two member satisfaction scores achieved by Excellus for measurement year 2022 performed statistically significantly better than the Mainstream Medicaid and Child Health Plus program average.	X	X	X
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	One of three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Eleven performance measure rates reported by Excellus for measurement year 2022 performed statistically significantly worse than	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		the statewide managed care program mean.			
	Health and Recovery Plan	One performance measure rate reported by Excellus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by Excellus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	None.			
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	Excellus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	Excellus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid	Excellus should use the findings from the HEDIS/Quality Assurance	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and Child Health Plus	Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Excellus should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	Excellus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Excellus should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Excellus should regularly monitor the effectiveness of the implemented corrective action plan to ensure that achieved compliance is sustained.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 76: Fidelis Care's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Fidelis Care should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Fidelis Care has continued to provide members with education regarding the importance of early childhood preventative screenings as well as the need for follow-up for those identified at-risk for elevated blood lead levels, hearing loss and/or developmental delay. Additionally, the enhancements that were made to the Clinical Care Advance systems to successfully support this performance improvement project are still active.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Fidelis Care should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Fidelis Care has continued the many interventions developed and implemented through the 2019-2021 Health and Recovery Plan performance improvement project, including offering incentives to members who have a 7-day follow-up visit following a behavioral health emergency department or inpatient mental health discharge. Fidelis Care continues to provide daily emergency department and inpatient alert reports to health homes and has continued to promote medication assisted treatment and telehealth to our members and providers.	Addressed.
Validation of Performance Measures			
Fidelis Care should continue to utilize the results of the HEDIS/Quality Assurance	Mainstream Medicaid and	Fidelis Care will continue to conduct root cause analyses and implement corrective action	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Fidelis should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Child Health Plus	plans for effectiveness of care domain indicators cited in the quality performance matrix as opportunities for improvement for the purpose of meeting or exceeding goals that are based on statewide 50th percentiles.	
Fidelis Care should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Fidelis should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	As part of quality performance matrix activities, Fidelis Care will continue to conduct root cause analyses and implement corrective action plans for each effectiveness of care domain indicator cited as opportunities for improvement for the purpose of meeting or exceeding set goals that are based on statewide averages.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Fidelis Care should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Fidelis Care has developed workgroups related to findings and citations received during contract reviews. The workgroups meet on a regular basis to ensure the excecution of submitted action plans, as well as monitor ongoing implementation. Findings, citations, and action plans are reviewed by the Quality Committes.The Fidelis Care	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
		Compliance Department takes lead annually to review contract requirements to further ensure compliance.	
Administration of Quality-of-Care Surveys – Member Experience			
Fidelis Care should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	On an annual basis, Fidelis Care conducts a mock CAHPS survey measuring member satisfaction. Upon receiving the results, an interdisciplinary workgroup conducts a thorough review and root cause analysis. Results are then shared with provider groups, action plans for improvement are developed, and routine stakeholder meetings are held to measure progress toward meeting the goal of exceeding the Medicaid average.	Partially addressed.
Fidelis Care should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	On an annual basis, Fidelis Care conducts a behavioral health member survey (CAHPS Experience of Care and Health Outcomes Survey). Upon receiving the results of the Experience of Care and Health Outcomes Survey, Fidelis Care creates a multidisciplinary workgroup to conduct a root cause analysis; develops and implements an action plan with goals to exceed the statewide average. Fidelis care does the same process for the every other year CAHPS survey. It should be noted that results are shared with providers and members through stakeholder meetings in the purpose to facilitate feedback and input into action plans.	Partially addressed.

Table 77: Fidelis Care's Mainstream Medicaid Performance Improvement Project Summary, 2022

Fidelis Care's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Medicaid Managed Care Adult Members **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulations With Health Disparity:** Members Ages 21-64 Years Residing in Central New York State; Members Ages 21-64 Residing in Western New York State
Global Aims ▪ Fidelis Care aims to increase preventive dental visits among members ages 21–64 years. ▪ Fidelis Care aims to decrease emergency department visits for ambulatory care sensitive non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aims ▪ Fidelis Care aims to increase preventive dental visits among members ages 21–64 years who reside in the central region of New York State. ▪ Fidelis Care aims to increase preventive dental visits among members ages 21–64 years who reside in the western region of New York State. Member-Focused 2022 Interventions ▪ Conducted interactive voice response telephonic outreach to members identified as non-compliant for an annual dental preventive screening. ▪ Hosted Dental Day and Dental Mobile Unit events in rural counties of New York State targeting members needing preventive dental screenings. ▪ Conducted targeted telephonic and mail outreach to members with an emergency department visit for a non-traumatic dental condition. ▪ Scheduled dental appointments for members who requested assistance. ▪ Published an article on the importance and benefits of preventive dental screenings in the member newsletter. ▪ Updated the Fidelis Care Health Resources website to include information on preventive screenings. Provider-Focused 2022 Interventions ▪ Notified dental providers of panel members with a dental emergency department visit. ▪ Published an article on dental health and preventive dental screenings in the provider newsletter.

Table 78: Fidelis Care's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	24.45%	23.52%	29.45%
Central New York State resident, ages 21–64 years[1]	17.07%	15.92%	21.07%
Western New York State resident, ages 21–64 years[1]	18.84%	17.10%	22.81%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	6.17	5.71	4.67

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 79: Fidelis Care's Health and Recovery Plan Performance Improvement Project Summary, 2022

Fidelis Care's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulations With Health Disparity:** Members Ages 21–64 Years with Diabetes Who Reside in the Central Region of New York State; Members Ages 21–64 Years with Diabetes Who Reside in Northeast Region of New York State; Members Ages 21–64 Years with Diabetes Who Reside in Western Region of New York State
Global Aims ▪ Fidelis Care aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ Fidelis Care aims to decrease the rate of poor hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ Fidelis Care aims to increase the rate of blood pressure control among members ages 21–64 years with diabetes. ▪ Fidelis Care aims to increase tobacco cessation medication utilization among members ages 21–64 years with diabetes. ▪ Fidelis Care aims to increase tobacco cessation counseling utilization among members ages 21–64 years with diabetes. ▪ Fidelis Care aims to increase tobacco cessation medication and counseling utilization among members ages 21–64 years with diabetes. Disparity Reduction Aims ▪ Fidelis Care aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes who live in the central region of New York State. ▪ Fidelis Care aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes who live in the northeast region of New York State. ▪ Fidelis Care aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes who live in the western region of New York State. Member-Focused 2022 Interventions ▪ Conducted quarterly automated calls to members with poor diabetes control and lacking a wellness visit with their primary care physician to encourage members to make an appointment to discuss diabetes management. ▪ Conducted quarterly automated calls to members with poor diabetes control who have a gap in medication adherence to encourage members to make an appointment with their primary care physician to discuss possible medication intervention for diabetes control. ▪ Encouraged members with poor blood pressure control and diabetes to speak to their primary care physician regarding the potential benefits of medication during quarterly automated calls. Provider-Focused 2022 Interventions ▪ Collaborated with health homes in the central, northeast, and western New York regions to develop shared initiatives to best address shared members with uncontrolled diabetes and/or uncontrolled blood pressure control. ▪ Met with providers and medical systems located in the central, northeast, and western New York regions to develop shared initiatives to address care gaps for shared members with uncontrolled diabetes and/or uncontrolled blood pressure control.

Fidelis Care's Health and Recovery Plan Performance Improvement Project Summary
▪ Distributed mailings identifying members with care gaps to primary care physicians located in the central, northeast, and western New York regions with members who have no blood pressure test on file, no hemoglobin A1c test on file, poor diabetes control, or poor blood pressure control. ▪ Hosted webinars to review mailings identifying members with care gaps for targeted physicians. ▪ Mailed physicians a list of members in their care with diabetes and poor tobacco cessation treatment utilization to encourage assessment and counseling on tobacco reduction/cessation.

Table 80: Fidelis Care's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	19.67%	24.21%	20.90%
Central New York State residents, ages 21–64 years[3]	9.48%	14.51%	11.70%
Northeast New York State residents, ages 21–64[3]	16.33%	17.22%	19.80%
Western New York State residents, ages 21–64 years[3]	15.12%	18.42%	17.60%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 4]			
Ages 21–64 years	77.49%	72.96%	76.20%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	21.39%	26.07%	22.70%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	16.83%	15.23%	18.00%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	15.51%	13.49%	16.60%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	5.73%	4.82%	6.50%

[1] Rates were calculated using the hybrid methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Subpopulation targeted for health disparity reduction.

[4] A lower rate indicates better performance.

Performance Measure Results

Table 81: Fidelis Care's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	12.97%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	56.83%	59.92%	58.74%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	41.12%	42.47%	42.12%	41.45%
Asthma Medication Ratio (5–64 Years)	58.08%	53.19%	55.26%	61.20%
Breast Cancer Screening	64.89%	62.68%	63.39%	65.60%
Cervical Cancer Screening[1]	63.99%	65.69%	67.40%	69.95%
Chlamydia Screening in Women (16–20 Years)	66.42%	66.36%	66.56%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	69.07%	70.26%	69.62%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	59.61%	59.85%	48.85%	52.96%
Controlling High Blood Pressure	58.88%	61.31%	64.48%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	57.42%	58.15%	59.61%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	38.93%	36.50%	38.93%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.60%	78.00%	77.85%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	39.81%	39.81%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	49.02%	42.31%	37.72%	35.47%
Childhood Immunization Status – Combination 3	66.91%	61.31%	64.48%	68.59%

Measure Description	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	35.77%	36.50%	38.20%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	81.75%	82.48%	80.29%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	73.97%	77.86%	76.16%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	66.17%	63.37%	63.24%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	58.29%	58.14%	57.37%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	65.93%	65.11%	62.95%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	59.62%	54.65%	58.51%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	70.35%	66.03%	66.58%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	32.31%	38.11%	40.79%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	22.75%	21.30%	30.36%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	41.26%	41.68%	41.77%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	46.55%	49.56%	45.93%
Pharmacotherapy for Opioid Use Disorder	42.09%	35.86%	34.89%	33.31%

Measure Description	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	72.79%	72.82%	73.82%	74.19%
Prenatal Immunization Status	25.55%	21.28%	17.85%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	52.09%	50.52%	51.53%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	21.87%	21.70%	18.06%
Annual Dental Visit (2–18 Years)	49.07%	54.30%	56.74%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	86.86%	86.86%	88.08%	86.75%
Prenatal and Postpartum Care – Postpartum Care	81.51%	81.51%	81.75%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	63.66%	66.30%	66.28%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	63.04%	62.93%	63.42%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	80.50%	76.45%	75.91%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 82: Fidelis Care's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	54.18%	55.58%	54.72%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	40.07%	41.64%	40.01%	38.03%
Asthma Medication Ratio (19-64 Years)	39.86%	35.63%	42.57%	52.89%
Breast Cancer Screening	53.99%	51.81%	52.26%	54.68%
Cervical Cancer Screening	68.13%	63.99%	58.88%	63.33%
Chlamydia Screening in Women (21–24 Years)	68.58%	68.41%	67.32%	72.23%
Colorectal Cancer Screening (50–75 Years)	51.34%	53.77%	44.89%	47.33%
Controlling High Blood Pressure	59.12%	60.34%	63.99%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	55.72%	57.42%	55.47%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	46.23%	44.04%	40.15%	37.57%
Flu Vaccination for Adults Ages 18-64	56.06%	44.00%	44.00%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	31.11%	32.43%	32.93%
Advising Smokers to Quit (CAHPS)	91.53%	83.97%	83.97%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	83.05%	75.32%	75.32%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	73.91%	65.82%	65.82%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	63.71%	63.74%	62.77%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	30.01%	28.19%	28.26%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.32%	65.76%	67.66%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.16%	79.22%	80.04%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	58.79%	56.78%	57.15%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	58.89%	56.63%	54.88%	49.48%

Measure Description	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Fidelis Care Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	68.74%	67.95%	68.70%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	33.61%	32.11%	44.32%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	43.47%	42.47%	42.81%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	44.83%	47.52%	42.80%
Pharmacotherapy for Opioid Use Disorder	42.39%	32.93%	36.30%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	28.01%	27.81%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	24.76%	23.59%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 83: Fidelis Care's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Open Period
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			NC
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	NC	Open Period
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	NC	Open Period
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement; Open Period: the timeline between the accepted plan of correction and the date certain for implementation.

Table 84: Fidelis Care's Compliance Review Summary of Results, 2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on staff interview and record review, Fidelis Care and its delegate failed to issue adverse determination notices for administrative denials that were factual in nature. Specifically, the adverse determination notices issued, either the initial or final included incorrect rights and information. During an interview on 08/18/2021, when asked about the incorrect information and rights included in the adverse determination notices issued to the members, plan staff stated that the wrong notice template was used to issue the administrative denials.	Contract Article 4405.10	438.228
Based on staff interview on 08/17/21 and review of initial adverse determination notices, Fidelis Care failed to ensure members enrolled in individual insurance plans received the correct appeal rights. Specifically, the initial adverse determination notices issued to the Essential Plan members included language that allowed the enrollees to file a standard appeal after an upheld expedited appeal denial determination. The Essential Plan coverage does not include a second level appeal. This was evident in the initial adverse determination notices issued for four of four concurrent Essential Plan cases reviewed.	Contract Article 4405.1	438.228
Based on staff interview on 08/17/21 and review of the initial adverse determination notices, the Fidelis Care failed to ensure the delegate Turning Point issued notices that were factual in nature to Child Health Plus members. Specifically, for two of two Child Health Plus prior authorization cases reviewed, fair hearing rights were included with the initial adverse determination notices issued. Child Health Plus coverage does not include fair hearing rights.	Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1	438.228
Based on interviews with Fidelis Care staff and document review, Fidelis Care failed to include the correct Medicaid payment information in their contract. Specifically, five of 10 behavioral health contracts still included "lesser of" language. "Lesser of" language was included in contracts behavioral health #1, behavioral health #2, behavioral health #4, behavioral health #5 and behavioral health #7. Additionally, during the behavioral health network/claims information technology interview on 08/12/2021, Fidelis Care staff confirmed no amendment had been distributed to behavioral health providers. This requirement was outlined in the behavioral health provider contract language notice issued by the Department of Health on 11/02/2017.	Contract Article 2005-98-1.12 (k)	438.214
Based on interview held on 08/17/2021 and review of documents, Fidelis Care failed to ensure the required credentialing components were included for three of 20 credentialing files. Specifically, the initial credentialing file did not include the verification of Medicaid fee-for-service enrollment.	Contract Article 2005-98-1.12	438.214

Table 85: Fidelis Care's Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Department of Health Finding	Total Number of Findings	Code of Federal Regulation
The health plan did not send a disenrollment/cancel 834-transaction to New York State of Health timely, for termination of coverage.	2	438.56

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 86: Fidelis Care's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Fidelis Care	Mainstream Medicaid and Child Health Plus Average	Fidelis Care	Mainstream Medicaid and Child Health Plus Average	Fidelis Care	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	85.50%	83.75%	86.84%	84.31%	82.74%	82.04%
Getting Care Quickly[1]	92.37%	88.14%	87.54%	87.84%	80.35%	83.82%
How Well Doctors Communicate[1]	94.08%	93.44%	94.04%	93.35%	93.88%	94.17%
Customer Service[1]	87.61%	85.84%	87.70%	86.53%	83.95%	86.07%
Rating of All Health Care[2]	88.56%	87.48%	90.01%	89.77%	83.60%	86.07%
Rating of Personal Doctor[2]	90.13%	90.40%	88.99%	90.08%	89.24%	89.41%
Rating of Specialist Talked to Most Often[2]	83.60%	83.58%	83.68%	87.11%	82.98%	81.40%
Rating of Health Plan[2]	86.46%	85.18%	86.23%	86.02%	77.98%	80.80%
Rating of Treatment or Counseling[2]	68.23%	68.99%	60.14%	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 87: Fidelis Care's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Fidelis Care's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		One of four performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Fidelis Care's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Six of nine performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Fidelis Care met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Seven performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Seven performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
	Health and Recovery Plan	One performance measure rate reported by Fidelis Care for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, Fidelis Care was in compliance with 12 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Three of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of nine performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Eleven performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		worse than the statewide managed care program mean.			
	Health and Recovery Plan	Four performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.			
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by Fidelis Care for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, Fidelis Care was not in full compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, Fidelis Care was not in full compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	Fidelis Care should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	Fidelis Care should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	Fidelis Care should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Fidelis Care should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.	X	X	X
	Health and Recovery Plan	Fidelis Care should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Fidelis Care should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and	Fidelis Care should execute the approved corrective action plan and conduct routine monitoring to	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	ensure compliance is achieved and maintained.			
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 88: Healthfirst's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Healthfirst should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Care Managers conduct screenings for social determinants of health needs to ensure our vulnerable pediatric members receive the appropriate supports, referrals, and resources in a timely manner. Live outreach calls remind members to complete their preventive well child visits and receive their immunizations. Education on the importance of routine screenings and follow-up care for lead exposure, newborn hearing, and developmental delay continues to be promoted through provider webinars and on Healthfirst's website.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Healthfirst should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Provider incentives, community-based programs and telehealth services are utilized to improve follow-up after emergency department and inpatient admissions for behavioral health. Case managers have expanded outreach beyond the telephonic model to include electronic messaging and field-based case management to facilitate transitions of care for behavioral health.	Addressed.
Validation of Performance Measures			
Healthfirst should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality	Mainstream Medicaid and Child Health Plus	Healthfirst utilizes provider incentives, community-based programs, telehealth, and an expanded case management model that deploys telephonic,	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Healthfirst should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.		electronic, and field-based outreach, to facilitate transitions of care for behavioral health. Enhanced care coordination, member outreach calls, and member incentives are employed to support asthma medication adherence. Vendor collaboration, provider network expansion, and community events are underway to increase access to preventive dental care.	
Healthfirst should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Healthfirst should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	Healthfirst utilizes provider incentives, community-based programs, and telehealth services to improve timely follow-up care after a behavioral health emergency department visit and inpatient admission. Healthfirst's case management model has expanded to include field-based case management to support discharge planning and transitions of care.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Healthfirst should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019 compliance findings. Healthfirst should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Healthfirst has a robust internal corrective action process to mitigate issues and prevent repeat occurrences. The 2019 findings have been addressed and in the 2021 Targeted Survey the Department of Health found no further action was required. All relevant business units review prior results to confirm compliance with the Medicaid standards and applicable Child Health Plus requirements. In addition, Healthfirst's Compliance and Regulatory teams work	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
		collaboratively to monitor and review ongoing compliance.	
Administration of Quality-of-Care Surveys – Member Experience			
Healthfirst should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Healthfirst performance is not statistically below statewide averages on any Medicaid managed care measure which is an improvement from prior years. We attribute this to our monitoring of member experience through traditional (i.e., surveys) and non-traditional (i.e., online communities) feedback tools. The output is used to inform managed care plan and provider engagement activities aimed at improving member experience.	Partially addressed.
Healthfirst should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	Healthfirst performance is not statistically below statewide averages on any Health and Recovery Plan measure and exceeds on multiple measures. We attribute this to our monitoring of member experience through traditional (i.e., surveys) and non-traditional (i.e., online communities) feedback tools. The output is used to inform managed care plan and provider engagement activities aimed at improving member experience.	Partially addressed.

Table 89: Healthfirst's Mainstream Medicaid Performance Improvement Project Summary, 2022

Healthfirst's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving the Oral Health Outcomes of Our 21–64-Year-Old Medicaid Population Through the Increased Utilization of Preventive Dental Care **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Male Members Ages 21-64 Years
Global Aims ▪ Healthfirst aims to increase preventive dental visits among members ages 21–64 years. ▪ Healthfirst aims to decrease emergency department visits for ambulatory care sensitive non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aim ▪ Healthfirst aims to increase preventive dental visits among male members ages 21–64 years. Member-Focused 2022 Interventions ▪ Conducted targeted outreach to members identified as missing a preventive care dental visit and/or having an emergency department visit for a non-traumatic dental condition. ▪ Updated the Healthfirst member website to include education materials on dental health. ▪ Targeted male members identified with no preventive dental visit and with an emergency department visit for a non-traumatic dental condition for telephonic outreach on the importance of routine dental care. Provider-Focused 2022 Interventions ▪ Posted clinical guidelines, best practices, member resources, and in-network dental providers listings on the Healthfirst provider website and provider portal. ▪ Issued listings of members with an emergency department visit for a non-traumatic dental condition to primary care providers. Managed Care Plan-Focused 2022 Interventions ▪ Collaborated with DentaQuest to update the dental provider directory and to include an indicator for members to identify providers who offer telehealth services.

Table 90: Healthfirst's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	24.34%	24.54%	29.00%
Males, ages 21–64 years[1]	23.43%	22.83%	28.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	95.59	97.37	91.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 91: Healthfirst's Health and Recovery Plan Performance Improvement Project Summary, 2022

Healthfirst's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving the Health Outcomes of Our Health and Recovery Plan Population with Diabetes Mellitus Through the Early Identification and Management of Members At-Risk for Complications Due to Uncontrolled Hemoglobin A1c, Blood Pressure, and Smoking **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Members Ages 25–34 Years with Diabetes
Global Aims ▪ Healthfirst aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ Healthfirst aims to decrease the rate of poor hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ Healthfirst aims to increase tobacco cessation counseling and/or pharmacotherapy among members ages 21–64 years with diabetes. Disparity Reduction Aim ▪ Healthfirst aims to decrease the rate of hemoglobin A1c poor control among members ages 25–34 years with diabetes. Member-Focused 2022 Interventions ▪ Identified high-risk members for the Healthfirst Diabetes Program to conduct a comprehensive diabetes assessment including social determinants of health needs and education regarding medication, nutrition, testing, supplies, and smoking cessation benefits. Monthly outreach was conducted until all goals were completed. ▪ Enrolled medium-risk members for the Healthfirst Diabetes Program to screen for initial needs and triage to care managers as needed. These members received assistance with making provider appointments, referrals for community and Quitline programs, and educational materials on disease management. ▪ Outreached the disparity target group (members with diabetes ages 25–34 years) to offer diabetes management through a combination of care manager outreach, digital care management, and coaching. Provider-Focused 2022 Interventions ▪ Provided health homes with quarterly and monthly care gap reports to inform them of shared members with diabetes in need of support in lowering their hemoglobin A1c, getting a hemoglobin A1c test done, controlling their blood pressure, and/or assistance with smoking cessation efforts. ▪ Conducted monthly follow-up with health homes to review performance metrics and compare performance with peers. Managed Care Plan-Focused 2022 Interventions ▪ Developed diabetes risk stratification system based on inpatient admissions, length of stay, and diagnoses. ▪ Implemented an automated alert system to inform care managers and diabetes care coordinators of members identified as at-risk in need of outreach for engagement in the Healthfirst Diabetes Program. ▪ Constructed job aides and training for identifying members through risk stratification and managing needs in the Healthfirst Diabetes Program. ▪ Trained staff on the new workflows for the Healthfirst Diabetes Program: opening new member cases, creating individualized care plans, and documenting appropriate interventions.

Table 92: Healthfirst's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	39.42%	43.60%	44.42%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	56.88%	49.24%	49.88%
Ages 25–34 years[4]	69.58%	62.24%	62.58%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	42.08%	42.92%	47.08%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	14.16%	7.79%	19.16%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	11.79%	6.63%	16.79%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	4.30%	1.83%	9.30%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 93: Healthfirst's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Healthfirst Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	21.00%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	52.56%	57.76%	55.90%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	36.70%	40.81%	40.01%	41.45%
Asthma Medication Ratio (5–64 Years)	53.11%	54.34%	69.41%	61.20%
Breast Cancer Screening	70.34%	69.38%	71.32%	65.60%
Cervical Cancer Screening[1]	71.68%	74.27%	77.57%	69.95%
Chlamydia Screening in Women (16–20 Years)	77.90%	80.59%	80.85%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	75.99%	80.06%	79.56%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	69.59%	69.34%	62.58%	52.96%
Controlling High Blood Pressure	43.07%	72.02%	70.45%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	65.69%	63.99%	65.63%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	46.47%	34.79%	29.52%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.02%	80.32%	81.30%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	44.97%	44.77%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	51.13%	45.02%	38.33%	35.47%
Childhood Immunization Status – Combination 3	79.81%	73.72%	75.18%	68.59%
Immunizations for Adolescents – Combination 2	57.78%	53.60%	53.41%	43.33%

Measure Description	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Healthfirst Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	59.02%	88.56%	86.13%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	53.11%	82.97%	81.51%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.39%	61.87%	64.86%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	2.83%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	83.46%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	42.85%	45.03%	50.81%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	73.45%	75.43%	73.69%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	67.13%	62.73%	64.41%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	77.85%	76.00%	73.16%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.60%	46.46%	51.12%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	17.23%	17.30%	28.97%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	37.47%	39.95%	39.48%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	30.98%	32.49%	45.93%
Pharmacotherapy for Opioid Use Disorder	32.50%	25.43%	30.58%	33.31%
Viral Load Suppression	74.82%	74.42%	76.16%	74.19%
Prenatal Immunization Status	33.62%	27.49%	29.26%	24.44%

Measure Description	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Healthfirst Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	44.23%	42.17%	42.77%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	14.53%	14.90%	18.06%
Annual Dental Visit (2–18 Years)	44.17%	49.68%	52.47%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	89.78%	90.88%	85.00%	86.75%
Prenatal and Postpartum Care – Postpartum Care	77.62%	83.11%	84.17%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	68.55%	73.94%	73.81%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	67.45%	70.59%	72.78%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	83.18%	80.53%	81.82%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 94: Healthfirst's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Healthfirst Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.33%	52.66%	51.05%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.07%	38.06%	34.93%	38.03%
Asthma Medication Ratio (19-64 Years)	34.78%	40.38%	66.52%	52.89%
Breast Cancer Screening	61.05%	61.88%	62.07%	54.68%
Cervical Cancer Screening	68.37%	65.21%	70.07%	63.33%
Chlamydia Screening in Women (21–24 Years)	68.93%	79.23%	82.88%	72.23%
Colorectal Cancer Screening (50–75 Years)	62.41%	62.56%	54.77	47.33%
Controlling High Blood Pressure	63.02%	69.27%	73.16%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	53.56%	63.02%	56.25%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	48.16%	38.69%	33.67%	37.57%
Flu Vaccination for Adults Ages 18-64	48.44%	48.54%	48.54%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	31.75%	32.12%	32.93%
Advising Smokers to Quit (CAHPS)	87.29%	87.02%	87.02%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	76.92%	68.99%	68.99%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	71.55%	66.41%	66.41%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	63.32%	66.38%	64.21%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	38.45%	27.40%	27.55%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.98%	65.70%	67.04%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.99%	81.96%	82.73%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	67.10%	71.83%	71.92%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	40.57%	40.93%	51.91%	49.48%

Measure Description	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Healthfirst Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	63.20%	63.68%	64.89%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	26.57%	27.11%	40.09%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	39.48%	38.90%	37.69%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	30.18%	28.22%	42.80%
Pharmacotherapy for Opioid Use Disorder	32.02%	28.71%	29.40%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	26.69%	28.22%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	16.99	15.00%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

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

Table 95: Healthfirst's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	Pended	C
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 96: Healthfirst's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on interviews with management staff from Healthfirst, and review of documents, the Healthfirst failed to complete oversight of the behavioral health delegate. Healthfirst failed to provide policies and procedures for care management and utilization management specific to their behavioral health vendor. Healthfirst also failed to provide evidence of monitoring of the behavioral health delegate care management activities and clinical rounds.	Contract Article 2005-98-1.11	438.230
Based on staff interview and review of initial adverse determination notices, Healthfirst and two delegates failed to ensure the enrollee was verbally notified of the determination within three business days of the receipt of necessary information but not more than 14 days from receipt of the request. Additionally, Healthfirst did not ensure its delegate completed two attempts to contact the enrollee, in accordance with the Department of Health's *Reasonable Effort* policy.	Contract Article 4903(2)(a)	438.228

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 97: Healthfirst's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Healthfirst	Mainstream Medicaid and Child Health Plus Average	Healthfirst	Mainstream Medicaid and Child Health Plus Average	Healthfirst	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	83.27%	83.75%	79.42%	84.31%	85.23%	82.04%
Getting Care Quickly[1]	82.86%	88.14%	87.41%	87.84%	81.71%	83.82%
How Well Doctors Communicate[1]	92.46%	93.44%	92.44%	93.35%	91.03%	94.17%
Customer Service[1]	80.77%	85.84%	88.72%	86.53%	88.57%	86.07%
Rating of All Health Care[2]	87.49%	87.48%	90.32%	89.77%	87.40%	86.07%
Rating of Personal Doctor[2]	89.19%	90.40%	89.93%	90.08%	86.70%	89.41%
Rating of Specialist Talked to Most Often[2]	87.43%	83.58%	94.77%	87.11%	87.99%	81.40%
Rating of Health Plan[2]	85.27%	85.18%	88.47%	86.02%	83.46%	80.80%
Rating of Treatment or Counseling[2]	Small Sample	68.99%	60.51%	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 98: Healthfirst's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Healthfirst's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		One of three performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Healthfirst's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Four of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Healthfirst met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Twenty-two performance measure rates reported by Healthfirst for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Eight performance measure rates reported by Healthfirst for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by Healthfirst for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, Healthfirst was in compliance with 12 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Two of three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Four performance measure rates reported by Healthfirst for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Four performance measure rates reported by Healthfirst for measurement year 2022 performed	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		statistically significantly worse than the statewide managed care program mean.			
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by Healthfirst for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	One performance measure rate reported by Healthfirst for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, Healthfirst was not in full compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	Healthfirst should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	Healthfirst should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid	Healthfirst should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and Child Health Plus	the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Healthfirst should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	Healthfirst should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Healthfirst should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Healthfirst should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. Healthfirst should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 99: Highmark BCBS WNY's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Highmark BCBS WNY should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Highmark BCBS WNY implemented quality improvement strategies in the first quarter of 2022 to address timely screenings in the Early Periodic and Screening, Diagnostic and Treatment program. Highmark BCBS WNY tracks outreach through monthly text and call campaigns, and has hosted several school-based wellness fairs. Providers receive quarterly gaps in care reports, and participate in an incentive program to close quality gaps. Maternal health equity interventions were launched in the second quarter of 2023 and are tracked monthly.	Addressed.
Validation of Performance Measures			
Highmark BCBS WNY 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, Highmark BCBS WNY should focus on the areas of care in which its rates did not meet	Mainstream Medicaid and Child Health Plus	Highmark BCBS WNY monitors monthly Quality Assurance Reporting Requirements measure performance. In the first quarter of 2022, Highmark BCBS WNY established collaborative workgroups with Network Relations and Marketing/Community Relations to improve provider experience and community-based organization outreach. Member complaints, appeals and services are tracked quarterly in Quality Assurance Committee meetings to identify quality of care and	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
mainstream Medicaid performance.		access issues. In the second quarter of 2023, Highmark BCBS WNY implemented 10 'Whole Health' interventions to address, track and monitor disparities.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Highmark BCBS WNY should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019 compliance findings. Highmark BCBS WNY should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	Mainstream Medicaid and Child Health Plus	As part of the measurement year 2019 Operational Survey, plans of correction were implemented in the second quarter of 2020. There is ongoing training for new associates and oversight of provider credentialing monitoring metrics. Turnaround times and operating standards are monitored for processing grievance and appeals. Ongoing operational performance reports are reviewed and discussed monthly. Systemic issues are escalated to the Joint Operations and Compliance committees.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience			
Highmark BCBS WNY should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Highmark BCBS WNY established a CAHPS workgroup in the first quarter of 2022 to track member experience outcomes. Interventions include: ▪ An annual CAHPS training to all Highmark BCBS WNY employees so all associates can impact member experience. ▪ A continuing education unit-accredited training online seminar for providers tracking attendance and feedback. ▪ A 'Voice of Consumer' survey after contact with the call center to evaluate member service experience. ▪ A claim-triggered post- visit survey to assess experience with a provider or specialist.	Partially addressed.

Table 100: Highmark BCBS WNY's Mainstream Medicaid Performance Improvement Project Summary, 2022

Highmark's Mainstream Performance Improvement Project Summary
Title: Adult Dental Performance Improvement Project **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulations With Health Disparity:** Male Members Ages 21-64 Years; Members Ages 25-44 Years; Black/African American Members; Hispanic Members
Global Aims ▪ Highmark aims to increase annual dental visits among members ages 21–64 years. ▪ Highmark aims to decrease non-traumatic dental condition emergency department visits among members ages 21–64 years. Disparity Reduction Aims ▪ Highmark aims to improve access to preventive dental care services for male members ages 21–64 years. ▪ Highmark aims to improve access to preventive dental care services for members ages 25–44 years. ▪ Highmark aims to reduce non-traumatic dental condition emergency department visits among Black/African American members. ▪ Highmark aims to reduce non-traumatic dental condition emergency department visits among Hispanic members. Member-Focused 2022 Interventions ▪ Hosted quarterly community dental education events targeting Black/African American, and Hispanic members. ▪ Conducted targeted educational outreach via short message service to members ages 25–44 years and male members ages 21–64 years on the importance of preventive dental care. ▪ Distributed educational mailers to all members on the importance of routine dental care. ▪ Offered teledentistry services to members following an emergency department visit for non-traumatic dental care. Provider-Focused 2022 Interventions ▪ Published articles on dental care disparity and available resources in the provider newsletter. ▪ Educated primary care providers on in-network dental homes and the importance of encouraging patients to seek appropriate dental care.

Table 101: Highmark BCBS WNY's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	26.07%	50.20%	31.00%
Males, ages 21–64 years[1]	22.04%	44.47%	27.00%
Ages 25–44 years[1]	25.29%	48.65%	27.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	223.67	171.27	200.00
Black/African American, ages 21–64 years[1]	380.91	278.41	223.70
Hispanic, ages 21–64 years[1]	411.91	616.16	223.70

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Performance Measure Results

Table 102: Highmark BCBS WNY's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Highmark Measurement Year 2020	Highmark Measurement Year 2021	Highmark Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	13.39%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	54.92%	56.62%	52.45%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	41.10%	42.80%	38.04%	41.45%
Asthma Medication Ratio (5–64 Years)	64.76%	63.90%	63.05%	61.20%
Breast Cancer Screening	54.36%	53.54%	57.12%	65.60%
Cervical Cancer Screening[1]	62.29%	66.49%	59.00%	69.95%
Chlamydia Screening in Women (16–20 Years)	58.83%	58.43%	63.27%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	64.65%	68.37%	68.11%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	52.55%	49.88%	40.10%	52.96%
Controlling High Blood Pressure	62.77%	63.02%	68.37%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	58.64%	59.37%	62.77%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	48.18%	35.77%	30.17%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.57%	72.82%	76.32%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	35.81%	37.39%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	25.64%	30.43%	21.08%	35.47%
Childhood Immunization Status – Combination 3	80.78%	81.27%	81.02%	68.59%
Immunizations for Adolescents – Combination 2	37.96%	41.85%	43.07%	43.33%

Measure Description	Highmark Measurement Year 2020	Highmark Measurement Year 2021	Highmark Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	86.37%	86.13%	81.51%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	80.78%	82.24%	79.81%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.59%	60.00%	58.70%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	72.17%	72.99%	75.36%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	60.74%	59.00%	58.37%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	48.60%	55.73%	53.96%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	64.29%	66.67%	60.56%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	21.53%	27.23%	37.56%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	25.00%	29.92%	40.61%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	45.02%	50.42%	47.25%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	55.77%	56.64%	45.93%
Pharmacotherapy for Opioid Use Disorder	41.37%	40.13%	36.44%	33.31%
Viral Load Suppression	83.33%	80.66%	79.80%	74.19%
Prenatal Immunization Status	16.85%	18.37%	19.13%	24.44%

Measure Description	Highmark Measurement Year 2020	Highmark Measurement Year 2021	Highmark Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	41.32%	43.37%	40.89%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	16.19%	13.91%	18.06%
Annual Dental Visit (2–18 Years)	53.38%	55.39%	55.82%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	88.81%	86.62%	86.49%	86.75%
Prenatal and Postpartum Care – Postpartum Care	77.13%	77.37%	83.78%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	68.89%	70.52%	70.93%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	68.72%	68.77%	69.28%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	89.44%	84.84%	83.79%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. 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 103: Highmark BCBS WNY's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	Pended	C
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 104: Highmark BCBS WNY's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on staff interview and review of initial adverse determination notices, Highmark and its delegate failed to ensure the notices included the required language to identify the final adverse determination as the start of the four-month timeframe to request an external appeal.	Contract Article 4914(2)(a)	438.228
Based on staff interview and review of initial adverse determination notices, Highmark its delegate failed to ensure the notices included the required appeal language.	Contract Article 4904(2)(b)	438.228

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 105: Highmark BCBS WNY's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Highmark BCBS WNY	Mainstream Medicaid and Child Health Plus Average	Highmark BCBS WNY	Mainstream Medicaid and Child Health Plus Average	Highmark BCBS WNY	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	88.34%	83.75%	90.02%	84.31%	87.08%	82.04%
Getting Care Quickly[1]	92.33%	88.14%	94.65%	87.84%	90.21%	83.82%
How Well Doctors Communicate[1]	94.32%	93.44%	94.56%	93.35%	94.30%	94.17%
Customer Service[1]	86.93%	85.84%	87.22%	86.53%	93.45%	86.07%
Rating of All Health Care[2]	87.76%	87.48%	89.36%	89.77%	89.46%	86.07%
Rating of Personal Doctor[2]	89.39%	90.40%	92.15%	90.08%	87.57%	89.41%
Rating of Specialist Talked to Most Often[2]	82.85%	83.58%	90.67%	87.11%	82.55%	81.40%
Rating of Health Plan[2]	82.36%	85.18%	83.44%	86.02%	83.88%	80.80%
Rating of Treatment or Counseling[2]	66.63%	68.99%	73.04%	65.85%	60.08%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 106: Highmark BCBS WNY's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Highmark BCBS WNY's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		Five of six performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	Highmark BCBS WNY met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Five performance measure rates reported by Highmark BCBS WNY for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by Highmark BCBS WNY for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by Highmark BCBS WNY for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid and Child Health Plus	During measurement year 2022, Highmark BCBS WNY was in compliance with 13 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid	Two member satisfaction scores achieved by Highmark BCBS WNY for	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and Child Health Plus	measurement year 2022 performed statistically significantly better than the Mainstream Medicaid and Child Health Plus program average.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	One of six performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Eleven performance measure rates reported by Highmark BCBS WNY for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by Highmark BCBS WNY for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid and Child Health Plus	During measurement year 2022, Highmark BCBS WNY was not in full compliance with one of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	Highmark BCBS WNY should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Mainstream Medicaid and Child Health Plus	Highmark BCBS WNY should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Highmark BCBS WNY should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, and Child Health Plus	Highmark BCBS WNY should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. Highmark BCBS WNY should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 107: HIP's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	HIP's Response	IPRO's Assessment of HIP's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, HIP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	HIP monitors children for appropriate screening and follow-up care. A member outreach hub contacts and encourages members to receive care. Through the 45 AdvantageCare Physicians New York sites, HIP members receive point of care lead testing. Behavioral health services are designed for each child. Physicians receive monthly gaps in care reports. The 2023 physicians' incentive program includes well visits and childhood immunizations. Effectiveness of interventions is monitored via HEDIS/Quality Assurance Reporting Requirements rates.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, HIP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	HIP's Medical Management team and member outreach hub call members enrolled in health homes or complex case management to coordinate care pre and post hospitalization. Regular meetings with Carelon are held to facilitate the successful transition from hospitalization to a lower level of care, to assess progress and the effectiveness of quality improvement strategies and to identify additional opportunities for improvement in access to care. Effectiveness is measured via HEDIS/Quality Assurance Reporting Requirements rates.	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	HIP's Response	IPRO's Assessment of HIP's Response
Validation of Performance Measures			
HIP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, HIP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	HIP's initiatives target pediatric well care, asthma (pest control / deep cleaning), breast and cervical cancer screening, diabetic hemoglobin A1c, and retinal eye exam. Initiatives include home visits, home testing kits, screening community events for diabetes and breast cancer, and coordinating care using HIP's member outreach hub. Physicians receive monthly gaps in care reports and can participate in an incentive program. Effectiveness is monitored via HEDIS/Quality Assurance Reporting Requirements.	Partially addressed.
HIP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, HIP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	HIP implemented initiatives targeting colorectal and cervical cancer, hemoglobin A1c rates and retinal eye, follow-up care for substance use disorders, pharmacotherapy for opioid use/dependence. Initiatives include home visits, home testing kits, diabetes and breast cancer screening community events, and member engagement using HIP's member outreach hub. Physicians receive monthly gaps in care reports and can participate in an incentive program. Effectiveness is monitored via HEDIS/Quality Assurance Reporting Requirements.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
HIP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	HIP routinely monitors the performance of key measures and quality initiatives as part of the approved action plan to ensure compliance. Monitoring consists of annual dental screening rates for members	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	HIP's Response	IPRO's Assessment of HIP's Response
		aged 2-18 years, coordination of care for children with chronic conditions, and diabetes screenings, which allows HIP to also measure effectiveness, with the expectation of improving quality performance. Effectiveness is monitored via HEDIS/Quality Assurance Reporting Requirements rates.	
Administration of Quality-of-Care Surveys – Member Experience			
HIP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	HIP continues to monitor member experience and prioritize opportunities for improvement. Activities include a Medicaid member advisory board to solicit feedback, CAHPS provider tip sheet, access to Plan and community-based services, member surveys regarding language services, diversity of the network, and providers. A provider quality incentive program includes satisfaction with the primary care provider. CAHPS results and data are reviewed by quality leadership to determine effectiveness.	Partially addressed.
HIP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	HIP continues to monitor member experience and prioritize opportunities for improvement. Activities include a Medicaid member advisory board, CAHPS provider tip sheet, access to HIP and community-based services, member surveys regarding language services, diversity of network and providers. A provider quality incentive program includes satisfaction with the PCP. CAHPS results and data, and value-based contract metrics are reviewed by quality leadership to determine effectiveness.	Partially addressed.

Table 108: HIP's Mainstream Medicaid Performance Improvement Project Summary, 2022

HIP's Mainstream Medicaid Performance Improvement Project Summary
Title: Adult Dental Care Performance Improvement Project **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulations With Health Disparity:** Black/African American Members Ages 21-64 Years; White Members 21-64 Years
Global Aims ▪ HIP aims to increase preventive dental visits among members ages 21–64 years. ▪ HIP aims to decrease emergency department utilization for non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aims ▪ HIP aims to increase preventive dental visits among Black/African American members ages 21–64 years. ▪ HIP aims to increase preventive dental visits among White members ages 21–64 years. Member-Focused 2022 Interventions ▪ HealthPlex conducted a member outreach call campaign to households with multiple HIP members who are non-compliant for an annual preventive dental visit. ▪ Executed a dental preventive care education campaign using the mode of communication selected by the member. ▪ Conducted outreach to members identified as non-compliant for an annual preventive dental visit and not included in the HealthPlex outreach initiative, as well as provided appointment scheduling assistance. ▪ Conducted outreach via telephone to members identified with at least one emergency department visit for a non-traumatic dental condition, as well as provided appointment scheduling assistance.

Table 109: HIP's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	16.28%	13.13%	25.00%
Black/African American, ages 21–64 years[1]	16.12%	13.86%	30.00%
White, ages 21–64 years[1]	14.50%	12.71%	30.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	107.80	93.55	97.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 110: HIP's Health and Recovery Plan Performance Improvement Project Summary, 2022

HIP's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Black/African American Members Ages 21–64 Years With Diabetes
Global Aims • HIP aims to increase the percentage of members ages 21–64 years with diabetes who have hemoglobin A1c control. • HIP aims to decrease the percentage of members ages 21–64 years with diabetes who have poor hemoglobin A1c control. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who have blood pressure control. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who have tobacco cessation pharmacotherapy. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who have tobacco cessation counseling. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who have one prescription for tobacco cessation pharmacotherapy and one outpatient visit including tobacco cessation counseling. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who use tobacco with a prescription for tobacco cessation pharmacotherapy. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who use tobacco with a prescription for tobacco cessation counseling. • HIP aims to increase the percentage of members ages 21–64 years with diabetes who use tobacco with one prescription for tobacco cessation pharmacotherapy and one outpatient visit including tobacco cessation counseling. Disparity Reduction Aim ▪ HIP aims to decrease the percentage of Black/African American ages 21–64 years with poor hemoglobin A1c control. Member-Focused 2022 Interventions ▪ Outreached members who were identified with poor diabetes and/or blood pressure control (by phone, mail, or email) to coordinate care for blood pressure and diabetes management through plans of care, monitoring, and communication with members and providers. ▪ Conducted point-of-care testing and education for members identified with poor diabetes control at HIP neighborhood care centers. ▪ Provided home testing kits for members identified with poor diabetes control through the HIP Matrix home vendor. ▪ Encouraged the use of tobacco cessation pharmacotherapy for members with diabetes who use tobacco products through one-on-one support, developing a quit plan, and education on tobacco cessation. ▪ Contacted the Black/African American members with poor diabetes control to schedule appointments for diabetes care. Managed Care Plan-Focused 2022 Interventions ▪ Improved care coordination between members and their primary care physicians by providing health homes with comprehensive diabetes care gaps-in-care data.

Table 111: HIP's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	36.01%	34.60%	46.01%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	62.31%	60.10%	52.31%
Black/African Americans, ages 21–64 years[4]	65.44%	61.89%	52.31%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	35.36%	34.85%	45.36%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	10.23%	10.23%	20.00%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	10.23%	8.59%	20.00%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	3.11%	3.16%	13.20%
The percentage of Health and Recovery Plan members with diabetes and use tobacco products who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	50.00%	54.36%	60.00%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	50.00%	45.64%	60.00%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	15.19%	16.75%	25.20%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 112: HIP's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	HIP Measurement Year 2020	HIP Measurement Year 2021	HIP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	18.27%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	59.42%	60.07%	60.10%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	41.79%	42.15%	44.95%	41.45%
Asthma Medication Ratio (5–64 Years)	67.30%	64.06%	70.13%	61.20%
Breast Cancer Screening	69.06%	66.34%	67.00%	65.60%
Cervical Cancer Screening[1]	67.46%	65.03%	68.88%	69.95%
Chlamydia Screening in Women (16–20 Years)	72.63%	74.10%	73.13%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	71.72%	75.06%	74.78%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	59.38%	61.79%	53.35%	52.96%
Controlling High Blood Pressure	64.48%	66.58%	72.24%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	58.05%	61.31%	60.64%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	45.12%	36.50%	32.76%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	72.78%	74.93%	76.29%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	37.70%	39.10%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	48.08%	45.22%	33.73%	35.47%
Childhood Immunization Status – Combination 3	70.07%	66.91%	68.61%	68.59%
Immunizations for Adolescents – Combination 2	38.69%	35.52%	38.93%	43.33%

Measure Description	HIP Measurement Year 2020	HIP Measurement Year 2021	HIP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	76.30%	83.54%	83.46%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	73.70%	81.71%	81.54%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.95%	59.79%	60.69%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.47%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	68.48%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	48.53%	54.98%	58.87%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	57.37%	59.47%	52.42%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	54.64%	48.94%	63.42%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	72.31%	60.00%	73.61%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	36.31%	41.40%	37.70%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	17.11%	20.23%	28.30%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	33.47%	37.61%	35.77%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	33.86%	35.08%	45.93%
Pharmacotherapy for Opioid Use Disorder	33.23%	26.44%	32.11%	33.31%
Viral Load Suppression	71.60%	71.78%	72.25%	74.19%
Prenatal Immunization Status	21.45%	19.78%	18.85%	24.44%

Measure Description	HIP Measurement Year 2020	HIP Measurement Year 2021	HIP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	50.02%	50.94%	56.53%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	21.66%	23.69%	18.06%
Annual Dental Visit (2–18 Years)	40.63%	42.56%	43.79%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	79.64%	79.23%	87.10%	86.75%
Prenatal and Postpartum Care – Postpartum Care	75.77%	80.51%	83.87%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	64.16%	69.68%	67.92%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	60.94%	62.12%	67.31%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	75.72%	74.79%	73.57%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 113: HIP's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	HIP Measurement Year 2020	HIP Measurement Year 2021	HIP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.42%	53.28%	57.56%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.31%	40.15%	44.54%	38.03%
Asthma Medication Ratio (19-64 Years)	52.63%	46.03%	57.30%	52.89%
Breast Cancer Screening	53.64%	52.61%	52.38%	54.68%
Cervical Cancer Screening	58.16%	58.35%	56.61%	63.33%
Chlamydia Screening in Women (21–24 Years)	77.27%	62.86%	Small Sample	72.23%
Colorectal Cancer Screening (50–75 Years)	48.66%	45.01%	43.79%	47.33%
Controlling High Blood Pressure	56.69%	62.47%	64.95%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	49.64%	48.42%	50.61%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	52.07%	45.99%	41.61%	37.57%
Flu Vaccination for Adults Ages 18-64	56.52%	46.59%	46.59%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	28.35%	31.26%	32.93%
Advising Smokers to Quit (CAHPS)	82.86%	77.78%	77.78%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	70.09%	62.14%	62.14%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	63.55%	51.06%	51.06%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	65.69%	65.18%	63.37%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	29.41%	33.80%	26.04%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.96%	68.09%	67.46%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	69.23%	75.65%	74.94%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	47.66%	50.22%	40.99%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	51.79%	53.67%	56.63%	49.48%
HIV Viral Load Suppression	63.27%	54.46%	64.91%	66.01%

Measure Description	HIP Measurement Year 2020	HIP Measurement Year 2021	HIP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	25.50%	31.11%	36.45%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	34.93%	36.46%	34.82%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	31.94%	34.20%	42.80%
Pharmacotherapy for Opioid Use Disorder	34.56%	28.10%	31.34%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	21.51%	24.12%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	21.54%	25.72%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 114: HIP's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	C	C	Open Period
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	C	NC	Open Period
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	C	C	Open Period
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	C	C	Open Period

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement; Open Period: the timeline between the accepted plan of correction and the date certain for implementation.

Table 115: HIP's Compliance Review Summary of Results, 2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on staff interview and record reviews, the HIP failed to issue final adverse determination notices that were factual in nature. The final adverse determination issued to the enrollee included external appeal rights with administrative denial determinations. This was evident in 18 of 25 HIP Medicaid cases reviewed.	Contract Article 4405(10)	438.228
Based on staff interview and record review, of expedited appeals cases for commercial and Medicaid members, HIP failed to ensure that written and/or phone notice was provided to the member and/or provider when additional information was requested.	Contract Article 98-2.9(b)	438.228
Based on staff interview and record review of the final adverse determination notices, HIP failed to ensure members enrolled in Medicaid received the correct appeal rights.	Contract Article 4405(10)	438.228

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 116: HIP's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	HIP	Mainstream Medicaid and Child Health Plus Average	HIP	Mainstream Medicaid and Child Health Plus Average	HIP	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	82.20%	83.75%	80.45%	84.31%	75.89%	82.04%
Getting Care Quickly[1]	89.03%	88.14%	86.10%	87.84%	82.67%	83.82%
How Well Doctors Communicate[1]	94.05%	93.44%	94.97%	93.35%	93.36%	94.17%
Customer Service[1]	84.81%	85.84%	83.88%	86.53%	84.52%	86.07%
Rating of All Health Care[2]	86.71%	87.48%	86.45%	89.77%	84.27%	86.07%
Rating of Personal Doctor[2]	89.67%	90.40%	88.40%	90.08%	92.39%	89.41%
Rating of Specialist Talked to Most Often[2]	88.77%	83.58%	71.22%	87.11%	85.69%	81.40%
Rating of Health Plan[2]	79.32%	85.18%	78.76%	86.02%	72.48%	80.80%
Rating of Treatment or Counseling[2]	Small Sample	68.99%	57.40%	65.85%	58.51%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 117: HIP's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	HIP's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		One of four performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	HIP's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Five of ten performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	HIP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Five performance measure rates reported by HIP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	One performance measure rate reported by HIP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by HIP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	One performance measure rate reported by HIP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, HIP was in compliance with 13 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, HIP was in compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Three of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Four of ten performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022, and one indicator rate remained the same.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Seven performance measure rates reported by HIP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	Seven performance measure rates reported by HIP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by HIP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by HIP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, HIP was not in full compliance with one of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	One member satisfaction score achieved by HIP for measurement year 2022 performed statistically significantly worse than the Mainstream Medicaid and Child Health Plus program average.	X	X	X
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	HIP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	HIP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	HIP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, HIP should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	HIP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, HIP should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	HIP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	HIP should strive to enhance its performance on the measure of member satisfaction where it did not perform at or significantly better than the Mainstream Medicaid and Child Health Plus average.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 118: IHA's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	IHA's Response	IPRO's Assessment of IHA's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, IHA should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	IHA continues to support performance improvement opportunities to address better health outcomes for child and adolescent members. One focus of IHA is to improve performance with the New York developmental screening measures for children aged 1, 2, and 3 years. These measures are included in IHA's value-based payment program, Primary Value, and improvement goals are directed to primary care providers. Additionally, these measures are supported by outreach and education from the Provider Engagement Team as needed.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, IHA should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	A goal of IHA is to ensure successful transitions from the emergency room or inpatient admission to a lower level of care. Follow-up care after mental health emergency department visits (7-day) is included in our value-based payment arrangements, as well as within independent physician association quality programs to ensure primary care providers are focused on reaching patients upon discharge. IHA partners with Carelon, a behavioral health organization, to monitor transitions of care related to behavioral health needs. IHA sets internal goals to, at minimum,	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	IHA's Response	IPRO's Assessment of IHA's Response
		achieve the statewide average for these measures.	
Validation of Performance Measures			
IHA should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, IHA should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	Annually, IHA reviews the provided quality improvement matrices to identify measures that are underperforming, or beneath the statewide average. Measures are selected, and improvement tactics are developed through the Quality Improvement Working Group and implemented by a cross-functional team for delivery of programs and services. HEDIS/Quality Assurance Reporting Requirements performance is trended and reviewed bi-weekly by the Quality Management Team, and negative trends identified drive additional quality improvement planning as needed.	Partially addressed.
IHA should continue to utilize the results of the HEDIS/ Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, IHA should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	Annually, IHA reviews the provided quality improvement matrices to identify measures that are underperforming, or beneath the statewide average. Measures are selected, and improvement tactics are developed through the Quality Improvement Working Group and implemented by a cross-functional team for delivery of programs and services. HEDIS/Quality Assurance Reporting Requirements performance is trended and reviewed bi-weekly by the Quality Management Team, and negative trends identified drive additional quality improvement planning as needed.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
IHA should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance	Mainstream Medicaid, Child Health Plus, and Health and	All departments at IHA are responsible for the quality assurance of their work. Compliance is assured through the review of standards, particularly	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	IHA's Response	IPRO's Assessment of IHA's Response
review conducted by the Department of Health.	Recovery Plan	those around delegated entities, and tracked by the IHA Compliance Team on a monthly basis. An overview of these internal reviews and tracking results are reviewed quarterly by the Executive Team. The goal is to meet or exceed regulatory requirements, and also to meet internal operational benchmarks.	
Administration of Quality-of-Care Surveys – Member Experience			
IHA should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	IHA did not have any experience measures that fell below the statewide average. IHA monitors member experience monthly through internal satisfaction survey distribution and reacts to areas where underperformance is trending. IHA has a CAHPS work team that monitors trends and develops cross-departmental solutions to drive and improve member experience. Additionally, experience measures are included in an independent physician association-level quality arrangements to gain provider attention to focus measures.	Partially addressed.
IHA should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	IHA did not have any experience measures that fell below the statewide average. IHA monitors member experience monthly through internal satisfaction survey distribution and reacts to areas where underperformance is trending. IHA has a CAHPS work team that monitors trends and develops cross-departmental solutions to drive and improve member experience. Additionally, experience measures are included in independent physician association-level quality arrangements to gain provider attention to focus measures.	Partially addressed.

Table 119: IHA's Mainstream Medicaid Performance Improvement Project Summary, 2022

IHA's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Medicaid Managed Care Adult Members **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Black/African American Members Ages 21-64 Years
Global Aims ▪ IHA aims to increase annual preventive dental visits among members ages 21–64 years. ▪ IHA aims to decrease emergency department utilization for non-traumatic oral health needs among members ages 21–64 years. Disparity Reduction Aim ▪ IHA aims to improve annual preventive dental visits among Black/African American members ages 21–64 years. Member-Focused 2022 Interventions ▪ Diverted and linked members who presented at the Erie County Medical Center emergency department with non-traumatic dental conditions to an Erie County Medical Center-affiliated outpatient dental clinic for treatment and/or follow-up care. ▪ Hosted quarterly community outreach events to educate members on oral health education. ▪ Targeted communities in Buffalo, New York with high percentages of Black/African American members for oral health education. Provider-Focused 2022 Interventions ▪ Conducted training for a single independent physician association on promoting oral health care to members. ▪ Implemented an incentive program for independent physician associations to develop processes linking members to preventive dental care. Managed Care Plan-Focused 2022 Interventions ▪ Collaborated with Erie County Medical Center on a pilot program to divert members with non-traumatic dental conditions from the emergency department to an Erie County Medical Center-affiliated outpatient dental clinic.

Table 120: IHA's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	24.19%	21.12%	34.00%
Black/African American, ages 21–64 years[1]	19.39%	15.72%	30.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	158.84	148.37	117.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 121: IHA's Health and Recovery Plan Performance Improvement Project Summary, 2022

IHA's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Black/African American Members Ages 21–64 Years With Diabetes
Global Aims ▪ IHA aims to increase the rate of blood pressure control among members ages 21–64 years with diabetes. ▪ IHA aims to decrease the rate of members with diabetes demonstrating poor control as evidenced by a hemoglobin A1c test result of greater than 9%, among members ages 21–64 years. ▪ IHA aims to increase the rate of members with diabetes demonstrating adequate disease control as evidenced by a hemoglobin A1c test result of less than 8%, among members ages 21–64 years. ▪ IHA aims to increase the rate of members ages 21–64 years with diabetes who use tobacco with at least one prescription for tobacco cessation pharmacotherapy at any time during the measurement year. ▪ IHA aims to increase the rate of members ages 21–64 years with diabetes who use tobacco with at least one outpatient visit including tobacco cessation counseling. ▪ IHA aims to increase the rate of members ages 21–64 years with diabetes who use tobacco with at least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit including tobacco cessation counseling at any time during the measurement year. Disparity Reduction Aim ▪ IHA aims to increase the rate of diabetic Black/African American members ages 21–64 years demonstrating adequate blood pressure control. Member-Focused 2022 Interventions ▪ Developed high-risk registry to identify members with poor control of diabetes to target with the Food First program. ▪ Referred high-risk members to the Food First program, which includes meeting with a registered dietician and food delivery with the Supplemental Nutrition Assistance Program benefit. ▪ Tracked enrollment of high-risk members to the Food First program. Provider-Focused 2022 Interventions ▪ Implemented an independent practice association incentive for developing a process to identify members in need of metabolic monitoring, strategy for completion of metabolic monitoring, and follow-up process for abnormal hemoglobin A1c or blood pressure results. ▪ Provided quarterly education series on cardiometabolic screening, monitoring, and outcomes to behavioral health providers. ▪ Enacted independent practice association incentive for developing a process to identify members with diabetes who use tobacco products to provide tobacco cessation education and recommendations. Managed Care Plan-Focused 2022 Interventions ▪ Instituted rounds with the lead health home to review enrolled members' diabetic management. ▪ Conducted quarterly meetings between Carelon care managers, primary care physicians, and behavioral health care providers to review performance data related to cardiometabolic screening. ▪ Integrated Holon Solution software into medical record systems at four lead behavioral health practices. The software provides behavioral health providers with access to physical health information.

Table 122: IHA's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	52.99%	59.73%	63.00%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	39.31%	32.06%	29.30%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	36.80%	60.11%	72.80%
Black/African Americans, ages 21–64 years[4]	27.78%	45.51%	63.80%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	14.89%	13.00%	21.10%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	18.38%	12.62%	28.40%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	6.58%	4.02%	12.60%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 123: IHA's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	IHA Measurement Year 2020	IHA Measurement Year 2021	IHA Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	24.25%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	54.38%	61.46%	64.90%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.21%	42.70%	43.76%	41.45%
Asthma Medication Ratio (5–64 Years)	66.56%	70.35%	71.92%	61.20%
Breast Cancer Screening	65.75%	61.27%	63.37%	65.60%
Cervical Cancer Screening[1]	72.20%	69.85%	71.47%	69.95%
Chlamydia Screening in Women (16–20 Years)	65.85%	67.40%	72.39%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	74.28%	73.26%	71.60%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	60.64%	60.80%	52.00%	52.96%
Controlling High Blood Pressure	66.42%	68.19%	68.61%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	61.27%	65.19%	63.54%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	32.15%	26.42%	24.48%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.86%	73.96%	73.06%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	41.42%	43.73%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	42.47%	30.43%	29.91%	35.47%

Measure Description	IHA Measurement Year 2020	IHA Measurement Year 2021	IHA Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Childhood Immunization Status – Combination 3	76.37%	76.89%	76.06%	68.59%
Immunizations for Adolescents – Combination 2	43.31%	44.04%	46.22%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	92.75%	94.97%	91.16%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	90.82%	91.82%	87.76%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	55.34%	59.17%	61.98%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	13.19%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	88.24%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	78.29%	79.22%	79.02%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	68.53%	65.15%	60.90%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	55.95%	54.03%	50.53%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	64.29%	73.17%	60.82%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	34.58%	31.40%	34.69%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	28.57%	25.35%	26.96%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	44.34%	47.67%	45.07%	41.50%

Measure Description	IHA Measurement Year 2020	IHA Measurement Year 2021	IHA Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	37.13%	42.12%	45.93%
Pharmacotherapy for Opioid Use Disorder	46.26%	43.67%	33.85%	33.31%
Viral Load Suppression	81.97%	77.40%	83.80%	74.19%
Prenatal Immunization Status	37.08%	36.63%	29.51%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	47.43%	44.71%	38.77%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	16.75%	14.52%	18.06%
Annual Dental Visit (2–18 Years)	52.00%	55.60%	60.93%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.21%	92.96%	90.38%	86.75%
Prenatal and Postpartum Care – Postpartum Care	80.05%	81.85%	85.00%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	72.28%	72.80%	72.83%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	72.96%	75.15%	73.41%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	88.27%	82.75%	82.07%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 124: IHA's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	IHA Measurement Year 2020	IHA Measurement Year 2021	IHA Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.79%	60.96%	57.08%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	42.64%	45.45%	42.47%	38.03%
Asthma Medication Ratio (19-64 Years)	48.78%	69.77%	65.22%	52.89%
Breast Cancer Screening	62.66%	56.68%	60.70%	54.68%
Cervical Cancer Screening	64.96%	67.11%	70.22%	63.33%
Chlamydia Screening in Women (21–24 Years)	Small Sample	Small Sample	Small Sample	72.23%
Colorectal Cancer Screening (50–75 Years)	56.33%	60.69%	54.24%	47.33%
Controlling High Blood Pressure	66.18%	67.39%	68.58%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	63.40%	63.01%	61.72%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	29.12%	25.00%	23.70%	37.57%
Flu Vaccination for Adults Ages 18-64	60.26%	50.14%	50.14%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	34.87%	37.16%	32.93%
Advising Smokers to Quit (CAHPS)	85.44%	86.19%	86.19%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	73.58%	71.35%	71.35%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	55.24%	54.70%	54.70%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	69.74%	70.42%	70.59%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	23.33%	26.92%	19.72%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.02%	65.26%	63.89%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.70%	76.63%	72.47%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	63.30%	54.13%	50.31%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	76.06%	79.17%	69.64%	49.48%
HIV Viral Load Suppression	82.81%	83.08%	79.31%	66.01%

Measure Description	IHA Measurement Year 2020	IHA Measurement Year 2021	IHA Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	34.25%	43.42%	52.31%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	59.11%	49.65%	46.15%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	30.23%	37.42%	42.80%
Pharmacotherapy for Opioid Use Disorder	36.14%	35.37%	45.08%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	26.45%	23.37%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	24.46%	17.76%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 125: IHA's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	Pended	C
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			NC
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 126: IHA's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on interviews with management staff from IHA and utilization management and care management staff from the behavioral health vendor, as well as the review of utilization management/care management policy and procedure documents, IHA failed to provide oversight of the behavioral health vendor's systems integration of physical health and behavioral health services.	Contract Article 2005-98-1.11(h)	438.230
Based on staff interview and review of final adverse determination notices, IHA failed to ensure its delegate included IHA's contact person and their telephone number in the final adverse determination notice.	Contract Article 98-2.9(e)(3)	438.228
Based on staff interview and review of initial adverse determination notices, IHA failed to ensure all required concurrent information was included in the notices.	Contract Article 4903(3)(a)	438.228
Based on staff interview and review of initial adverse determination notices, IHA failed to ensure its delegate issued initial adverse determination notices that were factual in nature, and not misleading to the member.	Contract Article 4405 (10)	438.228

Table 127: IHA's Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Department of Health Finding	Total Number of Findings	Code of Federal Regulation
The health plan disenrolled a child in KIDS for an incorrect effective date.	1	438.56
The health plan erroneously sent a disenrollment/cancel 834-transaction to New York State of Health for termination of coverage.	3	438.56

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 128: IHA's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	IHA	Mainstream Medicaid and Child Health Plus Average	IHA	Mainstream Medicaid and Child Health Plus Average	IHA	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	85.03%	83.75%	88.88%	84.31%	87.81%	82.04%
Getting Care Quickly[1]	88.68%	88.14%	88.92%	87.84%	88.66%	83.82%
How Well Doctors Communicate[1]	93.94%	93.44%	94.77%	93.35%	96.09%	94.17%
Customer Service[1]	91.27%	85.84%	86.28%	86.53%	86.79%	86.07%
Rating of All Health Care[2]	89.82%	87.48%	94.46%	89.77%	89.01%	86.07%
Rating of Personal Doctor[2]	90.16%	90.40%	92.48%	90.08%	91.35%	89.41%
Rating of Specialist Talked to Most Often[2]	81.81%	83.58%	97.79%	87.11%	82.02%	81.40%
Rating of Health Plan[2]	90.18%	85.18%	91.69%	86.02%	85.68%	80.80%
Rating of Treatment or Counseling[2]	65.64%	68.99%	71.52%	65.85%	57.73%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 129: IHA's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	IHA's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		One of three performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	IHA's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Four of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	IHA met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Twelve performance measure rates reported by IHA for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Seven performance measure rates reported by IHA for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by IHA for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by IHA for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, IHA was in compliance with 12 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	Two member satisfaction scores achieved by IHA for measurement year 2022 performed statistically significantly better than the Mainstream Medicaid and Child Health Plus program average.	X	X	X
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Two of three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by IHA for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	One performance measure rate reported by IHA for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by IHA for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, IHA was not in full compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, IHA was not in full compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	IHA should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	IHA should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	IHA should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, IHA should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	IHA should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, IHA should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	IHA should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. IHA should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 130: MetroPlus's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, MetroPlus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	The Medicaid KIDS performance improvement project was conducted between 2019 and 2021. The goal was to increase lead, hearing, and developmental screenings for children up to age 3 years. Interventions continue since completion of the performance improvement project. The Quality Assurance Reporting Requirements Developmental Screening measure is included in gaps-in-care reports and provider report cards. Education is provided to members and providers through provider meetings, mailings, text messaging, and calls focused on importance of well-visits and screenings.	Addressed.
MetroPlus 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.	HIV Special Needs Plan	The new Behavioral Health Care Management Model, launched in June 2023, is a field-based program focusing on engaging high-risk members, including HIV Special Needs Plan members. Members are met by peers and care managers while inpatient and up to 90 days post discharge to ensure appropriate linkage to medical and behavioral health care. MetroPlus submits to the New York Provider Network Data System on a quarterly basis. While very few deficiencies exist, when one is identified, they are reviewed and contracted.	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, MetroPlus should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	MetroPlus established a new care management program in June 2023 known as the Community Outreach Pod. This program is a field-based program focusing on high-risk members for transitions in care. Care Managers conduct in-person engagement with members inpatient and in community for up to 90 days post discharge to assure linkage to medical and behavioral health ambulatory care.	Addressed.
Validation of Performance Measures			
MetroPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MetroPlus should focus on the areas of care in which its rates did not meet Mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	MetroPlus monitors HEDIS/Quality Assurance Reporting Requirements results to develop interventions to improve quality, access, and outcomes. In 2021, asthma medication ratio, kidney health screening, colorectal cancer screening, well-child 30 months, follow-up after hospitalization for mental illness within 7-days measures performed below statewide average. Various interventions are in place to educate members/providers about necessary screenings and management of chronic conditions and utilize timely data for outreach.	Partially addressed.
MetroPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure	HIV Special Needs Plan	MetroPlus tracks HEDIS/Quality Assurance Reporting Requirements performance and uses results to develop action plans to improve health outcomes. In 2021, kidney health screening and follow-up after emergency department visit for mental illness within 7-days	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MetroPlus should focus on the areas of care in which its rates did not meet HIV Special Needs program performance.		measures performed below the statewide average. Action plans for these include educational text messaging campaigns for diabetes management, weekly email to health home providers for diabetic members missing a kidney health evaluation, and an outreach program to connect members to ongoing care post emergency department visit for mental illness.	
MetroPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MetroPlus should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	MetroPlus monitors HEDIS/Quality Assurance Reporting Requirements performance to improve health outcomes. In 2021, the following areas were below statewide average: medication adherence for asthma and depression; preventive cancer screenings; diabetic retinal eye exams and kidney health screening; viral load suppression; follow-up after emergency department visit and hospitalization for mental illness; pharmacotherapy for opioid dependence. Peer specialists and care managers support and educate members regarding needed services.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
MetroPlus should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan	MetroPlus maintains a Compliance Program to ensure adherence to all applicable requirements. This includes an effective system for routine monitoring, auditing, and identifying compliance risks. Through a risk assessment, MetroPlus's Compliance Committee develops an annual compliance workplan which is executed by the Compliance	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
		team. Identified risks such as utilization, grievance, appeals, and claims are included and monitored regularly. Results are reported to MetroPlus's governing body.	
Administration of Quality-of-Care Surveys – Member Experience			
MetroPlus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Customer experience continues to improve member access to care. ▪ Implemented net promoter score and a customer experience dashboard for the call center. ▪ Added a new vendor, ExpressCare, to increase member access to providers. ▪ Implemented more trainings to improve an enhanced customer experience. ▪ Created member engagements to educate members on virtual visits and urgent care. ▪ Facilitated the Member Advisory Board to gather key member insights around their experience and knowledge of benefits.	Partially addressed.
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.	HIV Special Needs Plan	MetroPlus implement a unified customer relationship management tool that supports member facing representatives and allows them to have up-to-date information related to the member available. MetroPlus developed ongoing series of trainings focused on improving customer service skills, phone courtesy, tone of voice, and listening and empathy. MetroPlus updated the member facing guidance documents that help members with easy-to-understand instructions.	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
		MetroPlus launched a "New Member Onboarding Learning Module."	
MetroPlus should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	▪ After-call surveys were implemented with MetroPlus's Case Management and Call Center departments to collect data on member experience with contacting MetroPlus. ▪ Surveys were conducted to understand members, access to care. ▪ Case management customer satisfaction training to ensure our team is meeting member needs at first contact. ▪ The Behavioral Health Case Management and Peer Specialist Program pivoted to community-based member visits to better support the member's medical and behavioral health care needs and to improve our ability to assess social determinants of health needs which impact member's experience with MetroPlus and overall satisfaction	Partially addressed.

Table 131: MetroPlus's Mainstream Medicaid and HIV Special Needs Plan Performance Improvement Project Summary, 2022

MetroPlus's Mainstream Medicaid and HIV Special Needs Plan Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Medicaid and HIV Special Needs Plan Adult Members **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Populations:** Mainstream Medicaid and HIV Special Needs Plan **Subpopulations With Health Disparity:** Black/African American Mainstream Medicaid Ages 21-64 Years; Black/African American HIV Special Needs Plan Members Ages 21-64 Years
Global Aims ▪ MetroPlus aims to increase preventive dental care visits among Mainstream Medicaid and HIV Special Needs Plan members ages 21–64 years. ▪ MetroPlus aims to decrease emergency department utilization for non-traumatic dental conditions among Mainstream Medicaid and HIV Special Needs Plan members ages 21–64 years. Disparity Reduction Aims ▪ MetroPlus aims to increase preventive dental care visits among Black/African American Mainstream Medicaid and HIV Special Needs Plan members ages 21–64 years. ▪ MetroPlus aims to decrease emergency department utilization for non-traumatic dental conditions among Black/African American Mainstream Medicaid and HIV Special Needs Plan members ages 21–64 years. Member-Focused 2022 Interventions ▪ Posted educational materials on the importance of preventive dental care on MetroPlus website. ▪ Conducted targeted outreach to HIV Special Needs Plan members with an emergency department visit for a non-traumatic dental condition. ▪ Executed an educational text message campaign targeting Black/African American members in the Mainstream Medicaid and HIV Special Needs Plan populations. ▪ Mailed MetroPlus-branded toothbrushes along with educational information to HIV Special Needs Plan Black/African American members. Provider-Focused 2022 Interventions ▪ Educated primary care providers during in-person and virtual visits on the importance of preventive dental care for their patients and how to link members to HealthPlex resources. Managed Care Plan-Focused 2022 Interventions ▪ Trained MetroPlus care managers and wellness advisors on dental benefits and clinical guidelines. ▪ Provided care managers and wellness advisors with access to the dental vendor's website to look up member-provider dental assignments. ▪ Enhanced the comprehensive annual assessment tool used for the HIV Special Needs Plan population to cover dental care and provide appointment scheduling assistance.

Table 132: MetroPlus's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	16.88%	15.76%	21.43%
Black/African American, ages 21–64 years[1]	15.55%	14.71%	19.16%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	115.31	115.57	107.89

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 133: MetroPlus's HIV Special Needs Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of HIV Special Needs Plan members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	16.89%	16.03%	21.36%
Black/African American, ages 21–64 years[1]	17.12%	15.47%	18.69%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 HIV Special Needs Plan member months[2]			
Ages 21–64 years	200.73	207.66	165.10

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 134: MetroPlus's Health and Recovery Plan Performance Improvement Project Summary, 2022

MetroPlus's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risrisk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Male Members Ages 21–64 Years with Diabetes
Global Aims ▪ MetroPlus aims to increase hemoglobin A1c testing among members ages 21–64 years with diabetes. ▪ MetroPlus aims to decrease poor hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ MetroPlus aims to increase blood pressure control among members ages 21–64 years with diabetes. ▪ MetroPlus aims to increase the percentage of members ages 21–64 years with diabetes who have at least one prescription for tobacco cessation pharmacotherapy. ▪ MetroPlus aims to increase the percentage of members ages 21–64 years with diabetes who have at least one outpatient visit that included tobacco cessation counseling. ▪ MetroPlus aims to increase the percentage of members ages 21–64 years with diabetes who have at least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling. Disparity Reduction Aim ▪ MetroPlus aims to increase blood pressure control among male members ages 21–64 years with diabetes. Member-Focused 2022 Interventions ▪ Outreached to members with diabetes who have gaps in care via text message with a reminder to attend routine primary care physician appointments every six months. ▪ Educated members with diabetes who have gaps in care via text messages on diabetes management and resources about the disease. ▪ Published a member newsletter article on diabetes management. ▪ Contacted members with diabetes and male members with diabetes and hypertension within a week of upcoming diabetes medication refill dates with a reminder to get their medications and medication adherence education. ▪ Sent a smoking assessment via text message to members who use tobacco products. Members who affirmed current use of tobacco products were provided information on smoking risks. ▪ Mailed education postcards to adult diabetic male members with poor blood pressure control. Provider-Focused 2022 Interventions • Educated behavioral health providers on the importance of coordinating care with primary care and getting "Release of Information" forms signed.

Table 135: MetroPlus's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	37.64%	44.73%	42.64%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 3]			
Ages 21–64 years	42.21%	49.56%	37.21%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	34.98%	39.28%	39.98%
Males, ages 21–64 years[4]	30.97%	35.08%	35.97%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	14.50%	13.87%	19.50%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	12.28%	11.37%	17.28%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	4.08%	3.67%	9.08%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] A lower rate indicates better performance.

[4] Subpopulation targeted for health disparity reduction.

Performance Measure Results

Table 136: MetroPlus's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	21.03%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	54.65%	58.65%	55.04%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.36%	41.49%	37.23%	41.45%
Asthma Medication Ratio (5–64 Years)	57.41%	54.60%	45.51%	61.20%
Breast Cancer Screening	68.41%	66.89%	67.31%	65.60%
Cervical Cancer Screening[1]	72.02%	64.72%	70.26%	69.95%
Chlamydia Screening in Women (16–20 Years)	80.03%	81.07%	81.19%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	77.43%	79.34%	78.58%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	58.15%	54.50%	52.77%	52.96%
Controlling High Blood Pressure	68.37%	67.15%	74.32%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	59.85%	65.69%	67.33%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	37.23%	27.98%	27.93%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.30%	81.24%	83.35%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	34.13%	50.28%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	38.93%	35.73%	35.51%	35.47%
Childhood Immunization Status – Combination 3	81.27%	69.34%	74.33%	68.59%

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	58.88%	55.72%	57.49%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	89.54%	89.78%	85.71%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	84.91%	87.59%	82.14%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.72%	60.87%	56.90%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	53.00%	53.48%	53.91%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	57.05%	56.32%	60.55%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	58.17%	59.75%	63.43%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	62.70%	71.13%	79.28%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	44.95%	51.55%	55.94%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	30.42%	21.35%	26.00%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	43.84%	40.87%	47.35%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	42.29%	40.85%	45.93%
Pharmacotherapy for Opioid Use Disorder	33.09%	25.82%	28.12%	33.31%

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	71.06%	72.32%	71.59%	74.19%
Prenatal Immunization Status	32.80%	41.32%	41.17%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	61.67%	55.73%	43.40%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	17.47%	13.77%	18.06%
Annual Dental Visit (2–18 Years)	44.93%	50.88%	51.29%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.94%	86.62%	89.95%	86.75%
Prenatal and Postpartum Care – Postpartum Care	85.89%	85.16%	85.84%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	65.58%	71.15%	68.13%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	66.00%	67.50%	71.90%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	82.36%	75.86%	76.93%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 137: MetroPlus's HIV Special Needs Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	15.56%	22.79%
Antidepressant Medication Management – Effective Acute Phase Treatment	63.04%	55.64%	58.06%	61.98%
Antidepressant Medication Management – Effective Continuation Phase Treatment	49.28%	40.60%	38.71%	46.31%
Asthma Medication Ratio (19-64 Years)	26.27%	27.10%	22.41%	40.27%
Breast Cancer Screening	69.54%	69.35%	72.11%	68.00%
Cervical Cancer Screening	82.48%	82.73%	83.20%	75.27%
Chlamydia Screening in Women (16–20 Years)	Small Sample	Small Sample	Small Sample	85.11%
Chlamydia Screening in Women (21–24 Years)	86.67%	Small Sample	Small Sample	78.72%
Colorectal Cancer Screening (50–75 Years)	65.21%	68.37%	66.42%	60.41%
Controlling High Blood Pressure	74.94%	75.67%	75.72%	61.61%
Diabetes – Eye Exam for Patients With Diabetes	51.34%	62.04%	71.05%	61.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)	25.30%	19.22%	18.73%	21.05%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	16.21%	41.67%	39.64%
Advising Smokers to Quit[1]	91.95%	87.58%	87.58%	88.55%
Discussing Smoking Cessation Medications[1]	84.46%	82.89%	82.89%	77.78%
Discussing Smoking Cessation Strategies[1]	79.05%	75.66%	75.66%	72.97%
Statin Therapy for Patients With Cardiovascular Disease – Adherence 80%	95.24%	78.26%	87.50%	82.13%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	16.67%	14.75%	12.50%	14.51%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.64%	65.52%	61.22%	59.47%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	4.02%

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	Small Sample
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	96.39%	99.37%	95.04%	96.70%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	43.04%	15.79%	41.38%	51.45%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	38.18%	34.48%	46.15%	36.82%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	28.69%	25.17%	29.13%	37.19%
Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder	Not Available	35.34%	28.44%	31.33%
Viral Load Suppression	79.74%	81.65%	82.48%	80.13%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	64.72%	73.70%	45.17%	45.09%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	14.39%	13.08%	11.08%

[1] Measure derives from adult CAHPS. Measurement year 2020 CAHPS results are reported for measurement year 2021 because the adult CAHPS survey is administered every other year.

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 138: MetroPlus's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.13%	47.49%	53.89%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.22%	35.26%	37.20%	38.03%
Asthma Medication Ratio (19-64 Years)	32.70%	32.78%	34.07%	52.89%
Breast Cancer Screening	50.75%	48.82%	47.87%	54.68%
Cervical Cancer Screening	63.02%	57.91%	62.28%	63.33%
Chlamydia Screening in Women (21–24 Years)	81.93%	77.11%	70.59%	72.23%
Colorectal Cancer Screening (50–75 Years)	45.74%	46.72%	41.51%	47.33%
Controlling High Blood Pressure	69.34%	65.21%	67.82%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	47.45%	45.74%	56.20%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	36.25%	39.66%	27.98%	37.57%
Flu Vaccination for Adults Ages 18-64	50.22%	48.38%	48.38%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	22.75%	38.31%	32.93%
Advising Smokers to Quit (CAHPS)	88.10%	81.12%	81.12%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	72.58%	67.61%	67.61%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	66.67%	59.44%	59.44%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	66.41%	64.86%	63.14%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	26.82%	24.66%	26.64%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.21%	65.50%	62.07%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.89%	83.51%	82.71%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	42.11%	40.39%	44.14%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	45.40%	40.92%	40.39%	49.48%
HIV Viral Load Suppression	55.19%	52.42%	54.47%	66.01%

Measure Description	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	MetroPlus Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	33.67%	26.94%	36.60%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	47.04%	43.92%	46.53%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	35.96%	39.87%	42.80%
Pharmacotherapy for Opioid Use Disorder	35.47%	26.08%	32.39%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	27.89%	29.02%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	20.37%	18.29%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 139: MetroPlus's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Open Period
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			NC
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	C	Open Period

[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: Managed care plan is in compliance with all standard requirements; Open Period: the timeline between the accepted plan of correction and the date certain for implementation.

Table 140: MetroPlus's Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Department of Health Finding	Total Number of Findings	Code of Federal Regulation
The child's coverage was terminated per the 834-transaction; however, the child was not disenrolled in KIDS.	1	438.56

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 141: MetroPlus's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	MetroPlus	Mainstream Medicaid and Child Health Plus Average	MetroPlus	Mainstream Medicaid and Child Health Plus Average	MetroPlus	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	78.34%	83.75%	79.33%	84.31%	76.58%	82.04%
Getting Care Quickly[1]	85.83%	88.14%	79.14%	87.84%	76.97%	83.82%
How Well Doctors Communicate[1]	90.30%	93.44%	87.17%	93.35%	91.88%	94.17%
Customer Service[1]	83.12%	85.84%	81.02%	86.53%	81.51%	86.07%
Rating of All Health Care[2]	85.92%	87.48%	88.43%	89.77%	83.12%	86.07%
Rating of Personal Doctor[2]	92.71%	90.40%	86.67%	90.08%	89.58%	89.41%
Rating of Specialist Talked to Most Often[2]	68.02%	83.58%	89.13%	87.11%	60.77%	81.40%
Rating of Health Plan[2]	87.91%	85.18%	84.89%	86.02%	77.69%	80.80%
Rating of Treatment or Counseling[2]	58.17%	68.99%	Small Sample	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 142: MetroPlus's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	MetroPlus's performance improvement project for the Mainstream Medicaid and HIV Special Needs Plan populations passed validation for measurement year 2022.			
		None.	X	X	X
	HIV Special Needs Plan	MetroPlus's performance improvement project for the HIV Special Needs Plan and Mainstream Medicaid populations passed validation for measurement year 2022.			
		None.	X	X	X
	Health and Recovery Plan	MetroPlus's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Three of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan	MetroPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Sixteen performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	HIV Special Needs Plan	Six performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Four performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	One performance measure rate reported by MetroPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by MetroPlus for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan	During measurement year 2021, MetroPlus was compliant with 14 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
	Mainstream Medicaid	All three performance improvement project indicator	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Projects		rates demonstrated performance decline between measurement years 2021 and 2022.			
	HIV Special Needs Plan	All three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Four of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Nine performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	HIV Special Needs Plan	Two performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Eight performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by MetroPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	HIV Special Needs Plan	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	One performance measure rate reported by MetroPlus for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan	None.	X	X	X
	Child Health Plus	During measurement year 2022, MetroPlus was not in full compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	One member satisfaction score achieved by MetroPlus for measurement year 2022 performed statistically significantly lower than the Mainstream Medicaid and Child Health Plus program average.	X		
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	MetroPlus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	HIV Special Needs Plan	MetroPlus should continue their performance improvement project interventions in an effort to	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		reach their target indicator rates.			
	Health and Recovery Plan	MetroPlus should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	MetroPlus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, MetroPlus should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.	X	X	X
	HIV Special Needs Plan	MetroPlus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, MetroPlus should concentrate on	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		improving areas of care where its rates fall below HIV Special Needs Plan performance standards.			
	Health and Recovery Plan	MetroPlus should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, MetroPlus should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, HIV Special Needs Plan, and Health and Recovery Plan	MetroPlus should ensure its 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	Mainstream Medicaid and Child Health Plus	MetroPlus should strive to enhance its performance on the measure of member satisfaction where it did not perform at or significantly better than the Mainstream Medicaid and Child Health Plus average.	X		

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 143: Molina's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	Molina's Response	IPRO's Assessment of Molina's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Molina should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	Molina continues to provide ongoing provider and member education to reinforce the need and timeliness for preventive health screenings. Member education is delivered digitally, but also through live outbound calls to caregivers to remind them of needed services like lead screenings and immunizations. Additionally, a provider incentive has been implemented to improve submission of correct codes for developmental and autism screening to ensure complete and accurate reporting.	Addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, Molina should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Timely notification of patient admissions is key to timely follow-up and engagement after discharge. Molina has since implemented automated hospital alerts from three major health information exchanges to allow our care managers visibility into members' utilization journey and to facilitate timely transitions of care. Molina's Care Management Department also has integrated a transitions of care assessment into its workflow to ensure al other health care needs are identified and addressed at discharge.	Addressed.
Validation of Performance Measures			
Molina should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in	Mainstream Medicaid and Child Health Plus	Molina recognizes the importance of the provider's role in ensuring high quality of care is maintained among our membership, and that	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Molina's Response	IPRO's Assessment of Molina's Response
the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Molina should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.		improving health outcomes requires collaboration between the provider and Molina. To that end, Molina is implementing a provider pay-for-performance program that includes measures aligned with those requiring the most year-over-year improvement. The incentives earned will support providers' member outreach and engagement initiatives throughout the year.	
Molina should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Molina should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	Molina recognizes the importance of the provider's role in ensuring high quality of care is maintained, and that improving health outcomes requires collaboration between the provider and the Plan. To that end, we are implementing both a provider and a Health Home incentive program that includes measures aligned with those requiring the most year-over-year improvement. The incentives earned will support providers' and Health Homes' outreach and engagement initiatives throughout the year.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
Molina should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019 compliance findings. Molina should conduct internal reviews as it prepares for	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Molina's Compliance Department conducts various internal reviews throughout the year to ensure compliance. Self-monitoring/auditing by department occurs at different frequencies throughout the year. The Compliance Department conducts an annual risk	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	Molina's Response	IPRO's Assessment of Molina's Response
the compliance review conducted by the Department of Health.		assessment which in turn develops the internal audit work plan and quarterly audits are conducted, corrective action plans are issued for non-compliance.	
Administration of Quality-of-Care Surveys – Member Experience			
Molina should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Molina continues to monitor member experience through several feedback loops. Most notably, a post-encounter survey has been implemented to allow for timely, qualitative, and actionable member- and provider-level feedback on utilization experience. Additionally, the Molina is currently implementing a quarterly member outreach program to proactively follow up with members who have specifically voiced quality of care concerns.	Partially addressed.
Molina should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	Molina continues to monitor member experience through several feedback loops. Most notably, a post-encounter survey has been implemented to allow for timely, qualitative, and actionable member- and provider-level feedback on utilization experience. Additionally, the Molina is currently implementing a quarterly member outreach program to proactively follow up with members who have specifically voiced quality of care concerns.	Partially addressed.

Table 144: Molina's Mainstream Medicaid Performance Improvement Project Summary, 2022

Molina's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care, Medicaid Managed Care Adult Members, Ages 21–64 Years Old **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulations With Health Disparity:** Black/African American Members Ages 21-64 Years; Members Ages 21-64 Years Residing in Long Island, New York
Global Aims ▪ Molina aims to increase preventive dental care visits among members ages 21–64 years. ▪ Molina aims to reduce non-traumatic dental condition emergency department visits among members ages 21–64 years. Disparity Reduction Aims ▪ Molina aims to reduce non-traumatic dental condition emergency department visits among Black/African American members ages 21–64 years. ▪ Molina aims to reduce non-traumatic dental condition emergency department visits among members ages 21–64 years residing in Long Island, New York. Member-Focused 2022 Interventions ▪ Launched a social media campaign to educate members on the benefits of dental visits. ▪ Targeted Black/African American members and all members living in Long Island, New York for an educational letter campaign on the importance of dental care. ▪ Conducted live outreach calls targeting Black/African American members with no preventive dental care and living in Long Island, New York. ▪ Executed an interactive voice recording campaign to members living in Long Island, New York on the importance of dental care. Provider-Focused 2022 Interventions ▪ Educated valued-based program participants on the importance of preventive dental visits and addressing the disparity among the Black/African American population. Managed Care Plan-Focused 2022 Interventions ▪ Collaborated with DentaQuest to identify members with no link to a dental provider and no dental utilization, as well as to link these members to "high performing" primary care dental providers.

Table 145: Molina's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	16.19%	14.95%	21.45%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[1]			
Ages 21–64 years	99.81	98.85	89.82
Black/African American, ages 21–64 years[2]	175.75	166.80	158.18
Long Island, New York resident, ages 21–64 years[2]	121.29	112.40	109.15

[1] A lower rate indicates better performance.

[2] Subpopulation targeted for health disparity reduction.

Table 146: Molina's Health and Recovery Plan Performance Improvement Project Summary, 2022

Molina's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulations With Health Disparity:** Members Ages 21–64 Years with Diabetes Who Reside in the Central Region of New York State; Members Ages 21–64 Years with Diabetes Who Reside in Western Region of New York State
Global Aims ▪ Molina aims to increase hemoglobin A1c control among members with diabetes. ▪ Molina aims to decrease hemoglobin A1c poor control among members with diabetes. ▪ Molina aims to increase blood pressure control among members with diabetes. ▪ Molina aims to increase the percentage of members with diabetes who have tobacco cessation pharmacotherapy. ▪ Molina aims to increase the percentage of members with diabetes who have at least one outpatient visit that included tobacco cessation counseling. ▪ Molina aims to increase the percentage of members with diabetes who have a prescription for tobacco cessation pharmacotherapy and an outpatient visit that included tobacco cessation counseling. Disparity Reduction Aims ▪ Molina aims to increase hemoglobin A1c control among members ages 21–64 years with diabetes who reside in the central region of New York State. ▪ Molina aims to increase hemoglobin A1c control among members ages 21–64 years with diabetes who reside in the western region of New York State. Member-Focused 2022 Interventions ▪ Referred members with diabetes and residing in the upstate region of New York state to health homes for outreach and facilitation of enrollment. ▪ Partnered with Roswell Park to offer tobacco cessation counseling and medical benefits to members. Provider-Focused 20222 Interventions ▪ Sent member-level gap-in-care reports to health homes in the upstate region of New York state. Managed Care Plan-Focused 2022 Interventions ▪ Collaborated with high-volume laboratories to increase the number of hemoglobin A1c laboratory values received.

Table 147: Molina's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	41.76%	30.71%	45.94%
Central New York State residents, ages 21–64 years[3]	22.83%	48.30%	50.73%
Western New York State residents, ages 21–64 years[3]	38.35%	41.48%	42.19%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 4]			
Ages 21–64 years	51.92%	65.73%	46.73%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	53.60%	28.49%	58.96%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	15.80%	16.40%	19.80%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	10.98%	10.28%	13.80%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	4.22%	3.56%	5.25%

[1] Managed care plan rates for HEDIS measures were calculated using the hybrid methodology, and Managed care plan rates for tobacco cessation measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Subpopulation targeted for health disparity reduction.

[4] A lower rate indicates better performance.

Performance Measure Results

Table 148: Molina's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Molina Measurement Year 2020	Molina Measurement Year 2021	Molina Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	14.62%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	57.86%	48.30%	57.41%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	42.56%	33.26%	41.93%	41.45%
Asthma Medication Ratio (5–64 Years)	66.59%	58.26%	57.77%	61.20%
Breast Cancer Screening	62.62%	57.96%	64.93%	65.60%
Cervical Cancer Screening[1]	63.33%	63.75%	69.10%	69.95%
Chlamydia Screening in Women (16–20 Years)	66.14%	68.55%	74.80%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	67.76%	71.72%	77.22%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	54.26%	48.80%	48.46%	52.96%
Controlling High Blood Pressure	57.66%	62.29%	53.77%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	59.85%	56.69%	60.83%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	47.20%	41.12%	52.31%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	70.89%	73.16%	76.64%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	37.75%	42.16%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	36.12%	28.65%	27.49%	35.47%
Childhood Immunization Status – Combination 3	74.70%	73.48%	72.02%	68.59%

Measure Description	Molina Measurement Year 2020	Molina Measurement Year 2021	Molina Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	42.82%	37.71%	45.26%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	85.40%	80.78%	75.91%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	78.83%	76.40%	72.51%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.36%	54.07%	54.05%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.74%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	97.44%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	43.83%	40.83%	38.04%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.77%	58.11%	50.99%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	75.85%	90.16%	95.47%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	70.21%	61.11%	61.32%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	23.31%	28.29%	39.70%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	20.00%	15.98%	20.27%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	51.30%	41.49%	38.91%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	55.82%	43.65%	45.93%
Pharmacotherapy for Opioid Use Disorder	50.59%	32.79%	39.16%	33.31%

Measure Description	Molina Measurement Year 2020	Molina Measurement Year 2021	Molina Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	80.65%	79.88%	72.31%	74.19%
Prenatal Immunization Status	26.45%	24.34%	25.84%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	35.91%	38.31%	43.23%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	13.70%	14.79%	18.06%
Annual Dental Visit (2–18 Years)	45.77%	69.72%	46.58%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	81.27%	82.00%	82.97%	86.75%
Prenatal and Postpartum Care – Postpartum Care	71.78%	69.34%	79.81%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	62.50%	65.81%	62.72%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	67.45%	67.33%	63.86%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	79.01%	75.37%	75.09%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 149: Molina's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	Molina Measurement Year 2020	Molina Measurement Year 2021	Molina Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	57.85%	47.17%	50.78%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	43.08%	31.45%	39.47%	38.03%
Asthma Medication Ratio (19-64 Years)	57.48%	56.52%	53.09%	52.89%
Breast Cancer Screening	58.86%	52.70%	54.84%	54.68%
Cervical Cancer Screening	65.35%	65.69%	67.88%	63.33%
Chlamydia Screening in Women (21–24 Years)	71.43%	72.97%	67.47%	72.23%
Colorectal Cancer Screening (50–75 Years)	58.39%	54.35%	43.93%	47.33%
Controlling High Blood Pressure	63.99%	63.02%	54.50%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	62.29%	58.64%	54.99%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	44.04%	43.55%	53.77%	37.57%
Flu Vaccination for Adults Ages 18-64	49.72%	54.00%	54.00%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	31.92%	32.65%	32.93%
Advising Smokers to Quit (CAHPS)	85.00%	80.93%	80.93%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	73.74%	72.02%	72.02%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	67.01%	63.02%	63.02%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	68.42%	63.53%	64.81%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	30.34%	21.98%	20.11%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	72.56%	65.30%	65.93%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	69.63%	74.62%	77.34%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	47.40%	40.00%	36.16%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	44.20%	34.11%	32.79%	49.48%

Measure Description	Molina Measurement Year 2020	Molina Measurement Year 2021	Molina Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	80.00%	86.44%	71.25%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	26.62%	26.87%	29.17%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	51.90%	41.62%	40.45%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	53.00%	39.17%	42.80%
Pharmacotherapy for Opioid Use Disorder	36.72%	30.86%	40.00%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	22.71%	23.30%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	18.09%	20.95%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 150: Molina's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	Pended	C
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			NC
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	Pended	C
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	Pended	NC
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 151: Molina's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on interviews with Molina's network and claims staff on 07/13/2022, and 08/25/2022, and review of Molina's documents and claims data, Molina failed to ensure 99 of 391 claims for assertive community treatment, a behavioral health service, were paid at the government rate as required.	Chapter 57 of the Laws of 2017, Part P § 48-a.1	438.242
Based on staff interview and the review of non-utilization review case files, Molina failed to ensure its delegate issued a written acknowledgement notice to members within 15 business days of receipt of the appeal.	Contract Article 4408-a.	438.228
Based on staff interview, review of utilization review approval and prior authorization cases, and the initial adverse determination notices, Molina and its delegate failed to provide the determination notice by telephone to the enrollee or designee, and the enrollee's health care provider. This was evident in 6 of 44 Medicaid utilization review approval cases and prior authorization cases.	Contract Article 4903	438.210
Based on staff interview and review of the utilization review final adverse determination notices, Molina failed to ensure its delegate included required information in the notices. Specifically, the final adverse determination notice did not include the utilization review agent address and/or contact person. This was evident in 2 of 2 Medicaid standard appeal utilization review cases and 2 of 2 Child Health Plus expedited appeal utilization review cases.	Contract Article 98-2.9	438.228
Based on staff interview and review of the notices sent to terminated providers, Molina failed to include the required termination and appeal rights to providers terminated for reasons other than cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or governmental agency that impairs the health care professional's ability to practice. Specifically, Molina failed to include the required termination and appeal rights to 6 of 7 provider termination notices reviewed during the comprehensive operational survey.	Contract Article 4406-d	Not Applicable
Based on staff interview and review of the utilization review final adverse determination notice, Molina, and its delegate failed to ensure the notice included required information in the document. Specifically, the final adverse determination notice did not include the Molina's contact person and phone number.	Contract Article 98-2.9	438.228

Table 152: Molina's Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Department of Health Finding	Total Number of Findings	Code of Federal Regulation
The child's coverage was terminated per the 834-transaction; however, the child was not disenrolled in KIDS.	1	438.56

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 153: Molina's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	Molina	Mainstream Medicaid and Child Health Plus Average	Molina	Mainstream Medicaid and Child Health Plus Average	Molina	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	80.91%	83.75%	81.26%	84.31%	73.03%	82.04%
Getting Care Quickly[1]	82.88%	88.14%	79.13%	87.84%	79.78%	83.82%
How Well Doctors Communicate[1]	90.77%	93.44%	91.40%	93.35%	94.53%	94.17%
Customer Service[1]	83.10%	85.84%	85.14%	86.53%	85.40%	86.07%
Rating of All Health Care[2]	84.51%	87.48%	84.97%	89.77%	83.40%	86.07%
Rating of Personal Doctor[2]	88.90%	90.40%	87.51%	90.08%	85.34%	89.41%
Rating of Specialist Talked to Most Often[2]	86.39%	83.58%	Small Sample	87.11%	82.14%	81.40%
Rating of Health Plan[2]	82.07%	85.18%	79.24%	86.02%	78.78%	80.80%
Rating of Treatment or Counseling[2]	55.25%	68.99%	Small Sample	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Table 154: Molina's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	Molina's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		Three of four performance improvement project indicator rates demonstrated performance improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Molina's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Three of eight performance improvement project indicator rates demonstrated performance improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Molina met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Four performance measure rates reported by Molina for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Two performance measure rates reported by Molina for measurement year 2022 performed statistically significantly better than	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		the statewide managed care program mean.			
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, Molina was in compliance with 11 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Five of eight performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Thirteen performance measure rates reported by Molina for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Health and Recovery Plan	Eight performance measure rates reported by Molina for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Four performance measure rates reported by Molina for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by Molina for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
	Health and Recovery Plan	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, Molina was not in full compliance with three of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, Molina was not in full compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	One member satisfaction score achieved by Molina for measurement year 2022 performed statistically significantly lower than the Mainstream Medicaid and Child Health Plus program average.		X	X
Recommendations					

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Improvement Projects	Mainstream Medicaid	Molina should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	Molina should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	Molina should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Molina should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.	X	X	X
	Health and Recovery Plan	Molina should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, Molina should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards	X	X	X
Compliance with Federal	Mainstream Medicaid,	Molina should ensure its compliance with federal and state	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Managed Care Standards	Child Health Plus, and Health and Recovery Plan	Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. Molina should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.			
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	Molina should strive to enhance its performance on the measure of member satisfaction where it did not perform at or significantly better than the Mainstream Medicaid and Child Health Plus average.		X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 155: MVP's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	MVP's Response	IPRO's Assessment of MVP's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, MVP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	MVP continues to promote the importance of timely wellness visits, screenings, and immunizations through use of ongoing member mailers, social media posts, gaps-in-care notifications in the member portal, and distribution of Baby Care Kits for newborns. MVP also creates monthly gaps-in-care reports for providers. MVP continues to monitor and evaluate applicable measures' quality performance.	Partially addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, MVP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Licensed MVP clinicians follow up with all members who have a behavioral health discharge to ensure timely linkage to an aftercare appointment. MVP partners with bridge providers who assist members with care transitions after discharge from inpatient or emergency department facilities. MVP offers multiple telehealth service options for follow up care. All MVP members are eligible for case management including care coordination with health homes and or other systems of care, assistance with transportation, etc.	Addressed.
Validation of Performance Measures			
MVP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in	Mainstream Medicaid and Child Health Plus	MVP is focusing on Well-Child Visits in the First 30 Months of Life and Follow-Up for Care for Children Prescribed ADHD Medication	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	MVP's Response	IPRO's Assessment of MVP's Response
the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MVP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.		(Continuation and Maintenance Phase) for our Medicaid Quality Performance Matrices. Over the course of 2023, MVP intends to implement and monitor various interventions to achieve performance goals and address barriers as outlined in the action plan of each Quality Performance Matrix.	
MVP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MVP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	MVP is focusing on Comprehensive Diabetes Care-Eye Exam and Follow Up After Emergency Department Visit for Mental Health-7 Days for our Health and Recovery Plan Quality Performance Matrices. Over the course of 2023, MVP intends to implement and monitor various interventions to achieve performance goals and address barriers as outlined in the action plan of each Quality Performance Matrix.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
MVP should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2020 compliance findings. MVP should conduct internal reviews as it prepares for	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	MVP performs annual readiness reviews to assess ongoing compliance with federal and state standards.	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	MVP's Response	IPRO's Assessment of MVP's Response
the compliance review conducted by the Department of Health.			
Administration of Quality-of-Care Surveys – Member Experience			
MVP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	MVP is committed to reviewing factors that affect member satisfaction and implementing interventions to address identified deficiencies.	Partially addressed.
MVP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	MVP is committed to reviewing factors that affect member satisfaction and implementing interventions to address identified deficiencies.	Partially addressed.

Table 156: MVP's Mainstream Medicaid Performance Improvement Project Summary, 2022

MVP's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Medicaid Managed Care Adult Members Ages 21–64 Years **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Members Residing in Northeast New York State
Global Aims ▪ MVP aims to increase annual dental visits among members ages 21–64 years. ▪ MVP aims to reduce ambulatory care sensitive emergency department visits for non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aim ▪ MVP aims to increase annual dental visits among members residing in the northeastern region of New York State. Member-Focused 2022 Interventions ▪ Conducted targeted educational outreach to members who had no dental visit in at least 24 months. ▪ Educated members on the health benefits of preventive dental care and health risks associated with poor dental care. ▪ Conducted follow-up outreach to members residing in the northeastern region of New York State with an emergency department visit for a non-traumatic dental condition and who are non-compliant for an annual dental visit. Provider-Focused 2022 Interventions ▪ Issued educational materials to providers on low member utilization of dental benefits and rate of non-traumatic dental emergency department visits. Managed Care Plan-Focused 2022 Interventions ▪ Conducted a survey of members residing in the northeastern region of New York State to learn about member-perceived barriers to care and social determinants of health contributing to low utilization of dental services.

Table 157: MVP's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	17.94%	15.79%	26.00%
Northeastern New York State resident, ages 21–64 years[1]	10.79%	10.62%	19.50%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	143.54	131.43	115.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 158: MVP's Health and Recovery Plan Performance Improvement Project Summary, 2022

MVP's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Members Ages 21–64 Years with Diabetes Who Reside in the Mid-Hudson Region of New York State
Global Aims ▪ MVP aims to increase hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ MVP aims to decrease hemoglobin A1c poor control among members ages 21–64 years with diabetes. ▪ MVP aims to increase blood pressure control among members ages 21–64 years with diabetes. ▪ MVP aims to improve tobacco cessation benefit utilization among members ages 21–64 years with diabetes. Disparity Reduction Aim ▪ MVP aims to increase hemoglobin A1c control among members ages 21–64 years with diabetes who reside in the mid-Hudson region of New York State. Member-Focused 2022 Interventions ▪ Informed members with no hemoglobin A1c test of the at-home screening services available through Scarlet Health and executed a follow-up call campaign for members who remained non-compliant for the hemoglobin A1c test. ▪ Targeted members residing in the Hudson Valley region who have both diabetes and gaps in care for outreach via telephone and mail. ▪ Educated members through newsletters and social media campaigns on diabetes management, tobacco cessation, healthy lifestyle, blood pressure control, and hemoglobin A1c control. ▪ Mailed tobacco cessation program information to members. ▪ Provided education and referral information through diabetes case management programs. Provider-Focused 2022 Interventions ▪ Contacted key providers to inform them of Scarlet Health's services. ▪ Emailed providers in the Hudson Valley regarding quality and gaps in care, as well as hemoglobin A1c test education, best practices, and MVP resources available to support gap closure.

Table 159: MVP's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	27.95%	31.13%	32.95%
Mid-Hudson New York State residents, ages 21–64 years[3]	22.21%	24.86%	27.21%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 4]			
Ages 21–64 years	68.92%	64.76%	63.92%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	19.29%	24.68%	24.29%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	17.15%	16.77%	22.14%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	1.15%	1.37%	6.15%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	0.49%	0.73%	5.49%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Subpopulation targeted for health disparity reduction.

[4] A lower rate indicates better performance.

Performance Measure Results

Table 160: MVP's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	MVP Measurement Year 2020	MVP Measurement Year 2021	MVP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	17.20%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	53.51%	54.88%	55.96%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.72%	39.27%	39.78%	41.45%
Asthma Medication Ratio (5–64 Years)	64.02%	62.55%	60.65%	61.20%
Breast Cancer Screening	63.05%	60.07%	60.33%	65.60%
Cervical Cancer Screening[1]	67.88%	67.40%	68.37%	69.95%
Chlamydia Screening in Women (16–20 Years)	62.62%	61.66%	64.77%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	71.08%	70.57%	70.47%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	56.45%	55.72%	51.65%	52.96%
Controlling High Blood Pressure	45.74%	57.91%	64.72%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	53.77%	55.47%	49.86%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	59.12%	51.09%	45.01%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.88%	75.06%	76.08%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	35.81%	36.27%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	38.03%	37.65%	32.22%	35.47%

Measure Description	MVP Measurement Year 2020	MVP Measurement Year 2021	MVP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Childhood Immunization Status – Combination 3	71.53%	70.32%	67.83%	68.59%
Immunizations for Adolescents – Combination 2	42.34%	42.82%	42.09%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	66.18%	76.89%	80.29%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	57.91%	74.70%	75.43%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	59.62%	58.37%	58.00%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	52.87%	48.87%	50.09%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	63.60%	63.73%	73.95%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	46.43%	38.30%	49.03%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	54.19%	42.18%	53.78%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	31.01%	38.43%	35.02%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	17.36%	13.22%	22.98%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	44.14%	41.06%	45.63%	41.50%

Measure Description	MVP Measurement Year 2020	MVP Measurement Year 2021	MVP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	47.11%	48.38%	45.93%
Pharmacotherapy for Opioid Use Disorder	35.95%	31.22%	29.48%	33.31%
Viral Load Suppression	80.43%	79.85%	79.91%	74.19%
Prenatal Immunization Status	29.52%	27.74%	24.37%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	46.00%	43.97%	44.71%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	19.25%	20.13%	18.06%
Annual Dental Visit (2–18 Years)	52.33%	58.02%	57.17%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	82.97%	87.59%	87.83%	86.75%
Prenatal and Postpartum Care – Postpartum Care	77.13%	76.89%	80.05%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	67.57%	70.22%	71.13%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	73.80%	72.57%	72.90%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	85.25%	80.60%	78.47%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 161: MVP's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	MVP Measurement Year 2020	MVP Measurement Year 2021	MVP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	47.83%	50.60%	52.70%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.99%	41.65%	41.51%	38.03%
Asthma Medication Ratio (19-64 Years)	38.86%	37.33%	37.30%	52.89%
Breast Cancer Screening	52.34%	47.77%	47.95%	54.68%
Cervical Cancer Screening	63.02%	63.75%	63.75%	63.33%
Chlamydia Screening in Women (21–24 Years)	66.27%	72.41%	75.38%	72.23%
Colorectal Cancer Screening (50–75 Years)	54.01%	53.15%	48.05%	47.33%
Controlling High Blood Pressure	42.34%	56.20%	63.50%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	48.66%	49.88%	47.93%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	58.88%	48.91%	40.63%	37.57%
Flu Vaccination for Adults Ages 18-64	58.95%	46.95%	46.95%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	31.33%	31.66%	32.93%
Advising Smokers to Quit (CAHPS)	88.24%	80.41%	80.41%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	79.21%	62.76%	62.76%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	70.10%	52.38%	52.38%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	59.21%	58.76%	62.13%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	30.40%	21.38%	22.61%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.24%	66.54%	68.01%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.41%	79.50%	78.77%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	47.67%	53.61%	63.70%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	46.56%	38.84%	40.30%	49.48%

Measure Description	MVP Measurement Year 2020	MVP Measurement Year 2021	MVP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	75.00%	79.41%	76.73%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	28.06%	23.49%	35.28%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	42.77%	44.35%	46.47%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	48.95%	50.82%	42.80%
Pharmacotherapy for Opioid Use Disorder	40.23%	33.26%	32.14%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	27.51%	30.71%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	21.75%	23.71%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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 162: MVP's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020	2021[1]	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	C	Pended	Not Reviewed
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			C
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	NC	Pended	NC
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	NC	Pended	C
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	NC	Pended	C
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	C	Pended	Not Reviewed

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 163: MVP's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
Based on staff interview and review of the completed disclosure documents submitted with the requested pre-survey documentation on 04/25/2022, MVP failed to provide evidence of a contract between MVP and an independent physician association, in a form and manner approved by the department. Upon review, the Department of Health has no record of a previously submitted contract. The department does not allow letter of agreements, and the letter of agreement dated 2007 provided between MVP and the independent physician association was not submitted to the Department of Health for review. Additionally, the letter of agreement did not incorporate and include the 2017 Department of Health's *Standard Clauses for the Managed Care Provider/IPA/ACO* contract. The letter of agreement also did not include a provision to ensure compliance with the *21st Century Cures Act*. Additional information was submitted by MVP on 06/09/2022, and 06/27/2022. This issue was discussed with MVP on 05/18/2022 and 06/22/2022.	Contract Article 98-1.13(a)	438.206

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 164: MVP's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	MVP	Mainstream Medicaid and Child Health Plus Average	MVP	Mainstream Medicaid and Child Health Plus Average	MVP	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	87.10%	83.75%	86.84%	84.31%	86.42%	82.04%
Getting Care Quickly[1]	88.98%	88.14%	93.99%	87.84%	82.34%	83.82%
How Well Doctors Communicate[1]	91.91%	93.44%	96.28%	93.35%	94.81%	94.17%
Customer Service[1]	86.40%	85.84%	89.99%	86.53%	89.47%	86.07%
Rating of All Health Care[2]	89.50%	87.48%	91.87%	89.77%	84.73%	86.07%
Rating of Personal Doctor[2]	93.14%	90.40%	93.28%	90.08%	90.55%	89.41%
Rating of Specialist Talked to Most Often[2]	86.80%	83.58%	87.16%	87.11%	86.36%	81.40%
Rating of Health Plan[2]	89.00%	85.18%	89.45%	86.02%	83.52%	80.80%
Rating of Treatment or Counseling[2]	68.50%	68.99%	71.47%	65.85%	63.82%	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Strengths, Opportunities for Improvement, and Recommendations

Table 165: MVP's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	MVP's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		One of three performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	MVP's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Six of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	MVP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by MVP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Three performance measure rates reported by MVP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by MVP for measurement year 2022 performed statistically significantly better than the		X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Availability of Care		statewide managed care program mean.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Two performance measure rates reported by MVP for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	X
	Health and Recovery Plan	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, MVP was in compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, MVP was in compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	Two of three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	One of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures –	Mainstream Medicaid	Twelve performance measure rates reported by MVP for measurement year 2022 performed statistically	X	X	

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Effectiveness of Care	and Child Health Plus	significantly worse than the statewide managed care program mean.			
	Health and Recovery Plan	Four performance measure rates reported by MVP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2022, MVP was not in full compliance with one of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	MVP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	MVP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid	MVP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and Child Health Plus	development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, MVP should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	MVP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, MVP should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	MVP should ensure its compliance with federal and state Medicaid standards by continuing its initiatives put in place to address the 2022 compliance findings. MVP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 166: UHCCP's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	UHCCP's Response	IPRO's Assessment of UHCCP's Response
Validation of Performance Improvement Projects			
Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, UHCCP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	Mainstream Medicaid and Child Health Plus	The Patient Care Opportunity Report is a comprehensive report delivered to providers with details about preventive care opportunities for members. Monthly, Quality Coordinators monitor and reinforce the Patient Care Opportunity Reports by engaging providers and communicating the importance of educating parents about scheduling blood lead level testing, developmental screening and newborn hearings testing within the appropriate timeframes. Clinical practice guidelines are posted on the member and provider portal.	Partially addressed.
Although the state's requirement to continue a performance improvement project on the topic of care transitions after emergency department and inpatient admissions ended with the 2021 measurement period, UHCCP should continue to facilitate successful transition among its membership from hospitalization or rehabilitation to a lower level of care.	Health and Recovery Plan	Utilizing regional health information organization emergency department reports, members discharged from emergency departments for mental illness or substance abuse are outreached via phone to arrange aftercare appointments. March 2023, two Emergency Department Wellness Coordinators were added to outreach to discharged members. Improvement opportunities will be addressed for cases where regional health information organizations lack diagnosis or reason coding, likely missing members eligible for this intervention. Actions and outcomes are monitored monthly.	Addressed.

2021 External Quality Review Recommendation	Managed Care Program	UHCCP's Response	IPRO's Assessment of UHCCP's Response
Validation of Performance Measures			
UHCCP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	Mainstream Medicaid and Child Health Plus	UHCCP targeted actions are modified to improve member education about access and benefits: member and provider portals, communications, quick-response code to access provider directory, quality of care delivered outcome reports to providers, case management, coordination of care, complaints and appeals, community outreach, live and interactive voice response calls, training for primary care providers and UHCCP staff. HEDIS outcomes are monitored via quarterly quality meetings, claims, and ad-hoc or customized reports.	Partially addressed.
UHCCP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP should focus on the areas of care in which its rates did not meet Health and Recovery Plan performance.	Health and Recovery Plan	UHCCP solicits member and provider feedback for barriers and targeted actions are modified to improve member education about access and benefits: member and provider portals, communications, quick-response code to access provider directory, quality of care delivered outcome reports to providers, case management, coordination of care, complaints and appeals, community outreach, live and interactive voice response calls, training for primary care providers and UHCCP staff. HEDIS outcomes are monitored via quarterly quality meetings, claims, and ad-hoc or customized reports.	Partially addressed.
Review of Compliance with Medicaid and Children's Health Insurance Program Standards			
UHCCP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	Credentialing files are reviewed quarterly, and supervisors provide training when errors occur. In December 2022, the Credentialing Policy Workgroup confirmed Cures Act requirements are in place. New York Regulatory Appendix and	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	UHCCP's Response	IPRO's Assessment of UHCCP's Response
		Standard Clauses were replaced in 2021, correcting language and Cures Act issues. Re-education on Cures Act occurred in November 2021. Beginning January 2022, the Senior Analyst sends staff reminders using the Part A Error Report to notice and term providers and reconciles against Provider Network Data System to ensure compliance.	
Administration of Quality-of-Care Surveys – Member Experience			
UHCCP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	Mainstream Medicaid and Child Health Plus	Between 2022 and 2023 the UHCCP examined barriers and applied interventions to address health literacy for proper and timely access to care to identified disparate populations. UHCCP continues to expand its provider network, build relationships with providers and community liaisons. With the development of clear and concise benefit communications and easy to use tools to engage with the healthcare system (i.e., telehealth, text), UHCCP looks to improve flexibility to accessing care.	Partially addressed.
UHCCP should work to improve its performance on measures of member satisfaction for which it did not exceed the Health and Recovery Plan average.	Health and Recovery Plan	UHCCP utilizes multiple pathways to connect members with preventive services: mailings, live calls, interactive voice response calls, text, in-home preventative care, complex case management, behavioral health peer support and targeted education. Quality Consultants, community-based supports, access, and availability surveys help providers understand and adhere to regulatory requirements. This is monitored via ad-hoc, monthly and quarterly provider meetings and annual surveys.	Partially addressed.

Table 167: UHCCP's Mainstream Medicaid Performance Improvement Project Summary, 2022

UHCCP's Mainstream Medicaid Performance Improvement Project Summary
Title: Improving Rates of Preventive Dental Care for Adults Ages 21–64 **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Mainstream Medicaid **Subpopulation With Health Disparity:** Black/African American Members Ages 21-64 Years
Global Aims ▪ UHCCP aims to increase preventive dental care visits among members ages 21–64 years. ▪ UHCCP aims to reduce ambulatory care sensitive emergency department visits for non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aims ▪ UHCCP aims to increase preventive dental care visits among Black/African American members ages 21–64 years. ▪ UHCCP aims to reduce the number of ambulatory care sensitive emergency department visits for non-traumatic dental conditions among Black/African American members ages 21–64 years. Member-Focused 2022 Interventions ▪ Distributed enhanced educational materials describing benefits and how to access appointment scheduling assistance to members. ▪ Conducted live educational outreach calls to Black/African American members who had no preventive dental visit and/or at least one emergency department visit for a non-traumatic dental condition. Members were educated on the importance of preventive dental care visits and offered appointment scheduling assistance. Provider-Focused 2022 Interventions ▪ Educated the top 25 providers with the largest number of Black/African American members with no preventive dental care visit.

Table 168: UHCCP's Mainstream Medicaid Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of Mainstream Medicaid members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	22.17%	19.29%	32.00%
Black/African American, ages 21–64 years[1]	19.41%	19.48%	29.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 Mainstream Medicaid member months[2]			
Ages 21–64 years	103.96	92.86	94.00
Black/African American, ages 21–64 years[1]	201.92	166.54	192.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Table 169: UHCCP's Health and Recovery Plan Performance Improvement Project Summary, 2022

UHCCP's Health and Recovery Plan Performance Improvement Project Summary
Title: Improving Cardiometabolic Monitoring and Outcomes for Health and Recovery Plan Members with Diabetes Mellitus **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** Health and Recovery Plan **Subpopulation With Health Disparity:** Members Ages 21–64 Years With Diabetes Who Reside in the Central Region of New York State
Global Aims ▪ UHCCP aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes. ▪ UHCCP aims to decrease the rate of hemoglobin A1c poor control among members ages 21–64 years with diabetes. ▪ UHCCP aims to increase the rate of blood pressure control among members ages 21–64 years with diabetes. ▪ UHCCP aims to increase smoking cessation treatment engagement among members ages 21–64 years with diabetes. Disparity Reduction Aim ▪ UHCCP aims to increase the rate of hemoglobin A1c control among members ages 21–64 years with diabetes who live in the central region of New York State. Member-Focused 2022 Interventions ▪ Referred members to a health home or case management. ▪ Developed care plans for members with gaps in diabetes care and reported tobacco use. Provider-Focused 2022 Interventions ▪ Sent member-level gaps-in-care reports to health homes and assertive community treatment teams.

Table 170: UHCCP's Health and Recovery Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021[1]	Interim Measurement Year 2022[1]	Target
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was controlled (less than 8.0%) during the measurement year[2]			
Ages 21–64 years	29.35%	30.57%	48.00%
Central New York State residents, ages 21–64 years[3]	16.31%	17.85%	48.00%
The percentage of Health and Recovery Plan members with diabetes whose hemoglobin A1c was not controlled (greater than 9.0%) during the measurement year[2, 4]			
Ages 21–64 years	67.49%	65.75%	60.00%
The percentage of Health and Recovery Plan members with diabetes whose blood pressure was adequately controlled (less than 140/90 mm Hg) during the measurement year[2]			
Ages 21–64 years	26.53%	33.78%	30.00%
The percentage of Health and Recovery Plan members with diabetes who had at least one claim for tobacco cessation treatment during the measurement year			
At least one prescription for tobacco cessation pharmacotherapy, ages 21–64 years	14.23%	13.69%	15.00%
At least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	12.75%	11.48%	14.00%
At least one prescription for tobacco cessation pharmacotherapy and at least one outpatient visit that included tobacco cessation counseling, ages 21–64 years	4.56%	4.07%	6.00%

[1] Managed care plan rates for all measures were calculated using the administrative methodology.

[2] The HEDIS measure rates reported by the managed care plan in this table are different than the rates reported by the managed care plan in the Performance Measure sections of this report. Rate differences are attributed to the managed care plan's use of distinct technical specifications for the calculation of performance improvement project rates and performance measure rates.

[3] Subpopulation targeted for health disparity reduction.

[4] A lower rate indicates better performance.

Performance Measure Results

Table 171: UHCCP's Mainstream Medicaid/Child Health Plus Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	UHCCP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	15.89%	17.19%
Antidepressant Medication Management – Effective Acute Phase Treatment	58.66%	61.33%	58.77%	57.69%
Antidepressant Medication Management – Effective Continuation Phase Treatment	43.41%	44.28%	43.11%	41.45%
Asthma Medication Ratio (5–64 Years)	63.69%	60.50%	58.00%	61.20%
Breast Cancer Screening	61.14%	59.03%	59.25%	65.60%
Cervical Cancer Screening[1]	64.07%	68.37%	64.23%	69.95%
Chlamydia Screening in Women (16–20 Years)	66.15%	66.11%	66.45%	71.89%
Chlamydia Screening in Women (21–24 Years)[1]	69.12%	71.30%	69.91%	73.49%
Colorectal Cancer Screening (50–75 Years)[1]	56.45%	53.53%	46.85%	52.96%
Controlling High Blood Pressure	60.10%	63.26%	66.91%	66.70%
Diabetes – Eye Exam for Patients With Diabetes	57.66%	64.23%	60.34%	62.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[2]	36.98%	36.01%	35.04%	34.84%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.18%	78.50%	77.22%	78.48%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	33.88%	36.88%	42.18%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease[1]	46.74%	33.30%	34.77%	35.47%
Childhood Immunization Status – Combination 3	61.80%	55.96%	53.28%	68.59%

Measure Description	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	UHCCP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Immunizations for Adolescents – Combination 2	27.74%	26.03%	25.48%	43.33%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	77.37%	79.81%	76.40%	82.28%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	74.70%	76.40%	71.78%	78.24%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62.59%	61.87%	61.50%	61.79%
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.22%	1.39%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	58.06%	82.65%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	43.31%	43.10%	42.24%	53.50%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	65.54%	67.47%	63.75%	64.42%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	63.57%	54.46%	59.60%	57.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	70.45%	60.68%	71.81%	64.25%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	35.34%	38.27%	37.70%	41.57%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	16.61%	14.60%	21.82%	27.90%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	40.90%	40.62%	36.03%	41.50%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	45.94%	45.05%	45.93%
Pharmacotherapy for Opioid Use Disorder	30.98%	30.88%	31.81%	33.31%

Measure Description	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	UHCCP Measurement Year 2022	Mainstream Medicaid/ Child Health Plus Mean Measurement Year 2022
Viral Load Suppression	68.71%	70.48%	70.04%	74.19%
Prenatal Immunization Status	21.62%	18.24%	15.07%	24.44%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	45.83%	42.87%	44.41%	46.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	16.23%	16.35%	18.06%
Annual Dental Visit (2–18 Years)	50.68%	54.75%	53.64%	54.16%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	80.54%	81.02%	79.08%	86.75%
Prenatal and Postpartum Care – Postpartum Care	77.86%	79.81%	79.56%	82.71%
Utilization and Risk Adjusted Utilization				
Child and Adolescent Well-Care Visits (Total)	60.78%	63.87%	61.79%	68.47%
Well-Child Visits in the First 30 Months of Life – First 15 Months	60.14%	58.04%	56.13%	67.34%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	78.22%	73.31%	70.90%	77.84%

[1] Rate reflects Mainstream Medicaid performance only.

[2] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid managed care/Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 172: UHCCP's Health and Recovery Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	UHCCP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
Effectiveness of Care				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.74%	55.18%	50.38%	52.60%
Antidepressant Medication Management – Effective Continuation Phase Treatment	40.45%	43.84%	36.01%	38.03%
Asthma Medication Ratio (19-64 Years)	45.89%	50.99%	45.67%	52.89%
Breast Cancer Screening	49.69%	48.10%	49.75%	54.68%
Cervical Cancer Screening	59.85%	59.37%	55.96%	63.33%
Chlamydia Screening in Women (21–24 Years)	65.66%	69.57%	74.76%	72.23%
Colorectal Cancer Screening (50–75 Years)	55.23%	44.77%	36.15	47.33%
Controlling High Blood Pressure	53.28%	61.07%	61.80%	66.27%
Diabetes – Eye Exam for Patients With Diabetes	45.01%	49.88%	51.82%	55.13%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)[1]	45.01%	41.61%	40.63%	37.57%
Flu Vaccination for Adults Ages 18-64	40.94%	40.41%	40.41%	47.31%
Kidney Health Evaluation for Patients With Diabetes (Total)	Not Available	22.78%	24.18%	32.93%
Advising Smokers to Quit (CAHPS)	85.29%	88.03%	88.03%	83.42%
Discussing Smoking Cessation Medications (CAHPS)	66.67%	74.13%	74.13%	68.96%
Discussing Smoking Cessation Strategies (CAHPS)	58.00%	61.54%	61.54%	59.37%
Statin Therapy for Patients With Cardiovascular Disease - 80% Adherence	54.70%	61.83%	62.90%	63.88%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	29.50%	26.58%	27.22%	26.23%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.47%	65.06%	60.42%	66.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.07%	79.39%	79.14%	80.22%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	56.42%	59.82%	54.79%	56.83%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	38.42%	36.33%	32.69%	49.48%

Measure Description	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	UHCCP Measurement Year 2022	Health and Recovery Plan Mean Measurement Year 2022
HIV Viral Load Suppression	62.35%	61.62%	56.32%	66.01%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	26.48%	26.96%	33.91%	39.88%
Follow-Up After High Intensity Care for Substance Use Disorder – 7 Days	40.87%	40.52%	40.91%	42.33%
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Not Available	45.62%	46.19%	42.80%
Pharmacotherapy for Opioid Use Disorder	32.01%	28.52%	28.98%	33.73%
Use of Pharmacotherapy for Alcohol Use Disorder	Not Available	25.61%	25.02%	27.52%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	19.85%	21.86%	20.42%

[1] Lower rate indicates better performance.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the Health and Recovery Plan statewide 2022 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 2022 performance is statistically significantly worse than the Health and Recovery Plan statewide 2022 performance. 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

UHCCP is actively contesting the outcomes of the 2022 compliance activity, consequently, the results are not available for public disclosure.

Table 173: UHCCP's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	Results Not Yet Available
438.56 Disenrollment: Requirements and Limitations (Children's Health Insurance Program)			NC
438.100 Enrollee Rights (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.114 Emergency and Poststabilization Services (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.206 Availability of Services (Medicaid/Children's Health Insurance Program)	Pended	NC	Results Not Yet Available
438.207 Assurances of Adequate Capacity and Services (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.208 Coordination and Continuity of Care (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.210 Coverage and Authorization of Services (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.214 Provider Selection (Medicaid/Children's Health Insurance Program)	Pended	NC	Results Not Yet Available
438.224 Confidentiality (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.228 Grievance and Appeal System (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.230 Subcontractual Relationships and Delegation (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.236 Practice Guidelines (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.242 Health Information Systems (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available
438.330 Quality Assessment and Performance Improvement Program (Medicaid/Children's Health Insurance Program)	Pended	C	Results Not Yet Available

[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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 174: UHCCP's Compliance Review Summary of Results, 2021

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
UHCCP failed to ensure that four of the 27 contracts reviewed included required components. Specifically, the contracts did not include the 21st Century Cures Act Amendment and/or the 2017 Standard Clause incorporation language or attachment.	98-1.13(a)	438.206
Based on an interview held on 6/16/2021, and a review of documents, UHCCP failed to ensure that credential files included the required components for four of 16 credential files reviewed.	Contract Article 2005-98-1.13(a)	438.214
Based on an interview held on 6/16/2021, and a review of documents, UHCCP failed to notify the New York State Department of Health, of the departure of former board member.	Contract Article 2005-98-1.12(k)	Not Applicable

Table 175: UHCCP's Child Health Plus Compliance Results for Disenrollment Requirements and Limitations, 2022

Department of Health Finding	Total Number of Findings	Code of Federal Regulation
The health plan erroneously sent a disenrollment/cancel 834-transaction to New York State of Health for termination of coverage.	1	438.56

Quality-of-Care Survey Results – Member Experience

Quality-of-care survey results represent Mainstream Medicaid and Child Health Plus.

Table 176: UHCCP's Child CAHPS Results, Measurement Years 2018, 2020, and 2022

Measure	Measurement Year 2018		Measurement Year 2020		Measurement Year 2022	
	UHCCP	Mainstream Medicaid and Child Health Plus Average	UHCCP	Mainstream Medicaid and Child Health Plus Average	UHCCP	Mainstream Medicaid and Child Health Plus Average
Getting Needed Care[1]	81.83%	83.75%	92.28%	84.31%	79.84%	82.04%
Getting Care Quickly[1]	91.50%	88.14%	91.96%	87.84%	81.55%	83.82%
How Well Doctors Communicate[1]	95.77%	93.44%	94.40%	93.35%	94.49%	94.17%
Customer Service[1]	88.61%	85.84%	84.19%	86.53%	88.01%	86.07%
Rating of All Health Care[2]	89.58%	87.48%	91.57%	89.77%	84.58%	86.07%
Rating of Personal Doctor[2]	94.28%	90.40%	92.19%	90.08%	88.72%	89.41%
Rating of Specialist Talked to Most Often[2]	90.43%	83.58%	91.61%	87.11%	72.85%	81.40%
Rating of Health Plan[2]	84.94%	85.18%	84.80%	86.02%	70.77%	80.80%
Rating of Treatment or Counseling[2]	78.76%	68.99%	Small Sample	65.85%	Small Sample	57.00%

[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 2022 performance is statistically significantly better than the Mainstream Medicaid and Child Health Plus statewide 2022 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 2022 performance is statistically significantly worse than the Mainstream Medicaid and Child Health Plus statewide 2022 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Small sample means that the denominator is less than 30 members, and the score is not suitable for public reporting.

Strengths, Opportunities for Improvement, and Recommendations

Table 177: UHCCP's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	Mainstream Medicaid	UHCCP's performance improvement project for the Mainstream Medicaid population passed validation for measurement year 2022.			
		Three of four performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	UHCCP's performance improvement project for the Health and Recovery Plan population passed validation for measurement year 2022.			
		Four of seven performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	UHCCP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	None.			
	Health and Recovery Plan	None.			
Performance Measures –	Mainstream Medicaid and	None.			

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Utilization and Risk Adjusted Utilization	Child Health Plus				
Compliance with Federal Managed Care Standards	Mainstream Medicaid and Child Health Plus	During measurement year 2021, UHCCP was in compliance with 12 of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	None.			
Opportunities for Improvement					
Performance Improvement Projects	Mainstream Medicaid	One of four performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
	Health and Recovery Plan	Three of seven performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	Mainstream Medicaid and Child Health Plus	Twelve performance measure rates reported by UHCCP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
	Health and Recovery Plan	Seven performance measure rates reported by UHCCP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	Mainstream Medicaid and Child Health Plus	Four performance measure rates reported by UHCCP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.		X	X
	Health and Recovery Plan	None.			

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Utilization and Risk Adjusted Utilization	Mainstream Medicaid and Child Health Plus	Three performance measure rates reported by UHCCP for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	During measurement year 2021, UHCCP was not in full compliance with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
	Child Health Plus	During measurement year 2022, UHCCP was not in full compliance with the standards reviewed for *42 Code of Federal Regulations 438.56 Disenrollment: Requirements and limitations.*	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	One member satisfaction score achieved by UHCCP for measurement year 2022 performed statistically significantly lower than the Mainstream Medicaid and Child Health Plus program average.	X	X	X
Recommendations					
Performance Improvement Projects	Mainstream Medicaid	UHCCP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
	Health and Recovery Plan	UHCCP should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	Mainstream Medicaid and Child Health Plus	UHCCP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care,	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, UHCCP should concentrate on improving areas of care where its rates fall below Mainstream Medicaid and/or Child Health Plus performance standards.			
	Health and Recovery Plan	UHCCP should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, UHCCP should concentrate on improving areas of care where its rates fall below Health and Recovery Plan performance standards.	X	X	X
Compliance with Federal Managed Care Standards	Mainstream Medicaid, Child Health Plus, and Health and Recovery Plan	UHCCP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Mainstream Medicaid and Child Health Plus	UHCCP should strive to enhance its performance on the measure of member satisfaction where it did not perform at or significantly better than the Mainstream Medicaid and Child Health Plus average.	X	X	X

Assessment of Managed Care Plan Follow-up on the 2021 External Quality Review Recommendations

Table 178: VNS Health's Response to the 2021 External Quality Review Recommendations

2021 External Quality Review Recommendation	Managed Care Program	VNS Health's Response	IPRO's Assessment of VNS Health's Response
Validation of Performance Improvement Projects			
VNS Health should continue its efforts to improve the health outcomes of its members living with diabetes.	HIV Special Needs Plan	Members receive education from the plan on diabetes care telephonically, via mail and social media. Outcomes are tracked and shared internally and externally with providers via member-level gaps in care reports that are reviewed with VNS Health's Quality team to identify barriers and opportunities. VNS Health collaborates with lab vendors and providers to offer in-home labs and coordinates receipt of glucose monitors for members in need, to improve testing adherence and blood sugar control.	Addressed.
Validation of 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.	HIV Special Needs Plan	Annually VNS Health reviews prior year HEDIS/Quality Assurance Reporting Requirements data and develops a workplan to address areas of care that did not meet program performance. The 2023 workplan includes improving blood sugar control for diabetes, controlling high blood pressure for hypertension, and increasing testing and treatment for viral load and sexually transmitted infections. VNS Health meets with HIV primary care providers and internal stakeholders to review rates and opportunities	Partially addressed.

2021 External Quality Review Recommendation	Managed Care Program	VNS Health's Response	IPRO's Assessment of VNS Health's Response
		and has expanded VNS Health's Non-clinical Case Management staff to increase member outreach and linkage to care.	
Review of Compliance with Medicaid and Children's Health Insurance Program 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.	HIV Special Needs Plan	Since the last Department of Health survey in 2022, VNS Health has worked to correct areas that were identified as needing improvement. This includes but is not limited to revising the provider manual, improving the timeliness of utilization management decisions, developing and implementing a policy on discharge planning, creating a provider complaint log and re-starting service verification calls. VNS Health's Compliance Department monitors corrective actions for alignment with the Department of Health requirements.	Partially addressed.
Administration of Quality-of-Care Surveys – Member Experience			
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.	HIV Special Needs Plan	Expanded staffing for VNS Health's non-clinical Case Management team has allowed for increased member engagement for education, care coordination and member inquiries. Member portals are slated to go-live in 2023, creating a space to access health resources, plan benefit information and observe wellness services identified by the care team for primary care provider follow-up. Updates to the customer experience platforms are in progress, allowing for greater tracking and reporting of call reasons.	Partially addressed.

Table 179: VNS Health's HIV Special Needs Plan Performance Improvement Project Summary, 2022

VNS Health's HIV Special Needs Plan Performance Improvement Project Summary
Title: Improving Dental Care in the Select Health Population **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results. **Global Medicaid Managed Care Population:** HIV Special Needs Plan **Subpopulation With Health Disparity:** Members Ages 35-44 Years
Global Aims ▪ VNS Health aims to increase preventive dental care visits among members ages 21–64 years. ▪ VNS Health aims to reduce emergency department visits for non-traumatic dental conditions among members ages 21–64 years. Disparity Reduction Aim ▪ VNS Health aims to increase preventive dental care visits among members ages 35–44 years. Member-Focused 2022 Interventions ▪ Added dental care education as an element to care coordination annual assessments specifically for members identified with no preventive dental care visit. ▪ Targeted mailing to members with no preventive dental visit. ▪ Conducted live outreach calls to members with no preventive dental visit to address social determinants of health, explain benefits, and establish a link to HealthPlex, VNS Health's dental vendor. ▪ Conducted educational outreach to members following an emergency department visit for a non-traumatic dental condition. Members were educated on the importance of dental care and to establish a link to HealthPlex. ▪ Conducted outreach to members ages 35–44 years who are assigned to an HIV care site with known dental care capacity issues to offer appointment scheduling assistance for preventive dental care. ▪ Implemented a member reward program for completed preventive dental care visits. ▪ Published articles in the member newsletter highlighting National Oral Health Month, the benefits of oral health care, transportation services for appointments, member incentive program, and HealthPlex. Provider-Focused 2022 Interventions ▪ Created and distributed provider education materials on the importance of preventive dental care for members living with HIV, referrals to in-network dental providers, and the member incentive program for dental visits. ▪ Published articles in the provider newsletter. ▪ Issued up-to-date dental directories to medical providers with known capacity issues treating members ages 35–44 years. Managed Care Plan-Focused 2022 Interventions ▪ Updated gaps in care reporting system to include members with no preventive dental visit.

Table 180: VNS Health's HIV Special Needs Plan Project Indicator Summary, Measurement Years 2021 and 2022

Measure/Population	Baseline Measurement Year 2021	Interim Measurement Year 2022	Target
The percentage of HIV Special Needs Plan members who had at least one preventive dental visit during the measurement year			
Ages 21–64 years	14.36%	14.24%	24.00%
Ages 35–44 years[1]	13.39%	14.86%	22.00%
The number of emergency department visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 HIV Special Needs Plan member months[2]			
Ages 21–64 years	135.41	209.80	90.00

[1] Subpopulation targeted for health disparity reduction.

[2] A lower rate indicates better performance.

Performance Measure Results

Table 181: VNS Health's HIV Special Needs Plan Performance Measure Results, Measurement Years 2020 to 2022

Measure Description	VNS Health Measurement Year 2020	VNS Health Measurement Year 2021	VNS Health Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Effectiveness of Care				
Adult Immunization Status - Influenza	New Measure in 2021	First Year Measure, Not Publicly Reported	12.05%	22.79%
Antidepressant Medication Management – Effective Acute Phase Treatment	67.00%	63.04%	72.94%	61.98%
Antidepressant Medication Management – Effective Continuation Phase Treatment	48.00%	48.91%	61.18%	46.31%
Asthma Medication Ratio (19-64 Years)	29.14%	30.15%	31.82%	40.27%
Breast Cancer Screening	68.45%	72.65%	72.98%	68.00%
Cervical Cancer Screening	78.08%	81.25%	76.92%	75.27%
Chlamydia Screening in Women (16–20 Years)	Small Sample	Small Sample	Small Sample	85.11%
Chlamydia Screening in Women (21–24 Years)	Small Sample	Small Sample	Small Sample	78.72%
Colorectal Cancer Screening (50–75 Years)	63.28%	64.30%	60.25%	60.41%
Controlling High Blood Pressure	59.37%	58.54%	62.34%	61.61%
Diabetes – Eye Exam for Patients With Diabetes	67.64%	68.73%	71.50%	61.01%
Diabetes – Hemoglobin A1c Control for Patients With Diabetes – Poor Control (>9.0%)	23.60%	29.38%	23.10%	21.05%
Kidney Health Evaluation for Patients With Diabetes (Total)	First Year Measure, Not Publicly Reported	32.76%	34.06%	39.64%
Advising Smokers to Quit[1]	95.57%	89.47%	89.47%	88.55%
Discussing Smoking Cessation Medications[1]	86.27%	75.00%	75.00%	77.78%
Discussing Smoking Cessation Strategies[1]	78.22%	70.87%	70.87%	72.97%
Statin Therapy for Patients With Cardiovascular Disease – Adherent	84.81%	79.55%	82.95%	82.13%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	21.15%	22.64%	18.52%	14.51%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	73.08%	75.00%	67.95%	59.47%

Measure Description	VNS Health Measurement Year 2020	VNS Health Measurement Year 2021	VNS Health Measurement Year 2022	HIV Special Needs Plan Mean Measurement Year 2022
Depression Screening and Follow-Up for Adolescents and Adults – Depression Screening	New Measure in 2021	First Year Measure, Not Publicly Reported	0.00%	4.02%
Depression Screening and Follow-Up for Adolescents and Adults – Follow-Up on a Positive Screen	New Measure in 2021	First Year Measure, Not Publicly Reported	Small Sample	Small Sample
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	95.24%	97.48%	97.41%	96.70%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	43.33%	21.28%	46.81%	51.45%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	40.48%	38.89%	33.33%	36.82%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	31.51%	21.33%	34.31%	37.19%
Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder	Not Available	26.42%	34.34%	31.33%
Viral Load Suppression	81.57%	81.14%	84.52%	80.13%
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	56.81%	61.11%	54.52%	45.09%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Not Available	13.58%	12.04%	11.08%

[1] Measure derives from adult CAHPS. Measurement year 2020 CAHPS results are reported for measurement year 2021 because the adult CAHPS survey is administered every other year.

Small Sample: Denominator was too small (e.g., less than 30) to report a valid rate.

Green shading indicates managed care plan's 2022 performance is statistically significantly better than the HIV Special Needs Plan statewide 2022 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 2022 performance is statistically significantly worse than the HIV Special Needs Plan statewide 2022 performance. 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 182: VNS Health's Compliance with Federal Standards Results

Code of Federal Regulation (Program Reviewed)	2020[1]	2021	2022
438.56 Disenrollment: Requirements and Limitations (Medicaid)	Pended	C	C
438.100 Enrollee Rights (Medicaid)	Pended	C	C
438.114 Emergency and Poststabilization Services (Medicaid)	Pended	C	C
438.206 Availability of Services (Medicaid)	Pended	C	NC
438.207 Assurances of Adequate Capacity and Services (Medicaid)	Pended	C	C
438.208 Coordination and Continuity of Care (Medicaid)	Pended	C	NC
438.210 Coverage and Authorization of Services (Medicaid)	Pended	C	NC
438.214 Provider Selection (Medicaid)	Pended	C	C
438.224 Confidentiality (Medicaid)	Pended	C	C
438.228 Grievance and Appeal System (Medicaid)	Pended	C	NC
438.230 Subcontractual Relationships and Delegation (Medicaid)	Pended	C	NC
438.236 Practice Guidelines (Medicaid)	Pended	C	C
438.242 Health Information Systems (Medicaid)	Pended	C	C
438.330 Quality Assessment and Performance Improvement Program (Medicaid)	Pended	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: Managed care plan is in compliance with all standard requirements; NC: Managed care plan is not in compliance with at least one standard requirement.

Table 183: VNS Health's Compliance Review Summary of Results, 2022

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
VNS Health did not report an allegation of abuse documented in a non-utilization review complaint case to the New York State Department of Health.	Contract Article 4404.1	Not Applicable
VNS Health did not receive Department of Health contract approval for the delegated management function of fraud, waste, and abuse.	Contract Article 98-1.11(j)	438.230
VNS Health did not obtain Department of Health approval prior to implementing a management contract with VNS Management Services Organization (a related party management contractor) on 1/1/2022.	Contract Article 98-1.11(j)	438.230
VNS Health did not submit extensions to management contracts to the Department of Health within 90 days of the expiration.	Contract Article 98-1.11(m)	438.230
VNS Health did not provide evidence that four behavioral health providers, contracted with Beacon, were sent an amendment that included the *2017 New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts Incorporation Language*.	Contract Article 98-1.13(a)	438.206
VNS Health issued termination notices to four providers that did not include a written explanation of the reasons for proposed termination and the rights for review or a hearing.	Contract Article 4406-D2. (a)	Not Applicable
VNS Health did not include the external appeal application and instructions with the final adverse determination notice.	Contract Article 98-2.9(h)(1)(i), F.2(5)(a)(iii)(J)(V)	438.228
VNS Health did not issue determination notices within three business days of the receipt of necessary information for one approval case, and three denials of pre-authorization cases.	Contract Article 4903.2(a) F.1(2)(a)(iv)	438.210
The VNS Health delegate MedImpact did not provide the enrollee with copies of information about the enrollee's case including medical records, other documents used in making the appeal determination in three cases.	Contract Article F.2(3)(a)(iv)	438.228
Based on the behavioral health case review interviews, conducted on 8/17/2022 and 8/182022, and the review of documents, VNS Health failed to demonstrate satisfactory systems for coordinating service delivery between physical health, substance use disorder, and mental health providers, and coordinating services with other available services, including health homes and social services for enrollees with chronic or ongoing mental health service needs or requiring substance use disorder services in accordance with the Medicaid model contract.	Contract Article 10.21 (b)(v) 10.23 (b)(iv)	438.208
VNS Health was not able to provide evidence of a process to verify services are being provided to enrollees.	Contract Article 23.3	438.208
VNS Health did not recognize an enrollee call, non-utilization review case, regarding allegations of abuse while an inpatient at an acute care facility as a crisis and did not provide immediate intervention to the enrollee.	Contract Article 12.1(c)(iii)(e)	Not Applicable

Department of Health Finding	Department of Health Citation	Code of Federal Regulation
VNS Health did not complete a thorough investigation for a non-utilization review case and did not issue a complaint resolution notice that included the complaint determination with a detailed reason for the determination.	Contract Article F.2 (9)(a)(i)(A)	438.228

Strengths, Opportunities for Improvement, and Recommendations

Table 184: VNS Health's Strengths, Opportunities, and Recommendations for Measurement Year 2022

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths					
Performance Improvement Projects	HIV Special Needs Plan	VNS Health's performance improvement project for the HIV Special Needs Plan population passed validation for measurement year 2022.			
		One of three performance improvement project indicator rates demonstrated improvement between measurement years 2021 and 2022.	X	X	X
Performance Measures	HIV Special Needs Plan	VNS Health met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.			
Performance Measures – Effectiveness of Care	HIV Special Needs Plan	Four performance measure rates reported by VNS Health for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	HIV Special Needs Plan	One performance measure rate reported by VNS Health for measurement year 2022 performed statistically significantly better than the statewide managed care program mean.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	HIV Special Needs Plan	None.			

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	During measurement year 2022, VNS Health was in compliance with nine of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Opportunities for Improvement					
Performance Improvement Projects	HIV Special Needs Plan	Two of three performance improvement project indicator rates demonstrated performance decline between measurement years 2021 and 2022.	X	X	X
Performance Measures – Effectiveness of Care	HIV Special Needs Plan	Four performance measure rates reported by VNS Health for measurement year 2022 performed statistically significantly worse than the statewide managed care program mean.	X	X	
Performance Measures – Access/ Availability of Care	HIV Special Needs Plan	None.			
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	During measurement year 2022, VNS Health was not in full compliance with five of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Recommendations					
Performance Improvement Projects	HIV Special Needs Plan	VNS Health should continue their performance improvement project interventions in an effort to reach their target indicator rates.	X	X	X
Performance Measures	HIV Special Needs Plan	VNS Health should use the findings from the HEDIS/Quality Assurance Reporting Requirements to inform the development of its annual quality assurance and performance improvement program. Low performance measure rates typically signify that managed care plan members received suboptimal care, encountered limited access to care, and/or suffered unfavorable health outcomes. To address this, VNS	X	X	X

External Quality Review Activity	Managed Care Program	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
		Health should concentrate on improving areas of care where its rates fall below HIV Special Needs Plan performance standards.			
Compliance with Federal Managed Care Standards	HIV Special Needs Plan	VNS Health should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X

Appendix A – Quality Assurance Reporting Requirements for Measurement Year 2022

Data Collection Method	Measure	Measure Abbreviation	Managed Care Plan Types			Technical Specifications
			Mainstream Medicaid/Child Health Plus	HIV Special Needs	Health and Recovery Plan	
Administrative	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	Required	Required	Required	HEDIS 2022
Administrative	Antidepressant Medication Management	AMM	Required	Required	Required	HEDIS 2022
Administrative	Appropriate Testing for Pharyngitis	CWP	Required	Required	Required	HEDIS 2022
Administrative	Appropriate Treatment for Upper Respiratory Infection	URI	Required	Required	Required	HEDIS 2022
Administrative	Asthma Medication Ratio	AMR	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Blood Pressure Control for Patients With Diabetes	BPD	Required	Not Required	Required	HEDIS 2022
Administrative	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	AAB	Required	Not Required	Required	HEDIS 2022
Administrative	Breast Cancer Screening	BCS	Required	Required	Required	HEDIS 2022
Administrative	Cardiac Rehabilitation	CRE	Required	Required	Required	HEDIS 2022
Administrative	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	SMC	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Cervical Cancer Screening	CCS	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Childhood Immunization Status	CIS	Required	Required	Not Required	HEDIS 2022
Administrative	Chlamydia Screening in Women	CHL	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Colorectal Cancer Screening	COL	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Controlling High Blood Pressure	CBP	Required	Required	Required	HEDIS 2022

Data Collection Method	Measure	Measure Abbreviation	Managed Care Plan Types			Technical Specifications
			Mainstream Medicaid/Child Health Plus	HIV Special Needs	Health and Recovery Plan	
Administrative	Diabetes Monitoring for People With Diabetes and Schizophrenia	SMD	Required	Required	Required	HEDIS 2022
Administrative	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Required	Required	Required	HEDIS 2022
Administrative	Developmental Screening in the First Three Years of Life	DEV-N	Required	Not Required	Not Required	Oregon Health and Sciences University
Administrative/ Hybrid	Eye Exam for Patients With Diabetes	EED	Required	Required	Required	HEDIS 2022
Survey	Flu Vaccinations for Adults Ages 18 - 64	FVA	Required	Required	Required	CAHPS 5.1H
Administrative	Follow-Up After High Intensity Care for Substance Use Disorder	FUI	Required	Required	Required	HEDIS 2022
Administrative	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Required	Required	Required	HEDIS 2022
Administrative	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Required	Required	Required	HEDIS 2022
Administrative	Follow-Up After Hospitalization for Mental Illness	FUH	Required	Required	Required	HEDIS 2022
Administrative	Follow-Up Care for Children Prescribed ADHD Medication	ADD	Required	Required	Not Required	HEDIS 2022
Administrative/ Hybrid	Hemoglobin A1c Control for Patients With Diabetes	HBD	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Immunizations for Adolescents	IMA	Required	Required	Not Required	HEDIS 2022
Administrative	Kidney Health Evaluation for Patients With Diabetes	KED	Required	Required	Required	HEDIS 2022
Administrative/ Hybrid	Lead Screening in Children	LSC	Required	Required	Not Required	HEDIS 2022

Data Collection Method	Measure	Measure Abbreviation	Managed Care Plan Types			Technical Specifications
			Mainstream Medicaid/Child Health Plus	HIV Special Needs	Health and Recovery Plan	
Survey	Medical Assistance With Smoking and Tobacco Use Cessation	MSC	Required	Required	Required	CAHPS 5.1H
Administrative	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Required	Required	Not Required	HEDIS 2022
Administrative	Non-Recommended Cervical Cancer Screening in Adolescent Females	NCS	Required	Not Required	Not Required	HEDIS 2022
Administrative	Persistence of Beta-Blocker Treatment After a Heart Attack	PBH	Required	Required	Required	HEDIS 2022
Administrative	Pharmacotherapy for Opioid Use Disorder	POD	Required	Required	Required	HEDIS 2022
Administrative	Pharmacotherapy Management of COPD Exacerbation	PCE	Required	Required	Required	HEDIS 2022
Administrative	Risk of Continued Opioid Use	COU	Required	Required	Required	HEDIS 2022
Administrative	Statin Therapy for Patients With Cardiovascular Disease	SPC	Required	Required	Required	HEDIS 2022
Administrative	Statin Therapy for Patients With Diabetes	SPD	Required	Required	Required	HEDIS 2022
Administrative	Use of Imaging Studies for Low Back Pain	LBP	Required	Required	Required	HEDIS 2022
Administrative	Use of Opioids at High Dosage	HDO	Required	Required	Required	HEDIS 2022
Administrative	Use of Opioids from Multiple Providers	UOP	Required	Required	Required	HEDIS 2022
Administrative	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	Required	Required	Required	HEDIS 2022
Administrative	Viral Load Suppression	VLS	Required	Required	Required	New York State 2022
Administrative/ Hybrid	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	WCC	Required	Required	Not Required	HEDIS 2022
Administrative	COVID-19 Immunization Status	CVS	Required	Required	Required	New York State 2022

Data Collection Method	Measure	Measure Abbreviation	Managed Care Plan Types			Technical Specifications
			Mainstream Medicaid/Child Health Plus	HIV Special Needs	Health and Recovery Plan	
Administrative	Adults' Access to Preventive/Ambulatory Health Services	AAP	Required	Required	Required	HEDIS 2022
Administrative	Annual Dental Visit	ADV	Required	Not Required	Not Required	HEDIS 2022
Administrative	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET	Required	Required	Required	HEDIS 2022
Administrative	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	POD-N	Required	Required	Required	New York State 2022
Administrative/ Hybrid	Prenatal and Postpartum Care	PPC	Required	Required	Required	HEDIS 2022
Administrative	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	Required	Required	Not Required	HEDIS 2022
Administrative	Use of Pharmacotherapy for Alcohol Abuse or Dependence	POA	Required	Required	Required	New York State 2022