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

EXTERNAL QUALITY REVIEW
ALL PLAN SUMMARY TECHNICAL REPORT FOR:
NEW YORK STATE
MEDICAID MANAGED CARE ORGANIZATIONS

Reporting Year 2018

FINAL REPORT

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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

The Centers for Medicare and Medicaid Services (CMS) require that states oversee Medicaid managed care organizations (MCOs) to ensure they are meeting the requirements set forth in the federal regulations that govern MCOs serving Medicaid recipients. State agencies must contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by MCOs. The EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that MCOs furnish to Medicaid recipients. CMS defines "quality" in Federal Regulation 42 CFR §438.320 as *"the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional knowledge, and through interventions for performance improvement."*

Components of Care: Quality, Access and Timeliness

Island Peer Review Organization (IPRO), New York State's (NYS) Medicaid EQRO, used 2018 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

- ***Quality*** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- ***Access*** is the timely use of personal health services to achieve the best possible health outcomes[1].
- ***Timeliness*** is the extent to which care and services, are provided within the periods required by the NYS Medicaid Managed Care (MMC) Contract, federal regulations, and as recommended by professional organizations and other evidence-based guidelines. Timely interventions improve the quality of care and services provided as well as enrollee and practitioner satisfaction. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of health care services.

In order to comply with federal regulations, the NYS Department of Health (NYSDOH) contracts with IPRO to conduct the annual EQR of the MCOs certified to provide Medicaid coverage in NYS. NYS is dedicated to providing and maintaining the highest quality of care for enrollees in MCOs. 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.

History of the New York State Medicaid Managed Care Program

The NYS Medicaid managed care program began in 1997 when NYS received approval from CMS to implement a mandatory Medicaid managed care program through a Section 1115 Waiver. Section 1115 waivers allow for "demonstration projects" to be implemented in states in order to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The NYS 1115 Waiver project began with several goals, including:

[1] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993. https://www.ncbi.nlm.nih.gov/books/NBK235882/

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

In 2011, the Governor of NYS established the Medicaid Redesign Team (MRT) with the goal of finding ways to lower Medicaid spending in NYS while maintaining a high quality of care. The MRT provided recommendations that were enacted, and the team continues to work toward its goals.

Scope of This Report

This report serves as an aggregate of the detailed information included in the MCO-specific technical reports. In accordance with federal regulations, these reports summarize the results of the 2018 EQR to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified survey vendor and other member surveys, such as the MLTC, HARP and DSME surveys. Technical assistance provided by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: MCO corporate profiles, enrollment data, provider network information, encounter data summaries PQI/compliance/satisfaction/, and deficiencies and citations summaries.

Structure of This Report

This report is organized into the following sections: MCO Corporate Profiles, Enrollment and Provider Network, Utilization, Performance Indicators, and Structure and Operation Standards. Although the technical reports focus primarily on Medicaid data, selected sections of the individual, MCO-specific 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 Children's 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 combined population of the Medicaid and CHP 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 the individual, MCO-specific technical reports provides an assessment of the MCOs' strengths and opportunities for improvement in the areas of access, timeliness, and quality of services. For areas in which the MCOs have opportunities for improvement, recommendations for improving the quality of the MCOs' health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCOs effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCOs were given the opportunity to describe current or proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCOs did not feel were within their ability to improve. The responses by the MCOs are appended to this section of the individual, MCO-specific reports.

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. This report includes data from Reporting Year 2018.

II. MCO Corporate Profiles

Table 1 on the following page displays an overview of each MCO's Corporate Profile. The table includes the dates the MCOs began their Medicaid managed care programs, the product lines each MCO carries, and the National Committee for Quality Assurance (NCQA) Accreditation rating each MCO received, where available. NCQA surveys health plans on various systems and processes and evaluates key dimensions of care and services provided by the MCOs. NCQA awards health plans a rating based on the survey results. The table below provides definitions of each rating the NCQA awards to health plans.

NCQA Accreditation Survey Key:	
Excellent	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS® results are in the highest range of national performance.
Commendable	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
Accredited	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
Provisional	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
Denied	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

Table 1: MCO Corporate Profiles

MCO	Medicaid Managed Care Start Date	Product Line(s)	NCQA Accreditation Rating[1] (as of 03/16/2020)
Affinity	10/09/1986	Medicaid, CHP, HARP	Unknown
BCBS WNY	08/01/1985	Medicaid, CHP, Commercial, Medicare	Medicaid – Expired Commercial - Commendable
CDPHP	04/30/1984	Medicaid, CHP, HARP, Commercial, Medicare	Commercial and Medicaid—Excellent
Empire BCBS HealthPlus	01/12/1996	Medicaid, CHP, HARP, MLTC	Medicaid - Commendable
Excellus	01/01/1998	Medicaid, CHP, HARP, Commercial, Medicare	Commercial and Medicaid - Commendable
Fidelis	11/03/1993	Medicaid, CHP, HARP, MLTC, Medicare	Medicaid - Accredited
Healthfirst	08/30/1994	Medicaid, CHP, HARP	Unknown
HIP	Prior to 1991	Medicaid, CHP, HARP, Commercial, MLTC, Medicare	Commercial—Accredited
IHA	07/01/1991	Medicaid, CHP, HARP, Commercial, Medicare	Commercial—Commendable
MetroPlus	06/15/1985	Medicaid, CHP, HARP	Unknown
Molina	10/16/2013	Medicaid, CHP, HARP	Unknown
MVP	08/01/1997	Medicaid, CHP, HARP, Commercial, Medicare	Commercial—Commendable
UHCCP	07/31/1987	Medicaid, CHP, HARP	Medicaid—Accredited
WellCare	02/12/1987	Medicaid, CHP	Medicaid—Commendable
YourCare	07/05/1996	Medicaid, CHP, HARP	Unknown

CHP: Child Health Plus; HARP: Health and Recovery Plan; FIDA: Fully Integrated Duals Advantage; MLTC: Managed Long-Term Care

[1]Please refer to the NCQA Accreditation Survey Key on the previous page for definitions of the Accreditation ratings. For more detail on the MCOs' Accreditation ratings, please see https://reportcards.ncqa.org/#/health-plans/list.

III. Enrollment and Provider Network

Enrollment

Table 2 depicts the total enrollment for the MCOs' Medicaid and CHP product lines for Calendar Years 2017 and 2018, as well as the percent change between 2017 and 2018. In 2018, 40% of MCOs had an increase in Medicaid enrollment. BCBS of WNY had the largest increase in Medicaid enrollment and YourCare had the largest decrease in 2018. In regards to CHP enrollment, 80% of MCOs had an increase in enrollment in 2018. HealthFirst had the largest increase for CHP enrollment.

Table 2: Medicaid and CHP Enrollment: 2017-2018

	Medicaid			CHP		
MCO	**2017**	**2018**	**% Change**	**2017**	**2018**	**% Change**
Affinity	219,160	204,017	-6.91	13,391	13,837	3.33
BCBS WNY	28,764	33,738	17.29	2,563	3,198	24.78
CDPHP	82,147	81,452	-0.85	12,987	13,057	0.54
Empire BCBS HealthPlus	346,593	323,073	-6.79	42,051	39,718	-5.55
Excellus	168,074	169,223	0.68	29,679	30,293	2.07
Fidelis	1,220,700	1,235,776	1.24	112,613	121,231	7.65
Healthfirst	921,471	925,998	0.49	40,650	51,285	26.16
HIP	141,780	130,406	-8.02	10,437	10,219	-2.09
IHA	59,212	55,109	-6.93	5,188	5,572	7.40
MetroPlus	377,045	366,732	-2.74	16,593	18,075	8.93
Molina	30,062	27,977	-6.94	1,104	837	-24.18
MVP	163,552	165,007	0.89	16,413	19,311	17.66
UHCCP	475,607	474,100	-0.32	47,484	52,355	10.26
WellCare	101,568	106,304	4.66	4,509	5,326	18.12
YourCare	41,143	37,731	-8.29	2,107	2,458	16.66
Statewide Total[1]	**4,378,153**	**4,336,643**	**-0.92**	**357,769**	**386,772**	**8.11**

Data Source: NYS OHIP Medicaid DataMart and NYSDOH OHIP Child Health Plus Program.

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

Table 3 gives a breakdown of the MCO's enrollment by age and gender as of December 31, 2018 for the Medicaid product line. Females are 53% of the total Medicaid membership. For both male and females, 20-44 year olds are the largest group within the Medicaid membership.

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

	Male							Female							
Plan Name	<1 Year	1-4 Years	5-14 Years	15-19 Years	20-44 Years	45-64 Years	65+ Years	<1 Year	1-4 Years	5-14 Years	15-19 Years	20-44 Years	45-64 Years	65+ Years	Total
Affinity	3,077	9,332	22,098	10,381	28,577	18,809	1,004	2,967	9,026	22,098	9,882	40,404	22,987	1,744	202,386
BCBS WNY	617	1,317	3,586	1,643	5,260	3,292	53	564	1,251	3,442	1,635	7,306	3,723	74	33,763
CDPHP	1,567	4,240	10,388	4,257	9,954	6,286	204	1,446	4,077	9,850	4,180	17,118	7,343	293	81,203
Empire BCBS HealthPlus	4,997	14,651	39,479	17,341	42,996	29,677	1,744	4,848	13,749	37,265	16,796	60,711	34,677	3,063	321,994
Excellus	3,155	8,814	21,917	8,698	21,529	12,527	206	3,187	8,301	20,800	8,744	36,015	14,672	336	168,901
Fidelis	23,599	61,215	139,328	58,886	183,486	109,804	5,883	22,556	58,833	132,786	57,622	239,680	125,193	8,892	1,227,763
Healthfirst	17,995	48,370	107,559	45,194	113,313	73,990	7,451	17,036	46,334	102,580	44,719	185,894	100,804	12,144	923,383
HIP	1,671	4,440	13,170	6,510	17,437	13,933	910	1,565	4,177	12,266	6,343	26,265	19,030	1,886	129,603
IHA	1,084	2,901	6,795	2,664	6,992	4,220	124	987	2,856	6,364	2,866	11,865	5,184	178	55,080
MetroPlus	6,684	18,774	47,780	20,860	47,184	31,093	2,146	6,247	17,973	46,030	19,923	63,533	32,696	3,705	364,628
Molina	529	1,513	4,005	1,634	3,165	1,929	79	496	1,467	3,710	1,546	5,550	2,223	95	27,941
MVP	3,523	9,186	22,552	8,852	18,904	11,485	282	3,461	8,759	21,334	8,663	32,260	15,076	562	164,899
UHCCP	9,998	24,649	52,107	22,968	74,096	43,532	2,017	9,531	23,411	49,509	22,474	86,919	48,839	3,255	473,305
WellCare	1,502	3,698	8,771	5,233	22,489	13,964	669	1,394	3,629	8,510	4,752	18,460	11,806	868	105,745
YourCare	596	1,841	4,782	2,039	4,646	3,173	82	590	1,708	4,539	1,936	7,849	3,812	108	37,701
Statewide Total	**80,594**	**214,941**	**504,317**	**217,160**	**600,028**	**377,714**	**22,854**	**76,875**	**205,551**	**481,083**	**212,081**	**839,829**	**448,065**	**37,203**	**4,318,295**

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

A breakdown of membership by aid category, as reported by the NYSDOH for December 31, 2018, is shown in **Table 4**. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼.

Table 4: Medicaid Enrollees by Aid Category—December 2018

	LDSS			
Plan Name	Temporary Aid for Needy Families	Safety Net	SSI	NYSoH
Affinity	16.2%	10.4%	6.3%	67.1%
BCBS WNY	14.4%	6.0%	10.5% ▲	69.1%
CDPHP	11.2%	2.3% ▼	8.6% ▲	77.9% ▲
Empire BCBS HealthPlus	6.9% ▼	3.6% ▼	4.3%	85.2% ▲
Excellus	15.2%	4.2% ▼	8.0%	72.6%
Fidelis	11.7%	7.1%	5.5%	75.7%
Healthfirst	19.8%	11.5%	6.7%	61.9%
HIP	20.8%	16.7% ▲	8.9% ▲	53.5% ▼
IHA	20.8%	5.4%	7.9%	65.9%
MetroPlus	23.9% ▲	11.5%	5.5%	59.1%
Molina	21.3%	4.6% ▼	11.0% ▲	63.1%
MVP	8.2% ▼	1.5% ▼	5.7%	84.6% ▲
UHCCP	16.4%	8.8%	4.3%	70.5%
WellCare	8.3% ▼	8.5%	4.7%	78.5% ▲
YourCare	19.6%	7.0%	8.7% ▲	64.7%
Statewide Average[1]	**16.4%**	**9.3%**	**6.1%**	**68.2%**

Data Source: NYS OHIP Medicaid DataMart
SSI: Supplemental Security Income
NYSoH: New York State of Health
[1]MCOs that were operational, but are no longer in business, are included in the statewide totals; however, they are not listed in the table.

Provider Network

This section of the report examines the MCOs' provider networks using HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey.

Network Adequacy Standards

In accordance with Federal Regulation 42 CFR §438.68, states that contract with MCOs are required to develop and enforce network adequacy standards, which include time and distance standards for various provider types within a provider network. These network adequacy standards must be developed with consideration of the anticipated number of Medicaid enrollees, the potential level of utilization of services, and the characteristics and health care needs of the population served. In order to comply with these requirements, NYS has developed access requirements for providers in an MCO's network within its contracts with the MCOs. Section 15 of the State's Medicaid Managed Care (MMC) Model Contract, defines access requirements for appointment availability standards, appointment wait times, and travel time and distance.

Section 15.1 of the Contract states *"The Contractor shall establish and implement mechanisms to ensure Participating Providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply."* In order to determine compliance with access standards, the NYSDOH uses several different methodologies.

Appointment Availability/Timeliness Standards

Appointment availability standards are outlined in Section 15.2 of the MMC Model Contract for various types of services, including, but not limited to, routine visits, urgent and emergency services, specialty care, and behavioral health. In order to monitor MCOs for compliance with appointment availability standards, the EQRO conducts the Primary Care and OB/GYN Access and Availability Survey, which is detailed in a subsequent section of this report. MCOs with rates of compliant providers below an established threshold must develop corrective action plans to address non-compliance.

The Model Contract also establishes standards for appointment wait times. Section 15.4 states *"Enrollees with appointments shall not routinely be made to wait longer than one hour."*

Travel Time and Distance Standards

With regard to travel time standards, the Contract defines time and distance standards for various provider types in Section 15.5. For primary care providers, Section 15.5(b)(i) of the Contract states *"Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Enrollee's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee's residence in non-metropolitan areas."* However, the Contract also states that the time/distance may exceed the established standard if the member chooses a provider outside that standard. Section 15.5(b)(ii) states *"Enrollees may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCPs themselves."*

For all other services, Section 15.5(c) states *"Travel time/distance to specialty care, hospitals, mental health, lab, and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence."* This section continues by stating that travel time/distance to these providers in rural areas *"…may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice."*

Table 5 shows the number of providers by various provider types in NYS Medicaid and each MCO's Medicaid product line for the fourth quarter of 2018. Other Specialties is 46% of the statewide total for Medicaid providers. Of the 46%, Fidelis has the largest number of Other Specialties in NYS. The provider type with the least number of providers is OB/GYNs, with 3.8% of the statewide total.

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

Plan Name	Primary Care Providers[1]	OB/GYN Specialty[2]	Behavioral Health	Other Specialties	Non-PCP Nurse Practitioners	Dentistry	Total
Affinity	6,178	1,714	7,598	15,943	2,812	3,008	37,253
BCBS WNY	968	314	675	3,769	1,643	293	7,662
CDPHP	3,084	547	1,963	6,796	1,364	219	13,973
Empire BCBS HealthPlus	5,204	1,878	4,067	20,542	3,294	1,873	36,858
Excellus	3,682	728	2,133	8,480	35	1,008	16,066
Fidelis	14,642	2,968	9,805	33,461	4,876	4,325	70,077
Healthfirst	5,682	1,879	3,831	20,414	3,517	3,192	38,515
HIP	6,549	1,658	5,375	14,331	1,810	3,328	33,051
IHA	856	217	312	3,506	847	405	6,143
MetroPlus	3929	758	5,363	7,058	252	1,812	19,172
Molina	193	58	142	824	306	277	1,800
MVP	4,379	953	5,237	11,651	2,423	1,110	25,753
UHCCP	11,286	2,914	6,230	28,881	6,225	3,015	58,551
WellCare	4,403	791	2,261	9,510	1,082	3,002	21,049
YourCare	3,209	642	517	4,210	977	612	10,167
Statewide Total[3]	25,277	4,949	22,209	59,508	11,241	6,285	129,469

Note: MCOs that were operational, but are no longer in business, are included in the statewide totals; however, they are not listed in the table.

Data Source: NYS Provider Network Data System (PNDS)

[1] Includes Family practice, general practice, internal medicine, PCP nurse practitioners and pediatrics.

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

[3] Totals include unique providers only.

Table 6 displays the ratio of enrollees to providers, as well as the ratio of enrollees to provider Full Time Equivalents (FTEs), for the MCOs' Medicaid product line. 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. In 2018, there were no MCOs with a rate below the statewide median. Molina had rates above the statewide median for all provider types.

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

	Ratio of Enrollees to Provider				
Plan Name	Primary Care Providers	Pediatrics (Under age 20)	OB/GYN (Females age 15-64)	Behavioral Health	Ratio of Enrollees to FTEs
Affinity	33 :1	57:1	43:1	27:1	42:1
BCBS WNY	35 :1	56:1	40:1	50:1	30:1
CDPHP	26 :1	67:1	52:1	41:1	32:1
Empire BCBS HealthPlus	62 :1	105:1	60:1	79:1	53:1
Excellus	46 :1	102:1	82:1	79:1	67:1
Fidelis	84 :1	164:1	142:1 ▲	125:1	110:1 ▲
Healthfirst	163 :1 ▲	251:1 ▲	176:1 ▲	241:1 ▲	167:1 ▲
HIP	20 :1	29:1	31:1	24:1	20:1
IHA	64 :1	116:1	92:1	177:1 ▲	53:1
MetroPlus	93 :1 ▲	199:1	153:1 ▲	68:1	128:1 ▲
Molina	145 :1 ▲	648:1 ▲	161:1 ▲	197:1 ▲	109:1 ▲
MVP	38 :1	70:1	59:1	31:1	36:1
UHCCP	42 :1	70:1	54:1	76:1	23:1
WellCare	24 :1	39:1	44:1	47:1	24:1
YourCare	12 :1	33:1	21:1	73:1	23:1
Statewide Median[1]	42 :1	70:1	59:1	73:1	42:1

Data Source: Derived ratios are 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 quarter of 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼. In 2018, 4 out of 15 MCOs had 100% of providers with an open panel. There were also 3 MCOs, Excellus, WellCare and YourCare which had rates below the statewide average.

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

	Number of PCPs with Open Panel	% of Providers
Plan Name	**Medicaid**	
Affinity	6,124	100.0%
BCBS WNY	925	100.0%
CDPHP	3,031	99.9%
Empire BCBS HealthPlus	5,071	100.0%
Excellus	526	14.7% ▼
Fidelis	8,461	58.6%
Healthfirst	5,311	94.7%
HIP	6,366	98.8%
IHA	512	61.8%
MetroPlus	3,867	98.6%
Molina	188	100.0%
MVP	3,663	86.1%
UHCCP	8,896	80.6%
WellCare	983	22.5% ▼
YourCare	864	27.6% ▼
Total Statewide	55,309	75.3%

Data Source: NYS Provider Network Data System (PNDS)

Board Certification

Board certification ensures physicians meet rigorous criteria. In order to maintain an "active" board certification, providers must have evidence of professional standing, commitment to lifelong learning and self-assessment, cognitive expertise, and evaluation of practice performance. The American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) member boards require participation in a program of ongoing maintenance of certification[2].

The quality of the providers participating in an organization's network has a significant effect on the overall quality of care delivered to members. As a result, purchasers and consumers want information that helps them assess the quality of an organization's physicians, though HEDIS® *Board Certification* does not directly measure the quality of every provider in an organization. The increased public needs to recredential physicians, and evidence that knowledge and skills of practicing physicians declines over time, motivated specialty boards to limit the duration of certification[3]. To date, all ABMS member boards have agreed to issue time-limited certificates that necessitate subsequent re-certification, usually at intervals of 10 years or less.

Board certification shows what percentage of the MCO's physicians have sought and obtained board certification. While there are valid reasons why physicians may not have done this, and board certification alone is not a guarantee of quality, certification provides a benchmark established by standardized, specialty-specific competency testing. HEDIS®/QARR *Board Certification* rates represent the percentage of physicians in the MCOs' provider networks that are board-certified in their specialty.

Table 8 displays HEDIS®/QARR *Board Certification* rates of providers in the MCOs' networks for 2018, as well as the statewide averages. The table also indicates whether the MCOs' rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. Pediatricians and OB/GYNs had the highest rates of board certification in NYS. Affinity had reported rates that were significantly above the statewide average for all provider types.

[2] American Board of Medical Specialties (ABMS). *The Meaning of Board Certification*. http://www.abms.org.

[3] Brennan, T.A., R.I. Horwitz, F.D. Duffy, C.K. Cassel, L.D. Goode, R.S. Lipner. 2004. "The Role of Physician Specialty Board Certification Status in the Quality Movement." *JAMA* 292 (9): 1038-43.

Table 8: HEDIS®/QARR Board Certification Rates—2018

MCO	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Affinity	86% ▲	87% ▲	91% ▲	86% ▲	81% ▲	86% ▲
BCBS WNY HealthNow	73%	75%	82%	82%	71%	82%
CDPHP	86%	80%	81%	73%	66%	79%
Empire BCBS HealthPlus[1]	36%	84%	85%	80%	54%	78%
Excellus	59% ▼	68% ▼	64% ▼	82%	68%	76%
Fidelis	84%	80%	85%	83%	61%	77%
Healthfirst	69%	74%	77%	70%	64%	77%
HIP	71%	72%	74%	73%	67%	74%
IHA	87%	73%	82%	80%	48%	85%
MetroPlus	69%	72%	75%	81%	65%	68%
Molina	91% ▲	84% ▲	81%	90%	*SS*	84% ▲
MVP[1]	81%	75%	80%	82%	70%	82%
UHCCP	73%	77%	80%	85% ▲	61%	80% ▲
WellCare	76%	73%	77%	70%	73%	65%
YourCare	83% ▲	75%	81%	73% ▼	57%	76%
Statewide Average	74%	76%	80%	80%	63%	77%

SS: Sample size too small to report (less than 30 providers), but included in the statewide average.
[1]Level of significance was unaudited in 2018.

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

On behalf of the NYSDOH OHIP'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 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 Medicaid Managed Care Contract outlines the timeliness standards for various types of services. For routine office hour appointments with primary care providers (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 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 week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends."* Section 15.3(b) of the Contract also states 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.

The validation of provider participation and the assessment of appointment availability are conducted during this survey of provider offices. The assessment of after-hours access requires a telephone call to provider offices during nonbusiness hours (7PM-7AM, 7 days a week) to determine that an after-hours protocol has been established by the provider.

MCO performance below the 75% threshold results in a NYSDOH-issued statement of deficiency and a requirement for the MCO to submit a plan of correction (POC) to the NYSDOH. POCs must be approved by the NYSDOH prior to implementation. Following an allowable time period for MCOs to execute their POCs, a resurvey of the failed providers is conducted.

Table 9 shows the MCOs' results of the 2018 Provider Access and Availability Survey. 33% of the MCOs surveyed, performed above the 75% threshold for all call types. 67% of the MCOs performed above the 75% threshold for 2 out of the 3 call types.

Table 9: Access and Availability Survey Results—2018

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Affinity				
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%**
BCBS WNY				
Routine	Internist/Family Practitioner	1	1	100.0%
	Pediatrician	5	5	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	**8**	**8**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	3	100.0%
	Pediatrician	3	2	66.7%
	OB/GYN	2	2	100.0%
	Total Non-Urgent	**8**	**7**	**87.5%**
After-Hours Access	Internist/Family Practitioner	5	2	40.0%
	Pediatrician	5	4	80.0%
	OB/GYN	3	2	66.7%
	Total After Hours	**13**	**8**	**61.5%**
CDPHP				
Routine	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	3	3	100.0%
	OB/GYN	3	2	66.7%
	Total Routine	**9**	**7**	**77.8%**
Non-Urgent "Sick"	Internist/Family Practitioner	1	1	100.0%
	Pediatrician	6	3	50.0%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**10**	**7**	**70.0%**
After-Hours Access	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	3	2	66.7%
	OB/GYN	3	3	100.0%
	Total After Hours	**10**	**8**	**80.0%**
Empire BCBS HealthPlus				

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	14	14	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	9	9	100.0%
	Total Routine	**36**	**36**	**100.00%**
Non-Urgent "Sick"	Internist/Family Practitioner	13	13	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	11	11	100.0%
	Total Non-Urgent	**37**	**37**	**100.0%**
After-Hours Access	Internist/Family Practitioner	11	5	45.5%
	Pediatrician	13	10	76.9%
	OB/GYN	5	3	60.0%
	Total After Hours	**29**	**18**	**62.1%**
Excellus				
Routine	Internist/Family Practitioner	7	7	100.0%
	Pediatrician	10	9	90.0%
	OB/GYN	6	6	100.0%
	Total Routine	**23**	**22**	**95.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	5	4	80.0%
	Pediatrician	9	5	55.6%
	OB/GYN	8	8	100.0%
	Total Non-Urgent	**22**	**17**	**77.3%**
After-Hours Access	Internist/Family Practitioner	7	5	71.4%
	Pediatrician	10	8	80.0%
	OB/GYN	9	9	100.0%
	Total After Hours	**26**	**22**	**84.6%**
Fidelis				
Routine	Internist/Family Practitioner	17	14	82.4%
	Pediatrician	16	12	75.0%
	OB/GYN	17	17	100.0%
	Total Routine	**50**	**43**	**86.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	7	7	100.0%
	Pediatrician	15	9	60.0%
	OB/GYN	16	15	93.8%
	Total Non-Urgent	**38**	**31**	**81.6%**
After-Hours Access	Internist/Family Practitioner	12	7	58.3%
	Pediatrician	19	18	94.7%
	OB/GYN	17	16	94.1%
	Total After Hours	**48**	**41**	**85.4%**
HealthFirst				
Routine	Internist/Family Practitioner	21	21	100.0%
	Pediatrician	20	20	100.0%
	OB/GYN	15	14	93.3%

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
	Total Routine	**56**	**55**	**98.2%**
Non-Urgent "Sick"	Internist/Family Practitioner	20	20	100.0%
	Pediatrician	19	17	89.5%
	OB/GYN	17	16	94.1%
	Total Non-Urgent	**56**	**53**	**94.6%**
After-Hours Access	Internist/Family Practitioner	18	10	55.6%
	Pediatrician	19	14	73.7%
	OB/GYN	16	11	68.8%
	Total After Hours	**53**	**35**	**66.0%**
HIP (EmblemHealth)				
Routine	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	6	6	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	**12**	**11**	**91.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	6	5	83.3%
	Pediatrician	4	3	75.0%
	OB/GYN	1	0	0.00%
	Total Non-Urgent	**11**	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	4	4	100.0%
	OB/GYN	2	1	50.0%
	Total After Hours	**10**	**8**	**80.0%**
IHA				
Routine	Internist/Family Practitioner	4	4	100.0%
	Pediatrician	4	3	75.0%
	OB/GYN	3	3	100.0%
	Total Routine	**11**	**10**	**90.9%**
Non-Urgent "Sick"	Internist/Family Practitioner	5	5	100.0%
	Pediatrician	4	2	50.0%
	OB/GYN	2	1	50.0%
	Total Non-Urgent	**11**	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	5	3	60.0%
	OB/GYN	4	3	75.0%
	Total After Hours	**12**	**8**	**66.7%**
MetroPlus				
Routine	Internist/Family Practitioner	13	13	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	9	9	100.0%
	Total Routine	**35**	**35**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	13	13	100.0%
	Pediatrician	15	15	100.0%

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
	OB/GYN	11	11	100.0%
	Total Non-Urgent	**39**	**39**	**100.0%**
After-Hours Access	Internist/Family Practitioner	10	6	60.0%
	Pediatrician	12	10	83.3%
	OB/GYN	11	7	63.6%
	Total After Hours	**33**	**23**	**69.7%**
Molina				
Routine	Internist/Family Practitioner	3	3	100.0%
	Pediatrician	6	5	83.3%
	OB/GYN	3	3	100.0%
	Total Routine	**12**	**11**	**91.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	5	3	60.0%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**11**	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	3	1	33.3%
	Pediatrician	5	5	100.0%
	OB/GYN	3	3	100.0%
	Total After Hours	**11**	**9**	**81.8%**
MVP				
Routine	Internist/Family Practitioner	8	6	75.0%
	Pediatrician	11	9	81.8%
	OB/GYN	5	5	100.0%
	Total Routine	**24**	**20**	**83.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	10	7	70.0%
	OB/GYN	10	9	90.0%
	Total Non-Urgent	**24**	**19**	**79.2%**
After-Hours Access	Internist/Family Practitioner	2	2	100.0%
	Pediatrician	9	8	88.9%
	OB/GYN	6	5	83.3%
	Total After Hours	**17**	**15**	**88.2%**
UHCCP				
Routine	Internist/Family Practitioner	7	6	85.7%
	Pediatrician	10	10	100.0%
	OB/GYN	13	12	92.3%
	Total Routine	**30**	**28**	**93.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	8	7	87.5%
	Pediatrician	12	8	66.7%
	OB/GYN	5	4	80.0%
	Total Non-Urgent	**25**	**19**	**76.0%**
After-Hours	Internist/Family Practitioner	9	7	77.8%

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Access	Pediatrician	11	9	81.8%
	OB/GYN	12	10	83.3%
	Total After Hours	**32**	**26**	**81.3%**
WellCare				
Routine	Internist/Family Practitioner	6	6	100.0%
	Pediatrician	4	4	100.0%
	OB/GYN	3	2	66.7%
	Total Routine	**13**	**12**	**92.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	6	4	66.7%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**12**	**9**	**75.0%**
After-Hours Access	Internist/Family Practitioner	2	2	100.0%
	Pediatrician	5	5	100.0%
	OB/GYN	3	1	33.3%
	Total After Hours	**10**	**8**	**80.0%**
YourCare				
Routine	Internist/Family Practitioner	2	2	100.0%
	Pediatrician	5	5	100.0%
	OB/GYN	3	3	100.0%
	Total Routine	**10**	**10**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	3	100.0%
	Pediatrician	6	3	50.0%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**12**	**9**	**75.0%**
After-Hours Access	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	6	4	66.7%
	OB/GYN	1	1	100.0%
	Total After Hours	**10**	**7**	**70.0%**

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

IV. Utilization

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

Encounter Data

Table 10 depicts Per Member Per Year utilization for select services in 2018. Plan averages 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 ▼. Regarding members utilization of specialists, 40% of MCOs had reported rates below the statewide average in 2018. Most notably, WellCare had a reported rate of 0 for dental services.

Table 10: Medicaid Encounter Data—2018

	Encounters (PMPY)				
MCO	PCPs and OB/GYNs	Specialty	Emergency Room	Inpatient Admissions	Dental
Affinity	3.71	2.33	0.53	0.14	0.87
BCBS WNY	2.82 ▼	2.28	0.61	0.1	0.91
CDPHP	3.86	2.22	1.02 ▲	0.11	1.00
Empire BCBS HealthPlus	1.35 ▼	2.64	0.42	0.09	1.01
Excellus	3.81	1.92 ▼	0.68	0.14	1.15
Fidelis	3.27	2.71 ▲	0.5	0.14	1.13
Healthfirst	4.37 ▲	2.33	0.57	0.13	1.01
HIP	3.40	2.31	0.44	0.14	0.79
IHA	4.15	1.92 ▼	0.63	0.35 ▲	1.15
MetroPlus	3.33	1.55 ▼	0.66	0.13	0.9
Molina	3.62	1.77 ▼	0.59	0.12	0.95
MVP	3.58	2.86 ▲	0.6	0.15	1.11
UHCCP	3.79	1.95 ▼	0.37 ▼	0.11	1.09
WellCare	3.14	1.87 ▼	0.58	0.13	0 ▼
YourCare	3.69	2.39	0.68	0.11	1.19
Statewide Average	**3.5**	**2.33**	**0.53**	**0.13**	**1.02**

Note: MCOs that were operational, but are no longer in business, are included in the statewide totals; however, they are not listed in the table.

Data Source: NYSDOH DataMart

PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a)(ii) of the MMC 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 percent of Medicaid enrollees receiving health screenings within 30 days of enrollment, in addition to displaying the statewide average. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. 4 out of 15 MCOs had rates above the statewide average for providing health screenings to new enrollees. 2 MCOs had rates significantly below the statewide average.

Table 11: Health Screenings—2018

Plan Name	Medicaid Health Screenings
Affinity	2.0% ▼
BCBS WNY	18.1%
CDPHP	31.6% ▲
Empire BCBS HealthPlus	10.7%
Excellus	12.6%
Fidelis	0.5% ▼
HealthFirst	17.6%
HIP	21.8%
IHA	22.6% ▲
MetroPlus	8.4%
Molina	23.4% ▲
MVP	17.1%
UHCCP	25.5% ▲
WellCare	6.1%
YourCare	21.5%
Statewide Average	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCOs' rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2018. The table displays whether the MCOs' rates were higher than 90% of all rates for that measure (indicated by ▲) or whether the MCOs' rates were lower than 90% of all rates for that measure (indicated by ▼). Regarding Outpatient Utilization, 27% of MCOs had rates above the statewide average and for Inpatient Utilization, 40% of MCOs had a rate above the statewide average. For the Inpatient ALOS measure, 40% of the MCOs had a rate above the statewide average.

Table 12: QARR Use of Services Rates—2018

	Outpatient Utilization (PTMY)		Inpatient Utilization (PTMY)			Inpatient ALOS		
MCO	**Visits**	**ER Visits**	**Medicine**	**Surgery**	**Maternity**	**Medicine**	**Surgery**	**Maternity**
Affinity	5,203	494	24	11	28	4.6	7.8	3.1
BCBS WNY	4,090 ▼	615	35	22 ▲	28	4.0	8.2 ▲	2.8
CDPHP	5,037	583	32	19	29	3.4 ▼	5.9 ▼	2.7
Empire BCBS HealthPlus	4,934	379 ▼	20 ▼	9 ▼	26	4.6	7.0	3.0
Excellus	4,440	613	29	12	27	3.8	6.4	2.6 ▼
Fidelis	5,785 ▲	478	32	15	32	3.5 ▼	6.1	2.7
Healthfirst	5,610	532	33	12	36	4.3	8.1	3.0
HIP	4,709	387	37	15	20	4.4	6.6	3.2 ▲
IHA	4,130 ▼	572	37	18	35	3.9	7.3	2.9
MetroPlus	4,539	618	42 ▲	9 ▼	38 ▲	8.1 ▲	9.6 ▲	3.2 ▲
Molina	4,528	625 ▲	31	17	36	3.7	7.4	2.7
MVP	4,984	567	28	13	37 ▲	3.7	5.6 ▼	2.8
UHCCP	5,647 ▲	348 ▼	18 ▼	9	35	4.8 ▲	6.8	2.7
WellCare	4,446	458	39 ▲	11	25 ▼	3.9	7.3	3.0
YourCare	4,170	630 ▲	38	20 ▲	30	3.9	6.9	2.9
Statewide Average	**5,317**	**492**	**30**	**12**	**32**	**4.5**	**7.0**	**2.9**

PTMY: Per Thousand Member Years
ER: Emergency Room
ALOS: Average Length of Stay. These rates are measured in days.

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 2019 audit findings, NYSDOH prenatal care findings, 2019 Child CAHPS® survey results and results from MCO Performance Improvement Projects (PIPs).

Validation of Performance Measures

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data to the NYSDOH for several measures. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2019 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2019 Compliance Audit™ are summarized in its Final Audit Report (FAR).

For Measurement Year (MY) 2013, the methodology for reporting performance measures was modified. Previously, Medicaid and Child Health Plus (CHP) were reported separately; however, since MY 2013, and for the most recent reporting period of QARR 2019 (MY 2018), rates for these populations were combined following HEDIS® methodology (summing numerators and denominators from each population). Trend analyses were applied over the time period, as the effect of combining the CHP and Medicaid product lines was determined to be negligible through an analysis of historical QARR data.

Summary of HEDIS® 2019 Information System Audit™

As part of the HEDIS® 2019 Compliance Audit™, auditors assessed the MCOs' compliance with NCQA standards in the six designated information system categories, as follows:

1. Sound Coding Methods for Medical Data
2. Data Capture, Transfer, and Entry—Medical Data
3. Data Capture, Transfer, and Entry—Membership Data
4. Data Capture, Transfer, and Entry—Practitioner Data
5. Data Integration Required to Meet the Demands of Accurate HEDIS® Reporting
6. Control Procedures that Support HEDIS® Reporting and Integrity

In addition, two HEDIS®-related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS® Reporting Functions

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.

Note: MCO summaries of the HEDIS® 2019 Final Audit Reports are available within the individual, MCO-specific technical reports.

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 are further categorized as: Quality Indicators (Effectiveness of Care, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains includes 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 MCOs' HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.

Quality Indicators

This section of the report explores the quality of health care services provided by the MCOs. Performance in the domains of Effectiveness of Care, Acute and Chronic Care, and Behavioral Health is examined.

Effectiveness of Care

This domain includes measures of preventive care and screenings, acute and chronic care and behavioral health care for several health conditions which allows for the evaluation of the MCO's performance.

The following table describes the measures included in the Effectiveness of Care: Prevention and Screening domain. These measures include BMI assessments for adults and children, immunizations for children and adolescents and certain cancer screenings.

Prevention and Screening Measures[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
HEDIS®	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
HEDIS®	Childhood Immunization Status—Combination 3 (CIS)	The percentage of children 2 years of age who had four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, and four PCV vaccines by their second birthday.
HEDIS®	Immunizations for Adolescents—Combination 2 (IMA)	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one Tdap vaccine, and have completed the HPV vaccine series by their 13th birthday.
HEDIS®	Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday.

Prevention and Screening Measures[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
HEDIS®	Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.
HEDIS®	Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

[1] Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® and CAHPS® measures.

[2] The measure description in the Quality Assurance Reporting Requirements (QARR) Technical Specifications Manual was used for this measure.

Table 13a displays HEDIS®/QARR performance rates for Measurement Year 2018 for prevention and screening measures, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). Most MCOs performed well for the Adult BMI Assessment measure with 67% of MCO's reporting a rate above the statewide average. MCOs also performed well in the Childhood Immunizations – Comb 3 measure with 60% of MCOs reporting a rate above the statewide average. Regarding the Chlamydia and Colorectal Cancer Screening measures, 53% of MCOs performed below the SWA. Also, for the Breast Cancer Screening measure, 60% of MCOs performed below the SWA.

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

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	HealthFirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	Wellcare	YourCare	Statewide
Adult BMI Assessment	96 ▲	96 ▲	97 ▲	85	94 ▲	87	92	81 ▼	96 ▲	94 ▲	93 ▲	93 ▲	82	97 ▲	92 ▲	**89**
WCC—BMI Percentile	84	85	94 ▲	82 ▼	89	88	84	81 ▼	93 ▲	94 ▲	91 ▲	88	78 ▼	90 ▲	91 ▲	**86**
WCC—Counseling for Nutrition	81	86 ▲	89 ▲	81	86	83	82	79	88 ▲	93 ▲	86 ▲	82	72 ▼	82	89 ▲	**83**
WCC—Counseling for Physical Activity	76	81 ▲	85 ▲	72	77	72	73	71	85 ▲	85 ▲	83 ▲	74	64 ▼	74	82 ▲	**74**
Childhood Immunizations—Combo 3	81 ▲	78 ▲	80 ▲	72	86 ▲	69	79 ▲	70	83 ▲	93 ▲	75	82 ▲	56 ▼	72	78 ▲	**73**
Lead Screening in Children	91	90	86	89	82 ▼	88	92 ▲	85	93 ▲	94 ▲	88	88	81 ▼	84 ▼	90	**89**
Adolescent Immunizations—Combo 2	42	35 ▼	36 ▼	42	40	41	54 ▲	39	35 ▼	61 ▲	44	44	19 ▼	39	36 ▼	**43**
Adolescents—Alcohol and Other Drug Use[2]	88 ▲	77	81 ▲	62	76	69	68	71	79 ▼	88 ▲	75	67	55 ▼	68	81 ▲	**70**
Adolescents—Depression[2]	88 ▲	71	80 ▲	64	73	62	68	69	77 ▼	84 ▲	75 ▲	65	50 ▼	60	77 ▲	**67**
Adolescents—Sexual Activity[2]	67	67	75 ▲	59 ▼	74	69	67	66	75 ▼	85 ▲	68	63	52 ▼	62	77 ▲	**67**
Adolescents—Tobacco Use[2]	89 ▲	80	93 ▲	67	84 ▲	74	69	74	85 ▼	91 ▲	82 ▲	78	58 ▼	71	85 ▲	**74**
Breast Cancer Screening	69 ▼	57 ▼	65 ▼	72 ▲	67 ▼	70 ▼	76 ▲	67 ▼	71	75 ▲	69	66 ▼	65 ▼	67 ▼	69	**71**
Colorectal Cancer Screening	65	49 ▼	54 ▼	58 ▼	59	61	73 ▲	63	57 ▼	67	52 ▼	58 ▼	56 ▼	63	55 ▼	**63**

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	HealthFirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	Wellcare	YourCare	Statewide
Chlamydia Screening (Ages 16-24)	79 ▲	63 ▼	70 ▼	78 ▲	59 ▼	74 ▼	82 ▲	76	72 ▼	82 ▲	75	72 ▼	70 ▼	81 ▲	70 ▼	**76**

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] NYS-specific measure.

[3] CAHPS® measure.

The following table describes the measures included in the Effectiveness of Care: Acute and Chronic Care domain. Measures included evaluate the quality of care provided to MCO members who have acute and chronic medical conditions. These include respiratory, cardiovascular, and musculoskeletal diseases, as well as diabetes and HIV.

Acute and Chronic Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Appropriate Testing for Children with Pharyngitis (CWP)	The percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
HEDIS®	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.
HEDIS®	Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement period and who were dispensed appropriate medications.
HEDIS®	Medication Management for People with Asthma (MMA)	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medication, and remained on an asthma controller medication for at least 50% of their treatment period.
HEDIS®	Asthma Medication Ratio (AMR)	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
HEDIS®	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.
HEDIS®	Comprehensive Diabetes Care (CDC)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c testing, HbA1c control (<8.0%); eye exam (retinal) performed; medical attention for nephropathy; and BP control (<140/90 mm Hg).
HEDIS®	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
HEDIS®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain that did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
HEDIS®	Annual Monitoring for Patients on Persistent Medications—Total Rate (MPM)	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
HEDIS®	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	The percentage of children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.
HEDIS®	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Acute and Chronic Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
CAHPS®	Flu Vaccinations for Adults Ages 18-64 (FVA)	The percentage of members 18-64 years of age who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS® 5.0H survey was completed.
CAHPS®	Advising Smokers and Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
CAHPS®	Discussing Cessation Medications	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
CAHPS®	Discussing Cessation Strategies	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods and strategies during the measurement year.
NYS-specific[2]	Adolescent Preventive Care (ADL)	The percentage of adolescents ages 12-17 who had at least one outpatient visit with a PCP or OB/GYN practitioner during the measurement year and received assessment, counseling, or education in the following four components of care: 1) risk behaviors and preventive actions associated with sexual activity; 2) depression; 3) risks of tobacco usage; and 4) risks of substance use, including alcohol.
NYS-specific[2]	HIV Viral Load Suppression	The percentage of Medicaid enrollees confirmed HIV-positive who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

COPD: Chronic Obstructive Pulmonary Disease; ED: Emergency Department; AMI: Acute Myocardial Infarction; BP: Blood Pressure

[1] Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

[2] The measure description in the Quality Assurance Reporting Requirements (QARR) Technical Specifications Manual was used for this measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). In 2018, the MCOs performed well for the *Pharmacotherapy Management for COPD—Corticosteroids*, *Persistence of Beta-Blocker Treatment After a Heart Attack*, and *Drug Therapy for Rheumatoid Arthritis* measures, with no MCO rates below the SWA. In regards to the Testing for Children with Pharyngitis, 40% of the MCOs reported rates above the SWA. 73% of MCOs performed below the SWA for the *Monitor Patients on Persistent Medications—Total Rate* measure.

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

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	HealthFirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	WellCare	YourCare	Statewide Average
Testing for Children with Pharyngitis	89 ▼	95 ▲	92	90 ▼	94 ▲	93 ▲	88 ▼	82 ▼	94 ▲	81 ▲	86 ▼	91	92 ▲	87 ▼	89	**91**
Spirometry Testing for COPD	54	36 ▼	35 ▼	53	40 ▼	61 ▲	68 ▲	51	42 ▼	46 ▲	38 ▼	47 ▼	51 ▲	53	45 ▼	**56**
Use of Imaging Studies for Low Back Pain	77	72	69 ▼	82	75	73 ▼	82 ▲	79	70 ▼	79 ▲	74	71 ▼	77	81 ▲	65 ▼	**77**
Pharmacotherapy Management for COPD—Bronchodilators	93	83	89	93	91	89	90	85	89	87	83	86	85 ▼	88	85	**88**
Pharmacotherapy Management for COPD—Corticosteroids	75	77	81	75	83 ▲	79 ▲	71 ▼	72	80	72	82	75	74	72	83	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	66 ▼	75	63 ▼	70	71	72 ▲	71	73	70	70	63	68	69	68	73	**70**
Medication Management for People with Asthma 50% (Ages 5-18)	50 ▼	60	65 ▲	59	61	62 ▲	59	61	50 ▼	57 ▼	55	55 ▼	58	53	61	**59**
Asthma Medication Ratio (Ages 19-64)	51 ▼	62	53 ▼	54 ▼	60	63 ▲	62 ▲	73	55	59	58	64	56 ▼	63	63	**60**
Asthma Medication Ratio (Ages 5-18)	69	72	69	67	66	72 ▲	67 ▼	66	75 ▲	62 ▼	70	72 ▲	73 ▲	64	70	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	70	*SS*	88	80	86	81	79	84	87	78	*SS*	75	77	75	*SS*	**79**

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	HealthFirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	WellCare	YourCare	Statewide Average
CDC—HbA1c Testing	99 ▲	85 ▼	91	92	89	92	95 ▲	91	92	90	94	95	89 ▼	92	90	**92**
CDC—HbA1c Control (<8%)	57	52 ▼	56	56	57	63	64	54 ▼	61	57	59	55	55	53 ▼	56	**60**
CDC—Eye Exam Performed	80 ▲	67	68	64	69	62 ▼	72 ▲	65	65	69	64	65	62	62 ▼	63	**67**
CDC—Nephropathy Monitor	91	90	90	92	89 ▼	93	94	93	93	89	90	92	92	91	91	**92**
CDC—BP Controlled (<140/90 mm Hg)	59 ▼	67	76 ▲	61 ▼	76 ▲	70	64	59 ▼	72 ▲	72 ▲	67	71 ▲	61	60 ▼	72 ▲	**66**
Drug Therapy for Rheumatoid Arthritis	84	77	85	83	82	82	84	86	79	89 ▲	78	78	79	75	78	**83**
Monitor Patients on Persistent Medications—Total Rate	91	85 ▼	89 ▼	92	87 ▼	93 ▲	92	89 ▼	88 ▼	92	90 ▼	90 ▼	91 ▼	93 ▲	88 ▼	**91**
Appropriate Treatment for URI	96 ▲	94	96 ▲	94 ▼	95	95	95	94	96	95	96	96 ▲	92 ▼	96	94	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	45 ▲	31	43 ▲	36	40 ▲	36	40 ▲	23 ▼	30	36	32	32	28 ▼	53 ▲	30	**36**
HIV Viral Load Suppression[2]	77	77	84	74	81 ▲	77	77	76	84	78	86	85 ▲	77	70 ▼	84	**77**

SS: Sample size too small to report (less than 30 members), but included in the statewide average.

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 noted otherwise.

[2] NYS-specific measure.

The following table describes the measures included in the Effectiveness of Care: Behavioral Health domain. This section examines the quality of care MCOs provide 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.

Behavioral Health Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Antidepressant Medication Management (AMM)	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (Effective Acute Phase Treatment) and for at least 180 days (Effective Continuation Phase Treatment).
HEDIS®	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	The percentage of children newly prescribed attention-deficit/ hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
HEDIS®	Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge and within 7 days after discharge.
HEDIS®	Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications (SSD)	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
HEDIS®	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	The percentage of members 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
HEDIS®	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

[1] Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 13c displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). MCOs performed well in the Behavioral Health domain, with 53% of MCOs having no rates below the SWA. 27% of MCOs had rates below the SWAs for the following measures: *Follow-Up Care for Children on ADHD Medication—Initiation* and *Follow-Up After Hospitalization for Mental Illness—(30 Days and 7 Days)* measures.

Table 13c: HEDIS®/QARR MCO Performance Rates 2018—Effectiveness of Care: Behavioral Health[1]

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	Healthfirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	WellCare	YourCare	Statewide Average
Antidepressant Medication Management—Effective Acute Phase	50	57	54	53	50 ▼	54 ▲	54	53	50	53	41 ▼	50	54	52	50	**53**
Antidepressant Medication Management—Effective Continuation Phase	35	43	39	38	38	38	37	39	36	36	28 ▼	35	39	39	34	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	74 ▲	48	47 ▼	58	45 ▼	60	67 ▲	63	49 ▼	62	97 ▲	51 ▼	56	55	53	**59**
Follow-Up Care for Children on ADHD Medication—Continue	83 ▲	64	53 ▼	66	53 ▼	67	74 ▲	80	56	77	85 ▲	61	61	*SS*	67	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	78 ▲	83 ▲	70	73	83 ▲	74	73	69 ▼	80	75	76	69 ▼	63 ▼	67 ▼	76	**73**
Follow-Up After Hospitalization for Mental Illness—7 Days	65	73 ▲	34 ▼	62	77 ▲	63	62	58 ▼	79 ▲	64	68	56 ▼	52 ▼	59	64	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	81	79	79	84	77 ▼	82	86 ▲	79	81	86 ▲	78	83	81	81	59	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	83	65	86	78	74	81	82	70	75	82	*SS*	78	85	73	*SS*	**80**
Antipsychotic Medications for Schizophrenia	65	65	60	62	60	63	63	69	63	61	44 ▼	62	66	63	59	**63**

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
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 MCOs 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.

Utilization

The measures included in this section evaluate member utilization of selected services. The table below provides descriptions of the HEDIS®/QARR measures selected for this domain.

Utilization Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Well-Child Visits in the First 15 Months of Life—6+ Visits (W15)	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.
HEDIS®	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.
HEDIS®	Adolescent Well-Care Visits (AWC)	The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.

[1] Measure descriptions in the HEDIS® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 14a displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Utilization domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). 60% of MCOs performed above the SWA for the *Well-Child Visits (First 15 Months)* measure. For the *Well-Child Visits (3 to 6 Year Olds)* and *Adolescent Well-Care Visits*, 40% of MCOs performed below the SWA for those measures.

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

MCO	Well-Child Visits—First 15 Months	Well-Child Visits—3 to 6 Year Olds	Adolescent Well-Care Visits
Affinity	88 ▲	86	70 ▲
BCBS WNY	88 ▲	85	69
CDPHP	85 ▲	85	68
Empire BCBS HealthPlus	81 ▲	87 ▲	71 ▲
Excellus	85 ▲	84 ▼	67
Fidelis	88 ▲	85	69
Healthfirst	84 ▲	89 ▲	72 ▲
HIP	77 ▼	82 ▼	64 ▼
IHA	88 ▲	86	70 ▲
MetroPlus	81	87 ▲	67 ▼

MCO	Well-Child Visits—First 15 Months	Well-Child Visits—3 to 6 Year Olds	Adolescent Well-Care Visits
Molina	79	80 ▼	60 ▼
MVP	86 ▲	85 ▼	67 ▼
UHCCP	65 ▼	86	65 ▼
WellCare	64 ▼	79 ▼	64 ▼
YourCare	68	84 ▼	68
Statewide Average	**81**	**86**	**68**

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

Access to Care

The HEDIS®/QARR Access to Care measures examine the percentage of children and adults who access primary and preventive services, prenatal and postpartum care, and dental services. The table below provides descriptions of the measures included in this domain.

Access to Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Children and Adolescents' Access to Primary Care Practitioners (CAP)	The percentage of children 12-24 months and 25 months-6 years who had a visit with a PCP during the measurement year and the percentage of children 7-11 years and adolescents 12-19 years who had a visit with a PCP during the measurement year or the year prior.
HEDIS®	Adults' Access to Ambulatory/ Preventive Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
HEDIS®	Timeliness of Prenatal Care (PPC)	The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization.
HEDIS®	Postpartum Care (PPC)	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.
HEDIS®	Annual Dental Visit (ADV)	The percentage of members 2-20 years of age who had at least one dental visit during the measurement year.

[1] Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 14b displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Access to Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCOs' rates were lower than 90% of all MCOs for that measure (indicated by ▼). The MCOs performed well for the *Children & Adolescents' Access to PCPs (12-24 Months)* measure, with 53% of the MCOs reporting rates above the SWA. The MCOs also performed well in the *Annual Dental Visit* measure, with 60% of MCOs reporting rates above the SWA.

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

	Children & Adolescents' Access to PCPs				Adults' Access to Preventive/Ambulatory Services			Access to Other Services		
MCO	12-24 Months	25 Months-6 Years	7-11 Years	12-19 Years	20-44 Years	45-64 Years	65+ Years	Timeliness of Prenatal Care	Postpartum Care	Annual Dental Visit[2]
Affinity	97	93 ▼	96 ▼	94 ▼	76 ▼	86 ▼	88 ▼	87	75 ▲	62 ▲
BCBS WNY	98	92 ▼	98	96 ▲	82	89	88	87	72	65 ▲
CDPHP	98 ▲	95 ▲	97	94 ▲	86 ▲	91 ▲	90	94 ▲	68	63 ▲
Empire BCBS HealthPlus	98 ▲	95 ▲	98 ▲	96 ▲	81	88 ▼	90 ▼	83 ▼	71	59 ▼
Excellus	99 ▲	94	97	96 ▲	87 ▲	91 ▲	92	92 ▲	69	62 ▲
Fidelis	98 ▲	94	97	95	81	89	92 ▲	89	69	61
Healthfirst	96 ▲	94	97	95	84 ▲	91 ▲	93 ▲	91	71	59 ▼
HIP	98	92 ▼	98	96 ▲	82	89	88	87	72	65 ▲
IHA	99 ▲	94	97	96	85 ▲	90 ▲	90	88	69	69 ▲
MetroPlus	93 ▼	91 ▼	95 ▼	93 ▼	76 ▼	87 ▼	91	89	70	59 ▼
Molina	99 ▲	92 ▼	96	95	82	89	91	82 ▼	62 ▼	50 ▼
MVP	98 ▲	95 ▲	97	96 ▲	84 ▲	89	91	85	67	67 ▲
UHCCP	97	95 ▲	97	95	82 ▲	88 ▼	91	85	68	62 ▲
WellCare	93 ▼	88 ▼	92 ▼	91 ▼	69 ▼	83 ▼	87 ▼	89	69	50 ▼
YourCare	99	93	97	95	84 ▲	90 ▲	95	90	70	75 ▲
Statewide Average	**97**	**94**	**97**	**95**	**81**	**89**	**91**	**88**	**70**	**61**

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

[2] For the Annual Dental Visit measure, the age group is 2-20 years.

NYSDOH-Calculated Prenatal Care Measures

Select 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 2017. In addition, the table indicates if the MCOs' rates were significantly better than the regional average (indicated by ▲) or if the MCOs' rates were significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates: 2015-2017

	Risk-Adjusted Low Birth Weight[1]	Prenatal Care in the First Trimester	Risk-Adjusted Primary Cesarean Delivery[1]	Vaginal Birth After Cesarean	Risk-Adjusted Low Birth Weight[1]	Prenatal Care in the First Trimester	Risk-Adjusted Primary Cesarean Delivery[1]	Vaginal Birth After Cesarean
MCO	**NYC**				**ROS**			
Affinity		73 ▼				77		
BCBS WNY						69		
CDPHP						74		
Empire BCBS HealthPlus		80 ▲				74		
Excellus						76		
Fidelis		77				74		
Healthfirst		74 ▼				78		
HIP		79				75		
IHA						75		
MetroPlus		67 ▼						
Molina						66 ▼		
MVP						79		
UHCCP		81 ▲				77		
WellCare		73				68		
YourCare						74		
Regional Average		**75**				**74**		

Note: 2017 rates were not available at the time of the report. The rows shaded in gray indicate that the MCO does not operate in that region.

NYC: New York City; ROS: Rest of State

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

Member Satisfaction

Under the CAHPS program, AHRQ funds, oversees, and works closely with a consortium of research organizations to conduct research on patient experience and develop surveys that ask consumers and patients to report on and evaluate their experiences with health plans, providers, and healthcare facilities. The CAHPS program also investigates and shares strategies for improving the reliability and validity of survey results, reporting survey results to interested audiences, and using the results to improve patients' experiences with care[4]. In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. The table below provides descriptions of the measures included in this domain.

Member Satisfaction Indicators[1]	
Measure Name	**Measure Description**
Getting Needed Care	The survey asked enrollees how often it was easy for them to get appointments for their child with specialists and get the care, tests, or treatment the child needed through their health plan.
Getting Care Quickly	The survey asked enrollees how often their child got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.
How Well Doctors Communicate	The survey asked enrollees how often their child's personal doctor explained things clearly both to the parent and to the child, listened carefully, showed respect, and spent enough time with the child.
How Well Doctors Communicate	The survey asked enrollees how often customer service staff were helpful and treated them with courtesy and respect.
Health Plan Customer Service	The survey asked enrollees how often customer service staff were helpful and treated them with courtesy and respect
Enrollees' Ratings	The survey asked enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best.

[1]Patient experience measures from the CAHPS Health Plan Survey.

Table 16 displays the question category, the MCOs' rates, and the statewide averages (SWAs) for Measurement Year 2018. The table also indicates whether the MCOs' rates were significantly better than the SWA (indicated by ▲) or whether the MCOs' rates were significantly worse than the SWA (indicated by ▼). 33% of

[4]Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/cahps/about-cahps/index.html

MCOs reported rates better than the SWA for the *Getting Care Quickly* measure. 13% of MCOs reported rates above the SWA for the *Overall Rating of Health Plan* measure.

Table 16 CAHPS®—2018

Plan Name	Getting Care Needed[1]	Getting Care Quickly[1]	Satisfaction with Provider Communication[1]	Customer Service[1]	Collaborative Decision Making	Rating of Personal Doctor	Rating of Specialist	Rating of Healthcare	Overall Rating of Health Plan
Affinity	88	90	94	88	64 ▼	90	86	85	85
BCBS WNY	88	92 ▲	94	87	80	89	83	88	80
CDPHP	88	92 ▲	97 ▲	93 ▲	80	91	82	90	88
Empire BCBS HealthPlus	81	82 ▼	93	82	74	89	75	86	84
Excellus	87	91	96 ▲	84	77	90	86	90	88
Fidelis	86	92 ▲	94	88	76	90	84	89	86
Healthfirst	83 ▼	83	92	81	72	89	87	87	**85**
HIP	82	89	94	85	77	90	89	87	94
IHA	85	89	94	91 ▲	84 ▲	90	82	90	90 ▲
MetroPlus	78	86	90 ▼	83	73	92	68 ▼	86	88
Molina	81	83 ▼	91	83	73	89	86	85	82
MVP	87	89	92	86	75	93	87	90	89 ▲
UHCCP	82	92 ▲	96 ▲	89	79	94 ▲	90 ▲	90	85
WellCare	74 ▼	81 ▼	91	86	74	87	84	83	82
YourCare	86	92 ▲	94	83	79	91	84	88	83
Statewide Average	**84**	**88**	**93**	**86**	**76**	**90**	**84**	**87**	**85**

[1] These indicators are composite measures.

Performance Improvement Projects

As part of the EQR 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 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 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 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 MCOs' 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 the State and other MCOs in conducting their PIPs. The common-themed PIP chosen for Reporting Years 2018-2019 was Improving Perinatal Care and Pre-term Births. Each plan designed and conducted a project involving appropriate measurement tools, including the following measures:

- HEDIS PPC: Timeliness of Prenatal Care.
- HEDIS PPC: Postpartum Care.
- Received at least one 17P injection between the 16th and 21st week of pregnancy, among women with a history of previous spontaneous pre-term singleton birth event.
- Screened for depression at one of the first two prenatal care visits.
- Screened for tobacco smoking at one of the first two prenatal care visits.
- Tobacco screening follow-up, i.e., smoking cessation counseling or a referral during pregnancy, among women identified as smoking during pregnancy.
- Were provided most effective or moderately effective FDA-approved methods of contraception within 3 and 60 days of delivery, itemized by 2 age groups.
- Were provided a LARC within 3 and 60 days of delivery, itemized by 2 age groups.

The NYS EQRO provided technical assistance to the MCOs throughout the PIP process in the following forms: 1) review of the MCOs' Project Proposals prior to the start of the PIP; 2) quarterly teleconferences with the MCOs for progress updates and problem-solving; 3) providing feedback on methodology, data collection tools, and implementation of interventions; 4) feedback on drafts of the MCOs' final reports; and 5) all plan webinars to share lessons learned.

In addition, the NYS EQRO validated the MCOs' PIPs 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 MCOs' improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCOs are likely to be able to sustain the documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among 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.

Note: MCO summaries on the implementation and results of the PIPs are available within the individual, MCO-specific technical reports.

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 to improve the quality of care for MCO members with at-risk characteristics.

In 2018, 12 out of 15 MCOs reported on activities regarding health disparities. Of the 12 MCOs that provided summaries, 100% of MCOs reported they analyzed their Medicaid population by at-risk characteristics to identify the differences in health outcomes. 100% of these MCOs provided key findings and the corresponding interventions that were created to reduce or eliminate differences in health outcomes for members identified with at-risk characteristics.

MCO specific summaries on activities performed related to health disparities are available within the individual technical reports.

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 healthcare.

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:

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

Table 17 displays the statewide results of the HIT survey. 13 out of 15 MCOs (86%) responded to the survey. Of the 13 MCOs that responded, 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, 80% of MCOs reported future plans to implement HIT.

[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.

Table 17: MCO Use of Health Information Technology—2018 Survey of NYS MCOs

Plan Name	Electronic Health Records (EHR)	Electronic Communication with Providers	Electronic Transfer of Member Data	Electronic Transfer of PHI to Patients and/or Providers	Use of CRG or Similar Software	Use of Telecommunications Software	Has Future Plans to Implement HIT
Affinity[1]	-	-	-	-	-	-	-
BCBS WNY	✔	✔	✔	✔	✔	✔	✔
CDPHP	✔	✔	✔	✔	✔	✔	-
Empire BCBS HealthPlus	✔	✔	✔	✔	✔	✔	✔
Excellus	✔	✔	✔	✔	✔	✔	✔
Fidelis	✔	✔	✔	✔	✔	✔	✔
Healthfirst	✔	✔	✔	✔	✔	✔	-
HIP	✔	✔	✔	✔	✔	✔	✔
IHA[1]	-	-	-	-	-	-	-
MetroPlus	✔	✔	✔	✔	✔	✔	✔
Molina	✔	✔	✔	✔	✔	✔	✔
MVP	-	✔	✔	✔	✔	✔	✔
UHCCP	✔	✔	✔	✔	✔	✔	✔
WellCare	✔	✔	✔	✔	✔	✔	-
YourCare	✔	✔	✔	✔	✔	✔	✔

PHI: Protected Health Information
CRG: Clinical Risk Group
[1] Affinity and IHA did not respond to the HIT Survey for RY 2018.

MCO summaries of HIT-related activities are available within the individual technical reports.

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 MCOs' 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 MCOs' compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in Table 21 of the individual, MCO-specific technical reports. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCOs were not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policies 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 MCOs after the monitoring review, and the MCOs are 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 structure and operation standards. The focused review types are summarized in **Table 18**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 19 reflects the total number of citations received by each MCO for the most current operational survey, where applicable, as well as from the focused reviews conducted in 2018. There were a total of 47 operational citations and 16 focused review citations. 67% of the MCOs received at least 2 citations as a result of the operational and focused reviews.

Table 18: 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 19: Summary of Citations—2018

MCO	Operational Citations	Focused Review Citations	Total Citations
Affinity	7	5	12
BCBS WNY	6	0	6
CDPHP	0	0	0
Empire BCBS HealthPlus	8	0	8
Excellus	8	0	8
Fidelis	0	0	0
Healthfirst	0	2	2
HIP	0	2	2
IHA	7	2	9
MetroPlus	0	1	1
Molina	2	0	2
MVP	8	2	10
UHCCP	1	0	1
WellCare	0	0	0
YourCare	0	2	2
Statewide Total	**47**	**16**	**63**

Note: MCO summaries of deficiencies and citations received are available within the individual, MCO-specific technical reports.

External Appeals

Table 20 displays external appeals for 2018 for the Medicaid product lines. This table reflects absolute numbers and is not weighted by MCO enrollment.

Table 20: Medicaid External Appeals – 2018

MCO	Overturned	Overturned in Part	Upheld	Total
Affinity	61	4	82	**147**
BCBS WNY	1	0	2	**3**
CDPHP	15	1	11	**27**
Empire BCBS HealthPlus	178	18	295	**491**
Excellus	8	0	11	**19**
Fidelis	231	18	312	**561**
Healthfirst	169	9	521	**699**
HIP	23	6	77	**106**
IHA	3	0	8	**11**
MetroPlus	73	7	177	**257**
Molina	3	0	1	**4**
MVP	20	1	56	**77**
UHCCP	275	27	510	**812**
WellCare	19	5	41	**65**
YourCare	3	0	2	**5**
Statewide Total	**1,082**	**96**	**2,106**	**3,284**

VIII. Strengths and Opportunities for Improvement[6]

This section summarizes the accessibility, timeliness, and quality of services provided by the MCOs to Medicaid and CHP recipients based on data presented in the various sections of the individual, MCO-specific technical reports. This section identifies the MCOs' strengths and weaknesses, and makes 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. An MCO's strengths are the valuable resources and capabilities it has developed or acquired over time, which are considered distinguishing characteristics. An MCO significantly exceeding the national average for a measure would be considered a strength. 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 Medicaid Managed Care Model Contract, federal and State regulations, or it performs substantially below both NYSDOHs' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS performance measure rate below the national average.

IPRO references both current and past performance, trends, benchmarks, and comparisons, along with specific NYSDOH goals and targets to make these determinations. Based on this evaluation, IPRO presents NYSDOH with a high-level commentary on the direction of each MCO's quality improvement programs and offers recommendations on facilitating positive change and further improving the care and services provided to enrollees of NY Medicaid Managed Care.

Note: Complete and detailed reports on strengths, opportunities for improvement, and recommendations made by the EQRO are available within the individual, MCO-specific technical reports.

Components of Care: Quality, Access and Timeliness

IPRO used 2017 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

- ***Quality*** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- ***Access*** is the timely use of personal health services to achieve the best possible health outcomes.[1]
- ***Timeliness*** is the extent to which care and services are provided within the periods required by the NYS Medicaid Managed Care Model Contract, federal regulations, and as recommended by professional organizations and other evidence-based guidelines. Timely interventions improve the quality of care and services provided as well as enrollee and practitioner satisfaction. Timeliness refers to the period during which an enrollee obtains needed care. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of healthcare services.

[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.

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
- *External Appeals Data:*
  - NYS Department of Financial Services, 2018