NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
OFFICE OF QUALITY AND PATIENT SAFETY

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

AFFINITY HEALTH PLAN, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

ALOS:	*Average Length of Stay*
AO:	*Area Office*
CFR:	*Code of Federal Regulations*
CHP:	*Child Health Plus*
CMS:	*Centers for Medicare and Medicaid Services*
COM:	*Commercial*
DBA:	*Doing Business As*
EQR:	*External Quality Review*
EQRO:	*External Quality Review Organization*
F/A:	*Failed Audit*
FAR:	*Final Audit Report*
FFS:	*Fee-For-Service*
FIDA:	*Fully Integrated Duals Advantage*
FTE:	*Full Time Equivalent*
HARP:	*Health and Recovery Plan*
HCS:	*Health Commerce System*
HEDIS:	*Healthcare Effectiveness Data and Information Set*
HIE:	*Health Information Exchange*
HIT:	*Health Information Technology*
HMO:	*Health Maintenance Organization*
HPN:	*Health Provider Network*
MAP:	*Medicaid Advantage Plus*
MCD:	*Medicaid*
MCO:	*Managed Care Organization*
MLTC:	*Managed Long-Term Care*
MMC:	*Medicaid Managed Care*
MMCOR:	*Medicaid Managed Care Operating Report*
MRT:	*Medicaid Redesign Team*
MY:	*Measurement Year*
N:	*Denominator*
N/A:	*Not Available*
NCQA:	*National Committee for Quality Assurance*
NP:	*Not Provided*
NR:	*Not Reported*
NV:	*Not Valid*
NYC:	*New York City*
NYCRR:	*New York Code of Rules and Regulations*
NYS:	*New York State*
NYSDOH:	*New York State Department of Health*
OB/GYN:	*Obstetrician/Gynecologist*
OHIP:	*Office of Health Insurance Programs*
OPMC:	*Office of Professional Medical Conduct*
OP:	*Optimal Practitioner Contact*
OQPS:	*Office of Quality and Patient Safety*
PCP:	*Primary Care Practitioner/Provider*
PHSP:	*Prepaid Health Services Plan*
PIP:	*Performance Improvement Project*
PIHP:	*Prepaid Inpatient Health Plan*
PNDS:	*Provider Network Data System*
POC:	*Plan of Corrective Action*
PMPY:	*Per Member Per Year*
PTMY:	*Per Thousand Member Years*
PQI:	*Prevention Quality Indicator*
Q1:	*First Quarter (Jan.—March)*
Q2:	*Second Quarter (Apr.—June)*
Q3:	*Third Quarter (July—Sept.)*
Q4:	*Fourth Quarter (Oct.—Dec.)*
QARR:	*Quality Assurance Reporting Requirements*
ROS:	*Rest of State*
RY:	*Reporting Year*
SN:	*Safety Net*
SOD:	*Statement of Deficiency*
SS:	*Small Sample (less than 30)*
SSI:	*Supplemental Security Income*
SWA:	*Statewide Average*
TANF:	*Temporary Aid to Needy Families*
TR:	*Technical Report*
UR:	*Utilization Review*

I. About This Report

Purpose of This Report

In order to comply with federal regulations, the New York State Department of Health (NYSDOH) contracts with Island Peer Review Organization (IPRO) to conduct the annual External Quality Review (EQR) of the MCOs certified to provide Medicaid coverage in New York State (NYS). NYS is dedicated to providing and maintaining the highest quality of care for enrollees in managed care organizations. The NYSDOH's Office of Health Insurance Programs (OHIP), and Office of Quality and Patient Safety (OQPS) collaboratively employ an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans, and to maintain the continuity of care to the public.

Structure of This Report

This report is organized into the following domains: MCO Corporate Profile, Enrollment and Provider Network, Utilization, Performance Indicators, Health Information Technology, and Structure and Operation Standards . Although the technical reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP) and Commercial product lines. The CHP product line is the NYS version of the federal Child Health Insurance Program (CHIP), which provides health coverage to eligible children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. CHP data are part of the Medicaid managed care data sets used in this report. For some measures, including QARR 2019 (MY 2018), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section VIII of this report provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's report. The MCO was given the opportunity to describe current or proposed interventions that address areas of concern, as well as an opportunity to explain areas the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. Where trending is desirable, data for prior years may also be included. This report includes data for Reporting Year 2018.

II. MCO Corporate Profile

Affinity Health Plan, Inc. (Affinity), formerly known as The Bronx Health Plan, is a regional, not-for-profit prepaid health services plan (PHSP). In January 2002, The Bronx Health Plan merged with Genesis Health Plan and the corporate name was changed to Affinity Health Plan. Affinity serves Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

Affinity Web Page: https://www.affinityplan.org/

*Participating Regions and Products			
New York City:	MCD	CHP	HARP
Long Island:	MCD	CHP	HARP
Hudson Valley[1]:	MCD	CHP	HARP

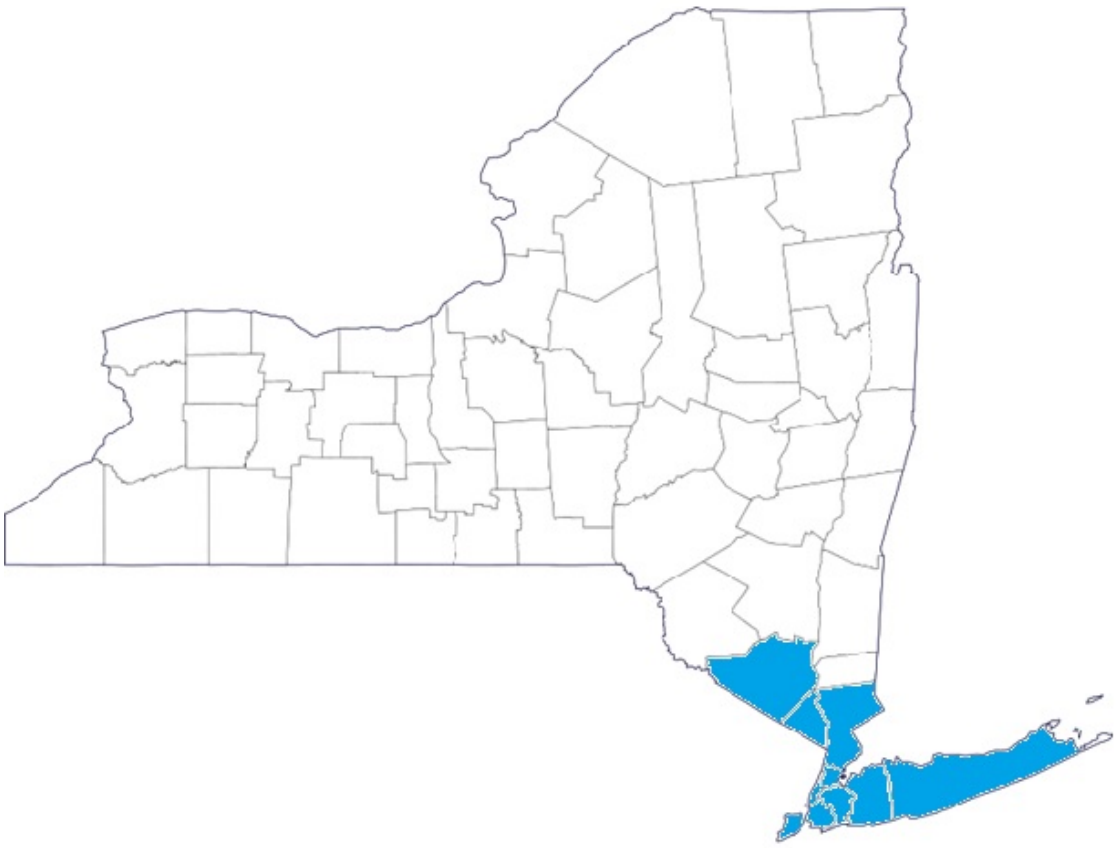
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

Region	Counties
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tomkins
Hudson Valley	Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
Long Island	Nassau, Suffolk
Northeast	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
New York City	Bronx, Kings, New York, Queens, Richmond
Western	Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates

[1] Affinity participates in Orange, Rockland and Westchester counties only.

Figure 1: Affinity Map of Participating Counties



III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has decreased from 2017 to 2018 by a rate of 6.9%. Affinity membership represents 4.6% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	228,823	219,160	204,017
% Change from Previous Year	-9.6%	-4.2%	-6.9%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	5.3%	5.0%	4.6%

Data Source: NYS OHIP Medicaid DataMart

[1] The statewide totals include MCOs that were operational during the measurement year, but did not have enough members to report sufficient data.

Table 2: Enrollment in Other Product Lines—2016-2018

	2016	2017	2018
CHP	12,383	13,391	13,837

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: Affinity Enrollment Trends—All Product Lines

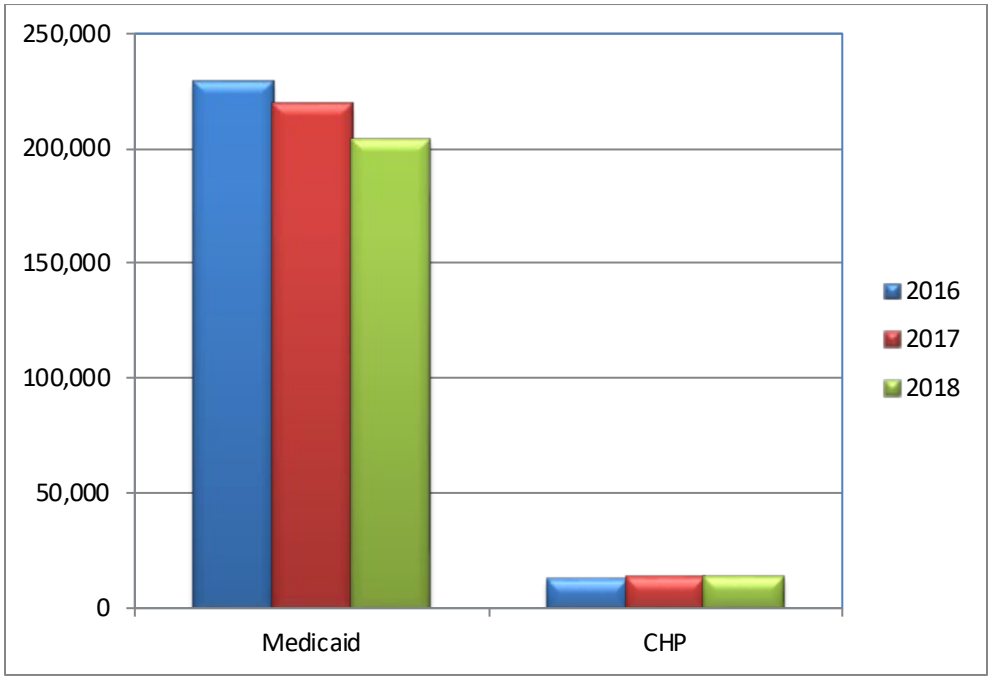


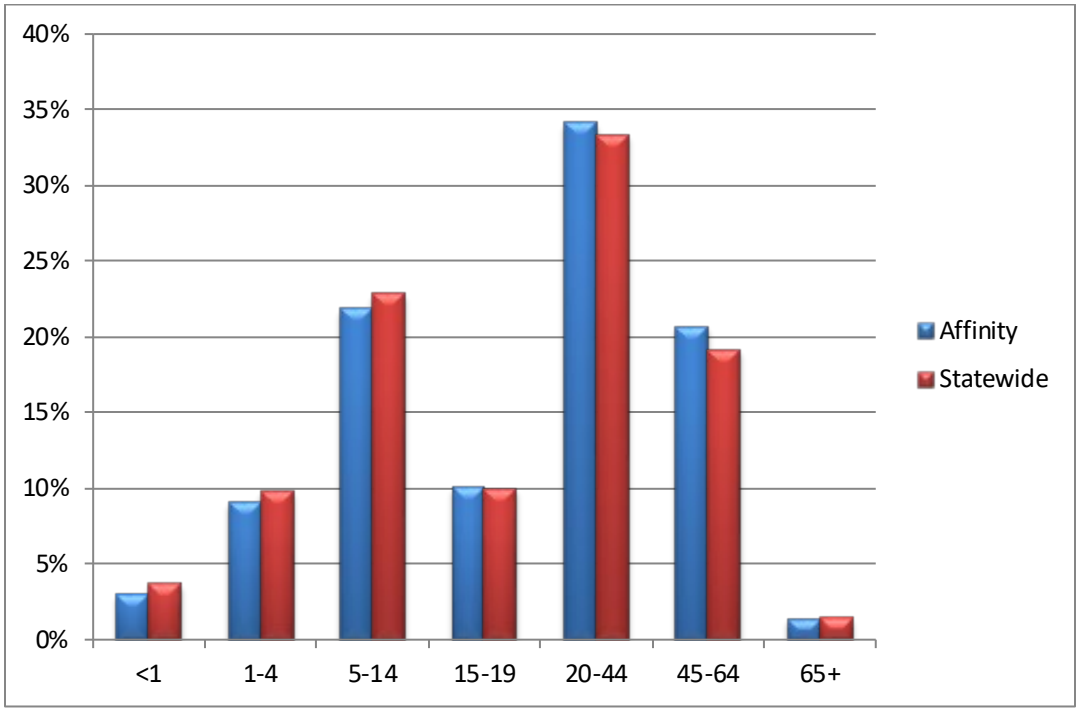
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. 20-44 year olds are the largest age group in Affinity's Medicaid membership.

Table 3: Medicaid Membership Age and Gender Distribution—December 2018

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	3,077	2,967	6,044	3.0% ▼	3.6%
1-4	9,332	9,026	18,358	9.1%	9.7%
5-14	22,098	22,098	44,196	21.8%	22.8%
15-19	10,381	9,882	20,263	10.0%	9.9%
20-44	28,577	40,404	68,981	34.1%	33.3%
45-64	18,809	22,987	41,796	20.7%	19.1%
65 and Over	1,004	1,744	2,748	1.4%	1.4%
Total	**93,278**	**109,108**	**202,386**		
Under 20	44,888	49,973	88,861	43.9%	46.1%
Females 15-64		73,273		36.2%	34.7%

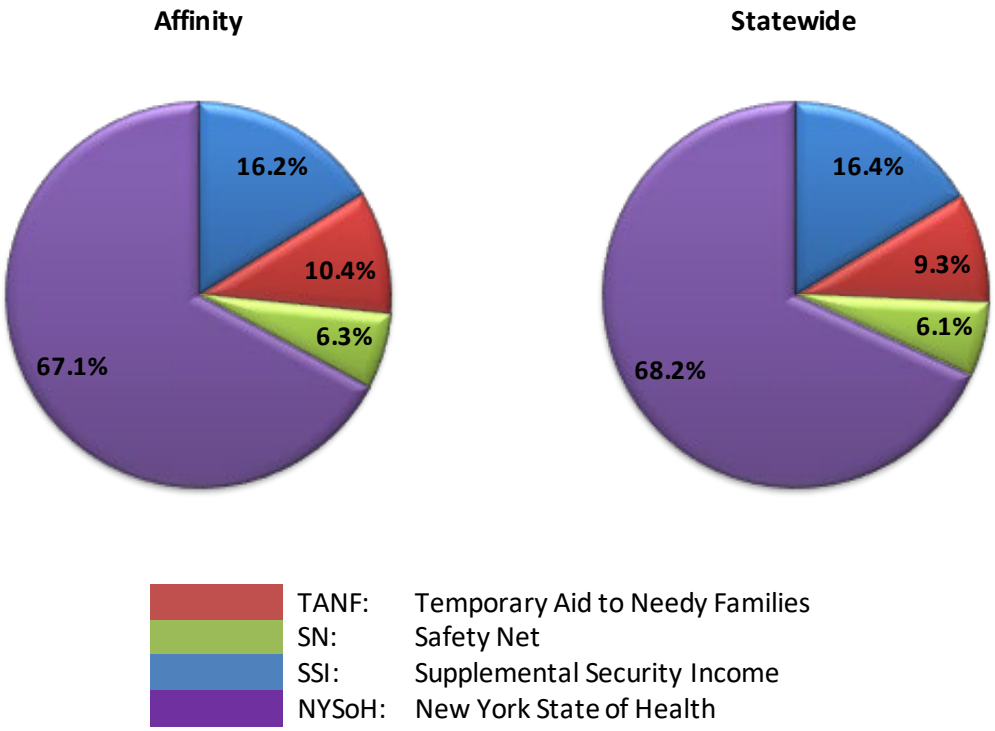
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



A breakdown of MCO membership by aid category, as reported by the NYSDOH for December 31, 2018, is shown in **Figure 4**.

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

This section of the report examines the MCO's provider network through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey. This section also includes an overview of network adequacy standards.

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. In 2018, Affinity performed well with rates above the statewide averages for all provider types. For detailed information regarding board certification of providers, please see the *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[2].

Table 4: HEDIS®/QARR Board Certification Rates—2016-2018

Provider Type	2016		2017		2018	
	Affinity	Statewide Average	Affinity	Statewide Average	Affinity	Statewide Average
			Medicaid/CHP			
Family Medicine	73%	71%	65% ▼	72%	86% ▲	74%
Internal Medicine	68% ▼	75%	66% ▼	76%	87% ▲	76%
Pediatricians	70% ▼	78%	70% ▼	79%	91% ▲	80%
OB/GYN	58% ▼	75%	64% ▼	77%	86% ▲	80%
Geriatricians	58%	63%	64%	63%	81% ▲	63%
Other Physician Specialists	69% ▼	75%	70% ▼	76%	86% ▲	77%

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. Other Specialties was the largest provider type in Affinity's Medicaid provider panel.

Table 5: Medicaid Providers by Specialty—2018 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	6,178	16.6%	19.5%
Pediatrics	1,559	4.2%	3.8%
Family Practice	1,133	3.0%	3.5%
Internal Medicine	2,698	7.2%	8.4%
Other PCPs	788	2.1%	3.8%
OB/GYN Specialty[1]	1,714	4.6%	3.8%
Behavioral Health	7,598	20.4%	17.2%
Other Specialties	15,943	42.8%	46.0%
Non-PCP Nurse Practitioners	2,812	7.5%	8.7%
Dentistry	3,008	8.1%	4.9%
Total	**37,253**		

Data Source: NYS Provider Network Data System (PNDS)

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

[2] *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations* https://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/

Table 6 displays the ratio of enrollees to providers, as well as the number of Full Time Equivalents (FTEs), and the ratio of enrollees to FTEs for the fourth quarter of 2018. Statewide data are also included. For this table, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Table 6: Ratio of Enrollees to Medicaid Providers—2018 (4th Quarter)

	Affinity			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	33:1	4,834	42:1	42:1	80,986	42:1
Pediatrics (Under age 20)	57:1			70:1		
OB/GYN (Females age 15-64)	43:1			59:1		
Behavioral Health	27:1			73:1		

Data Source: Derived ratios calculated from NYS OHIP Medicaid DataMart and NYS Provider Network Data System (PNDS).

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

The number of Medicaid PCPs with an "Open Panel" is presented in **Table 7** for the fourth quarters of 2016 through 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼. Affinity had 100% of PCPs with an Open Panel for 3 consecutive years.

Table 7: Medicaid PCPs with an Open Panel—2016-2018 (4th Quarter)

	2016			2017			2018		
	Affinity		Statewide	Affinity		Statewide	Affinity		Statewide
	Number	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**
Medicaid									
Providers with Open Panel	5,099	100.0% ▲	85.0%	6,241	100.0%	95.7%	6,124	100.0%	90.8%

Data Source: NYS Provider Network Data System (PNDS)

Primary Care and OB/GYN Access and Availability Survey—2018

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Primary Care and OB/GYN Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid Managed Care (MMC) Contract. The survey evaluates the availability of routine and non-urgent "sick" office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after-hours access.

Section 15.2 of the MMC Contract outlines the timeliness standards for various types of services. For routine office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(vi) states *"Routine, non-urgent, preventive appointments … within four (4) weeks of request."* For non-urgent "sick" office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(v) states that appointments must be scheduled *"…within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated."* Note that the timeliness standard for these types of appointments excludes weekends and holidays. The timeliness standard for prenatal appointments with OB/GYN providers is stated in Section 15.2(a)(ix) as follows: *"… within three (3) weeks during the first trimester, within two (2) weeks during the second trimester, and within one (1) week during the third trimester."*

As noted previously, the Survey also assesses MCO compliance with standards for after-hours access. Section 15.3 of the Contract outlines requirements for providers for 24-hour access to care for members. Section 15.3(a) states *"The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour, seven (7) days a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends."* The Contract also states, in Section 15.3(b), that MCOs can satisfy this requirement *"… by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after-hours "on-call" telephone resources to members with medical problems."* For the purposes of the Survey, after-hours access is considered compliant if a "live voice" representing the named provider is reached, or if the provider's beeper number is reached.

For call type categories in which compliance is below the 75% threshold, MCOs will receive a Statement of Deficiency (SOD) issued by the NYSDOH and will be required to develop a Plan of Correction (POC). These POCs must be approved by the NYSDOH before implementation. Following an allowable time period for MCOs to execute their POCs, a resurvey of the failed providers is conducted.

Table 8: displays the Affinity provider participation rate. The total number of providers surveyed (or sample size) is based on MCO Medicaid enrollment size and provider network size. The total number of compliant providers is the number of providers that will be included in the Appointment Availability and After-Hours Access Survey.

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
100	83	**83%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 81 providers (total number of providers who were compliant for participation (83), less total number of providers with closed panels (2)). Affinity performed above the threshold for Routine and Non-Urgent call types.

Table 9: Appointment Availability and After-Hours Access Rates — 2018

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	10	10	100.0%
	Pediatrician	12	12	100.0%
	OB/GYN	9	9	100.0%
	Total Routine	**31**	**31**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	11	11	100.0%
	Pediatrician	8	8	100.0%
	OB/GYN	6	6	100.0%
	Total Non-Urgent	**25**	**25**	**100.0%**
After-Hours Access	Internist/Family Practitioner	6	3	50.0%
	Pediatrician	11	6	54.5%
	OB/GYN	8	4	50.0%
	Total After-Hours	**25**	**13**	**52.0%**

[1]Timeliness was not considered when determining appointment availability rates.

IV. Utilization

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

Encounter Data

Table 10 depicts selected Medicaid encounter data for 2016 through 2018. Rates for this period are also compared to the statewide averages. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	Affinity	Statewide Average	Affinity	Statewide Average	Affinity	Statewide Average
PCPs and OB/GYNs	3.62	3.85	3.57	3.56	3.71	3.50
Specialty	2.33	2.45	2.31	2.30	2.33	2.33
Emergency Room	0.50	0.54	0.51	0.55	0.53	0.53
Inpatient Admissions	0.15	0.14	0.15	0.14	0.14	0.13
Dental	0.87	1.03	0.85	1.02	0.87	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a)(ii) of the Medicaid Managed Care Model Contract, MCOs must make reasonable efforts to contact new enrollees within 30 days of enrollment, either in person, by telephone, or by mail, and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 11** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2016 through 2018, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. The MCO's rates have decreased from 2016 to 2018.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	Affinity	SWA	Affinity	SWA	Affinity	SWA
	Medicaid					
Enrollee Health Screenings	14.9%	12.5%	1.7%	12.7%	2.0% ▼	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). From 2016 to 2018, the MCO's rates for *Outpatient Utilization (PTMY)* and *Inpatient Utilization (ALOS)* have trended upwards and the rates for *Inpatient Utilization (Discharges)* have trended downwards.

Table 12: QARR Use of Services Rates—2016-2018

Measure	Medicaid/CHP			
	2016	2017	2018	2018 Statewide Average
Outpatient Utilization (PTMY)				
Visits	4,939	4,904	5,203	5,317
ER Visits	565	503	494	492
Inpatient Utilization (ALOS)				
Medicine	4.2	4.0	4.6	4.5
Surgery	7.1	7.1	7.8	7.0
Maternity	3.0 ▲	3.0	3.1	2.9
Total	4.3	4.2	4.7	4.4
Inpatient Utilization (Discharges)				
Medicine Cases	34	32	24	30
Surgery Cases	13	12	11	12
Maternity Cases	33	33	28	32
Total Cases	71	68	55	66

PTMY: Per Thousand Member Years
ER: Emergency Room
ALOS: Average Length of Stay

V. Performance Indicators

To measure the quality, accessibility, and timeliness of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of performance indicators. This section is a summary of findings from those reports, including HEDIS®/QARR 2018 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

The NYS EQRO provided technical assistance to MCOs throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new MCOs, 3) serving as a liaison between the MCOs and NCQA to clarify questions regarding measure specifications, and 4) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® Final Audit Report (FAR) prepared for Affinity indicated that the MCO had no significant issues in any areas related to reporting. Affinity demonstrated compliance with all areas of Information Systems and all areas of Measure Determination required for successful HEDIS® reporting. The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well.

Affinity used NCQA-certified software to produce its HEDIS® rates. Supplemental databases that were used to capture additional data were validated and determined to be HEDIS®-compliant by the auditors. No issues were identified with the transfer or mapping of the data elements required for reporting.

HEDIS®/QARR Performance Measures

For Reporting Year (RY) 2018, performance measures were organized into the following domains:

- Effectiveness of Care
  - Prevention and Screening
  - Acute and Chronic Care
  - Behavioral Health
- Utilization
- Access to Care

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[3]

Quality Indicators

This section of the report explores the quality of health care services provided by the MCOs. Performance in the Effectiveness of Care domain is examined.

[3] Additional information on the Performance Indicators/Measures is reported in the *2018 External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*.

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO has shown an improvement in prevention and screening measures.

Table 13a: HEDIS®/QARR MCO Performance Rates 2016-2018-Effectiveness of Care: Prevention and Screening[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	66 ▼	89	96 ▲	**89**
WCC—BMI Percentile	59 ▼	83	84	**86**
WCC—Counseling for Nutrition	59 ▼	80	81	**83**
WCC—Counseling for Physical Activity	40 ▼	72	76	**74**
Childhood Immunizations—Combo 3	70 ▼	77	81 ▲	**73**
Lead Screening in Children	87	90	91	**89**
Adolescent Immunizations—Combo 2[2]		49 ▲	42	**43**
Adolescents—Alcohol and Other Drug Use[3]	45 ▼	71	88 ▲	**70**
Adolescents—Depression[3]	41 ▼	65	88 ▲	**67**
Adolescents—Sexual Activity[3]	42 ▼	70	67	**67**
Adolescents—Tobacco Use[3]	45 ▼	75	89 ▲	**74**
Breast Cancer Screening	69 ▼	68 ▼	69 ▼	**71**
Colorectal Cancer Screening	55	61	65	**63**
Chlamydia Screening (Ages 16-24)	77 ▲	77 ▲	79 ▲	**76**

Note: Rows shaded in grey indicate that the measure is not required to be reported

BMI: Body Mass Index; WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; COPD: Chronic Obstructive Pulmonary Disease

[1] All measures included in this table are HEDIS® measures, unless noted otherwise.

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2018, *Combination 2* is reported, as it includes the HPV component.

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). While Affinity's rates have trended upwards for most measures, the plan has 25% of their rates below the SWA in 2018.

Table 13b: HEDIS®/QARR MCO Performance Rates 2016-2018—Effectiveness of Care: Acute and Chronic Care[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	84 ▼	86 ▼	89 ▼	**91**
Spirometry Testing for COPD	45 ▼	50	54	**56**
Use of Imaging Studies for Low Back Pain	72 ▼	75	77	**77**
Pharmacotherapy Management for COPD—Bronchodilators	82	91	93	**88**
Pharmacotherapy Management for COPD—Corticosteroids	68	80	75	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	68	66	66 ▼	**70**
Medication Management for People with Asthma 50% (Ages 5-18)	49 ▼	49 ▼	50 ▼	**59**
Asthma Medication Ratio (Ages 19-64)	54	50 ▼	51 ▼	**60**
Asthma Medication Ratio (Ages 5-18)	59 ▼	53 ▼	69	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	83	76	70	**79**
CDC—HbA1c Testing	90	91	99 ▲	**92**
CDC—HbA1c Control (<8%)	51 ▼	52 ▼	57	**60**
CDC—Eye Exam Performed	53 ▼	63	80 ▲	**67**
CDC—Nephropathy Monitor	90	90	91	**92**
CDC—BP Controlled (<140/90 mm Hg)	38 ▼	54 ▼	59 ▼	**66**
Drug Therapy for Rheumatoid Arthritis	83	83	84	**83**
Monitor Patients on Persistent Medications—Total Rate	91 ▼	92	91	**91**
Appropriate Treatment for URI	94	96 ▲	96 ▲	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	37 ▲	45 ▲	45 ▲	**36**
HIV Viral Load Suppression[2,3]	76	78	77	**77**
Flu Shots for Adults (Ages 18-64)[4]	45	44		
Advising Smokers to Quit[4]	68	85		
Smoking Cessation Medications[4]	49	54		
Smoking Cessation Strategies[4]	44	46		

Note: Rows shaded in grey indicate that the measure is not required to be reported.

COPD: Chronic Obstructive Pulmonary Disease; CDC: Comprehensive Diabetes Care; BP: Blood Pressure; URI: Upper Respiratory Infection

[1] All measures included in this table are HEDIS® measures, unless otherwise noted.

[2] NYS-specific measure.

[3] The *HIV Viral Load Suppression* measure was introduced in Reporting Year 2016.

[4] CAHPS® measure.

Behavioral Health

This section examines the health care services the MCO provided to members with behavioral health conditions through performance on several HEDIS®/QARR Behavioral Health measures. The table below describes the measures included in this domain.

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Affinity has shown improvement in 8 out of 9 behavioral health measures.

Table 13c: HEDIS®/QARR MCO Performance Rates 2016-2018—Behavioral Health[1]

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	49	50	50	**53**
Antidepressant Medication Management—Effective Continuation Phase	35	34 ▼	35	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	63	63	74 ▲	**59**
Follow-Up Care for Children on ADHD Medication—Continue	73	75	83 ▲	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	71 ▼	70 ▼	78 ▲	**73**
Follow-Up After Hospitalization for Mental Illness—7 Days	53 ▼	52 ▼	65	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	79	79	81	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	71 ▼	79	83	**80**
Antipsychotic Medications for Schizophrenia	62	62	65	**63**

ADHD: Attention Deficit/Hyperactivity Disorder

[1] All measures included in this table are HEDIS® measures.

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."* Performance indicators related to Utilization and Access to Care are included in this section.[4]

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Affinity has shown improvement in rates for all 3 measures.

Table 14a: HEDIS®/QARR MCO Performance Rates 2016-2018—Utilization[1]

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	80 ▲	83 ▲	88 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	79 ▼	82 ▼	86	**86**
Adolescent Well-Care Visits	66 ▼	64 ▼	70 ▲	**68**

[1] All measures included in this table are HEDIS® measures.

[4] Additional information on Access/Timeliness indicators are reported in the *2018 External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*.

Access to Care

The HEDIS®/QARR Access to Care measures examine the percentage of children and adults who access certain services, including preventive services, prenatal and postpartum care, and dental services.

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). Affinity had rates below the SWA for 80% of the age groups in the *Children and Adolescents' Access to PCPs.* The MCO also had rates below the SWA for 100% of the age groups in the *Adults' Access to Preventative/Ambulatory Services.* Affinity showed an improvement in the measures related to *Access to Other Services.*

Table 14b: HEDIS®/QARR MCO Performance Rates 2016-2018—Access to Care[1]

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	97	96	97	**97**
25 Months-6 Years	90 ▼	91 ▼	93 ▼	**94**
7-11 Years	93 ▼	93 ▼	96 ▼	**96**
12-19 Years	93 ▼	93 ▼	94 ▼	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	80 ▼	78 ▼	76 ▼	**81**
45-64 Years	88 ▼	88 ▼	86 ▼	**89**
65+ Years	87 ▼	88 ▼	88 ▼	**91**
Access to Other Services				
Timeliness of Prenatal Care	88	92 ▲	87	**88**
Postpartum Care	68	68	75 ▲	**70**
Annual Dental Visit[2]	52 ▼	53 ▼	62 ▲	**60**

[1] All measures included in this table are HEDIS® measures.

[2] For the Annual Dental Visit measure, the Medicaid age group is 2-20 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 15** presents prenatal care rates calculated by the NYSDOH for QARR 2015 through 2017 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15 QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	Affinity	Regional Average	Affinity	Regional Average	Affinity	Regional Average
			NYC			
Risk-Adjusted Low Birth Weight[1]	5%	6%	6%	6%	-	-
Prenatal Care in the First Trimester	72% ▼	75%	73% ▼	76%	73% ▼	75%
Risk-Adjusted Primary Cesarean Delivery[1]	15%	14%	15%	14%	-	-
Vaginal Birth After Cesarean	11% ▼	18%	11% ▼	18%		
			ROS			
Risk-Adjusted Low Birth Weight[1]	7%	7%	8%	7%	-	-
Prenatal Care in the First Trimester	77%	74%	76%	74%	77%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	15%	14%	14%	13%	-	-
Vaginal Birth After Cesarean	12%	14%	12%	14%	-	-

Note: Some of the 2017 rates were not available at the time of the report.

NYC: New York City; ROS: Rest of State

[1] A low rate is desirable for this measure.

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). The MCO's rates have trended upwards for 67% of the measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	Affinity	Statewide Average	Affinity	Statewide Average	Affinity	Statewide Average
			Medicaid			
Getting Care Needed[1]	79	**83**	80	**85**	88	**84**
Getting Care Quickly[1]	84	**87**	87	**88**	90	**88**
Customer Service[1]	84	**82**	83	**86**	88	**86**
Coordination of Care[1]	76	**74**	69	**74**	78	**75**
Collaborative Decision Making[1]	52	**53**	67 ▼	**74**	64 ▼	**76**
Rating of Personal Doctor[1]	90	**89**	90	**98**	90	**90**
Rating of Specialist	75	**80**	80	**84**	86	**84**
Rating of Healthcare	83	**85**	85	**85**	85	**87**
Satisfaction with Provider Communication[1]	90	**93**	94	**94**	94	**93**
Rating of Counseling/Treatment	54	**64**	72	**68**	80	**69**
Rating of Health Plan—High Users	88	**84**	74 ▼	**85**	82	**84**
Overall Rating of Health Plan	86	**85**	84	**85**	85	**85**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

Table 17 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Utilization and Access to Care measures reported annually in the New York State Managed Care Plan Performance Report. Thirty-six measures were included for the Measurement Year (MY) 2018 Medicaid Quality Performance Matrix, which include combined measures for the Medicaid and CHP product lines. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid MCOs through a percentile ranking.

The Quality Performance Matrix is partitioned into cell categories (A-F). The cell category in which the measures are placed is determined by year-over-year performance on the horizontal axis, and an evaluation of the MCO's performance based on a percentile ranking, on the vertical axis. The percentile ranking is partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. For MY 2018, the MCO was required to follow up on no more than three measures from the D and F categories of the Matrix. If the MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow up.

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	**A** Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Monitoring Diabetes - Eye Exams Postpartum Care
No Change	**D** Antidepressant Medication Management-Effective Acute Phase Treatment Antidepressant Medication Management-Effective Continuation Phase Treatment Asthma Medication Ratio (Ages 5-64) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement of AOD - Total Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD - Total Managing Diabetes Outcomes - Poor HbA1C Control Medication Management for People with Asthma 50% Days Covered (Ages 5-64) Medication Management for People with Asthma 75% Days Covered (Ages 5-64) Statin Therapy for Patients with Cardiovascular Disease - Adherent Weight Assessment for Children and Adolescents - BMI Percentile Weight Assessment for Children and Adolescents - Counseling for Nutrition Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Timeliness of Prenatal Care Viral Load Suppression	**C** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Adolescent Immunization (Combo2) Annual Dental Visits (Ages 2-18) Breast Cancer Screening Cervical Cancer Screening Childhood Immunization Status (Combo 3) Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Colon Cancer Screening Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days Metabolic Monitoring for Children and Adolescents on Antipsychotics Use of Spirometry Testing in the Assessment and Diagnosis of COPD Weight Assessment for Children and Adolescents - Counseling for Physical Activity	**B** Controlling High Blood Pressure
↓	**F**	**D**	**C** Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)

Performance Improvement Project

As part of the external quality review responsibilities, IPRO assists the MCOs through many steps of the Performance Improvement Project (PIP) process. The contract between the NYSDOH and the MCOs instructs the MCOs to conduct at least one PIP each year. The PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: 1) measurement of performance using objective quality indicators, 2) implementation of interventions to achieve improvement in the access to and quality of care, and 3) evaluation of the effectiveness of interventions based on the performance measures.

The purpose of a PIP is to assess and improve the processes and outcomes of the health care provided by an MCO. Protocol 3 of CMS' Federal Regulation 42 CFR §438, subpart E specifies procedures for EQROs to use in assessing the validity and reliability of a PIP. Protocol 3 describes how to conduct the following activities: assessment of study methodology, verification of study findings, and evaluation of overall reliability and validity of study results. The results of the PIPs are available on the CMS Medicaid website and in the EQR technical report. States may incorporate specific PIPs as part of their State quality strategy, required by Section 1932(c)(1) of the Social Security Act, to align with the HHS National Quality Strategy for Quality Improvement in Health Care.

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may be categorized as infrequent conditions or services, and also exist for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special needs place them at high risk. The State may select the MCO's study topic(s), or topics may be selected based on enrollee input. While MCOs have the option to select a study topic of their choosing, they are encouraged to participate collaboratively with other MCOs in conducting their PIPs. In Report Year 2018, the common-themed two-year PIP that was chosen was Perinatal Care and Pre-term Births.

The NYS EQRO provided technical assistance to the MCOs throughout the PIP process in the following forms: 1) review of the MCO's Project Proposal prior to the start of the PIP; 2) quarterly teleconferences with the MCO for progress updates and problem-solving; 3) providing feedback on methodology, data collection tools, and implementation of interventions; and 4) feedback on drafts of the MCO's final report.

In addition, the NYS EQRO validated the MCO's PIP by reviewing the project topic, aim statement, performance indicators, study population, sampling methods (if sampling was used), data collection procedures, data analysis, and interpretation of project results, as well as assessing the MCO's improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCO is likely to be able to sustain its documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among the validation teams. The validation process concluded with a summary of strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of PIP results was at risk.

In 2018, Affinity continued with the PIP topic *"Improving Perinatal Care and Reducing Preterm Births for Affinity Health Plan's Medicaid Population"*. The following interventions were implemented:

Member-Focused Interventions:

- Optum's OB Homecare services will administer 17p to members and provide ongoing case management for members to ensure the continued use of 17p. Optum is the MCO's current case management vendor.
- Optum provides telephonic outreach to all pregnant members to invite them to be part of their Healthy Beginnings program.
- Publication of articles on the MCO's blog addressing prenatal and postpartum depression, smoking cessation techniques, and preconception care, as well as the importance of continued 17p treatment.
- Promotion of the NYS Smokers' Quitline and provision of instructions on how to access their counseling program. Members received added support through the Quitline partnership with the MCO's Smoking Cessation program.

Provider-Focused Interventions:

- Optum nurses conducted telephonic and on-site outreach to high volume OB providers who were not presently utilizing Optum's home and case management services. Literature and referral forms were shared during the meetings.
- Clinical quality consultants provide face-to-face education meetings with providers to reinforce the information provided through gaps in care reports and completed assessments.
- Optum educated providers on the importance of 17p treatment and the availability of home therapy for members.
- Provision of a prenatal care toolkit including coding information, clinical practice guidelines, best practices, PHQ-9 depression screening tool, gaps in care reports, HEDIS® technical specifications, and member prenatal care educational resources through email and on-site visits.
- Optum distributes copies of the initial assessments with associated providers to ensure documentation is stored in the members' charts and reinforce importance of depression screening during provider education discussions.

MCO-Focused Interventions:

- Identification of members who are pregnant and have had a previous preterm birth.
- Review claims data and medical records quarterly to assess rates of depression screenings.
- Review monthly depression screenings and follow up using tracking methods.
- Screening for depression is conducted for each new program member during the initial assessment with members.
- Members who screened positive for depression were referred to Beacon Health Strategies for follow up.
- Affinity case manages the members who opt out of joining the Optum program.

Table 18 presents a summary of Affinity's 2017-2018 PIP. Affinity demonstrated an improvement for all but one indicator.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	88%	87%	10% Increase	Performance declined
Postpartum Care	68%	75%	2% Increase	Demonstrated improvement
Received at least one 17P injection	61%*	83%**	2% Increase	Demonstrated improvement
Depression Screening	57%*	100%**	5% Increase	Demonstrated improvement
Tobacco Screening	74%*	100%**	5% Increase	Demonstrated improvement
Tobacco Screening Follow-Up	40%*	0%**	5% Increase	Performance level was maintained from Interim to Final
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	2%	7%	2% Increase	Demonstrated improvement
Age 15-20 years; within 60 days	21%	33%	2% Increase	Demonstrated improvement
Age 21-44 years; within 3 days	3%	7%	2% Increase	Demonstrated improvement
Age 21-44 years; within 60 days	18%	34%	2% Increase	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	1%	8%	2% Increase	Demonstrated improvement
Age 15-20 years; within 60 days	11%	21%	2% Increase	Demonstrated improvement
Age 21-44 years; within 3 days	2%	7%	2% Increase	Demonstrated improvement
Age 21-44 years; within 60 days	8%	18%	2% Increase	Demonstrated improvement

* Baseline numerators and denominators of four measures, reported by Optum and Beacon, were not available. These rates were calculated plan-wide, and not limited to case management.

**Members from high-risk case management program.

Health Disparities

For this year's technical report, the NYS EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

1. Characterization, identification, or analysis of the MCO's Medicaid population according to at-risk characteristics.
2. Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
3. Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
4. Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
5. Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

Affinity did not report on activities that were performed in 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.

VI. Health Information Technology

According to the US Department of Health & Human Services, health information technology (HIT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT will improve health care quality, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.

In 2018, the NYS EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

- Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
- Use of telecommunications technologies
- Use of Electronic Health Records (EHR)
- Use of electronic internal registries
- Use of clinical risk group (CRG) or similar software
- Secure electronic transfer of member data between the MCO, its vendors, and network providers
- Electronic communication with providers
- Electronic communication with members
- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)[5]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

Table 19 displays the statewide results of the HIT survey. Of the thirteen MCOs who responded to the survey, 100% utilized secure electronic transfer of member data between the MCO, its vendors, and/or network providers. Additionally, 100% of MCOs utilized electronic communication with providers and secure electronic transfer of PHI to patients and/or providers. Some of the other forms of HIT utilized by the majority of MCOs include telecommunications technologies, Electronic Health Records (EHR), and use of clinical risk group (CRG) or similar software. In addition, 77% of MCOs reported future plans to implement HIT.

Table 19: MCO Use of Health Information Technology—2018 Survey of NYS MCOs

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Electronic communication with providers	100%
Secure electronic transfer of protected health information to patients and/or providers	100%
Future plans to implement HIT	77%
Use of clinical risk group (CRG) or similar software	100%
Use of telecommunications technologies	100%

[5] Regional Health Information Organizations/Health Information Exchanges are organizations that exist to enable interoperable health information exchange through governance and collaboration with an overall mission to improve health care quality and safety, and reduce costs.

Health Information Technology	% of MCOs Reporting Use
Use of Electronic Health Records (EHR)	92%
Electronic communication with members	100%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	69%
Participation in a medical home pilot or program	46%
Use of electronic internal registries	46%
Participation in State, Federal or privately funded HIT initiatives	46%

Note: IHA and Affinity did not provide responses to the 2018 HIT questionnaire and therefore are not included in results.

Affinity did not report on any HIT-related activities in 2018.

VII. Structure and Operation Standards

This section of the report examines deficiencies identified by the NYSDOH in operational and focused surveys as part of the EQRO's evaluation of the MCO's compliance with State structure and operation standards.

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO with Article 44 of the Public Health Law and Part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in **Table 21**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO was not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers, adverse determination utilization review files, complaints and grievances files, meeting minutes, and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys". The NYSDOH retains the option to deem compliance with standards for credentialing/ re-credentialing, quality assurance/improvement, and medical record review.

The Monitoring Review Report documents any data obtained and deficiencies cited in the survey tools. Any statements of deficiencies (SODs) are submitted to the MCO after the monitoring review, and the MCO is required to respond with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and MCOs are required to resubmit. Ultimately, all MCOs with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the MCOs to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of compliance with structure and operation standards. The focused review types are summarized in **Table 20**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 21 reflects the total number of citations for the most current operational survey of the MCO, if applicable, as well as from focused reviews conducted in 2018. This table reflects the findings from reviews of the MCO as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can result in multiple citations.

For the focused reviews, Affinity was in compliance with 13 of the 14 categories. The category in which Affinity was not compliant was Organization and Management (5 citations). For the operational survey, Affinity was in compliance with 11 of the 14 categories. The categories in which Affinity was not compliant were Member services (1 citation), Organization and Management (1 citation), and Service Delivery Network (5 citations).

Table 20: Focused Review Types

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

AO: Area Office; HCS: Health Commerce System; MEDS: Medicaid Encounter Data Set; SOD: Statement of Deficiency; QARR: Quality Assurance Reporting Requirements

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Type	
Complaints and Grievances	0	0		
Credentialing	0	0		
Disclosure	0	0		
Family Planning	0	0		
HIV	0	0		
Management Information Systems	0	0		
Medicaid Contract	0	0		
Medical Records	0	0		
Member Services	1	0		
Organization and Management	1	5	Contracts	2
			Behavioral Health Claims	*3*
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	5	0		
Utilization Review	0	0		
Total	**7**	**5**		

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, Affinity had 41% of external appeals overturned and 3% were overturned in part.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	120	47	61
Overturned in Part	15	3	4
Upheld	198	81	82
Medicaid Total	**333**	**131**	**147**
		CHP	
Overturned	0	0	1
Overturned in Part	0	0	0
Upheld	0	1	1
CHP Total	**0**	**1**	**2**

VIII. Strengths and Opportunities for Improvement[6]

One of the purposes of this report is to identify strengths and opportunities for improvement, and make recommendations to help each MCO improve care delivery and health services. Understanding these strengths and weaknesses helps assess an organization's readiness to take on new tasks, identify initiatives that match the MCO's skills, and recognize areas where additional training or resources are necessary. IPRO references both current and past performance, trends, benchmarks, and comparisons, along with specific DOH goals and targets to make these determinations. Based on this evaluation, IPRO presents the DOH with a high-level commentary on the direction of each MCO's quality improvement programs and offers advice on facilitating positive change and further improving the care and services provided to enrollees of NYS Medicaid Managed Care. An assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths

An MCO's strengths are the valuable resources and capabilities it has developed or acquired over time, which are seen as distinguishing characteristics. An MCO significantly exceeding the national average for a measure would be considered a strength.

Strengths:

- In the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO continues to have a rate above the statewide average for the HEDIS®/QARR *Chlamydia Screening in Women (Ages 16-24)* measure. Additionally, the MCO had rates above the statewide average for 2018 in the following HEDIS®/QARR measures: *Adult BMI assessment, Childhood Immunizations-Combination 2, Adolescents-Depression, Sexual Activity, Tobacco Use* and *Alcohol and Other Drug Use*.
- Within the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain, the MCO's rates for *CDC HbA1c Testing* and *Eye Exam* has improved from 2017 and are above the statewide average for 2018. The MCO's rates remained above the statewide average for the *Appropriate Treatment for Children with Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*.
- The MCO's performance rates for behavioral health services has trended upwards demonstrating the MCO's effectiveness in providing services to members with behavioral health conditions. Notably, the HEDIS®/QARR rates for *Follow-Up Care for Children on ADHD Medication (Initiation and Continue)* and *Follow-Up After Hospitalization for Mental Illness-30 Days* are statistically above the statewide averages for 2018.
- In regard to the Access/Timeliness Indicators, the MCO's rate for HEDIS®/QARR *Well-Child Visits in the First 15 Months of Life—6+ Visits* has been reported above the statewide average for three consecutive reporting years, while the rates for *Adolescent Well-Care Visits, Postpartum Care* and *Annual Dental Visit* were above the statewide average for 2018.

[6] This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement", rather than "Strengths" and "Weaknesses", as indicated in federal regulations.

- In regard to the primary care and OB/GYN access and availability survey, the MCO performed well with an appointment rate of 100% for routine and non-urgent ("sick") appointments.

Opportunities for Improvement

An MCO's weaknesses are those resources or capabilities of an organization that are deficient and viewed as shortcomings in its ability or performance. IPRO identifies an organization's resource or capability as a weakness when that entity is not compliant with provisions of the NYS MMC Contract, federal and State regulations, or it performs substantially below both the DOHs' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS performance measure rate below the national average.

Opportunities for Improvement:

- In regards to new enrollee health screenings, the MCO has a reported rate of 2.0% which is below the statewide average for 2018.
- In the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO continues to demonstrate opportunities for improvement in the *Breast Cancer Screening*. The rates have been reported below the statewide average for at least three consecutive reporting years.
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO continues to demonstrate opportunities for improvement. The MCO's rate for *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18)* and *Appropriate Testing for Children with Pharyngitis* have been reported below the statewide average for at least three consecutive reporting years, while rates for *Medication Management for People with Asthma 50% of Days Covered (Ages 19-64), Asthma Medication Ratio (Ages 19-64), and Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* were reported below the statewide average for 2018.
- The MCO continues to demonstrate an opportunity for improvement in regard to the Access/Timeliness Indicators. The MCO's rates have been reported below the statewide average for at least three consecutive reporting periods for the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* measures: *25 Months-6 Years, 7-11 Years, 12-19 Years, 20-44 Years, 45-64 Years,* and *65+ Years*.
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 5 citations from the focused review surveys related to Organization and Management. The MCO received 7 citations from the operational review surveys related to Member Services, Organization and Management, and Service Delivery Network.
- There is an opportunity for improvement with member access to primary care and OB/GYN providers during after-hours. The MCO has a total appointment rate of 52.0% for after-hours access.
- The MCO should address the issues noted in the focused and operational review surveys. The areas Affinity received citations were in Organization and Management, Member services and Service Delivery Network.

Recommendations:

- With the MCO's appointment rate for primary care and OB/GYN providers during after-hours below the 75% threshold, Affinity should continue with the process of identifying providers who did not meet the necessary after-hours access and availability requirements. Affinity should continue the procedure of educating and monitoring the identified providers, as stated in the MCO's response to the 2017 recommendations. The MCO should also consider including reminders in existing provider communications on the importance of having after-hours availability.

- In regards to new enrollee health screenings, the MCO should make reasonable efforts to contact new enrollees within thirty (30) days of enrollment to conduct brief health screenings. This assists in determining if new members have special healthcare needs.
- With the MCO's rate for breast cancer screenings statistically worse than the statewide average, Affinity should conduct a root cause analysis to determine the reason this rate has not improved. Interventions should target the barriers of access to providers, member education and any social disparities regarding breast cancer screenings.
- Affinity demonstrates an opportunity to improve asthma care. The MCO should continue the asthma care (MMA 50%, AMR) intervention that includes a monthly robocall to members and informs providers of members who are behind in filling their prescriptions. The MCO should consider the use of pharmacists to educate members on the importance of refilling their prescriptions and providing assistance on how and when to use the medications. The MCO should also consider collaborating with a community based organization (CBO) that outreaches to members face-to-face to assist with asthma education.
- Although the rate for the *Comprehensive Diabetes Care – BP control* measure has trended upwards, the rates remained below the statewide average. Affinity should continue its interventions to improve this rate as it has shown to be effective with an increase from 38% in 2016 to 59% in 2018. The MCO should consider including the option for members to attend evidence based diabetes self-management programs.
- The MCO should continue to investigate reasons behind its continued poor performance in regard to measures related to access to primary and preventive care for children and adults. The MCO should conduct thorough, population-specific barrier analyses to determine factors preventing members from seeking or receiving care, such as transportation issues, lack of child care during appointment times, or any accessibility issues. Additionally, the MCO should consider examining these measures in terms of geographic areas, such as by county, to determine if some areas have more significant issues in order to target initiatives to drive improvement. [Repeat recommendation.]

Response to Previous Year's Recommendations:

The BBA, Section 42 CFR section 438.364(a)(5), states that the EQRO (IPRO) "must provide an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed MCO-specific recommendations from the RY2017 technical report. The following responses are taken directly from the MCO and are not edited for content.

- **2017 Recommendation:** As the MCO continues to struggle with several HEDIS®/QARR measures related to asthma care, diabetes care, and behavioral health follow-up care, the MCO should re-evaluate its current improvement strategy. As the MCO stated in its response to a previous recommendation, the current strategy seems to focus mainly on the accurate collection and reporting of data. While accurate reporting is a vital component of determining improvement, the MCO should consider a stronger focus on members and providers in order to effect changes. The MCO should develop and implement initiatives directed at educating and engaging members in their care, as well as ensuring providers are aware of current best practices and of their patients' needs. *[Repeat recommendation.]*

  MCO Response:

  Over the past two years, Affinity has made a strong commitment to ensuring that quality performance indicators are a true and accurate reflection of the Plan's (and its providers') ability to provide quality care to its members. The overall approach to achieving the Plan's' best performance in these key indicators has followed along three main tracks: 1. Ensuring comprehensive data acquisition and that data we have is

complete and accurate; (2) Improving provider engagement and; (3) Enhancing member outreach and engagement.

The first track (Data) was an extremely important milestone to accomplish first. Without an accurate accounting or view of performance throughout the year, Affinity could not rely on the results we were observing nor were we able to conduct effective performance improvement meetings with our providers because the rates we reported were always being questioned. Now that we have overcome the majority of our data issues, we've better positioned ourselves to enhancing member and provider engagement. Ensuring complete and accurate data, of course, will remain an ongoing and needed part of the overall quality strategy.

The subsequent tracks (Provider and Member Engagement) have been and continue to be the Plan's focus as of mid-2018. The specific interventions that have been developed, implemented and enhanced to improve performance are detailed below.

Asthma Care (MMA 50%, AMR):

- Monthly robocall outreach to members to remind them to refill their prescriptions.
- Monthly reports to providers of asthmatic members who are one month behind in filling their prescriptions.
- Monthly/Quarterly* Affinity-provider performance review meetings to develop individualized plans for improving performance.

**Frequency based on mutually agreed upon timeframes with provider partners.*

Diabetes (CDC-HbA1c Control, CDC-BP Control):

Data remains a large factor in why we've continued to struggle with performance in this area. The fact that the CBP measure was modified to allow for administrative collection of BPs has helped Affinity's performance in some way to improve dramatically.

- Modified the provider quality incentive program to incentivize for controlling A1C levels versus the previous years' incentive which paid for completion of the A1c test only; also included incentive for submitting lab result values via supplemental data—specifically two large hospital-based lab providers (Montefiore and NY Presbyterian).
- Monthly reports to providers of diabetic members who (1) have no record on an A1C test, or (2) have a reported A1C test, but no result value reported, or (3) have a reported high A1C test result. The monthly reports also include members who (1) have no record on a blood pressure, or (2) have a reported BP, but no BP reading reported, or (3) have a reported high BP reading.
- Affinity-provider performance review meetings to develop individualized plans for improving performance.

**Frequency based on mutually agreed upon timeframes with provider partners.*

Behavioral Health Follow-up (FUH 7/30 Days):

- Implemented a P4P/Incentive contract with 4 Health Homes, covering eight of Affinity's ten counties; the incentive is earned upon completion of a community visit with a member between the date of discharge and three days post-discharge with the intent of scheduling the 7-day follow up visit as well as getting the member connected to a Health Home.
- Implemented a member incentive which rewards a $25 gift card for completing the 7-day follow-up visit with a mental health practitioner.

- Increased the data exchange frequency with our behavioral health vendor (Beacon) from quarterly to monthly to allow for a more timely and comprehensive view of where members are accessing behavioral health services.
- Reconcile claims data with PSYCKES on a quarterly basis—instead of annually—for a more timely and accurate understanding of the gaps in care.
- Contracted with the Bronx RHIO to receive ED alerts across all counties served by Affinity. This started in May 2019 and was subsequently enhanced in October 2019 include Admit/Discharge/Transfer alerts for both ED and Inpatient.

As of the 2018 and 2019 reporting years, Affinity has shown significant improvement in these categories and will continue to enhance the member and provider engagement strategy to ensure the momentum is not lost.

- **2017 Recommendation:** The MCO should continue to investigate reasons behind its continued poor performance in regard to measures related to access to primary and preventive care for children and adults. The MCO should conduct thorough, population-specific barrier analyses to determine factors preventing members from seeking or receiving care, such as transportation issues, lack of child care during appointment times, or any accessibility issues. Additionally, the MCO should consider examining these measures in terms of geographic areas, such as by county, to determine if some areas have more significant issues in order to target initiatives to drive improvement. *[Repeat recommendation.]*

  MCO Response:
  As reported in the earlier section, a three-pronged strategy has guided Affinity to significantly improved quality performance over the past two years. Most significantly is the improvement in the Annual Dental Visit measure which is no doubt a result of a more committed and collaborative relationship between the Plan and its dental benefit vendor, DentaQuest.

  The specific interventions that have been developed, implemented and enhanced to improve performance for measures related to access to primary and preventive care for children and adults are detailed below.

  Children, Adolescent and Adult Access to Primary and Preventive Care
  - Including well-child visit and childhood/adolescent immunizations schedules within the post-partum packets that are mailed to all new mom's upon notification of live birth delivery.
  - Include annual wellness calendar in new member packets.
  - Implemented member incentive for completing an annual comprehensive wellness visit within the first 90 days of the year as well as a separate incentive for completing an annual Health Risk Assessment. The goal is to identify and address all health concerns during the initial stages of Plan enrollment and provide early case management and outreach interventions as appropriate.
  - Throughout the year, we incorporate important health messages on the outside of envelopes used for all member correspondence as a passive, yet effective reminder of the need to complete important health goals—like the annual comprehensive wellness visit.
  - Generating and mailing semi-annual member "gaps-in-care" report cards to remind all members of the care gaps that are still outstanding as well as the incentives that can be received upon completion.
  - Continuing to work with capitated primary care providers on submitting encounters/supplemental data for ALL visits performed for assigned members—whether separately reimbursable as part of their capitation or not.

- Implemented a standard electronic data exchange with two data aggregators directly working with 17 in-network FQHC's (approx. 40K member lives) and two large volume IPAs (approx. 30K member lives) to allow for timely, complete and accurate exchange of data directly sourced from their EMRs.

Annual Dental Visit:

- Instead of incentivizing primary care providers, incentivize members for completing their annual dental visit.
- Implemented with our dental vendor (DentaQuest) a dental provider quality incentive program to encourage improved performance throughout the year; additionally, members who had no evidence of a dental visit in 2 years were re-assigned from low-performing dental providers (with 2 years of sub-par performance) to high-performing dental providers within the DentaQuest network.

As of the 2018 and 2019 reporting years, Affinity has shown significant improvement in these categories and will continue to enhance the member and provider engagement strategy to ensure the momentum is not lost.

- **2017 Recommendation:** The MCO should take several steps toward addressing the issues noted in the focused review surveys. First, the MCO should re-train its Member Services staff to ensure all staff members are able to appropriately answer questions and address issues. Second, the MCO should ensure that all providers in its network are aware of access requirements and have appropriate after-hours access in place. Last, the MCO should continue to make concerted efforts toward improving the accuracy of information in provider directories, and that all information about provider sites is included. The MCO should systematically evaluate the effectiveness of its proposed online provider update process once initiated to ensure it is a useful tool for improving information accuracy. *[Repeat recommendation.]*

  MCO Response:
  Providers identified as not meeting the necessary After Hours Care, Access & Availability requirements were re-educated on the State regulations identified in the Model Contract. Affinity has also assigned an Internal Provider Services Representative responsible for monitoring throughout the year. Providers that fail are tracked and forwarded to the Account Manager for Provider Education. The Affinity procedure is summarized below:

  The surveys will be conducted quarterly by secret shopper call method.

  Once the samples are completed, based on results, Affinity may place provider(s) on a corrective action plan.

  If the provider passes, he/she will be removed until the next survey is conducted.

  Providers that fail survey:

  - Failed providers are immediately educated via telephone and referred to both their agreement and to the provider manual for access and availability standards.
  - The provider will be placed on an excel tracker for three consecutive months to be resurveyed each month.
  - Once provider passes, the provider will be removed until the next survey is conducted.
  - If the provider continues to fail the surveys, a site visit is conducted.

After the site visit, provider is referred to Affinity's Chief Medical Officer for possible termination where applicable.

With regard to Member Services, Affinity re-trained its member services representatives on various topics including the benefit packages as well as enrollment and disenrollment criteria. The Compliance Department will also conduct ad hoc secret shopper calls to ensure the member services are providing accurate responses.

Lastly, regarding the provider directory, in an effort to improve the quality of provider demographic information, Affinity created an online function which went live in May 2019 for Providers to submit a demographic change or update request for immediate resolution. This online functionality has helped to eliminate the delay or lag in demographic updates meeting a higher accuracy rate for provider mailings and outreach campaigns. We are also in the process of completing a reconciliation of our credentialing and claims systems to ensure all provider demographic data in both systems match.

IX. Appendix

References

A. MCO Corporate Profiles

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory
- NCQA Accreditation website, https://reportcards.ncqa.org

B. Enrollment and Provider Network

- *Enrollment:*
  - NYS OHIP Medicaid DataMart, 2018
  - NYSDOH OHIP Child Health Plus Program, 2018
- *Provider Network:*
  - NYS Provider Network Data System (PNDS), 2018
  - QARR Measurement Year 2018

C. Utilization

- *Encounter Data:*
  - NYS OHIP Medicaid DataMart, 2018
- *QARR Use of Services:*
  - QARR Measurement Year 2018

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
  - QARR Measurement Year 2018
- *CAHPS® 2018:*
  - QARR Measurement Year 2018
- *Performance Improvement Project:*
  - 2017-2018 PIP Reports

E. Structure and Operations

- MMC Operational Deficiencies by Plan/Category, 2018
- Focused Deficiencies by Plan/Survey Type/Category, 2018