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Introduction

Plan-led care management, also referred to as case management, is an intervention-based program intended to improve the health plan members' health outcomes. In this context, care management includes: a comprehensive assessment of a member's needs, an individualized care plan, and interventions. The care plan is developed from the assessment, and the interventions are designed to achieve the care plan goals. The aim is to provide coordinated, efficient, quality care, and optimize health outcomes for people with complex health issues. Medicaid managed care (MMC) health plans are required to provide case management and disease management services for their members with chronic health conditions, or complex health issues or situations. MMC is a Medicaid health insurance plan that coordinates the provision, quality, and cost of care for its membership. With this kind of information, over the past 10 years there have been gains in building a foundation to: 1) explore the effectiveness of care management on health service use and outcomes, 2) determine which populations or members benefit the most, and 3) understand if any program models are associated with more effective results.

In New York State, plans have been required to provide case management and disease management services since the 1997 Partnership Program implementation. In 2008, the Medicaid managed care contract requirement for case management and disease management services (section 10.19 and 10.20 of the Medicaid contract) was amended to include specific data requirements for the evaluation of care management by the New York State Department of Health (NYSDOH). Since 2011 (measurement year 2010), NYSDOH has collected and evaluated case management and disease management services and outcomes through standardized measures. Plans are required to submit specific information for all Medicaid members involved in plan-administered care management programs during each calendar year. The collection of this standardized data provides NYSDOH with information that is used to evaluate care management programs, including the number of individuals receiving these services, the types of conditions individuals have, and the impact of care management services on outcomes.

The Department is committed to sharing information about care management services with the public, plans, and stakeholders. Therefore, this report provides a summary of each plan’s most recent care management data submission. This submission included data about member and program characteristics for all members who received care management services administered by health plans during measurement year 2016. The goal of this annual report is 1) to provide information about plan care management programs, the members identified for care management, and the efficiency of their programs, 2) to describe utilization patterns for emergency department visits, inpatient stays, and outpatient services for members in care management, and 3) to describe quality results for members in care management.
Data/Methodology

This report is principally based on two data sources, the Health Plan Care Management Assessment Reporting Tool (CMART) and the New York State Medicaid Data. These data provide information regarding which members received care management services; the scope and nature of those services; and claims, encounters, and demographic details. To understand outcomes of members receiving plan-led care management, two additional data sources were used: the Vital Statistics Birth file for High-Risk obstetrics (HROB) was used to calculate birth outcomes of pregnancies receiving HROB care management and the Clinical DataMart was used for quality measures.

The Health Plan CMART is submitted annually to the Department of Health. This data documents the process of plan-led care management services which include:

- Members triggered to receive care management
- Date members are triggered to receive management
- For those who enroll in plan-led care management, CMART includes:
  - Start and end date of care management
  - Type of care management service received
  - Number of interventions
  - Type of interventions: letter, phone, in-person intervention

The Medicaid Data contains all claims and encounters data as well as demographics, diagnoses, etc. regarding health plan members. The Clinical Risk Groups (CRGs) (developed by 3M®) used for stratifications are also from this data source.

The Vital Statistics Birth file consists of all live births that occur in NYS during each calendar year. This data provides the following information about the infants and mothers, which is not recorded in CMART:

- Mother characteristics
  - Demographics (nationality, race/ethnicity, Medicaid aid category, education level, age at time of delivery, region of NYS child was delivered)
  - Gestational weeks at delivery
  - Number of prenatal visits
  - Maternal risk factors
    - Diabetes
    - Gestational diabetes
    - Hypertension
    - Gestational hypertension
  - Referral to High-Risk OB provider
  - Number of times hospitalized during the pregnancy
  - Number of previous live births

- Infant characteristics
  - Neonatal Intensive Care Unit (NICU) use
  - Sex
  - Birthweight
The DOH Clinical DataMart is utilized to calculate quality measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures from the National Committee for Quality Assurance, and Prevention Quality Indicators (PQIs) from the Agency for Healthcare Research and Quality. PQIs can be used to identify potential problem areas in health care quality. These quality measures and quality indicators are used to better understand the quality of care provided by health plan care management.
Limitations

The tables provided in this report are for comparison to the statewide rates/numbers only. These comparisons tell us many characteristics about the care managed recipients, however, the data does not tell us the reason(s) why the recipients are enrolled in the care management program. Program variation between plans/programs limits the ability to compare one plan to another. Plans differ in their methods to identify members as eligible for care management services and plans differ in how care management services are carried out. Trends over time for a single plan may be useful, but because plans can change their internal policies, discontinuities in the data may or may not reflect changes in practice. The variation in plan-led care management programs may create differences in results that would not be apparent.

Variation and/or extreme values in results are difficult to interpret where numbers are small. Therefore, results with fewer than 30 eligible individuals are reported in the tables as SS (small sample).
Measures
This report represents the health plan population during 2016 and contains the following four sections:

- **Outreach**: Descriptive statistics and process measures for members contacted for acute/active care management services.
- **Enrollment**: Descriptive statistics and process measures for members enrolled in acute/active care management services.
- **Quality Measures**: quality measures for members enrolled in care management services at any point in the calendar year.

The Outreach, Enrollment, and Quality Measures sections do not include members who are in the HROB care management program; these members are in the HROB section only.

Data presented in this report are often stratified by Clinical Risk Group (CRG). CRGs are a categorical clinical model (developed by 3M®) which assigns each member of a population to a single mutually exclusive risk category. The CRGs provide a way to consider illness and resource utilization of a full range of patient types, including low income, elderly, commercial beneficiaries, and those with disabilities. CRGs use standard claims data, and when available, additional data such as pharmaceutical data and functional health status which is collected longitudinally. Each CRG is clinically meaningful and correlates with health care utilization and cost. The Standard Model set of CRGs was used, which removes the effects of pregnancy/delivery during the calendar year.

We have combined the Standard Model CRGs as shown below. Each CRG group is defined and includes examples of conditions which could qualify a member for that CRG group.

- **Healthy**: Non-User and CRG number 1 (Healthy)
  - **Non-User**: No medical care encounters
  - **CRG #1**: Uncomplicated upper respiratory infection
- **Stable**: CRG numbers 2 (Significant acute disease) and 3 (Single minor chronic disease)
  - **CRG #2**: Pneumonia
  - **CRG #3**: Migraine Headache
- **Simple Chronic**: CRG numbers 4 (Minor chronic disease in multiple organ systems) and 5 (Single dominant or moderate chronic disease)
  - **CRG #4**: Migraine Headache and Hyperlipidemia
  - **CRG #5**: Diabetes
- **Complex Chronic**: CRG numbers 6 (Pairs – significant chronic disease in multiple organ systems) and 7 (Triples – dominant chronic disease in three or more organ systems)
CRG #6: Diabetes and Congestive Heart Failure (CHF)
CRG #7: Diabetes and CHF and Chronic Obstructive Pulmonary Disorder
• Critical/HIV: CRG numbers 8 (Malignancies – dominant, metastatic, and complicated) and 9 (Catastrophic conditions/HIV)
  CRG #8: Metastatic Colon Malignancy, under active treatment
  CRG #9: History of Major Organ Transplant
Outreach

Table 1 shows the enrollment in mainstream health plans as of December 31, 2016, and the total number of triggered care management episodes for the entire year of 2016.

Table 1: Enrollment and total episodes for each health plan

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Enrollment</th>
<th>Total Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>240,114</td>
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<td>Empire BlueCross BlueShield Health Plus</td>
<td>358,256</td>
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<td>HealthNow New York Inc.</td>
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<td>1,036</td>
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<td>172,508</td>
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<td>Independent Health's MediSource</td>
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<td>1,684</td>
</tr>
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<td>MetroPlus Health Plan</td>
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<td>Molina Healthcare</td>
<td>35,029</td>
<td>896</td>
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<tr>
<td>MVP Health Care</td>
<td>165,659</td>
<td>5,992</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>457,440</td>
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<tr>
<td>WellCare of New York</td>
<td>145,000</td>
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<tr>
<td>YourCare Health Plan</td>
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<td>1,165</td>
</tr>
<tr>
<td>Statewide</td>
<td>4,586,886</td>
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</table>

Plans identify members in need of care management services throughout the year; the State does not identify members for plan-led care management. The first step in the plan-led care management process is outreach, which starts with the trigger. Criteria for eligibility, the trigger, for care management varies by plan and may include utilization patterns, diagnoses, or other healthcare metrics. Members who trigger and do not enroll are referred to as “triggered only.” In general, the process is as follows:

- Outreach is a process that occurs between the trigger date and when the plan contacts the member. Not all triggered members are contacted by the plans.
- The plan identifies and triggers the eligible member, which initiates the plan’s care management protocol. A member may trigger more than one time during a measurement year. If a Medicaid member changes plans during the calendar year, one or more plans may trigger that member for plan-led care management services.
- Plans may have additional information which can further refine members they attempt to outreach.
Table 2 shows the number of care management triggered episodes, stratified by CRG.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Healthy N</th>
<th>Healthy %</th>
<th>Stable N</th>
<th>Stable %</th>
<th>Simple Chronic N</th>
<th>Simple Chronic %</th>
<th>Complex Chronic N</th>
<th>Complex Chronic %</th>
<th>Critical/HIV N</th>
<th>Critical/HIV %</th>
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</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>188</td>
<td>11</td>
<td>105</td>
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<td>820</td>
<td>46</td>
<td>392</td>
<td>22</td>
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<tr>
<td>CDPHP</td>
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<td>156</td>
<td>5</td>
<td>562</td>
<td>19</td>
<td>1,818</td>
<td>61</td>
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<tr>
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<td>8,792</td>
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<td>Excellus BlueCross BlueShield</td>
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<td>693</td>
<td>8</td>
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<td>3</td>
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<td>12</td>
<td>1,039</td>
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<td>MetroPlus Health Plan</td>
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<td>8</td>
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<td>MVP Health Care</td>
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<td>5</td>
<td>37</td>
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<td>14</td>
<td>760</td>
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<td>151</td>
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<td>Statewide</td>
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<td>8,537</td>
<td>7</td>
<td>21,714</td>
<td>18</td>
<td>58,075</td>
<td>48</td>
<td>15,210</td>
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</table>

Note: CRG % by plan may not sum to 100% because of missing data

Members in the Complex Chronic CRG, significant chronic disease in multiple organ systems and dominant chronic disease in three or more organ systems, account for just under 50 percent of triggered Statewide.

Once the member is triggered, the plan’s care management program will attempt to contact the member and offer care management services. This is the outreach phase. Outreach is usually conducted by phone, but occasionally is conducted in-person.
Table 3 shows the percentage of triggered members who were contacted. The percentage contacted is the number of members successfully contacted by the plan divided by the number triggered during the calendar year. The percentage contacted same day, contacted 1-30 days, and contacted 31+ days is the number of members successfully contacted by the plan in each time frame divided by the total number contacted. The percentage of members contacted varies across plans because of differences in eligibility criteria, outreach strategies, and other factors.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Triggered</th>
<th>Contacted Total</th>
<th>Contacted Same Day</th>
<th>Contacted 1-30 Days</th>
<th>Contacted 31+ Days</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>5,992</td>
<td>3,433</td>
<td>57</td>
<td>1,485</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,816</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>132</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>31,163</td>
<td>14,810</td>
<td>48</td>
<td>2,317</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10,190</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,303</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>1,239</td>
<td>1,239</td>
<td>100</td>
<td>939</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>245</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>55</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>1,165</td>
<td>846</td>
<td>73</td>
<td>304</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>401</td>
<td>47</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>141</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Statewide</td>
<td>119,901</td>
<td>54,353</td>
<td>45</td>
<td>18,095</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25,147</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11,111</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

Statewide, a little less than half of outreach efforts end in a successful contact. Most successful contacts occur within the first month after the member is triggered.

Once the plan contacts the member, the member may choose to engage in care management or decline the offer.
Table 4 shows the percentage of contacted members who enroll in plan-led care management services. The percentage enrolled is the number of members enrolled by the plan divided by the number successfully contacted during the calendar year. The percentage enrolled same day, enrolled 1-30 days, and enrolled 31+ days is the number of members enrolled by the plan in each time frame divided by the total number successfully contacted.

Table 4: Member enrollment and timing for each health plan

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Contacted N</th>
<th>Enrolled Total N</th>
<th>Enrolled Same Day N</th>
<th>Enrolled 1-30 Days N</th>
<th>Enrolled 31+ Days N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>1,095</td>
<td>483</td>
<td>154</td>
<td>209</td>
<td>120</td>
</tr>
<tr>
<td>CDPHP</td>
<td>2,104</td>
<td>2,042</td>
<td>1,346</td>
<td>858</td>
<td>334</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>3,692</td>
<td>1,550</td>
<td>358</td>
<td>865</td>
<td>465</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>2,865</td>
<td>2,063</td>
<td>733</td>
<td>865</td>
<td>465</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>8,596</td>
<td>5,917</td>
<td>5,809</td>
<td>102</td>
<td>6</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>6,773</td>
<td>6,278</td>
<td>381</td>
<td>3,281</td>
<td>2,616</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>386</td>
<td>362</td>
<td>96</td>
<td>256</td>
<td>10</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>3,678</td>
<td>2,255</td>
<td>1,548</td>
<td>604</td>
<td>103</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>1,075</td>
<td>959</td>
<td>473</td>
<td>385</td>
<td>101</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>3,251</td>
<td>2,785</td>
<td>1,118</td>
<td>977</td>
<td>690</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>510</td>
<td>371</td>
<td>72</td>
<td>240</td>
<td>59</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>3,433</td>
<td>2,390</td>
<td>1,239</td>
<td>1,103</td>
<td>48</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>14,810</td>
<td>2,367</td>
<td>738</td>
<td>915</td>
<td>714</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>1,239</td>
<td>1,160</td>
<td>826</td>
<td>267</td>
<td>67</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>846</td>
<td>484</td>
<td>199</td>
<td>191</td>
<td>94</td>
</tr>
<tr>
<td>Statewide</td>
<td>54,353</td>
<td>31,466</td>
<td>15,090</td>
<td>10,910</td>
<td>5,466</td>
</tr>
</tbody>
</table>

Note: This table excludes 38 enrollments for which enrollment timeframe could not be calculated.

Statewide, almost 60% of contacted members enroll in health plan care management, with slightly less than half enrolling on the day of contact.
Enrollment

Members who are enrolled in plan-led care management services receive interventions. Services and referrals made to the enrolled member are based on an individualized plan of care.

Table 5 shows the number of care management enrolled episodes, stratified by CRG. An episode is a distinct unit of care management with a begin date and an end date. A member may trigger for and enroll in a care management episode more than one time during the measurement year, and therefore have more than one episode during the measurement year. The percentage enrolled in each CRG group is the number of members enrolled in each CRG group divided by the total number enrolled in care management episodes by plan.

| Table 5: Enrolled episodes by CRG for each health plan |
|---------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                      | Healthy | Stable | Simple Chronic | Complex Chronic | Critical/HIV |
|                                      | N | % | N | % | N | % | N | % | N | % |
| Affinity Health Plan                 | 41 | 8 | 35 | 7 | 61 | 13 | 246 | 51 | 104 | 21 |
| CDPHP                                 | 167 | 8 | 101 | 5 | 358 | 18 | 1,288 | 63 | 128 | 6 |
| Empire BlueCross BlueShield Health Plus | 54 | 3 | 56 | 4 | 192 | 12 | 1,011 | 65 | 238 | 15 |
| Excellus BlueCross BlueShield         | 61 | 3 | 45 | 2 | 196 | 10 | 1,480 | 72 | 281 | 14 |
| Fidelis Care New York, Inc.           | 138 | 2 | 102 | 2 | 538 | 9 | 4,120 | 70 | 1,019 | 17 |
| HealthFirst PHSP                      | 313 | 5 | 160 | 3 | 1,017 | 16 | 3,652 | 58 | 1,136 | 18 |
| HealthNow New York Inc.               | 9 | 2 | 13 | 4 | 50 | 14 | 261 | 72 | 29 | 8 |
| HIP (EmblemHealth)                    | 196 | 9 | 148 | 7 | 438 | 19 | 1,178 | 52 | 295 | 13 |
| Independent Health's MediSource       | 32 | 3 | 22 | 2 | 82 | 9 | 605 | 63 | 218 | 23 |
| MetroPlus Health Plan                 | 339 | 12 | 111 | 4 | 362 | 13 | 1,174 | 42 | 827 | 29 |
| Molina Healthcare                      | 22 | 6 | 9 | 2 | 69 | 19 | 251 | 68 | 20 | 5 |
| MVP Health Care                       | 185 | 8 | 125 | 5 | 307 | 13 | 1,449 | 61 | 324 | 14 |
| UnitedHealthCare Community Plan       | 212 | 9 | 160 | 7 | 212 | 9 | 1,384 | 58 | 399 | 17 |
| WellCare of New York                  | 84 | 7 | 66 | 6 | 159 | 14 | 669 | 57 | 187 | 16 |
| YourCare Health Plan                  | 14 | 3 | 11 | 2 | 42 | 9 | 362 | 75 | 55 | 11 |
| Statewide                             | 1,867 | 6 | 1,164 | 4 | 4,083 | 13 | 19,130 | 61 | 5,260 | 17 |

As in Table 2 Triggered by CRG, the Complex Chronic CRG is the largest group.
Services offered to members within care management programs will differ by plan and by member needs. These differences impact the duration of enrollment and the number of interventions provided to enrolled members. Of the 31,504 enrolled episodes in 2016, 13,104 episodes remained open while 1,541 enrolled and closed the same day and 16,859 closed one or more days after enrollment. Table 6 shows the median number of days enrolled in care management and mean number of interventions, stratified by the number of days to closure per each episode.

Table 6: Median number of days and interventions by episode duration for each health plan

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>1-30 Days</th>
<th>31+ Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Enrolled Episodes</td>
<td>Median days</td>
</tr>
<tr>
<td>Affinity Health Plan</td>
<td>67</td>
<td>20.0</td>
</tr>
<tr>
<td>CDPHP</td>
<td>222</td>
<td>23.0</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>115</td>
<td>19.0</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>88</td>
<td>20.0</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>88</td>
<td>20.5</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>927</td>
<td>16.0</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>69</td>
<td>18.0</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>117</td>
<td>20.0</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>247</td>
<td>17.0</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>290</td>
<td>12.0</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>14</td>
<td>27.0</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>1,068</td>
<td>16.0</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>433</td>
<td>25.0</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>45</td>
<td>20.0</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>17</td>
<td>22.0</td>
</tr>
<tr>
<td>Statewide</td>
<td>3,807</td>
<td>18.0</td>
</tr>
</tbody>
</table>

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table.

The plans vary in both the median number of days enrolled in care management and the mean number of interventions. The variation is largely driven by differences in member's needs to successfully meet the goals of their care plan. One method used to determine the success of care management is to look at the reason the episode closed.
Table 7 shows the number of closed episodes by reason for closure, the median number of days enrolled in care management, and the mean number of interventions for each reason for closure.

**Table 7: Reasons for Closure**

<table>
<thead>
<tr>
<th>Reason for Closure</th>
<th>N</th>
<th>%</th>
<th>Median # days</th>
<th>Mean Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met program goals</td>
<td>8,219</td>
<td>49</td>
<td>70.0</td>
<td>9.3</td>
</tr>
<tr>
<td>Lost to follow up</td>
<td>5,146</td>
<td>31</td>
<td>62.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Disenrolled from plan</td>
<td>2,237</td>
<td>13</td>
<td>108.0</td>
<td>6.8</td>
</tr>
<tr>
<td>Refused to continue</td>
<td>774</td>
<td>5</td>
<td>99.5</td>
<td>6.0</td>
</tr>
<tr>
<td>Missing</td>
<td>319</td>
<td>2</td>
<td>61.0</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table.

An episode that met program goals is considered a success. Table 8 shows the percentage of episodes that closed with goals met. The total percentage of closure is the number of episodes that met program goals divided by the total number of episodes that closed. The percentage closed by CRG is the number of episodes closed in each CRG divided by the total number of episodes closed for each health plan.

**Table 8: Episodes closed for met program goals by CRG for each health plan**

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Total % of Closure</th>
<th>Healthy %</th>
<th>Stable %</th>
<th>Simple Chronic %</th>
<th>Complex Chronic %</th>
<th>Critical/HIV %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>40</td>
<td>14 10</td>
<td>21 15</td>
<td>20 15</td>
<td>64 47</td>
<td>17 13</td>
</tr>
<tr>
<td>CDPHP</td>
<td>47</td>
<td>54 8</td>
<td>29 4</td>
<td>120 18</td>
<td>401 62</td>
<td>46 7</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>37</td>
<td>12 3</td>
<td>33 8</td>
<td>53 13</td>
<td>237 58</td>
<td>77 19</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>30</td>
<td>6 2</td>
<td>11 4</td>
<td>32 11</td>
<td>221 73</td>
<td>34 11</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>17</td>
<td>3 1</td>
<td>9 3</td>
<td>28 11</td>
<td>142 55</td>
<td>78 30</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>25</td>
<td>35 4</td>
<td>37 5</td>
<td>124 15</td>
<td>474 59</td>
<td>133 17</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>40</td>
<td>3 3</td>
<td>3 3</td>
<td>4 4</td>
<td>71 76</td>
<td>13 14</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>82</td>
<td>164 10</td>
<td>118 7</td>
<td>346 21</td>
<td>892 54</td>
<td>126 8</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>28</td>
<td>8 5</td>
<td>7 5</td>
<td>15 10</td>
<td>109 71</td>
<td>15 10</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>57</td>
<td>32 4</td>
<td>18 2</td>
<td>92 12</td>
<td>488 66</td>
<td>110 15</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>43</td>
<td>5 5</td>
<td>2 2</td>
<td>14 13</td>
<td>79 74</td>
<td>7 7</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>83</td>
<td>97 6</td>
<td>76 5</td>
<td>195 12</td>
<td>1,025 64</td>
<td>215 13</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>70</td>
<td>129 12</td>
<td>114 10</td>
<td>93 8</td>
<td>624 56</td>
<td>152 14</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>74</td>
<td>8 11</td>
<td>4 6</td>
<td>8 11</td>
<td>38 53</td>
<td>14 19</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>43</td>
<td>1 1</td>
<td>3 2</td>
<td>9 7</td>
<td>100 83</td>
<td>8 7</td>
</tr>
<tr>
<td>Statewide</td>
<td>49</td>
<td>571 7</td>
<td>485 6</td>
<td>1,153 14</td>
<td>4,965 60</td>
<td>1,045 13</td>
</tr>
</tbody>
</table>

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table.

Statewide, most of the members that ended care management because they met episode program goals were in the complex chronic CRG group (60%). Please note,
this does not include episodes that are not closed within the measurement year. There may be episodes which successfully meet goals and close in the subsequent year.
Quality Measures

Quality measures and PQIs, used to measure performance across health plans in New York State, can also be used to identify problems, opportunities for improvement, and obtain a baseline assessment of current practices. They are used as a first step to establishing performance benchmarks for the care management group. Table 9 shows the quality measure performance among enrolled care management members by CRG. These measures are expressed as the percentage of members meeting the criteria definition for the quality measures.

Table 9: Percent of members meeting quality measures by CRG

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy</th>
<th>Stable</th>
<th>Simple Chronic</th>
<th>Complex Chronic</th>
<th>Critical/HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI Assessment (ABA)</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>95</td>
<td>SS</td>
</tr>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>15</td>
<td>SS</td>
<td>63</td>
<td>68</td>
<td>65</td>
</tr>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td>72</td>
<td>80</td>
<td>75</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>Chlamydia Screening (CHL)</td>
<td>80</td>
<td>80</td>
<td>76</td>
<td>72</td>
<td>51</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (COL)</td>
<td>27</td>
<td>40</td>
<td>39</td>
<td>56</td>
<td>56</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Test (CDC)</td>
<td>70</td>
<td>72</td>
<td>87</td>
<td>87</td>
<td>83</td>
</tr>
<tr>
<td>HIV/AIDS Comprehensive Care - Syphilis Screening</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>45</td>
<td>72</td>
</tr>
<tr>
<td>HIV/AIDS Comprehensive Care - Viral Load Monitoring</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>67</td>
</tr>
<tr>
<td>HIV/AIDS Comprehensive Care - Engaged in Care</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>94</td>
<td>91</td>
</tr>
<tr>
<td>Medication Management for People with Asthma - 50% Days covered (MMA)</td>
<td>SS</td>
<td>SS</td>
<td>55</td>
<td>68</td>
<td>75</td>
</tr>
<tr>
<td>Medication Management for People with Asthma - 75% Days covered (MMA)</td>
<td>SS</td>
<td>SS</td>
<td>26</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Acute Phase (84 days) (AMM)</td>
<td>SS</td>
<td>39</td>
<td>50</td>
<td>58</td>
<td>52</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Continuation Phase (180 days) (AMM)</td>
<td>SS</td>
<td>19</td>
<td>36</td>
<td>45</td>
<td>41</td>
</tr>
<tr>
<td>Follow Up After Hospitalization for Mental Illness - 7 days (FUH)</td>
<td>62</td>
<td>74</td>
<td>68</td>
<td>58</td>
<td>51</td>
</tr>
<tr>
<td>Follow Up After Hospitalization for Mental Illness - 30 days (FUH)</td>
<td>78</td>
<td>86</td>
<td>82</td>
<td>75</td>
<td>68</td>
</tr>
<tr>
<td>Initiation of Alcohol and Other Drug Dependence Treatment (IET)</td>
<td>60</td>
<td>43</td>
<td>59</td>
<td>56</td>
<td>50</td>
</tr>
<tr>
<td>Engagement of Alcohol and Other Drug Dependence Treatment (IET)</td>
<td>20</td>
<td>12</td>
<td>21</td>
<td>13</td>
<td>8</td>
</tr>
</tbody>
</table>

SS: Small Sample Size
The measures in Table 10 are rates of potentially preventable hospitalizations for specific chronic conditions. These chronic conditions are prevalent for many of the members enrolled in care management. The measures are expressed as the rate of events per 100,000 members.

Table 10: Prevention Quality Indicator Rates per 100,000 Enrollees by CRG

<table>
<thead>
<tr>
<th>Measure</th>
<th>Healthy</th>
<th>Stable</th>
<th>Simple Chronic</th>
<th>Complex Chronic</th>
<th>Critical/HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Short-Term Complications Admission Rate (PQI #1)</td>
<td>29</td>
<td>41</td>
<td>434</td>
<td>2,297</td>
<td>1,460</td>
</tr>
<tr>
<td>Diabetes Long-Term Complications Admission Rate (PQI #3)</td>
<td>117</td>
<td>SS</td>
<td>170</td>
<td>2,264</td>
<td>1,675</td>
</tr>
<tr>
<td>COPD or Asthma in Older Adults Admission Rate (PQI #5)</td>
<td>1,770</td>
<td>337</td>
<td>1,931</td>
<td>8,608</td>
<td>6,629</td>
</tr>
<tr>
<td>Hypertension Admission Rate (PQI #7)</td>
<td>29</td>
<td>SS</td>
<td>38</td>
<td>543</td>
<td>86</td>
</tr>
<tr>
<td>Heart Failure Admission Rate (PQI #8)</td>
<td>350</td>
<td>41</td>
<td>226</td>
<td>4,123</td>
<td>4,854</td>
</tr>
<tr>
<td>Dehydration Admission Rate (PQI #10)</td>
<td>146</td>
<td>82</td>
<td>151</td>
<td>1,047</td>
<td>1,267</td>
</tr>
<tr>
<td>Bacterial Pneumonia Admission Rate (PQI #11)</td>
<td>58</td>
<td>SS</td>
<td>226</td>
<td>1,371</td>
<td>1,740</td>
</tr>
<tr>
<td>Urinary Tract Infection Admission Rate (PQI #12)</td>
<td>29</td>
<td>41</td>
<td>208</td>
<td>691</td>
<td>795</td>
</tr>
<tr>
<td>Uncontrolled Diabetes Admission Rate (PQI #14)</td>
<td>SS</td>
<td>SS</td>
<td>151</td>
<td>817</td>
<td>816</td>
</tr>
<tr>
<td>Asthma in Younger Adults Admission Rate (PQI #15)</td>
<td>139</td>
<td>62</td>
<td>418</td>
<td>2,127</td>
<td>2,899</td>
</tr>
<tr>
<td>Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16)</td>
<td>SS</td>
<td>SS</td>
<td>19</td>
<td>389</td>
<td>279</td>
</tr>
</tbody>
</table>

SS: Small Sample Size
Utilization

Utilization of medical services is a major component of the total cost of health care. One of the goals of care management is to lower utilization cost by decreasing emergency department (ED) and inpatient use, while simultaneously increasing outpatient use. The shift from ED and inpatient treatment of acute episodes to outpatient long-term management and prevention is also expected to improve outcomes. Tables 11 through 13 show the utilization rates of emergency department, inpatient care, and outpatient care for anytime during the calendar year that the care management episode occurred.

Emergency department utilization is defined as visits to the ED that do not transfer to an inpatient stay. Inpatient utilization is defined as hospitalizations. Outpatient utilization is defined as ambulatory visits to providers.

Table 11: Emergency Department Rates per 1,000 member years by CRG

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Healthy</th>
<th>Stable</th>
<th>Simple Chronic</th>
<th>Complex Chronic</th>
<th>Critical/HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>957</td>
<td>1,612</td>
<td>1,553</td>
<td>2,032</td>
<td>1,248</td>
</tr>
<tr>
<td>CDPHP</td>
<td>1,037</td>
<td>1,544</td>
<td>1,566</td>
<td>2,470</td>
<td>2,986</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>1,133</td>
<td>1,778</td>
<td>1,173</td>
<td>1,550</td>
<td>1,906</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>681</td>
<td>996</td>
<td>1,098</td>
<td>1,873</td>
<td>1,932</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>696</td>
<td>1,271</td>
<td>952</td>
<td>1,386</td>
<td>1,461</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>1,240</td>
<td>1,714</td>
<td>1,488</td>
<td>2,250</td>
<td>2,019</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>1,392</td>
<td>2,784</td>
<td>1,136</td>
<td>2,457</td>
<td>1,067</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>743</td>
<td>920</td>
<td>676</td>
<td>1,060</td>
<td>1,029</td>
</tr>
<tr>
<td>Independent Health’s MediSource</td>
<td>1,394</td>
<td>1,870</td>
<td>1,487</td>
<td>2,311</td>
<td>1,462</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>646</td>
<td>1,568</td>
<td>997</td>
<td>1,611</td>
<td>1,154</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>1,412</td>
<td>1,707</td>
<td>1,816</td>
<td>3,109</td>
<td>3,056</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>981</td>
<td>1,652</td>
<td>1,578</td>
<td>2,838</td>
<td>2,393</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>783</td>
<td>768</td>
<td>1,091</td>
<td>2,055</td>
<td>1,546</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>599</td>
<td>1,044</td>
<td>992</td>
<td>1,591</td>
<td>1,707</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>1,815</td>
<td>2,531</td>
<td>1,773</td>
<td>2,112</td>
<td>2,768</td>
</tr>
<tr>
<td>Statewide</td>
<td>926</td>
<td>1,408</td>
<td>1,245</td>
<td>1,913</td>
<td>1,659</td>
</tr>
</tbody>
</table>
### Table 12: Inpatient Rates per 1,000 member years by CRG

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Healthy</th>
<th>Stable</th>
<th>Simple Chronic</th>
<th>Complex Chronic</th>
<th>Critical/ HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>1,074</td>
<td>1,020</td>
<td>1,165</td>
<td>1,890</td>
<td>1,883</td>
</tr>
<tr>
<td>CDPHP</td>
<td>513</td>
<td>524</td>
<td>506</td>
<td>1,156</td>
<td>3,210</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>848</td>
<td>752</td>
<td>602</td>
<td>1,229</td>
<td>2,521</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>540</td>
<td>563</td>
<td>466</td>
<td>895</td>
<td>1,672</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>635</td>
<td>687</td>
<td>401</td>
<td>816</td>
<td>1,681</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>682</td>
<td>820</td>
<td>483</td>
<td>1,315</td>
<td>2,615</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>1,094</td>
<td>667</td>
<td>746</td>
<td>1,673</td>
<td>2,286</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>433</td>
<td>716</td>
<td>489</td>
<td>904</td>
<td>1,899</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>918</td>
<td>659</td>
<td>754</td>
<td>1,353</td>
<td>1,244</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>338</td>
<td>803</td>
<td>520</td>
<td>1,187</td>
<td>833</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>318</td>
<td>659</td>
<td>484</td>
<td>1,180</td>
<td>2,111</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>930</td>
<td>951</td>
<td>802</td>
<td>1,388</td>
<td>2,961</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>973</td>
<td>844</td>
<td>1,144</td>
<td>1,564</td>
<td>2,558</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>574</td>
<td>787</td>
<td>602</td>
<td>1,277</td>
<td>1,618</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>630</td>
<td>1,359</td>
<td>674</td>
<td>1,155</td>
<td>2,582</td>
</tr>
<tr>
<td>Statewide</td>
<td>717</td>
<td>793</td>
<td>601</td>
<td>1,161</td>
<td>1,942</td>
</tr>
</tbody>
</table>

### Table 13: Outpatient Rates per 1,000 member years by CRG

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Healthy</th>
<th>Stable</th>
<th>Simple Chronic</th>
<th>Complex Chronic</th>
<th>Critical/ HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>15,667</td>
<td>15,507</td>
<td>16,860</td>
<td>20,664</td>
<td>19,286</td>
</tr>
<tr>
<td>CDPHP</td>
<td>5,923</td>
<td>6,975</td>
<td>8,145</td>
<td>13,337</td>
<td>19,810</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>11,472</td>
<td>13,802</td>
<td>11,741</td>
<td>18,033</td>
<td>24,247</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>5,880</td>
<td>7,693</td>
<td>8,801</td>
<td>15,350</td>
<td>15,080</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>9,617</td>
<td>10,863</td>
<td>10,543</td>
<td>18,429</td>
<td>21,087</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>10,093</td>
<td>12,556</td>
<td>8,864</td>
<td>17,749</td>
<td>22,343</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>5,436</td>
<td>7,804</td>
<td>4,780</td>
<td>10,616</td>
<td>10,210</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>5,567</td>
<td>9,072</td>
<td>7,566</td>
<td>16,167</td>
<td>22,592</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>4,822</td>
<td>6,323</td>
<td>5,339</td>
<td>12,639</td>
<td>10,667</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>4,562</td>
<td>9,155</td>
<td>7,173</td>
<td>14,856</td>
<td>13,195</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>6,424</td>
<td>10,220</td>
<td>7,047</td>
<td>11,868</td>
<td>16,278</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>13,455</td>
<td>12,575</td>
<td>11,188</td>
<td>19,281</td>
<td>25,316</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>9,169</td>
<td>10,397</td>
<td>12,117</td>
<td>19,750</td>
<td>21,249</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>6,780</td>
<td>9,526</td>
<td>8,555</td>
<td>16,113</td>
<td>18,117</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>5,074</td>
<td>8,344</td>
<td>7,356</td>
<td>14,588</td>
<td>15,181</td>
</tr>
<tr>
<td>Statewide</td>
<td>9,036</td>
<td>10,814</td>
<td>9,470</td>
<td>17,009</td>
<td>19,321</td>
</tr>
</tbody>
</table>
High-Risk Obstetrics (HROB)

The Health Plan CMART has a total of ten program type choices. Not all plans have all ten programs; however, all plans offer the HROB program. This section describes the HROB population served by the plans and the population’s health outcomes. The HROB care management program is different from the other program types, because there is a definitive closure day to each person’s time in the program (either the birth of the child or two weeks after the birth). In this section, measures are based on women who were referred to an HROB care management group and numbers and percentages are based on a rolling three years. For this report, 2013-2015 data is included.

The HROB care management program is not included in the counts, percentages, or rates in any other section of this Report.

Table 14 shows the distribution of HROB pregnancies across the plans by enrollment. The percentage contacted is the number of pregnancies for which the mothers were successfully contacted divided by the total number of pregnancies triggered during the calendar year. The percentage enrolled is the number of pregnancies for which the mothers enrolled in care management services divided by the total number successfully contacted.

Table 14: High-risk pregnancies triggered, contacted, and enrolled in HROB care management services for each health plan

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Triggered Preg.</th>
<th>Contacted N</th>
<th>Contacted %</th>
<th>Enrolled N</th>
<th>Enrolled %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>2,381</td>
<td>1,334</td>
<td>56</td>
<td>818</td>
<td>61</td>
</tr>
<tr>
<td>CDPHP</td>
<td>631</td>
<td>418</td>
<td>66</td>
<td>372</td>
<td>89</td>
</tr>
<tr>
<td>Empire BlueCross BlueShield Health Plus</td>
<td>2,979</td>
<td>1,859</td>
<td>62</td>
<td>1,211</td>
<td>65</td>
</tr>
<tr>
<td>Excellus BlueCross BlueShield</td>
<td>1,812</td>
<td>1,134</td>
<td>63</td>
<td>602</td>
<td>53</td>
</tr>
<tr>
<td>Fidelis Care New York, Inc.</td>
<td>1,605</td>
<td>1,021</td>
<td>64</td>
<td>220</td>
<td>22</td>
</tr>
<tr>
<td>HealthFirst PHSP</td>
<td>19,666</td>
<td>5,414</td>
<td>28</td>
<td>5,343</td>
<td>99</td>
</tr>
<tr>
<td>HealthNow New York Inc.</td>
<td>362</td>
<td>350</td>
<td>97</td>
<td>349</td>
<td>100</td>
</tr>
<tr>
<td>HIP (EmblemHealth)</td>
<td>2,993</td>
<td>2,487</td>
<td>83</td>
<td>918</td>
<td>37</td>
</tr>
<tr>
<td>Independent Health's MediSource</td>
<td>2,632</td>
<td>1,919</td>
<td>73</td>
<td>1,909</td>
<td>99</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>1,486</td>
<td>1,378</td>
<td>93</td>
<td>1,341</td>
<td>97</td>
</tr>
<tr>
<td>Molina Healthcare</td>
<td>124</td>
<td>84</td>
<td>68</td>
<td>63</td>
<td>75</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>2,319</td>
<td>1,248</td>
<td>54</td>
<td>800</td>
<td>64</td>
</tr>
<tr>
<td>UnitedHealthCare Community Plan</td>
<td>2,716</td>
<td>1,567</td>
<td>58</td>
<td>1,567</td>
<td>100</td>
</tr>
<tr>
<td>WellCare of New York</td>
<td>219</td>
<td>197</td>
<td>90</td>
<td>196</td>
<td>99</td>
</tr>
<tr>
<td>YourCare Health Plan</td>
<td>529</td>
<td>444</td>
<td>84</td>
<td>402</td>
<td>91</td>
</tr>
<tr>
<td>Statewide</td>
<td>42,454</td>
<td>20,854</td>
<td>49</td>
<td>16,111</td>
<td>77</td>
</tr>
</tbody>
</table>
Although CMART provides basic demographic information about the mothers, it does not provide any demographic data about the infants. The CMART data is matched to the Vital Statistics Birth file to provide additional information on the mother and infant.

Table 15 shows the maternal demographics and other characteristics for members who triggered compared to those who enrolled in HROB care management services during the measurement year.

**Table 15: HROB Maternal Demographics and Characteristics**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Triggered</th>
<th>Enrolled Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Place of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>21,772</td>
<td>51</td>
</tr>
<tr>
<td>Other</td>
<td>20,682</td>
<td>49</td>
</tr>
<tr>
<td>Region of NYS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>965</td>
<td>2</td>
</tr>
<tr>
<td>Hudson Valley</td>
<td>1,743</td>
<td>4</td>
</tr>
<tr>
<td>Long Island</td>
<td>4,426</td>
<td>11</td>
</tr>
<tr>
<td>Northeast</td>
<td>661</td>
<td>2</td>
</tr>
<tr>
<td>NYC</td>
<td>27,556</td>
<td>66</td>
</tr>
<tr>
<td>Western</td>
<td>6,371</td>
<td>15</td>
</tr>
<tr>
<td>Aid Category</td>
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<td></td>
</tr>
<tr>
<td>FHP</td>
<td>1,418</td>
<td>3</td>
</tr>
<tr>
<td>SSI</td>
<td>982</td>
<td>2</td>
</tr>
<tr>
<td>TANF</td>
<td>40,008</td>
<td>94</td>
</tr>
<tr>
<td>Education Level</td>
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<td></td>
</tr>
<tr>
<td>Not HS Graduate</td>
<td>12,781</td>
<td>30</td>
</tr>
<tr>
<td>HS Graduate</td>
<td>13,350</td>
<td>31</td>
</tr>
<tr>
<td>College</td>
<td>16,100</td>
<td>38</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 18 Years</td>
<td>852</td>
<td>2</td>
</tr>
<tr>
<td>18 - 19 Years</td>
<td>1,749</td>
<td>4</td>
</tr>
<tr>
<td>20 - 29 Years</td>
<td>22,354</td>
<td>53</td>
</tr>
<tr>
<td>&gt; 29 Years</td>
<td>17,499</td>
<td>41</td>
</tr>
<tr>
<td>Race</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>13,738</td>
<td>32</td>
</tr>
<tr>
<td>Black</td>
<td>10,249</td>
<td>24</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3,790</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>14,677</td>
<td>35</td>
</tr>
</tbody>
</table>
## Table 15 (Cont.): HROB Maternal Demographics and Characteristics

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Triggered</th>
<th></th>
<th>Enrolled Only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%*</td>
<td>N</td>
<td>%*</td>
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<tr>
<td>CRG Group</td>
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<tr>
<td>Healthy</td>
<td>9,721</td>
<td>23</td>
<td>3,389</td>
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<tr>
<td>Stable</td>
<td>11,136</td>
<td>26</td>
<td>4,317</td>
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<tr>
<td>Simple Chronic</td>
<td>12,086</td>
<td>28</td>
<td>4,925</td>
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<tr>
<td>Complex Chronic</td>
<td>9,026</td>
<td>21</td>
<td>4,155</td>
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<td>Critical/HIV</td>
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<td>241</td>
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<td>Diabetes</td>
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<td>1,669</td>
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<td>Hypertension</td>
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<td>985</td>
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<td>Characteristics</td>
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<tr>
<td>High-Risk Referral</td>
<td>3,274</td>
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<td>1,503</td>
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<td>Hospitalized during Pregnancy</td>
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<td>1,179</td>
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<tr>
<td>Number Previous Pregnancies</td>
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<tr>
<td>0</td>
<td>10,881</td>
<td>26</td>
<td>4,075</td>
<td>24</td>
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<tr>
<td>1 - 2</td>
<td>18,561</td>
<td>44</td>
<td>7,469</td>
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<tr>
<td>3 - 4</td>
<td>8,394</td>
<td>20</td>
<td>3,552</td>
<td>21</td>
</tr>
<tr>
<td>5 +</td>
<td>4,618</td>
<td>11</td>
<td>1,931</td>
<td>11</td>
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*: Category % may not sum to 100% because of missing data
Table 16 reports demographic data for infants born to the women triggering and enrolling in HROB care management.

Table 16: Infant Demographics and Characteristics

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<thead>
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<th>Demographic</th>
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<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
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</tr>
<tr>
<td>Female</td>
<td>21,540</td>
<td>49</td>
<td>8,759</td>
<td>49</td>
</tr>
<tr>
<td>Male</td>
<td>22,270</td>
<td>51</td>
<td>9,085</td>
<td>51</td>
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<tr>
<td><strong>Gestational Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 33 weeks</td>
<td>1,408</td>
<td>3</td>
<td>639</td>
<td>4</td>
</tr>
<tr>
<td>33 - 35 weeks</td>
<td>2,260</td>
<td>5</td>
<td>1,024</td>
<td>6</td>
</tr>
<tr>
<td>36 - 38 weeks</td>
<td>13,083</td>
<td>30</td>
<td>5,645</td>
<td>32</td>
</tr>
<tr>
<td>39 + weeks</td>
<td>27,060</td>
<td>62</td>
<td>10,537</td>
<td>59</td>
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<tr>
<td><strong>NICU Use</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>6,436</td>
<td>15</td>
<td>2,767</td>
<td>16</td>
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<tr>
<td><strong>Birthweight</strong></td>
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<tr>
<td>Very Low Birthweight</td>
<td>968</td>
<td>2</td>
<td>440</td>
<td>2</td>
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<tr>
<td>Low Birthweight</td>
<td>3,990</td>
<td>9</td>
<td>1,736</td>
<td>10</td>
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<tr>
<td>Large for Gestational Age</td>
<td>2,630</td>
<td>6</td>
<td>1,127</td>
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<tr>
<td>Macrosomia</td>
<td>2,887</td>
<td>7</td>
<td>1,185</td>
<td>7</td>
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<tr>
<td><strong>Modified Kessner Index</strong></td>
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<tr>
<td>Intensive</td>
<td>4,996</td>
<td>11</td>
<td>2,211</td>
<td>12</td>
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<tr>
<td>Adequate</td>
<td>23,174</td>
<td>53</td>
<td>9,614</td>
<td>54</td>
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<tr>
<td>Intermediate</td>
<td>11,317</td>
<td>26</td>
<td>4,506</td>
<td>25</td>
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<tr>
<td>Inadequate</td>
<td>2,930</td>
<td>7</td>
<td>931</td>
<td>5</td>
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<tr>
<td>No Care</td>
<td>150</td>
<td>0</td>
<td>47</td>
<td>0</td>
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<tr>
<td>Missing</td>
<td>1,067</td>
<td>2</td>
<td>471</td>
<td>3</td>
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<tr>
<td><strong>Statewide</strong></td>
<td>43,811</td>
<td></td>
<td>17,845</td>
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</tr>
</tbody>
</table>

* Adequacy of prenatal care is defined in terms of timing and quantity of prenatal visits, adjusted for gestation length.

Note: Demographic groups may not total the Statewide total due to missing data.
The amount of time the women are in the HROB program is an important piece of the high-risk pregnancy care management program. The shorter the time the woman is enrolled in the HROB care management program, the less time there is to provide interventions that could increase positive outcomes.

Table 17 shows the number and percentage of time women are enrolled in the HROB program prior to delivery. The percentage of mothers who were triggered and enrolled after the infant was born were most likely members of a mom and infant oriented care management program that occurs during the first two weeks of the infants' lives.

Table 17: Time in Care Management to Delivery

<table>
<thead>
<tr>
<th>Length of Time Before Delivery</th>
<th>Enrolled Only</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
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<tr>
<td>More than 8 Months</td>
<td>46</td>
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</tr>
<tr>
<td>8 Months</td>
<td>664</td>
<td>4</td>
</tr>
<tr>
<td>7 Months</td>
<td>2,047</td>
<td>11</td>
</tr>
<tr>
<td>6 Months</td>
<td>2,538</td>
<td>14</td>
</tr>
<tr>
<td>5 Months</td>
<td>2,770</td>
<td>16</td>
</tr>
<tr>
<td>4 Months</td>
<td>2,650</td>
<td>15</td>
</tr>
<tr>
<td>3 Months</td>
<td>2,695</td>
<td>15</td>
</tr>
<tr>
<td>2 Months</td>
<td>2,005</td>
<td>11</td>
</tr>
<tr>
<td>1 Month</td>
<td>1,318</td>
<td>7</td>
</tr>
<tr>
<td>Same Day Delivery</td>
<td>82</td>
<td>0</td>
</tr>
<tr>
<td>After Delivery</td>
<td>1,030</td>
<td>6</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Number of Months</td>
<td>3.6</td>
<td></td>
</tr>
</tbody>
</table>
Appendix

Quality Measures

Improving Preventive Care

Adult BMI Assessment (ABA): Percent of members, with an outpatient visit, who had their BMI documented during the measurement year or the year prior to the measurement year.

Breast Cancer Screening (BCS): Percent of women who had one or more mammograms to screen for breast cancer at any time two years prior up through the measurement year.

Cervical Cancer Screening (CCS): Percent of women, who had cervical cytology performed every 3 years or who had cervical cytology/human papillomavirus co-testing performed every 5 years.

Chlamydia Screening (CHL): Percent of sexually active young women who had at least one test for Chlamydia during the measurement year.

Colorectal Cancer Screening (COL): Percent of adults who had appropriate screening for colorectal cancer during the measurement year.

Improving Disease-related Care for Chronic Conditions

Comprehensive Diabetes Care - HbA1c Test (CDC): The percent of members with diabetes who received at least one Hemoglobin A1c (HbA1c) test within the year.

HIV/AIDS Comprehensive Care - Syphilis Screening: The percent of members with HIV/AIDS who were screened for syphilis in the past year.

HIV/AIDS Comprehensive Care - Viral Load Monitoring: The percent of members with HIV/AIDS who had two viral load tests performed with at least one test during each half of the past year.

HIV/AIDS Comprehensive Care - Engaged in Care: The percent of members with HIV/AIDS who had two visits for primary care or HIV-related care with at least one visit during each half of the past year.

Medication Management for People with Asthma - 50% Days covered (MMA): The percent of members with persistent asthma who filled prescriptions for asthma controller medications during at least 50% of their treatment period.
Medication Management for People with Asthma - 75% Days covered (MMA): The percent of members with persistent asthma who filled prescriptions for asthma controller medications during at least 75% of their treatment period.

Improving Outcomes for Persons with Mental Illness

Antidepressant Medication Management - Acute Phase (84 days) (AMM): The percent of members who remained on antidepressant medication during the entire 12-week acute treatment phase.

Antidepressant Medication Management - Continuation Phase (180 days) (AMM): The percent of members who remained on antidepressant medication for at least six months.

Follow Up After Hospitalization for Mental Illness - 7 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge.

Follow Up After Hospitalization for Mental Illness - 30 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge.

Improving Outcomes for Persons with Substance Use Disorders

Initiation of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment within 14 days of the diagnosis.

Engagement of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Prevention Quality Indicators; Reducing Avoidable Hospitalizations

Diabetes Short-Term Complications Admission Rate (PQI #1): Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population; excludes obstetric admissions.
Diabetes Long-Term Complications Admission Rate (PQI #3): Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 population; excludes obstetric admissions.

COPD or Asthma in Older Adults Admission Rate (PQI #5): Admissions with a principal diagnosis of COPD or asthma per 100,000 population, ages 40 and older; excludes obstetric admissions.

Hypertension Admission Rate (PQI #7): Admissions with a principal diagnosis of hypertension per 100,000 population; excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, and obstetric admissions.

Heart Failure Admission Rate (PQI #8): Admissions with a principal diagnosis of heart failure per 100,000 population; excludes cardiac procedure admissions and obstetric admissions.

Dehydration Admission Rate (PQI #10): Admissions with a principal diagnosis of dehydration per 100,000 population; excludes obstetric admissions.

Bacterial Pneumonia Admission Rate (PQI #11): Admissions with a principal diagnosis of bacterial pneumonia per 100,000 population; excludes sickle cell or hemoglobin-5 admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Urinary Tract Infection Admission Rate (PQI #12): Admissions with a principal diagnosis of urinary tract infection per 100,000 population; excludes kidney or urinary tract disorder admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Uncontrolled Diabetes Admission Rate (PQI #14): Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population; excludes obstetric admissions.

Asthma in Younger Adults Admission Rate (PQI #15): Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years; excludes
admissions with an indication of cystic fibrosis or anomalies of the respiratory system and obstetric admissions.

**Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16):**
Admissions for any-listed diagnosis of diabetes and any-listed procedure of lower-extremity amputation per 100,000 population; excludes any-listed diagnosis of traumatic lower-extremity amputation admissions, toe amputation admissions, and obstetric admissions.

**Reducing Utilization Associated with Avoidable IP stays and ED visits**

**Ambulatory Care - Emergency Department (AMB-ED):** Utilization of ambulatory care ED visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

**Ambulatory Care - Outpatient (AMB-OP):** Utilization of ambulatory care OP visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

**Inpatient Utilization (IPU):** Utilization of total acute inpatient stays per 1,000 member years. Does not include mental health- or chemical dependency-related inpatient stays.
### Mainstream Plan Covered Counties

<table>
<thead>
<tr>
<th>Counties in NYS each Mainstream plan cover</th>
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<tbody>
<tr>
<td><strong>Affinity Health Plan</strong></td>
</tr>
<tr>
<td>Bronx</td>
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<tr>
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<td>Schenectady</td>
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<table>
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<td>Seneca</td>
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<td>Counties in NYS each Mainstream plan cover (continued)</td>
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<td>Queens</td>
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