

**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 2017

FINAL REPORT

Published April 2019

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Acronyms Used in This Report

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

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.”*

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

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:

- 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 2017 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 technical assistance 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/quality points and incentive, and deficiencies and citations summaries¹.

Structure of This Report

This report is organized into the following domains: 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 Child Health Insurance Program (CHIP), which provides health coverage to eligible children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. CHP data are part of the Medicaid managed care data sets used in this report. For some measures, including QARR 2018 (MY 2017), 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 VII of the individual, MCO-specific technical reports provides an assessment of the MCOs' strengths and opportunities for improvement in the areas of accessibility, 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 2017.

¹ External Appeals data are reported in the Full EQR Technical Report prepared every third year.

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 NCQA Accreditation rating each MCO received, where available. The National Committee for Quality Assurance (NCQA) surveys health plans on various systems and processes, and evaluates key dimensions of care and services provided by the MCOs. The 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.
No stars	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 10/15/18)	Medicaid Dental Benefit Status
Affinity	10/09/1986	Medicaid, CHP, HARP	Unknown	Mandatory
BCBS WNY	08/01/1985	Medicaid, CHP, Commercial, Medicare		Mandatory
CDPHP	04/30/1984	Medicaid, CHP, HARP, Commercial, Medicare	Commercial and Medicaid—Excellent	Mandatory
Empire BCBS HealthPlus	01/12/1996	Medicaid, CHP, HARP, Medicaid Advantage, MAP, Medicare, MLTC		Mandatory
Excellus	01/01/1998	Medicaid, CHP, HARP, Commercial, Medicare		Mandatory
Fidelis	11/03/1993	Medicaid, CHP, HARP, MLTC, FIDA, MAP, Medicaid Advantage		Mandatory
Healthfirst	08/30/1994	Medicaid, CHP, HARP	Unknown	Mandatory
HIP	Prior to 1991	Medicaid, CHP, HARP, Commercial, MLTC, Medicare, FIDA, Medicaid Advantage, MAP	Commercial—Accredited	Mandatory
IHA	07/01/1991	Medicaid, CHP, HARP, Commercial, Medicare	Commercial—Commendable	Mandatory
MetroPlus	06/15/1985	Medicaid, CHP, HARP	Unknown	Mandatory
Molina	10/16/2013	Medicaid, CHP, HARP, Medicaid Advantage		Mandatory
MVP	08/01/1997	Medicaid, CHP, HARP, Commercial, Medicare	Commercial—Commendable	Mandatory
UHCCP	07/31/1987	Medicaid, CHP, HARP	Medicaid—Commendable	Mandatory
WellCare	02/12/1987	Medicaid, CHP	Medicaid—Commendable	Mandatory
YourCare	07/05/1996	Medicaid, CHP, HARP	Unknown	Mandatory

CHP: Child Health Plus; HARP: Health and Recovery Plan; FIDA: Fully Integrated Duals Advantage; MAP: Medicaid Advantage Plus; 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 2016 and 2017, as well as the percent change between 2016 and 2017.

Table 2: Medicaid and CHP Enrollment—2016-2017

MCO	Medicaid			CHP		
	2016	2017	% Change	2016	2017	% Change
Affinity	228,823	219,160	-4.2%	12,383	13,391	8.1%
BCBS WNY	21,421	28,764	34.3%	1,560	2,563	64.3%
CDPHP	85,544	82,147	-4.0%	12,479	12,987	4.1%
Empire BCBS HealthPlus	361,963	346,593	-4.2%	42,251	42,051	-0.5%
Excelsus	166,408	168,074	1.0%	26,719	29,679	11.1%
Fidelis	1,168,283	1,220,700	4.5%	95,403	112,613	18.0%
Healthfirst	906,628	921,471	1.6%	34,750	40,650	17.0%
HIP	168,855	141,780	-16.0%	10,803	10,437	-3.4%
IHA	60,952	59,212	-2.9%	4,516	5,188	14.9%
MetroPlus	382,190	377,045	-1.3%	14,573	16,593	13.9%
Molina	32,832	30,062	-8.4%	1,328	1,104	-16.9%
MVP	164,132	163,552	-0.4%	13,928	16,413	17.8%
UHCCP	458,021	475,607	3.8%	41,344	47,484	14.9%
WellCare	98,565	101,568	3.0%	3,900	4,509	15.6%
YourCare	44,182	41,143	-6.9%	943	2,107	123.4%
Statewide Total¹	4,349,457	4,378,153	0.7%	316,880	357,769	12.9%

Data Source: MEDS II (Medicaid) and Managed Care Enrollment Report (CHP)

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.

Provider Network

This section of the report examines the MCOs' provider networks through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey². This section also includes an overview of network adequacy standards.

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. In the State's Medicaid Managed Care Model Contract, Section 15 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 utilizes several different methodologies.

Appointment Availability/Timeliness Standards

Appointment availability standards are outlined in Section 15.2 of the Medicaid Managed Care 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

In 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."*

² Additional data on the provider networks, including panel data, enrollee-to-provider ratios, and number of providers by specialty, are reported in the Full EQR Technical Report prepared every third year.

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 certification³.

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 changing scope of medical information, increased public concern for the need to recredential physicians, and evidence that knowledge and skills of practicing physicians decays over time motivated specialty boards to limit the duration of certificates⁴. 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 organization’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 baseline 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 3** displays HEDIS®/QARR *Board Certification* rates of providers in the MCOs’ networks for 2017, 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.

³ American Board of Medical Specialties (ABMS). *The Meaning of Board Certification*. <http://www.abms.org>.

⁴ 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 3: HEDIS®/QARR Board Certification Rates—2017

MCO	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Affinity	65 ▼	66 ▼	70 ▼	64 ▼	64	70 ▼
BCBS WNY	75	76	82	78	68	81 ▲
CDPHP	85 ▲	80	82	74	65	79 ▲
Empire BCBS HealthPlus	35 ▼	70 ▼	75 ▼	75	49 ▼	76
Excellus	60 ▼	69 ▼	65 ▼	83 ▲	68	77
Fidelis	81 ▲	81 ▲	86 ▲	81 ▲	60	79 ▲
Healthfirst	72	80 ▲	81	81 ▲	73 ▲	83 ▲
HIP	75	75	76 ▼	74 ▼	72 ▲	75
IHA	82 ▲	73	82	80	SS	84 ▲
MetroPlus	68	66 ▼	67 ▼	67 ▼	55	52 ▼
Molina	89 ▲	92 ▲	89 ▲	86	SS	41 ▼
MVP	81 ▲	75	78	80	70	80 ▲
UHCCP	69 ▼	77 ▲	80	85 ▲	62	80 ▲
WellCare	73	73 ▼	76	66 ▼	62	63 ▼
YourCare	87 ▲	83 ▲	85 ▲	82	81	84 ▲
Statewide Average	72	76	79	77	63	76

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

Primary Care and OB/GYN Access and Availability Survey—2017

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Primary Care and OB/GYN Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid Managed Care 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 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.

Note: The Primary Care and OB/GYN Access and Availability Survey was not conducted for Reporting Year 2017. The results of the next survey will be published in a future report.

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 4 depicts select Medicaid encounter data for 2017. Rates for this year are also compared to the statewide averages. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼.

Table 4: Medicaid Encounter Data—2017

MCO	Encounters (PMPY)				
	PCPs and OB/GYNs	Specialty	Emergency Room	Inpatient Admissions	Dental
Affinity	3.57	2.31	0.51	0.15	0.85
BCBS WNY	2.84	2.19	0.62	0.09	0.88
CDPHP	3.98	2.29	1.04 ▲	0.10	0.99
Empire BCBS HealthPlus	1.42 ▼	2.74 ▲	0.43	0.09	1.10
Excellus	3.72	1.96	0.72 ▲	0.14	1.20
Fidelis	3.63	2.57	0.53	0.14	1.15
Healthfirst	4.55 ▲	2.52	0.60	0.14	0.98
HIP	3.73	2.41	0.49	0.14	0.77
IHA	4.15	1.99	0.65	0.41 ▲	1.14
MetroPlus	3.38	1.54 ▼	0.67	0.15	0.92
Molina	3.82	2.05	0.66	0.14	1.02
MVP	1.20 ▼	1.02 ▼	0.60	0.16	1.12
UHCCP	3.83	2.07	0.36 ▼	0.13	1.03
WellCare	3.22	1.89	0.57	0.13	0.00 ▼
YourCare	3.60	2.42	0.75 ▲	0.11	1.24
Statewide Average	3.56	2.30	0.55	0.14	1.02

Data Source: MEDS II

PMPY: Per Member Per Year

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 5** lists the Use of Services rates for 2017. 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 ▼).

Table 5: QARR Use of Services Rates—2017

MCO	Outpatient Utilization (PTMY)		Inpatient ALOS			Inpatient Utilization (PTMY)		
	Visits	ER Visits	Medicine	Surgery	Maternity	Medicine	Surgery	Maternity
Affinity	4,904	503	4.0	7.1	3.0	32	12	33
BCBS WNY	4,251	656	4.3	7.6	2.7	37	22 ▲	23 ▼
CDPHP	4,980	654	3.7 ▼	6.3	2.7	33	21 ▲	30
Empire BCBS HealthPlus	4,807	379 ▼	4.6	7.4	3.0	24 ▼	10 ▼	26
Excellus	4,529	653	3.8	6.0	2.6 ▼	31	13	29
Fidelis	5,852 ▲	505	3.8	5.5	2.7 ▼	33	16	33
Healthfirst	5,489	545	4.2	6.2	3.0	35	15	37
HIP	5,054	392	4.6 ▲	4.9 ▼	3.1 ▲	26	20	5 ▼
IHA	4,234 ▼	692 ▲	3.9	7.1	2.9	41 ▲	19	35
MetroPlus	4,580	636	6.9 ▲	7.7 ▲	3.1 ▲	43 ▲	9 ▼	41 ▲
Molina	4,980	661	3.7 ▼	6.2	2.9	39	18	37
MVP	4,972	587	3.9	4.9 ▼	2.8	30	13	39 ▲
UHCCP	5,616 ▲	369 ▼	4.4	6.7	3.0	23 ▼	12	36
WellCare	4,907	452	4.2	7.6 ▲	3.1	40	12	25
YourCare	4,123 ▼	663 ▲	4.0	7.1	2.9	40	17	29
Statewide Average	5,302	512	4.4	6.2	2.9	32	14	33

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 2018 audit findings, as well as results of quality improvement studies, enrollee surveys, and 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® 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2018 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 2018 (MY 2017), 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® 2018 Information System Audit™

As part of the HEDIS® 2018 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® 2018 Final Audit Reports are available within the individual, MCO-specific technical reports.

HEDIS®/QARR Performance Measures

For Reporting Year (RY) 2017, performance measures were organized into the following domains:

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

These domains were further categorized into 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 include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the 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 of measures includes various indicators which are used to measure preventive care and screenings for several health issues. These indicators are used to evaluate how well the MCOs provided these services for their enrollees. The following table describes the measures included in the Effectiveness of Care domain.

Effectiveness of Care Performance 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 13 th 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.
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.

Effectiveness of Care Performance Measures ¹		
Measure Type	Measure Name	Measure Description
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.
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®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
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.

COPD: Chronic Obstructive Pulmonary Disease

¹ Measure descriptions in the HEDIS® 2018 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 6a displays HEDIS®/QARR performance rates for Measurement Year 2017 for the Effectiveness of 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 ▼).

Table 6a: HEDIS®/QARR MCO Performance Rates 2017—Effectiveness of Care¹

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excelsus	Fidelis	Healthfirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	WellCare	YourCare	Statewide Average
Adult BMI Assessment	89	99 ▲	96 ▲	84	94 ▲	88	84	77 ▼	93 ▲	92 ▲	82 ▼	84	78 ▼	94 ▲	88	86
WCC—BMI Percentile	83	84	86	81	90 ▲	87	79 ▼	77 ▼	90 ▲	93 ▲	73 ▼	87 ▲	78 ▼	84	86	84
WCC—Counseling for Nutrition	80	83	83	81	89 ▲	84	81	75 ▼	89 ▲	90 ▲	68 ▼	84	80	81	81	83
WCC—Counseling for Physical Activity	72	76	75	67 ▼	80 ▲	74	69	66 ▼	85 ▲	78 ▲	65 ▼	74	74	70	76	73
Childhood Immunizations—Combo 3	77	74	79	67 ▼	83 ▲	74	80 ▲	68 ▼	81 ▲	87 ▲	80 ▲	77	63 ▼	75	74	75
Lead Screening in Children	90	87	83 ▼	88	87	88	90	85	91 ▲	95 ▲	87	91	83 ▼	85	89	88
Adolescent Immunizations—Combo 2	49 ▲	28 ▼	31 ▼	42	39	37	51 ▲	28 ▼	38	64 ▲	47 ▲	42	18 ▼	37	30 ▼	41
Adolescents—Alcohol and Other Drug Use ²	71	76 ▲	72	61	71	67	63	68	85 ▲	80 ▲	54 ▼	65	61	67	73	67
Adolescents—Depression ²	65	65	66	53	77 ▲	59	54	61	81 ▲	82 ▲	62	60	55	57	71 ▲	61
Adolescents—Sexual Activity ²	70	68	58	58	69	64	63	65	86 ▲	81 ▲	53 ▼	59	59	62	68	65
Adolescents—Tobacco Use ²	75	84 ▲	78	62 ▼	85 ▲	73	64	70	89 ▲	85 ▲	65	72	65	73	76	71
Breast Cancer Screening	68 ▼	59 ▼	65 ▼	73 ▲	65 ▼	71	77 ▲	67 ▼	69	74 ▲	70	68 ▼	65 ▼	67 ▼	69	71
Colorectal Cancer Screening	61	50 ▼	53 ▼	61	56 ▼	61	69 ▲	60	53 ▼	67 ▲	54 ▼	54 ▼	53 ▼	57	55 ▼	62
Chlamydia Screening (Ages 16-24)	77 ▲	62 ▼	67 ▼	77 ▲	59 ▼	72 ▼	81 ▲	75	70 ▼	78 ▲	72	72 ▼	68 ▼	80 ▲	68 ▼	74
Testing for Children with Pharyngitis	86 ▼	92	91	90 ▼	93 ▲	93 ▲	86 ▼	88 ▼	95 ▲	88 ▼	82 ▼	93 ▲	95 ▲	89	92	91
Spirometry Testing for COPD	50	30 ▼	36 ▼	56	43 ▼	59 ▲	65 ▲	50	42 ▼	51	38 ▼	40 ▼	56	54	44 ▼	55
Use of Imaging Studies for Low Back Pain	75	75	71 ▼	83 ▲	74 ▼	72 ▼	81 ▲	78	69 ▼	79 ▲	73	71 ▼	78	80	67 ▼	77
Flu Shots for Adults (Ages 18-64) ³	44	43	42	39	48 ▲	37 ▼	48	44	41	46	45	39	35 ▼	39	46	42
Advising Smokers to Quit ³	85	83	81	76	81	84	77	80	78	79	77	82	69	79	81	80
Smoking Cessation Medications ³	54	64	64	52	65	56	50	57	63	58	63	60	48	63	58	59
Smoking Cessation Strategies ³	46	50	53	45	49	51	38	52	53	55	54	48	43	63	54	51

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.

Acute and Chronic Care

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

Acute and Chronic Care Performance Indicators ¹		
Measure Type	Measure Name	Measure Description
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®	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.
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® 2018 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 6b displays HEDIS®/QARR performance rates for Measurement Year 2017 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 ▼).

Table 6b: HEDIS®/QARR MCO Performance Rates 2017—Acute and Chronic Care¹

Measure	Affinity	BCBS WNY	CDPHP	Empire BCBS HealthPlus	Excellus	Fidelis	Healthfirst	HIP	IHA	MetroPlus	Molina	MVP	UHCCP	WellCare	YourCare	Statewide Average
Pharmacotherapy Management for COPD—Bronchodilators	91	88	84	85	88	89	89	87	93	90	91	86	86	85	83	88
Pharmacotherapy Management for COPD—Corticosteroids	80	79	78	71	80	79 ▲	68 ▼	72	85 ▲	73	82	80	76	72	78	76
Medication Management for People with Asthma 50% (Ages 19-64)	66	70	67	69	69	72 ▲	70	66	63 ▼	70	61	62 ▼	70	69	62 ▼	69
Medication Management for People with Asthma 50% (Ages 5-18)	49 ▼	51	59	54 ▼	60	61 ▲	59 ▲	50 ▼	42 ▼	57	50	52 ▼	56	44 ▼	52	57
Asthma Medication Ratio (Ages 19-64)	50 ▼	56	61	52 ▼	60	63 ▲	51 ▼	58	62	54 ▼	58	61	59	65 ▲	64 ▲	57
Asthma Medication Ratio (Ages 5-18)	53 ▼	68	68	65	68 ▲	73 ▲	54 ▼	66	69	61 ▼	61	70 ▲	72 ▲	67	79 ▲	64
Persistence of Beta-Blocker Treatment After a Heart Attack	76	SS	86	82	85	92 ▲	84	83	97	79	SS	80	82	79	89	85
CDC—HbA1c Testing	91	88 ▼	89	91	89	91	93	91	88 ▼	94 ▲	90	89	90	92	89	91
CDC—HbA1c Control (<8%)	52 ▼	56	60	54	54	64 ▲	59	57	60	59	36 ▼	58	59	59	57	59
CDC—Eye Exam Performed	63	66	69	63	71	72 ▲	70	60 ▼	64	66	64	56 ▼	59 ▼	59 ▼	67	67
CDC—Nephropathy Monitor	90	91	91	93	91	94	92	93	92	93	89 ▼	91	91	93	92	93
CDC—BP Controlled (<140/90 mm Hg)	54 ▼	68 ▲	74 ▲	54 ▼	72 ▲	59	61	56 ▼	69 ▲	70 ▲	57 ▼	66	60	63	65	61
Drug Therapy for Rheumatoid Arthritis	83	74	84	82	90	84	82	84	80	89 ▲	80	80	79	81	82	83
Monitor Patients on Persistent Medications—Total Rate	92	87 ▼	88 ▼	93 ▲	87 ▼	93 ▲	92	91 ▼	88 ▼	93 ▲	90 ▼	90 ▼	92	93	89 ▼	92
Appropriate Treatment for URI	96 ▲	93	94	93 ▼	94 ▼	96 ▲	95	95	95	96 ▲	96	95	92 ▼	95	93 ▼	95
Avoidance of Antibiotics for Adults with Acute Bronchitis	45 ▲	29	36	34	38 ▲	36 ▲	38 ▲	27 ▼	26 ▼	35	30	29 ▼	26 ▼	46 ▲	28	34
HIV Viral Load Suppression ²	78	81	84	73	84 ▲	76	78	72	79	76	80	85 ▲	75	66 ▼	76	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.

Behavioral Health

This section examines the health care services 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® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 6c displays HEDIS®/QARR performance rates for Measurement Year 2017 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 ▼).

Table 6c: HEDIS®/QARR MCO Performance Rates 2017—Behavioral Health¹

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	49	54	53	47 ▼	54 ▲	53	52	49	53	45 ▼	51	54	54	49	52
Antidepressant Medication Management—Effective Continuation Phase	34 ▼	34	37	38	35 ▼	38	38	38	35	37	33	37	39	35	35	37
Follow-Up Care for Children on ADHD Medication—Initiation	63	46 ▼	51 ▼	66 ▲	44 ▼	59	66 ▲	65 ▲	50 ▼	62	61	51 ▼	58	59	51	58
Follow-Up Care for Children on ADHD Medication—Continue	75	60	59	74	51 ▼	67	78 ▲	76	70	80 ▲	77	56 ▼	66	SS	55	66
Follow-Up After Hospitalization for Mental Illness—30 Days	70 ▼	75	84 ▲	77	72 ▼	79 ▲	85 ▲	77	78	69 ▼	61 ▼	79	75 ▼	62 ▼	75	78
Follow-Up After Hospitalization for Mental Illness—7 Days	52 ▼	57	68 ▲	60	56 ▼	63	74 ▲	57	60	51 ▼	43 ▼	62	63	39 ▼	58	62
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	79	76 ▼	81	84	78 ▼	82	85 ▲	79	78	86 ▲	79	82	81	80	79	82
Diabetes Monitoring for People with Diabetes and Schizophrenia	79	56 ▼	85	80	68	81	84	82	86	86	SS	79	80	79	SS	81
Antipsychotic Medications for Schizophrenia	62	65	62	63	61	64	61	67	57	59	52	66	64	65	55	62

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 7a displays HEDIS®/QARR performance rates for Measurement Year 2017 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 ▼).

Table 7a: HEDIS®/QARR MCO Performance Rates 2017—Utilization¹

MCO	Well-Child Visits— First 15 Months	Well-Child Visits— 3 to 6 Year Olds	Adolescent Well-Care Visits
Affinity	83 ▲	82 ▼	64 ▼
BCBS WNY	74	82 ▼	67
CDPHP	63 ▼	83 ▼	66 ▼
Empire BCBS HealthPlus	66 ▼	86 ▲	72 ▲
Excellus	70 ▲	82 ▼	67 ▼
Fidelis	66 ▼	84 ▼	66 ▼
Healthfirst	71 ▲	89 ▲	73 ▲
HIP	66	87 ▲	77 ▲
IHA	66	86	68
MetroPlus	70 ▲	87 ▲	67 ▼
Molina	62 ▼	79 ▼	62 ▼
MVP	69	84 ▼	67 ▼
UHCCP	59 ▼	83 ▼	65 ▼
WellCare	61 ▼	78 ▼	64 ▼
YourCare	61 ▼	84	66 ▼
Statewide Average	68	85	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 certain services, including 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® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 7b displays HEDIS®/QARR performance rates for Measurement Year 2017 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 ▼).

Table 7b: HEDIS®/QARR MCO Performance Rates 2017—Access to Care¹

MCO	Children & Adolescents' Access to PCPs				Adults' Access to Preventive/Ambulatory Services			Access to Other Services		
	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	96	91 ▼	93 ▼	93 ▼	78 ▼	88 ▼	88 ▼	92 ▲	68	53 ▼
BCBS WNY	97	93	98	96 ▲	85 ▲	89	84	88	68	68 ▲
CDPHP	98 ▲	94	97	96 ▲	86 ▲	91 ▲	90	91	68	60
Empire BCBS HealthPlus	97 ▲	95 ▲	98 ▲	96 ▲	81 ▼	88 ▼	90 ▼	87	73	59 ▼
Excelsus	99 ▲	94	97	97 ▲	87 ▲	91 ▲	91	92 ▲	63 ▼	63 ▲
Fidelis	98 ▲	95 ▲	97	96 ▲	82	90	92 ▲	90	73	62 ▲
Healthfirst	93 ▼	94	97	95	84 ▲	92 ▲	93 ▲	90	75	58 ▼
HIP	93 ▼	93 ▼	96 ▼	95	83 ▲	89	88 ▼	80 ▼	61 ▼	50 ▼
IHA	99 ▲	94	97	95	84 ▲	89	85 ▼	87	66 ▼	69 ▲
MetroPlus	94 ▼	92 ▼	96 ▼	93 ▼	77 ▼	89 ▼	91	92 ▲	71	60
Molina	97	93 ▼	96	96	85 ▲	91	90	78 ▼	56 ▼	53 ▼
MVP	98 ▲	95 ▲	98 ▲	97 ▲	83 ▲	89	89	83 ▼	69	66 ▲
UHCCP	97 ▲	94	97	96 ▲	81 ▼	88 ▼	90	76 ▼	71	60
WellCare	92 ▼	87 ▼	93 ▼	92 ▼	69 ▼	83 ▼	88 ▼	88	71	49 ▼
YourCare	97	94	97	95	83 ▲	90	90	86	67	67 ▲
Statewide Average	96	94	97	95	82	90	91	88	71	60

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

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH’s Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO’s rate. Vital statistics data are used in the risk adjustment. **Table 8** presents prenatal care rates calculated by the NYSDOH for QARR 2016. 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 8: QARR Prenatal Care Rates—2016

MCO	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
	NYC				ROS			
Affinity	6%	73% ▼	15%	11% ▼	8%	76%	14%	12%
BCBS WNY					9%	69%	11%	11%
CDPHP					7%	74%	13%	18%
Empire BCBS HealthPlus	6%	80% ▲	14%	15%	13% ▼	74%	17%	13%
Excellus					6%	76%	11%	16%
Fidelis	7%	77%	15%	22%	7%	74%	12%	15%
Healthfirst	6%	74% ▼	14%	15% ▼	8%	78%	11%	12%
HIP	6%	79%	17%	20%	9%	75%	17%	11%
IHA					7%	75%	12%	14%
MetroPlus	7%	67% ▼	14%	14% ▼				
Molina					6%	66% ▼	13%	23%
MVP					6%	79%	13%	11%
UHCCP	6%	81% ▲	13% ▲	39% ▲	8%	76%	15%	10%
WellCare	8%	73%	19%	10%	6%	69%	14%	6%
YourCare					7%	74%	15%	18%
Regional Average	6%	76%	14%	18%	7%	74%	13%	14%

Note: 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

In 2017, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 9** displays the question category, the MCOs' rates, and the statewide averages (SWAs) for Measurement Year 2017. 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 ▼).

Table 9: CAHPS®—2017

MCO	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	74	73	94	85	83	83	77	75	74
BCBS WNY	79	85 ▲	89	83	81	75 ▼	81	70 ▼	66 ▼
CDPHP	86 ▲	85 ▲	93	91 ▲	82	85 ▲	84	83 ▲	87 ▲
Empire BCBS HealthPlus	76	75	89	86	81	78	74	71	76
Excellus	82	79	92	83	79	83	79	84 ▲	80
Fidelis	80	80	93	86	82	81	80	78	77
Healthfirst	73 ▼	75	90	84	76	79	78	75	79
HIP	75	76	90	89	82	78	76	72	67 ▼
IHA	82	82	94 ▲	86	82	86 ▲	88 ▲	79	81 ▲
MetroPlus	71 ▼	71 ▼	90	88	74 ▼	78	77	74	79
Molina	83	78	88	82	83	85	86	78	72
MVP	83 ▲	77	93	92 ▲	80	85 ▲	81	81	85 ▲
UHCCP	76	80	90	81	79	78	79	74	70 ▼
WellCare	78	75	91	84	81	82	76	76	72
YourCare	83	85 ▲	90	87	77	76 ▼	80	77	74
Statewide Average	79	78	91	86	80	81	80	77	76

¹ These indicators are composite measures.

NYSDOH Quality Incentive

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. The NYSDOH Office of Health Insurance Programs (OHIP) calculated the quality incentive using an algorithm which considers the following data elements: QARR data, the most recent Medicaid CAHPS® results, PDI 90 Overall Quality Composite and PQI 90 Preventive Quality Composite, and regulatory compliance information from MY 2015 and MY 2016. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCOs qualified for. MCOs can earn 100 points for quality measures, 30 points for satisfaction measures, 20 points from the PDI/PQI measures, and up to 6 points for approved telehealth plans. A maximum of 20 points may be subtracted from the MCOs' total points based on compliance measures, as well. The total points are normalized to a 100-point scale to determine the MCOs' final scores. MCOs are then placed into one of five tiers to determine the incentive award. The highest performing MCOs are placed in Tier 1, while the lowest performing MCOs are placed in Tier 5. Tiers are based on the percentage of total points earned, and MCOs must meet or exceed the tier threshold to be eligible for the incentive award. **Table 10** displays the points each MCO earned in 2017, as well as the tier the MCOs achieved based on the previous measurement year's data.

Table 10: Quality Incentive Points Earned—2017

MCO	PQI Points (20 Possible)	Compliance Points (-20 Possible)	Satisfaction Points (30 Possible)	Quality Points ¹ (100 Possible)	Bonus Points	Total Points Earned ²	Tier
Affinity	0.0	-12.0	15.0	57.3	6	66.3	Tier 4
BCBS WNY	15.0	-8.0	10.0	55.1	6	78.1	Tier 3
CDPHP	20.0	-4.0	30.0	66.3	6	118.3	Tier 2
Empire BCBS HealthPlus	12.5	-4.0	15.0	73.0	6	102.5	Tier 2
Excellus	5.0	-8.0	15.0	74.2	6	92.2	Tier 3
Fidelis	10.0	-8.0	15.0	88.8	6	111.8	Tier 2
Healthfirst	0.0	-8.0	10.0	97.8	6	105.8	Tier 2
HIP	0.0	-12.0	10.0	55.1	6	59.1	Tier 4
IHA	0.0	-4.0	20.0	67.4	6	89.4	Tier 3
MetroPlus	5.0	-4.0	10.0	100.0	6	117.0	Tier 2
Molina	7.5	-4.0	15.0	39.3	6	63.8	Tier 4
MVP	15.0	-8.0	30.0	61.8	6	104.8	Tier 2
UHCCP	15.0	-4.0	10.0	48.3	6	75.3	Tier 3
WellCare	5.0	-8.0	15.0	57.3	6	75.3	Tier 3
YourCare	0.0	-12.0	15.0	49.4	6	58.4	Tier 4
Statewide Average	7.3	-7.2	15.7	66.1	6	87.9	

¹ Quality points are normalized and rounded to the nearest tenth.

² Total points are rounded to the nearest tenth.

Performance Improvement Projects

As part of the external quality review responsibilities, IPRO assists the MCOs through many steps of the Performance Improvement Project (PIP) process. The contract between the NYSDOH and the MCOs instructs the MCOs to conduct at least one PIP each year. The PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following elements: 1) measurement of performance using objective quality indicators, 2) implementation of interventions to achieve improvement in 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 other MCOs in conducting their PIPs. The common-themed PIP chosen for Reporting Years 2017-2018 was Perinatal Care and Pre-term Births.

The NYS EQRO provided technical assistance to the MCOs throughout the PIP process in the following forms: 1) review of the 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; and 4) feedback on drafts of the MCOs' final reports.

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 conduct of the PIPs are available within the individual, MCO-specific technical reports.

VI. Structure and Operation Standards⁵

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 15 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 11**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 12 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 2017.

⁵ External Appeals data are reported in the Full EQR Technical Report prepared every third year.

Table 11: 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 do 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 12: Summary of Citations—2017

MCO	Operational Citations	Focused Review Citations	Total Citations
Affinity¹	—	9	9
BCBS WNY	12	9	21
CDPHP	5	6	11
Empire BCBS HealthPlus	2	10	12
Excellus¹	—	14	14
Fidelis¹	—	9	9
Healthfirst	2	10	12
HIP¹	—	10	10
IHA	1	4	5
MetroPlus	10	12	22
Molina	3	7	10
MVP¹	—	12	12
UHCCP¹	—	8	8
WellCare	5	9	14
YourCare¹	—	10	10
Statewide Total²	51	153	204

¹ The MCO did not have an operational survey in 2017.

² Note that the statewide totals include findings for MCOs that were operational during the measurement year, but did not have enough members to report sufficient data.

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

VII. Strengths and Opportunities for Improvement⁶

This section summarizes the accessibility, timeliness, and quality of services provided by the MCOs to Medicaid and Child Health Plus recipients based on data presented in the various sections of the individual, MCO-specific technical reports. The MCOs' strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of health care are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCOs have effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCOs' responses to the previous year's recommendations, wherein the MCOs were given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas the MCO did not feel were within their ability to improve, is appended to this section of the MCO-specific technical reports.

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.

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.

VIII. 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:*
 - NYSDOH OMC Membership Data, 2016-2017
 - MEDS II
 - Managed Care Enrollment Report
- *Provider Network:*
 - State Model Contract
 - QARR Measurement Year 2017

C. Utilization

- *Encounter Data:*
 - MMC Encounter Data System, 2017
 - MEDS II
- *QARR Use of Services:*
 - QARR Measurement Year 2017

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
 - QARR Measurement Year 2017
- *CAHPS® 2017:*
 - QARR Measurement Year 2017
- *NYSDOH Quality Incentive:*
 - Quality/Satisfaction Points and Incentive, 2017
- *Performance Improvement Project:*
 - 2017-2018 PIP Reports

E. Structure and Operations

- MMC Operational Deficiencies by Plan/Category, 2017
- Focused Deficiencies by Plan/Survey Type/Category, 2017