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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

EMPIRE BCBS HEALTHPLUS, LLC.
[AN AMERIGROUP COMPANY]

Reporting Year 2017

FINAL REPORT

Published April 2019

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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 (C):	*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 (M):	*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*
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."*

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 toward its goals.

Scope of This Report

In accordance with federal regulations, the technical report summarizes 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 structure, enrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction/quality points and incentive, and deficiencies and citations summaries[1].

Structure of This Report

This report is organized into the following domains: MCO Corporate Profile, Enrollment and Provider Network, Utilization, Performance Indicators, and Structure and Operation Standards. Although the technical reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP) and Commercial product lines. The CHP product line is the NYS version of the federal Child Health Insurance Program (CHIP), which provides health coverage to eligible children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. CHP data are part of the Medicaid managed care data sets used in this report. For some measures, including QARR 2018 (MY 2017), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

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

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. Where trending is desirable, data for prior years may also be included. This report includes data for Reporting Year 2017.

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

II. MCO Corporate Profile

HealthPlus HP, LLC (formerly known as Amerigroup New York, LLC) is a regional, for-profit prepaid health services plan (PHSP) that serves Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Medicare, and Managed Long-Term Care (MLTC) populations. In 2004, AMERIGROUP Corporation (parent company of Amerigroup New York, LLC) acquired CarePlus, which operated as a distinct business entity until 2006. In 2007, the CarePlus health plan rebranded to Amerigroup New York, LLC. In May 2012, AMERIGROUP Corporation acquired HealthPlus PHSP, Inc. and rebranded the Amerigroup New York, LLC health plan to its current name, Empire BlueCross BlueShield HealthPlus (HealthPlus). In November 2012, AMERIGROUP Corporation was purchased by WellPoint, Inc., and Indiana Corporation (Anthem). The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

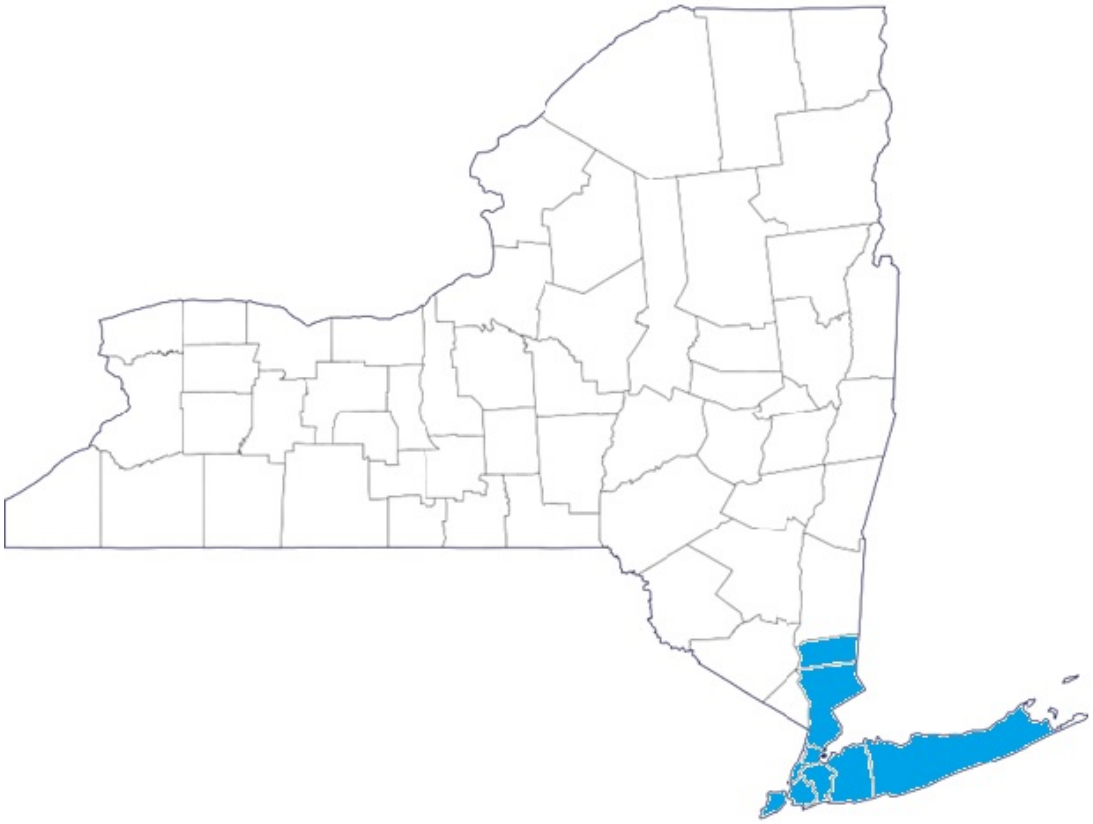
- Plan ID: 2180196
- DOH Area Office: MARO
- Corporate Status: PHSP
- Tax Status: For-profit
- Medicaid Managed Care Start Date: January 12, 1996
- Product Line(s): Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Medicaid Advantage, Medicaid Advantage Plus (MAP), Medicare, and Managed Long-Term Care (MLTC)
- Contact Information: 9 Pine Street, 14th Floor
  New York, NY 10005
  (212) 372-6902
- NCQA Accreditation Rating[2] (as of 10/15/18):
- Medicaid Dental Benefit Status: Mandatory

Participating Counties and Products

Bronx:	MCD	CHP	**Kings:**	MCD	CHP		**Nassau:**	MCD	CHP	HARP
New York:	MCD	CHP	**Putnam:**	MCD	CHP	HARP	**Queens:**	MCD	CHP	
Richmond:	MCD	CHP	**Suffolk:**		CHP		**Westchester:**		CHP	

[2] For further information on the NCQA Accreditation Rating, please refer to www.ncqa.org.

Figure 1: HealthPlus Map of Participating Counties



III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2015, 2016, and 2017, as well as the percent change from the previous year. Enrollment has decreased from 2016 to 2017 by a rate of 4.2%. HealthPlus' membership represents 7.9% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2015-2017

	2015	2016	2017
Number of Members	393,872	361,963	346,593
% Change from Previous Year		-8.1%	-4.2%
Statewide Total[1]	4,593,911	4,349,457	4,378,153
% of Total Medicaid Enrollment	8.6%	8.3%	7.9%

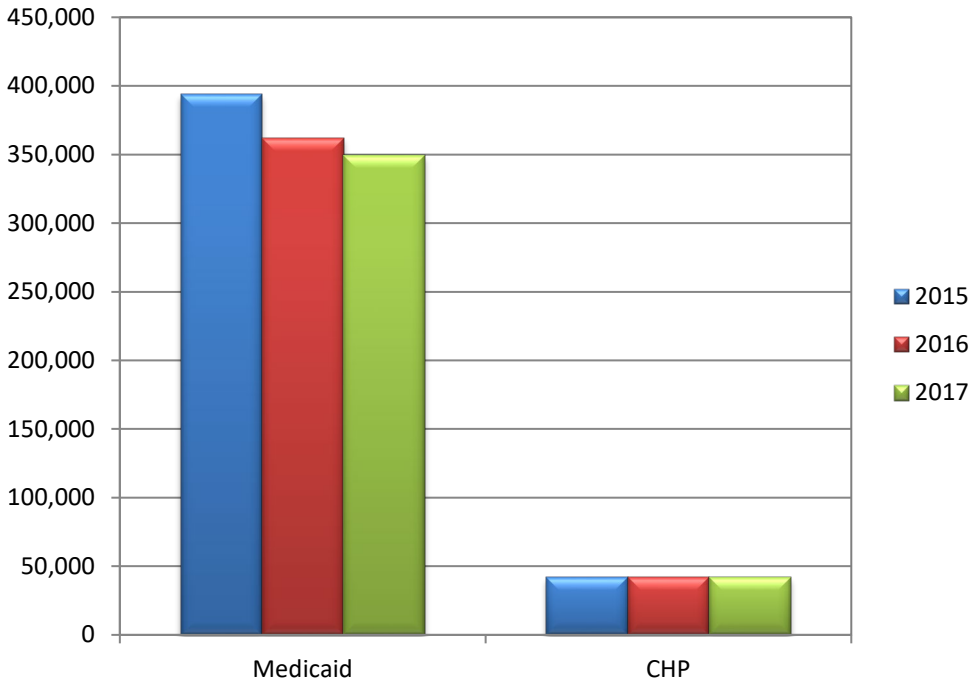
Data Source: MEDS II

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

Table 2: Enrollment in Other Product Lines—2015-2017

	2015	2016	2017
CHP	41,757	42,251	42,051

Figure 2: HealthPlus Enrollment Trends—All Product Lines



Provider Network

This section of the report examines the MCO's provider network through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey[3]. 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 that 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."*

[3] Additional data on 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 certification[4].

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 certificates[5]. 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 MCO's provider network that are board-certified in their specialty. **Table 3** displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2015 through 2017, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average.

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

[5] 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—2015-2017

Provider Type	2015		2016		2017	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
			Medicaid/CHP			
Family Medicine	*SS*	77%	31% ▼	71%	35% ▼	72%
Internal Medicine	66% ▼	76%	72% ▼	75%	70% ▼	76%
Pediatricians	66% ▼	79%	75% ▼	78%	75% ▼	79%
OB/GYN	72% ▼	76%	70% ▼	75%	75%	77%
Geriatricians	50% ▼	63%	51% ▼	63%	49% ▼	63%
Other Physician Specialists	71% ▼	76%	72% ▼	75%	76%	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 with OB/GYN providers is stated in Section 15.2(a)(ix) as follows: *"…within three (3) weeks during the first trimester, within two (2) weeks during the second trimester, and within one (1) week during the third trimester."*

As noted previously, the Survey also assesses MCO compliance with standards for after-hours access. Section 15.3 of the Contract outlines requirements for providers for 24-hour access to care for members. Section 15.3(a) states *"The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour, seven (7) days a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends."* The Contract also states, in Section 15.3(b), that MCOs can satisfy this requirement *"…by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after-hours "on-call" 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 MCO's services by examining encounter data, as well as QARR Use of Services rates.

Encounter Data

Table 4 depicts selected Medicaid encounter data for 2015 through 2017. Rates for this period are also compared to the statewide averages. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼.

Table 4: Medicaid Encounter Data—2015-2017

	Encounters (PMPY)					
	2015		2016		2017	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
PCPs and OB/GYNs	2.67 ▼	4.12	1.47 ▼	3.85	1.42 ▼	3.56
Specialty	2.35	1.92	2.83	2.45	2.74 ▲	2.30
Emergency Room	0.44	0.54	0.44	0.54	0.43	0.55
Inpatient Admissions	0.11	0.14	0.10	0.14	0.09	0.14
Dental	0.93	0.99	1.11	1.03	1.10	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 MCO's rates reached the 90th or 10th percentile. **Table 5** lists the Use of Services rates for 2015 through 2017, as well as the statewide averages for 2017. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

Table 5: QARR Use of Services Rates—2015-2017

Measure	Medicaid/CHP			
	2015	2016	2017	2017 Statewide Average
Outpatient Utilization (PTMY)				
Visits	4,966	4,798	4,807	5,302
ER Visits	420	403 ▼	379 ▼	512
Inpatient ALOS				
Medicine	4.0	4.1	4.6	4.4
Surgery	7.3	6.9	7.4	6.2
Maternity	3.1	3.0 ▲	3.0	2.9
Total	4.3	4.2	4.5	4.3
Inpatient Utilization (PTMY)				
Medicine Cases	30 ▼	26 ▼	24 ▼	32
Surgery Cases	11 ▼	10 ▼	10 ▼	14
Maternity Cases	30	29	26	33
Total Cases	64	57 ▼	52 ▼	71

PTMY: Per Thousand Member Years

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 the 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 the 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 MCO's 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.

The HEDIS® Final Audit Report prepared for Empire BCBS HealthPlus indicated that the MCO had no significant issues in any areas related to reporting. The MCO demonstrated compliance with all areas of Information Systems and all areas of Measure Determination required for successful HEDIS® reporting. The MCO was able to report

rates for all measures for all applicable product lines. Empire BCBS HealthPlus passed Medical Record Review for the five measures validated, as well as for Exclusions.

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

HEDIS®/QARR Performance Measures

For Reporting Year (RY) 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 MCO's 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 MCO provided these services for their enrollees. The following table describes the measures included in the Effectiveness of Care domain.

Effectiveness of Care Performance Indicators[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.
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, one HiB, 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.

Effectiveness of Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
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.
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 vaccine 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 the HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Effectiveness of Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 6a: HEDIS®/QARR MCO Performance Rates 2015-2017—Effectiveness of Care[1]

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Adult BMI Assessment	83 ▼	81 ▼	84	**86**
WCC—BMI Percentile	71 ▼	75	81	**84**
WCC—Counseling for Nutrition	76	78	81	**83**
WCC—Counseling for Physical Activity	65 ▼	64 ▼	67 ▼	**73**
Childhood Immunizations—Combo 3	76	73	67 ▼	**75**
Lead Screening in Children	92 ▲	89	88	**88**
Adolescent Immunizations—Combo 2[2]			42	**41**
Adolescents—Alcohol and Other Drug Use[3]	61	63	61	**67**
Adolescents—Depression[3]	47 ▼	56	53	**61**
Adolescents—Sexual Activity[3]	57	64	58	**65**
Adolescents—Tobacco Use[3]	57 ▼	65 ▼	62 ▼	**71**
Breast Cancer Screening	73 ▲	71	73 ▲	**71**
Colorectal Cancer Screening	57	60	61	**62**
Chlamydia Screening (Ages 16-24)	76 ▲	75 ▲	77 ▲	**74**
Testing for Children with Pharyngitis	90 ▲	89	90 ▼	**91**
Spirometry Testing for COPD	57	54	56	**55**
Use of Imaging Studies for Low Back Pain	80 ▲	84 ▲	83 ▲	**77**
Flu Shots for Adults (Ages 18-64)[4]	47 ▲	47 ▲	39	**72**
Advising Smokers to Quit[4]	74	74	76	**80**
Smoking Cessation Medications[4]	51	51	52	**59**
Smoking Cessation Strategies[4]	49	49	45	**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] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2017, *Combination 2* is reported, as it includes the HPV component.

[3] NYS-specific measure.

[4] 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 period.
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 Years 2015, 2016, and 2017 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 6b: HEDIS®/QARR MCO Performance Rates 2015-2017—Acute and Chronic Care[1]

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Pharmacotherapy Management for COPD—Bronchodilators	91	87	85	**88**
Pharmacotherapy Management for COPD—Corticosteroids	74	68	71	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	65	63 ▼	69	**69**
Medication Management for People with Asthma 50% (Ages 5-18)	51	52	54 ▼	**57**
Asthma Medication Ratio (Ages 19-64)	51 ▼	51 ▼	52 ▼	**57**
Asthma Medication Ratio (Ages 5-18)	67 ▲	67 ▲	65	**64**
Persistence of Beta-Blocker Treatment After a Heart Attack	84	81	82	**85**
CDC—HbA1c Testing	90	93	91	**91**
CDC—HbA1c Control (<8%)	54	56	54	**59**
CDC—Eye Exam Performed	63	65	63	**67**
CDC—Nephropathy Monitor	93	95 ▲	93	**93**
CDC—BP Controlled (<140/90 mm Hg)	67	66	54 ▼	**61**
Drug Therapy for Rheumatoid Arthritis	81	83	82	**83**
Monitor Patients on Persistent Medications—Total Rate	92	92	93 ▲	**92**
Appropriate Treatment for URI	93 ▼	94	93 ▼	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	33 ▲	35 ▲	34	**34**
HIV Viral Load Suppression[2,3]		73 ▼	73	**77**

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.

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

Behavioral Health

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

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 Years 2015, 2016, and 2017 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 6c: HEDIS®/QARR MCO Performance Rates 2015-2017—Behavioral Health[1]

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Antidepressant Medication Management—Effective Acute Phase	53	48	53	**52**
Antidepressant Medication Management—Effective Continuation Phase	37	35	38	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	61	68 ▲	66 ▲	**58**
Follow-Up Care for Children on ADHD Medication—Continue	75	79 ▲	74	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	77	76	77	**78**
Follow-Up After Hospitalization for Mental Illness—7 Days	63	61	60	**62**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	81	82	84	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	75	85	80	**81**
Antipsychotic Medications for Schizophrenia	63	61	63	**62**

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

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

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 the 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 Years 2015, 2016, and 2017 for the Utilization domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 7a: HEDIS®/QARR MCO Performance Rates 2015-2017—Utilization[1]

Measure	2015	2016	2017	2017 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	66 ▲	64	66 ▼	**68**
Well-Child Visits—3 to 6 Year Olds	86 ▲	86 ▲	86 ▲	**85**
Adolescent Well-Care Visits	69 ▲	70 ▲	72 ▲	**68**

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

Access to Care

The HEDIS®/QARR Access to Care measure 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 Preventive/ Ambulatory 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 Years 2015, 2016, and 2017 for the Access to Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼).

Table 7b: HEDIS®/QARR MCO Performance Rates 2015-2017—Access to Care[1]

Measure	Medicaid/CHP			
	2015	2016	2017	2017 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	95%	97%	97% ▲	**96%**
25 Months-6 Years	95% ▲	96% ▲	95% ▲	**94%**
7-11 Years	98% ▲	98% ▲	98% ▲	**97%**
12-19 Years	96% ▲	96% ▲	96% ▲	**95%**
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	82% ▼	82% ▼	81% ▼	**82%**
45-64 Years	89% ▼	89% ▼	88% ▼	**90%**
65+ Years	89%	89%	90% ▼	**91%**
Access to Other Services				
Timeliness of Prenatal Care	87%	90%	87%	**88%**
Postpartum Care	74% ▲	71%	73%	**71%**
Annual Dental Visit[2]	62% ▲	61% ▲	59% ▼	**60%**

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 8** presents prenatal care rates calculated by the NYSDOH for QARR 2014 through 2016 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 8: QARR Prenatal Care Rates—2014-2016

Measure	2014		2015		2016	
	Empire BCBS HealthPlus	Regional Average	Empire BCBS HealthPlus	Regional Average	Empire BCBS HealthPlus	Regional Average
NYC						
Risk-Adjusted Low Birth Weight[1]	6%	6%	7%	6%	6%	6%
Prenatal Care in the First Trimester	79% ▲	75%	78% ▲	75%	80% ▲	76%
Risk-Adjusted Primary Cesarean Delivery[1]	16% ▼	15%	16% ▼	14%	14%	14%
Vaginal Birth After Cesarean	11% ▼	18%	15%	18%	15%	18%
ROS						
Risk-Adjusted Low Birth Weight[1]	7%	7%	9%	7%	13% ▼	7%
Prenatal Care in the First Trimester	74%	74%	74%	74%	74%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	10%	13%	15%	14%	17%	13%
Vaginal Birth After Cesarean	9%	13%	13%	14%	13%	14%

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 MCO's rates, and the statewide averages for Measurement Years 2013, 2015, and 2017 for the Medicaid product line. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼).

Table 9: CAHPS®—2013, 2015, 2017

Measure	2013		2015		2017	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
			Medicaid			
Flu Shots for Adults Ages 18-64	48	**44**	47 ▲	**40**	39	**42**
Advising Smokers to Quit	67 ▼	**78**	74	**80**	76	**80**
Getting Care Needed[1]	76	**78**	74 ▼	**79**	76	**79**
Getting Care Quickly[1]	71 ▼	**78**	75	**80**	75	**78**
Customer Service[1]	82	**82**	82	**84**	86	**86**
Coordination of Care[1]	77	**78**	76	**80**	79	**81**
Collaborative Decision Making[1]	49	**48**	75	**79**	81	**80**
Rating of Personal Doctor[1]	76	**78**	76	**80**	78	**81**
Rating of Specialist	73	**76**	74	**80**	74	**80**
Rating of Healthcare	70	**71**	74	**75**	71	**77**
Satisfaction with Provider Communication[1]	89	**89**	89	**91**	89	**91**
Wellness Discussion	62 ▼	**71**	64	**68**	68	**72**
Getting Needed Counseling/Treatment	60	**70**	60 ▼	**74**	42 ▼	**69**
Rating of Counseling/Treatment	59	**61**	59	**64**	37 ▼	**60**
Rating of Health Plan—High Users	71	**77**	77	**77**	76	**80**
Overall Rating of Health Plan	74	**76**	78	**76**	76	**76**
Recommend Plan to Family/Friends	92	**92**	94	**93**	92	**92**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2017

Table 10 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Utilization and Access to Care measures reported annually in the New York State Managed Care Plan Performance Report. Thirty-nine measures were included for the Measurement Year (MY) 2017 Medicaid Quality Performance Matrix, which include combined measures for the Medicaid and CHP product lines. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid MCOs through a percentile ranking.

The Quality Performance Matrix is partitioned into cell categories (A-F). The cell category in which the measures are placed is determined by year-over-year performance on the horizontal axis and an evaluation of the MCO's performance based on a percentile ranking on the vertical axis. The percentile ranking is partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. For MY 2017, the MCO was required to follow up on no more than three measures from the D and F categories of the Matrix. If the MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow up.

Table 10: Quality Performance Matrix—Measurement Year 2017

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
▲	**C**	**B**	**A**
No Change	**D** Annual Dental Visits (Ages 2-18) Childhood Immunization Status (Combo 3) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days Engagement of Alcohol and Other Drug Dependence Treatment—Total Rate Managing Diabetes Outcomes—HbA1c Control (<8.0%) Medication Management for People with Asthma 75% of Days Covered (Ages 5-64) Weight Assessment for Children and Adolescents—BMI Percentile Weight Assessment for Children and Adolescents—Counseling for Physical Activity Well-Child Visits in the First 15 Months of Life (5+ Visits) Timeliness of Prenatal Care HIV Viral Load Suppression	**C** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Adolescent Immunizations (Combo 2) Antidepressant Medication Management—Effective Acute Phase Treatment Antidepressant Medication Management—Effective Continuation Phase Treatment Breast Cancer Screening Cervical Cancer Screening Colon Cancer Screening Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications Follow-Up After Emergency Department Visit for Mental Illness—7 Days Follow-Up After Hospitalization for Mental Illness—7 Days Initiation of Alcohol and Other Drug Dependence Treatment—Total Rate Medication Management for People with Asthma 50% of Days Covered (Ages 5-64) Monitoring Diabetes—Received All Tests Statin Therapy for Patients with Cardiovascular Disease—Adherence Use of Spirometry Testing in the Assessment and Diagnosis of COPD Weight Assessment and Counseling for Children and Adolescents—Counseling for Nutrition Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Postpartum Care	**B** Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase Metabolic Monitoring for Children and Adolescents on Antipsychotics
▼	**F** Advising Smokers to Quit Controlling High Blood Pressure Discussing Smoking Cessation Medications Discussing Smoking Cessation Strategies Flu Shots for Adults (Ages 18-64)	**D** Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase	**C**

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 MCO 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 MCO's total points based on compliance measures, as well. The total points are normalized to a 100-point scale to determine the MCO's final score. 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 11** displays the points the MCO earned from 2015 to 2017, as well as the tier of incentive awards the MCO achieved based on the previous measurement year's data. **Table 12** displays the measures that were used to calculate the 2017 incentive, as well as the points the MCO earned for each measure.

Table 11: Quality Incentive Points Earned—2015-2017

	2015		2016		2017	
	Empire BCBS HealthPlus	**Statewide Average**	**Empire BCBS HealthPlus**	**Statewide Average**	**Empire BCBS HealthPlus**	**Statewide Average**
Total Points *(150 Possible Points)*	79.2	75.2	87.7	92.5	102.5	87.9
PQI Points *(20 Possible Points)*	0.0	6.9	0.0	7.3	12.5	7.3
Compliance Points *(-20 Possible Points)*	-2.0	-3.6	-2.0	-2.3	-4.0	-7.2
Satisfaction Points *(30 Possible Points)*	10.0	20.0	15.0	15.7	15.0	15.7
Bonus Points *(6 Possible Points)*			6.0	6.0	6.0	6.0
Quality Points[1] *(100 Possible Points)*	71.2	56.0	68.7	66.4	73.0	66.1
Financial Incentive Award Designation[2]	Tier 3		Tier 3		Tier 2	

[1] Quality points presented here are normalized.

[2] The highest performing tier level is Tier 1, while the lowest performing tier level is Tier 5.

Table 12: Quality Incentive Measures and Points Earned—2017

Measure	MCO Points
PQI (10 points each)	**12.5**
Adult Prevention Quality Overall Composite (PQI 90)	7.5
Pediatric Quality Overall Composite (PDI 90)	5.0
Compliance (-4 points each, except where noted)	**-4.0**
MMCOR	0.0
MEDS	0.0
QARR	0.0
Access/Availability *(-2 points)*	-2.0
Provider Directory *(-2 points)*	-2.0
Member Services	0.0
Satisfaction (10 points each)	**15.0**
Rating of Health Plan	5.0
Getting Care Needed	5.0
Customer Service	5.0
Bonus Points (6 points)	**6.0**
Telehealth Plan	6.0
Quality (3.33 points each)	**54.113**
Annual Dental Visit (Ages 2-18)	0.00
Antidepressant Medication Management	3.33
Breast Cancer Screening	3.33
Cervical Cancer Screening	1.665
Chlamydia Screening	2.498
Childhood Immunization Status—Combination 3	0.00
Colorectal Cancer Screening	2.498
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	0.00
Comprehensive Diabetes Care—Received All Tests	1.665
Controlling High Blood Pressure	0.00
Flu Shots for Adults	0.00
Immunizations for Adolescents—Combination 2	3.33
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3.33
Medical Assistance with Tobacco Cessation (Composite Rate)	0.00
Medication Management for People with Asthma (Ages 5-64)	1.665
Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	2.498
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	3.33
Weight Assessment and Counseling for Children and Adolescents	0.00
Well-Child Visits in the First 15 Months of Life—Five or More Visits	0.00
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	2.498
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1.665
Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications	3.33
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	3.33
Follow-Up After Emergency Department Visit for Mental Illness—7 Days	3.33
Follow-Up After Hospitalization for Mental Illness—7 Days	3.33
Follow-Up for Children Prescribed ADHD Medication	1.665
Metabolic Monitoring for Children and Adolescents on Antipsychotics	3.33
Timeliness of Prenatal Care	0.00
Postpartum Care	2.498
HIV Viral Load Suppression	0.00
Total Normalized Quality Points[1]	**73.0**
Total Points Earned	**102.5**

MMCOR: Medicaid Managed Care Operating Report; MEDS: Medicaid Encounter Data Set

[1] Quality Points were normalized before being added to the total points earned. The points each MCO earned for each quality measure were aggregated and converted to normalized quality points. Quality points were normalized in order to control

for a difference in base points, as not every MCO could earn points for each measure due to small sample sizes (less than 30 members).

Performance Improvement Project

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

The purpose of a PIP is to assess and improve the processes and outcomes of the health care provided by an MCO. Protocol 3 of CMS' Federal Regulation 42 CFR §438, subpart E specifies procedures for EQROs to use in assessing the validity and reliability of a PIP. Protocol 3 describes how to conduct the following activities: assessment of study methodology, verification of study findings, and evaluation of overall reliability and validity of study results.

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may be categorized as infrequent conditions or services, and also exist for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special needs place them at high risk. The State may select the MCO's study topic(s), or topics may be selected based on enrollee input. While MCOs have the option to select a study topic of their choosing, they are encouraged to participate collaboratively with other MCOs in conducting their PIPs. 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 MCO's Project Proposal prior to the start of the PIP; 2) quarterly teleconferences with the MCO for progress updates and problem-solving; 3) providing feedback on methodology, data collection tools, and implementation of interventions; and 4) feedback on drafts of the MCO's final report.

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

Empire BCBS HealthPlus' 2017-2018 PIP topic was *"Perinatal Care: A collaborative approach to improve maternal health outcomes"*. During 2017, the MCO implemented the following interventions:

Member-Focused Interventions:

- Members identified as smokers via the OB Screening Tool will receive HealthCrowd Texting to promote smoking cessation.
- Women identified as pregnant via the OB Screening Tool and women 2-4 weeks postpartum will receive the Family Planning Brochure from the OB Health Promotion Team, which covers family life plans, optimal birth spacing, and contraception options.
- Members receive access to the multi-channel maternity outreach program "My Advocate", which delivers messages to pregnant women via phone, text, app, or web. Messages include education and continuous screening for depression and smoking cessation during pregnancy and postpartum.

Provider-Focused Interventions:

- Universal provider education, including quarterly fax blasts to all OB/GYN providers in the following topics: 17P usage and authorization process, depression screening guidelines, tobacco screening guidelines, LARC insertion guidelines, billing guidance (including appropriate CPT codes for depression and tobacco screening), and the NYCDOHMH Depression Screening and Treatment Guidelines.
- Targeted provider outreach to 22 OB/GYN providers, including quarterly face-to-face visits to discuss comprehensive perinatal services and highlight the four focus areas of the PIP.
- Collaboration between the MCO's OB Case Management Program and NYU Lutheran's Women's Health Services for care coordination and follow-up on high-risk pregnant women screened for depression and for smoking counseling.

MCO-Focused Interventions:

- OB Health Promotion Team will track tobacco use via the OB Screening Tool administered to all pregnant women upon enrollment. Identified members will be educated on the NYS Smokers' Quitline and provided assistance to complete and submit the referral. Referral data will also be tracked.
- The Health Promotion Team will include education on the four focus areas of the PIP into maternal child health workshops.

Table 13 presents a summary of Empire BCBS HealthPlus' 2017-2018 PIP.

Table 13: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	85.6%		90.6%	
Postpartum Care	66.7%		71.7%	
17P—One Injection within 16-21 Weeks Gestation	0.0%		25.0%	
17P—Any Claim in 280 Days Before Delivery	27.0%		32.0%	
Tobacco Screening	83.0%		88.0%	
Screened Positive for Tobacco Use	32.0%		22.0%	
Positive for Smoking with Follow-Up	47.0%		52.0%	
Depression Screening	45.0%		50.0%	
Depression Screening with Standardized Tool	41.0%		46.0%	
Screened Positive for Depression	11.0%		6.0%	
Screened Positive for Depression with Evidence of Follow-Up	22.0%		27.0%	

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Most or Moderately Effective Contraception within 3 days of delivery(Ages 15-20)	0.0%		5.0%	
Most or Moderately Effective Contraception within 3 days of delivery(Ages 21-44)	1.0%		9.0%	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 15-20)	33.0%		38.0%	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 21-44)	31.0%		36.0%	
LARC within 3 days of delivery(Ages 15-20)	0.0%		5.0%	
LARC within 3 days of delivery(Ages 21-44)	0.0%		5.0%	
LARC within 60 days of delivery(Ages 15-20)	2.0%		7.0%	
LARC within 60 days of delivery(Ages 21-44)	4.0%		9.0%	
Postpartum Care	65.0%		70.0%	
Postpartum Visit with Evidence of Discussion of Contraception	72.0%		77.0%	

LARC: Long-Acting Reversible Contraception

Note: Results are not shown, as 2017 was the first phase of the MCO's two-year PIP. Results will be included in the 2018 EQR Technical Report.

VI. Structure and Operation Standards[6]

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

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO with Article 44 of the Public Health Law and Part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in **Table 15**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO was not in compliance.

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

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

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of compliance with structure and operation standards. The focused review types are summarized in **Table 14**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 15 reflects the total number of citations for the most current operational survey of the MCO, if applicable, as well as from focused reviews conducted in 2017. This table reflects the findings from reviews of the MCO as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can result in multiple citations.

Empire BCBS HealthPlus was in compliance with 11 of the 14 categories. The categories in which the MCO was not compliant were Disclosure (4 citations), Organization and Management (4 citations), and Service Delivery Network (4 citations).

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

Table 14: 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 15: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	4
Provider Directory Information		*2*
Provider Participation—Directory		*2*
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	0	4
Access and Availability		*2*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	2	2
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Utilization Review	0	0
Total	**2**	**10**

VII. Strengths and Opportunities for Improvement[7]

This section summarizes the accessibility, timeliness, and quality of services provided by the MCO to Medicaid and Child Health Plus recipients based on data presented in the previous sections of this report. The MCO's 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 MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths:

- In the HEDIS®/QARR Effectiveness of Care domain, the MCO has reported rates above the statewide average for at least three consecutive reporting years for *Chlamydia Screening in Women (Ages 16-24)* and *Use of Imaging Studies for Low Back Pain*. Additionally, the MCO's rate for *Breast Cancer Screening* was reported above the statewide average for 2017.
- In the HEDIS®/QARR Acute and Chronic Care and Behavioral Health domains, the MCO reported rates above the statewide average for *Annual Monitoring for Patients on Persistent Medications—Total Rate* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase.*
- The MCO performed well in regard to HEDIS®/QARR Access/Timeliness Indicators for children and adolescents. The MCO has reported rates above the statewide average for at least three consecutive reporting years for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures, as well as for the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* measure: *25 Months-6 Years, 7-11 Years,* and *12-19 Years*. The MCO's rate for the *12-24 Months* age group of the *Children and Adolescents' Access to Primary Care Practitioners* measure was reported above the statewide average for 2017, as well.

Opportunities for Improvement:

- The MCO has reported rates below the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *Internal Medicine, Pediatricians,* and *Geriatricians*. The MCO's rate for *Family Medicine* was reported below the statewide average for 2017, as well. *(Note: board certification was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Weight Assessment and Counseling for Children and Adolescents—Counseling for Physical Activity* and *Adolescent Preventive Care—Tobacco Use*. Additionally, the MCO's rates for *Childhood Immunization Status—Combination 3* and *Appropriate Testing for Children with Pharyngitis* were reported below the statewide average for 2017. *(Note: Weight Assessment and Counseling for Children and Adolescents—Counseling for Physical Activity and Adolescent Preventive Care—Tobacco Use were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Acute and Chronic Care domain. The MCO has reported a rate below the statewide average for at least three consecutive

[7] 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.

reporting years for the *Asthma Medication Ratio (Ages 19-64)* measure, while rates for *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18), Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg),* and *Appropriate Treatment for Children with Upper Respiratory Infection* were reported below the statewide average for 2017. *(Note: Asthma Medication Ratio (Ages 19-64) was an opportunity for improvement in the previous year's report.)*

- The MCO continues to demonstrate opportunities for improvement in regard to access to care for specific populations, including adults and infants. The MCO has reported rates below the statewide average for at least three consecutive years for the *Adults' Access to Preventive/Ambulatory Health Services* measure for both *20-44 Years* and *45-64 Years*, while the rate for the *65+ Years* age group was reported below the statewide average for 2017. Additionally, rates for *Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Annual Dental Visit (Ages 2-20)* were reported below the statewide average for 2017. *(Note: Adults' Access to Preventive/Ambulatory Health Services was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regard to member satisfaction. The MCO reported rates below the statewide average for *Getting Needed Counseling/Treatment* and *Rating of Counseling/Treatment* for the 2017 CAHPS® member satisfaction survey.
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 12 citations from the operational and focused review surveys related to Disclosure, Organization and Management, and Service Delivery Network. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO should evaluate its current intervention strategies aimed at improving HEDIS®/QARR measures that consistently perform below average. The MCO should also continue to analyze and identify barriers to care in order to inform the intervention strategy. *[Repeat recommendation.]*
- The MCO should investigate the performance of preventive care measures for children and adolescents in comparison with the performance of measures related to access to care. As the MCO performed well in regard to access to care for these populations, but reported below average rates for certain preventive care measures for the same, the MCO should look at barriers preventive providers from conducting these services, such as time during well-visits or improper or missing coding.
- As the MCO continues to struggle to improve performance related to access to care for adult members, the MCO should re-evaluate its current strategy aimed at improving performance in this area and continue to conduct barrier and root cause analyses to determine the key drivers of poor performance to inform enhancing current initiatives or implemented new initiatives. *[Repeat recommendation.]*
- The MCO should work to address the issues identified in the operational and focused review surveys. As the citations are all related to provider data accuracy and accessibility of providers, the MCO should enhance its current strategy of an annual request for updated information to a more frequent request, such as quarterly. The MCO should also assess the impact of the suppression of providers who do not respond to the annual request on members' access to care to ensure that there is not a negative impact. *[Repeat recommendation.]*

Response to Previous Year's Recommendations:

Note: The responses below are taken directly from the MCO and are not edited for content.

- **2016 Recommendation:** As the MCO did not meet the 75% compliance threshold for most call types included in the Primary Care and OB/GYN Access and Availability Survey, the MCO should take steps to

ensure providers in its network are aware of the appointment availability standards, are scheduling appointments within the contractual timeframes, and have appropriate after-hours access in place.

MCO Response: Empire Blue Cross Blue Shield HealthPlus (the Plan continually monitors its provider network to ensure providers are aware of what is required from them when it comes to Appointment Availability and After Hours standards. As part of the Plan's strategy to increase the compliance threshold to said standards, the Plan routinely educates Primary Care and OB/GYN providers of their Access and Availability responsibilities. Provider Relations Account Managers were provided with a detailed communication to remind providers of their responsibilities as part of a re-education campaign by Leadership for use during provider contact or provider office visits. Moreover, said communication was posted to the health plan's public provider website (https://mediproviders.empireblue.com/ProviderUpdates/NYNY_CAID_ApptAccessAvailability.pdf) for reference by Empire BlueCross BlueShield HealthPlus' provider network.

Additionally, the Plan performs a detailed telephonic provider survey twice per year to confirm adherence to Appointment Availability and After Hours standards and further increase the compliance threshold. This is accomplished through the Plan's survey partner, Morpace. The Morpace surveyor contacts Primary Care and OB/GYN provider office telephonically and would speak with a representative at said provider's office. The surveyor would reveal he or she was calling on behalf of the Plan to evaluate member access to care. The calls would not be conducted using a secret shopper methodology. The Morpace surveyor presented different scenarios of seeking care and asked when a provider in that office could see a member for each scenario. The responses would then be measured against the Appointment Availability and After Hours contractual timeframes for each type of care sought.

Additionally, providers who failed the Plan's Appointment Availability and After Hours standards after completion of the survey would be contacted by mail in a follow-up education mailing campaign. The mailing would outline the provider's specific areas of noncompliance and asked providers to respond to the health plan within 15 business days outlining actions taken to remedy the issues. The Plan then works with its survey partner to resurvey the failing providers during its next wave to ensure compliance. If a Physician's office continually fails, the Plan will escalate the matter to the appropriate Committees for additional disciplinary actions, which can include suppression, or termination from the Plan's network.

Lastly, Empire HealthPlus' Provider Manual includes the Appointment Availability and After Hours standards for reference at any time. Providers can find the most up-to-date copy of the Manual online at https://mediproviders.empireblue.com/Documents/NYNY_CAID_ProviderManual.pdf, or they can contact their Provider Relations representative by phone or email. The Plan believes it is its role to educate and ensure that physicians in its network meet the highest care standards for our members.

- **2016 Recommendation:** The MCO should continue to work to improve poorly performing HEDIS®/QARR and CAHPS® measures. The MCO should conduct thorough root cause analyses for each measure to determine key drivers of poor performance and develop intervention strategies to address identified drivers. *[Repeat recommendation.]*

  MCO Response: Empire Blue Cross Blue Shield HealthPlus conducts detailed analyses of our performance on HEDIS® and CAHPS® measures and have workgroups dedicated to the following clinical areas; Access to Care, Respiratory, Chronic Conditions, Women's Health, Behavioral Health, HIV, and CAHPS®. Each workgroup consists of a cross functional team with representation from our clinical, member services,

provider relations, marketing and community relations, and data analytics. These workgroups all report to senior leadership both at the health plan and corporate level.

During MY2017, the following interventions were implemented to address the opportunities for improvement identified when comparing health plan performance with the statewide averages:

- Text messaging reminders for well visits and measure specific service gaps
- Enhanced clinic days at provider sites and Empire community centers to address gaps for CDC Eye Exams, well-visits, and Breast Cancer Screening
- Home visits for Diabetes care gaps
- Maternity baby shower events for expecting mothers
- Member telephonic outreach to address all open care gaps throughout the year
- Enhanced health plan provider P4P program to include behavioral health measures
- Changed focus of provider education visits to touch all providers with a large panel for in person visits and providers with small panels with telephonic outreach
- Joint onsite visits with provider relations and marketing and outreach associates to address all provider concerns
- Expanded data connectivity through partnerships with the HealthIX regional health exchange, increased the number of direct SFTP connections to providers/facilities and increased the number of EMR data feeds from providers
- Deployed community health workers to conduct visits for asthma triggers in the home environment

In MY 2017, the CAHPS® workgroup implemented the following initiatives to address the opportunities for improvement identified when assessing member satisfaction with care and comparing health plan data to the statewide averages for HEDIS®/QARR and CAHPS® performance measures:
Getting needed care:

- Track, monitor, and trend member complaints related to access to care
- Monitoring progress versus performance goals for Provider Access and Availability specifically to identify access issues for Family & General Practice, Internist, and Pediatricians
- Analyze Member complaints/grievances and appeals specifically related to behavioral healthcare and services in at least the following categories to identify negative trends, perform root cause/barrier analysis, and develop appropriate interventions to decrease Member complaints/grievances:
  - Quality of Care
  - Access
  - Attitude and Service
  - Billing and Financial Issues
  - Quality of Practitioner Office Site
- Onsite visits and presentations to high-volume provider sites (hospitals, FQHCs) to increase provider collaboration and inform providers about the health plan's medical management services and programs and quality improvement initiatives
- To address getting needed care, the plan sent out annual birthday and overdue service well visit reminders to all members in addition to sending care gap lists to all PCPs with assigned membership
- Analyzed Member disenrollment reports to identify disenrollment reasons, identify negative reasons, perform root cause/barrier analysis, and develop appropriate interventions to decrease preventable disenrollment reasons

- The health plan continued to produce and disseminate Member Newsletters which are translated into 5 languages: English, Spanish, Chinese, Arabic, and Russian
- The health plan continued offering a member incentive program to encourage member preventive and chronic care services

In addition to the ongoing initiatives listed above, the health plan continues to seek innovative ways to improve member satisfaction and HEDIS® performance measures. The health plan will continue tracking outcomes to meet the goal of exceeding the statewide 50th percentile benchmarks for all measures.

- **2016 Recommendation:** As the MCO continues to perform poorly for the *Adults' Access to Preventive/ Ambulatory Services* measure, the MCO should conduct a population-specific barrier analysis to determine barriers to adult members seeing or receiving preventive care and develop interventions to address identified barriers. *[Repeat recommendation.]*

  MCO Response: Empire Blue Cross Blue Shield HealthPlus conducts detailed analyses of our performance on HEDIS® and CAHPS® measures to identify barriers related to Access to Care and implemented interventions to promote the utilization of preventive care services for our adult members. Empire's Access to Care workgroup which consists of representatives from our clinical, member services, provider relations, marketing and community relations, and data analytics teams implemented a series of interventions including the following:
  - Distributing text message reminders for well visits and measure specific service gaps
  - Hosting enhanced clinic days at provider sites, Empire community centers, and at radiology clinics to address gaps for CDC Eye Exam, well-visits, and Breast Cancer Screening
  - Home visits for Diabetes care gaps
  - Distributing gaps in care lists and quality report cards to PCP to identify members who have outstanding care gaps
  - Member education regarding the availability of urgent care centers
  - Partnering with IPAs and large hospital systems within our provider network to conduct non-user outreach for members with 12 or more months with no claims
  - Distributing co-branded mailings in partnership with PCPs with large member panels to encourage members to contact their PCPs for preventive well visits
  - Onsite provider visits to review quality measure performance including well and chronic care services and the importance of PCPs building a relationship with all assigned members

  Empire provider solutions also conducts bi-annual access and availability surveys of network providers to assess provider compliance with NYS DOH appointment availability standards. The health plan will continue tracking outcomes to meet the goal of exceeding the statewide 50th percentile benchmarks for all measures.

- **2016 Recommendation:** The MCO should continue to work to resolve the issues identified in the operational and focused review surveys. First, the MCO should take steps to ensure that all documentation and notification letters in the areas of Complaints and Grievances and Utilization Review, both internally and from its vendors, contain the correct information and all required language. Second, the MCO should ensure that all contracts enacted with providers/vendors contain all required language and provisions. Lastly, the MCO should continue to work to improve the accuracy of the information in its provider directories. *[Repeat recommendation.]*

MCO Response:

Initial Adverse Determination (IAD) letters

Empire Health Care Management department is responsible for reviewing all IADs that are issued by the plan and our vendors to ensure compliance with all elements required by NYSDOH. Three issues will be addressed in this response.

The issue of incorrectly documenting standard appeal timeframe of 60 business days by HealthPlex was initially identified in the Plan's full operational survey conducted from 02/22/16 through 02/26/16. The expectation was an implementation of the correct timeframe by June 1, 2016 for all delegated vendors to include language that informs the member that he/she has 90 calendar days to file a standard appeal. This template correction was not confirmed as implemented until July 28, 2016 with HealthPlex manually updating its IAD letters to conform to the 90 calendar day standard noting when a member wished to file an appeal. The template was automated by HealthPlex and launched September 28, 2016.

A second finding identified by the plan's full operational survey conducted from 2/22/16 through 2/26/16 identified that this statement must be removed from the HealthPlex IAD: *We must receive your written response within 10 calendar days after you made your internal action appeal request over the phone. If we do not get your written request within 10 calendar days, we will close your file and take no further action*.

The reason for the delay in implementing both changes at HealthPlex was a series of change requests and template submissions between Empire and the NYSDOH causing delays in the implementation. Empire acknowledges that it would have been beneficial to keep the NYSDOH plan manager updated of any delays in implementation.

The third finding was identified by the plan's full operation survey conducted from 2/22/16 through 2/26/16 that identified an outdated "Managed Care Action Taken" form dated 5/2004 on Orthonet's IAD. Since July 28, 2016, Orthonet has been triggering a NYSDOH approved Initial Adverse Determination (IAD) letter with the correct "Managed Care Action Taken" form dated March 2016.

In order to ensure ongoing compliance, the health plan and all Empire vendors, including HealthPlex are subject to a monthly audit completed by HCM operations department. The plan's internal auditor requests a sample of IAD determination letters and reviews against all regulatory and contractual requirements. Audit findings are shared monthly with the plan compliance officer, the vendor, and any associate at the plan in order to correct deficiencies regardless if it is system or end user error. Lastly, there are monthly and quarterly compliance meetings with internal leadership and the vendors to discuss audit findings and address deficiencies with timeline action plan.

The expected outcome is to meet all NYSDOH compliance requirements.

Complaint and Grievance Letters

The Empire Appeals and Grievance (A&G) department reviews and triggers all Complaint and Grievance letters for its vendors, with the exception of Liberty Dental.

In December 2016, the Director of the A&G Department ("the department") concluded that: (1) the system letter templates required manual intervention to comply with contract rules (2) letter content was

being reviewed with an internal audit tool that differed from the NYSDOH T-Tools and (3) the team was reviewing too small of a sample size to ascertain compliance.

In order to assure on-going compliance, in 2017 a comprehensive review of all Complaint and Grievance letters was conducted. Letters were modified and all required Complaint and Grievance letter templates were programmed into the appropriate Empire letter generating systems. It was confirmed that old templates were removed from all letter generating systems as well as from local drives. All of the letters were fully vetted to include but not limited to the requirements of the NYSDOH T-Tools, Article 44/49, Department of Finance (DFS) and NYS Medicaid contracts to assure compliance.

In 2018, with the adoption of the changes to CFR 42, NY State Department of Health (NYSDOH) provided health plans with model compliant notices for the Medicaid and MLTC contracts. As a result, new Complaint and Grievance letter templates specific to these programs were created. The templates were submitted and subsequently approved for use by the NYSDOH. The approved letter templates were programmed into the appropriate letter generating systems and old letter templates were removed from the systems, as needed.

On 5/1/18 Empire contracted with Liberty Dental which is delegated to resolve Complaints and Grievances related to their services. To ensure compliance with Complaint and Grievance notices, all Empire letter templates were submitted to Liberty for use. Liberty updated the letters with the appropriate vendor details such as logos and phone numbers. The Liberty letter templates for Medicaid and MLTC were submitted and approved for use by NYSDOH. The remaining letter templates that did not require NYSDOH approval were vetted through Empire's internal letter control processes to ensure compliance.

In 2017, in addition to programming the updated letter templates into the appropriate Anthem (Empire) systems, Empire instituted an internal audit process to review each Complaint and Grievance letter prior to its distribution. There is a two-phase audit of every letter generated.

- Phase I requires the department letter creator to manually audit their own work against the State T-tool.
- Phase II calls upon a separate auditor to conduct a second State T-Tool audit of the letter prior to its being sent.

Audit findings from the two-phase Audit are shared monthly with the Compliance Committee and any score below 95% results in a failure. If the failure is due to systemic and consistent errors, Empire's compliance committee will place the department on a written corrective action plan until it can demonstrate full compliance for multiple months are the corrective action plan is delivered.

The audit program criteria was revised in 2018 to conform to the CFR 42 regulation changes.

The Director of the Appeals and Grievance Department is responsible for assuring compliance and completion of the corrective action plan.

In addition to the internal audits, Liberty Dental is subject to a monthly audit completed by Empire's Grievance and Appeals Department. Any score below 95% results in a failure. The Liberty audit findings are shared monthly with the Vendor Oversight Committee as well as the Compliance Committee. If the failure is due to systemic and consistent errors, Empire's compliance committee will place Liberty on a written corrective action plan until it can demonstrate full compliance for multiple months after the corrective action plan is delivered.

Provider Directory

Over the last several years, Empire BCBS has administered a process where every active service address that is listed that we have in our database is either compiled in a roster format or sent individually on a fax verification form to all participating providers and facilities. The provider is asked to review the information and then return the roster via email or fax the individual sheets back to Empire so that we can confirm the information is correct or update any changes. The providers/facilities that do not respond are suppressed from our online and printed directories. In 2018 we added our Medicaid providers to this process and plan to continue including the Medicaid providers in this annual verification proves to ensure that all data that is posted or published is accurate.

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