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 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

ALOS:	*Average Length of Stay*
AO:	*Area Office*
CFR:	*Code of Federal Regulations*
CHP:	*Child Health Plus*
CMS:	*Centers for Medicare and Medicaid Services*
COM (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

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

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.

Empire BCBS HealthPlus Web Page: https://mss.empireblue.com/

*Participating Regions and Products			
Hudson[1]:	MCD	CHP	
Long Island[2]:	MCD	CHP	
New York City:	MCD	CHP	HARP

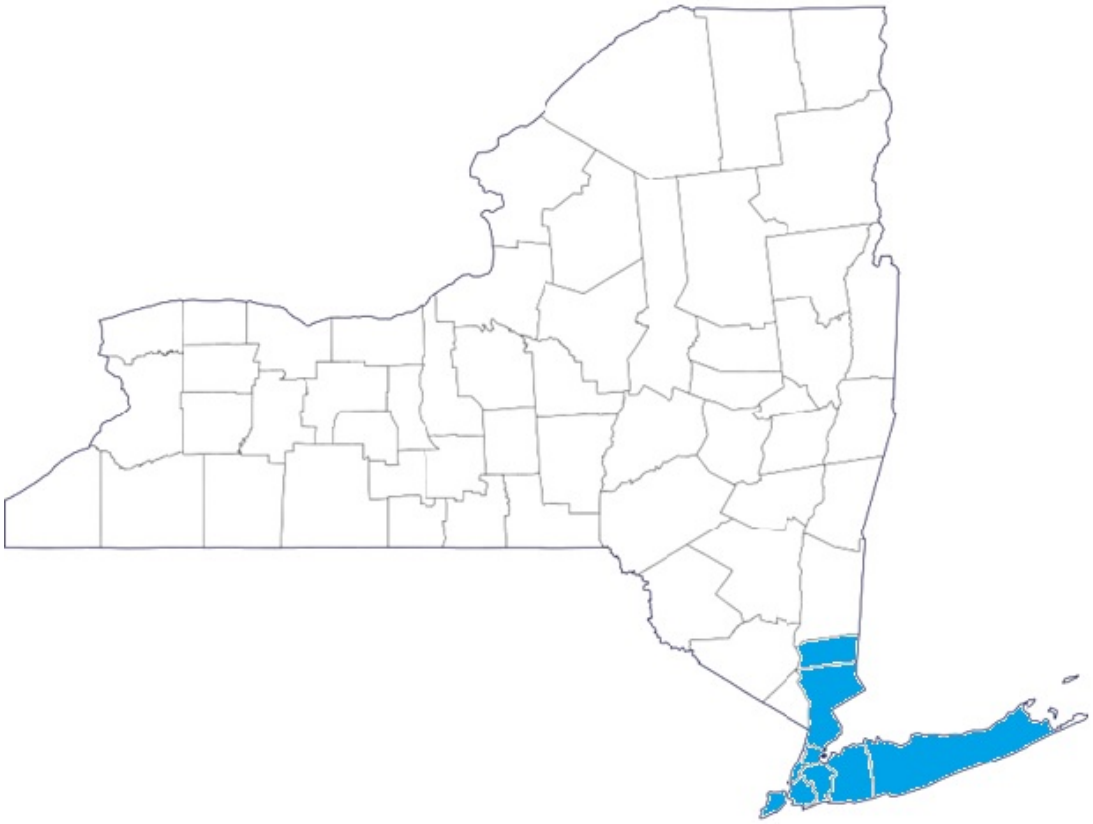
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

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

[1] Participating in Putnam (MCD and CHP) and Westchester (CHP) Counties only.
[2] MCD and CHP offered in Nassau County and CHP only in Suffolk County.

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 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has decreased from 2017 to 2018 by a rate of 4.2%. HealthPlus' membership represents 7.4% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	361,963	346,593	323,073
% Change from Previous Year	-8.1%	-4.2%	-6.8%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	8.3%	7.9%	7.4%

Data Source: NYS OHIP Medicaid DataMart

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

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

	2016	2017	2018
CHP	42,251	42,051	39,718

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: HealthPlus Enrollment Trends—All Product Lines

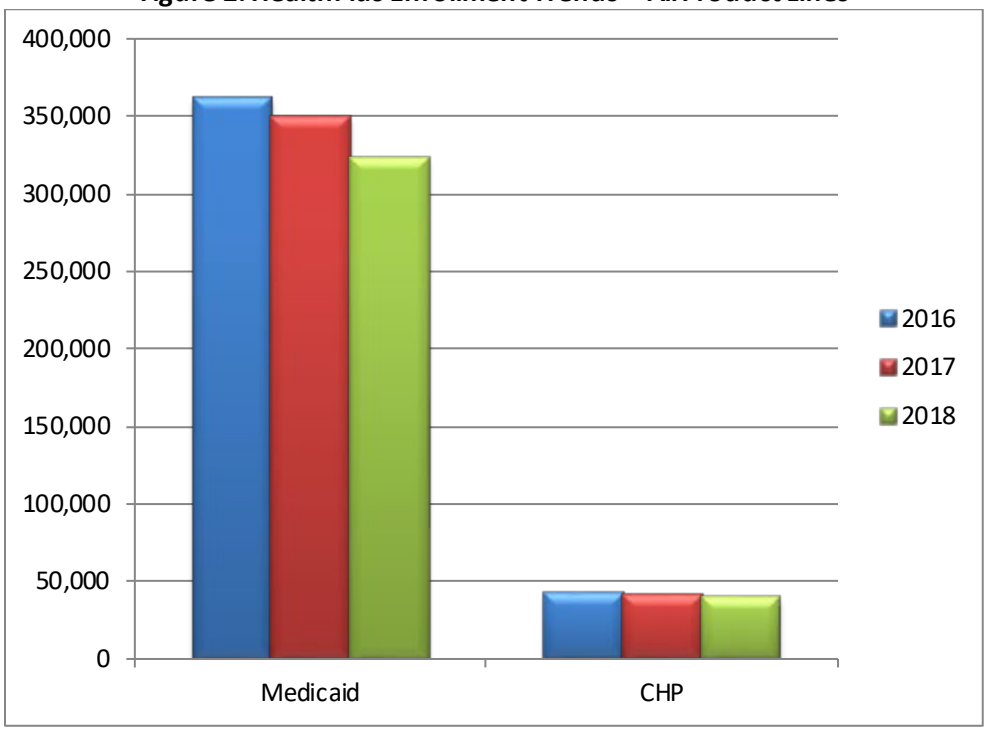


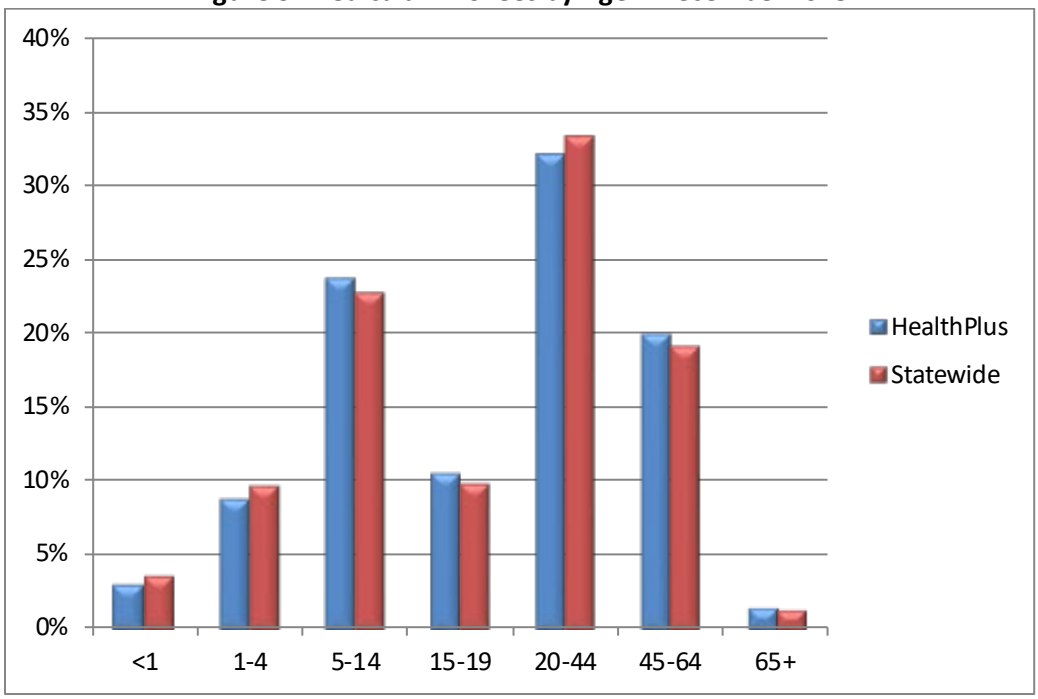
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average (SWA). In 2018, HealthPlus' rate for members aged 15-19 years old was above the SWA.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	4997	4848	9845	3.1% ▼	3.6%
1-4	14651	13749	28400	8.8%	9.7%
5-14	39479	37265	76744	23.8%	22.8%
15-19	17341	16796	34137	10.6% ▲	9.9%
20-44	42996	60711	103707	32.2%	33.3%
45-64	29677	34677	64354	20.0%	19.1%
65 and Over	1744	3063	4807	1.5%	1.4%
Total	150885	171109	321994		
Under 20	76468	72658	149126	46.3%	46.1%
Females 15-64		112184		34.8%	34.7%

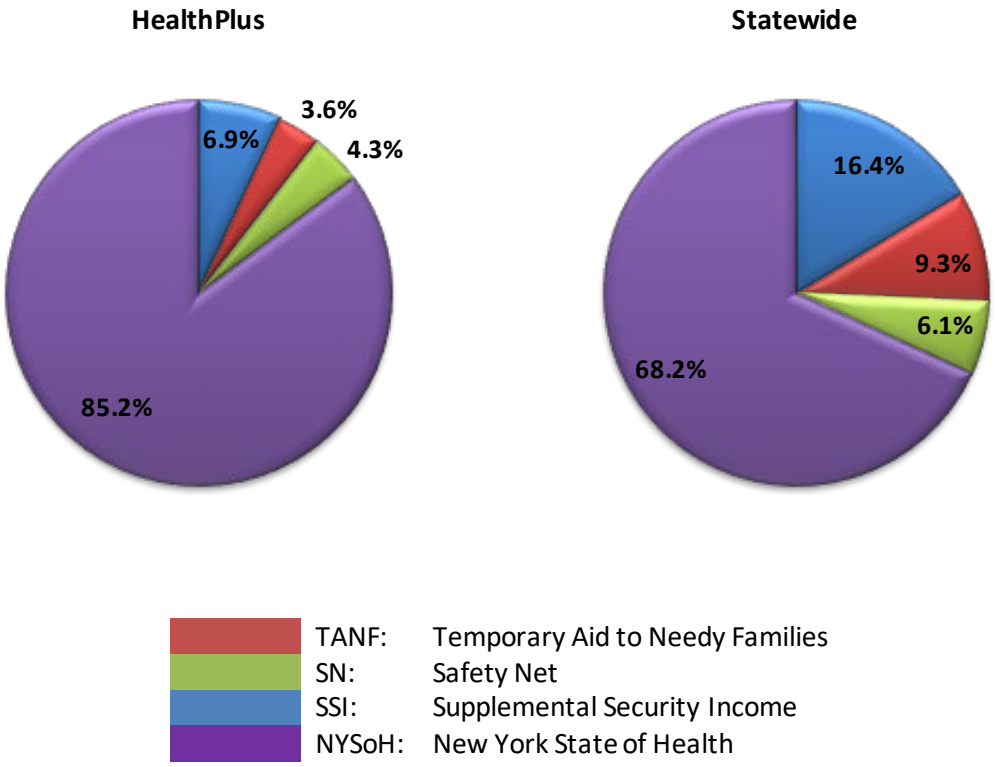
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. In 2018, HealthPlus had an improvement in rates for all provider types. For detailed information regarding board certification of providers, please see the *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[3].

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

Provider Type	2016		2017		2018[1]	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
			Medicaid/CHP			
Family Medicine	31% ▼	71%	35% ▼	72%	36%	74%
Internal Medicine	72% ▼	75%	70% ▼	76%	84%	76%
Pediatricians	75% ▼	78%	75% ▼	79%	85%	80%
OB/GYN	70% ▼	75%	75%	77%	80%	80%
Geriatricians	51% ▼	63%	49% ▼	63%	54%	63%
Other Physician Specialists	72% ▼	75%	76%	76%	78%	77%

[1] Level of significance was unaudited.

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average (SWA) are indicated by ▼. Other Specialties and OB/GYN specialists had rates above the SWA.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	5,204	14.1%	19.5%
Pediatrics	1,415	3.8%	3.8%
Family Practice	861	2.3%	3.5%
Internal Medicine	2,302	6.2%	8.4%
Other PCPs	626	1.7%	3.8%
OB/GYN Specialty[1]	1,878	5.1% ▲	3.8%
Behavioral Health	4,067	11.0%	17.2%
Other Specialties	20,542	55.7% ▲	46.0%
Non-PCP Nurse Practitioners	3,294	8.9%	8.7%
Dentistry	1,873	5.1%	4.9%
Total	36,858		

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

Specialty Type	HealthPlus			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median Ratio of Enrollees to Providers[1]	Total Number of FTEs	Median Ratio of Enrollees to FTEs
Medicaid						
Primary Care Providers	62:1	6087	53:1	42:1	80986	42:1
Pediatrics (Under age 20)	105:1			70:1		
OB/GYN (Females age 15-64)	60:1			59:1		
Behavioral Health	79:1			73:1		

Data Source: Derived ratios calculated from NYS OHIP Medicaid DataMart and NYS Provider Network Data System (PNDS).
[1]The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers.

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

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

	2016			2017			2018		
	HealthPlus		Statewide	HealthPlus		Statewide	HealthPlus		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	4120	100.0% ▲	85.0%	4361	100.0%	95.7%	5071	100.0%	90.8%

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
150	110	**73.3%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 105 providers (total number of providers who were compliant for participation (110), less total number of providers with closed panels (5)). HealthPlus performed above the threshold for Routine and Non-Urgent call types.

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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	14	14	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	9	9	100.0%
	Total Routine	**36**[2]	**36**	**100.00%**
Non-Urgent "Sick"	Internist/Family Practitioner	13	13	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	11	11	100.0%
	Total Non-Urgent	**37**[3]	**37**	**100.0%**
After-Hours Access	Internist/Family Practitioner	11	5	45.5%
	Pediatrician	13	10	76.9%
	OB/GYN	5	3	60.0%
	Total After-Hours	**29**	**18**	**62.1%**

[1]Timeliness was not considered when determining appointment availability rates.
[2]Final routine sample less excluded providers. Two (2) providers were excluded because surveys could not be completed.
[3]Final non-urgent sample less excluded providers. One (1) provider was excluded because the survey could not be completed.

IV. Utilization

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

Encounter Data

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

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
PCPs and OB/GYNs	1.47 ▼	3.85	1.42 ▼	3.56	1.35 ▼	3.50
Specialty	2.83	2.45	2.74 ▲	2.30	2.64	2.33
Emergency Room	0.44	0.54	0.43	0.55	0.42	0.53
Inpatient Admissions	0.10	0.14	0.09	0.14	0.09	0.13
Dental	1.11	1.03	1.10	1.02	1.01	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

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

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	HealthPlus	SWA	HealthPlus	SWA	HealthPlus	SWA
	Medicaid					
Enrollee Health Screenings	11.0%	12.3%	12.1%	12.7%	10.7%	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages (SWA) for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). The MCO's rates for Inpatient Utilization (PTMY) have been below the SWA for three consecutive years for the following measures: Medicine, Surgery and Total Cases.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	4,798	4,807	4,934	5,317
ER Visits	403 ▼	379 ▼	379 ▼	492
Inpatient ALOS				
Medicine	4.1	4.6	4.6	4.5
Surgery	6.9	7.4	7.0	7.0
Maternity	3.0 ▲	3.0	3.0	2.9
Total	4.2	4.5	4.4	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	26 ▼	24 ▼	20 ▼	30
Surgery Cases	10 ▼	10 ▼	9 ▼	12
Maternity Cases	29	26	26	32
Total Cases	57 ▼	52 ▼	48 ▼	66

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

V. Performance Indicators

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

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 2017 HEDIS® Final Audit Report prepared for HealthPlus indicated that the MCO had no significant issues in any areas related to reporting. HealthPlus demonstrated compliance with all areas of Information Systems and all areas of Measure Determination required for successful HEDIS® reporting. The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well. HealthPlus did not have a 2018 HEDIS® final audit review.

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[4]

Quality Indicators

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

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO has shown an improvement in rates for prevention and screening measures. 2 out of 14 measures had rates above the SWA in 2018.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	81 ▼	84	85	**89**
WCC—BMI Percentile	75	81	82 ▼	**86**
WCC—Counseling for Nutrition	78	81	81	**82**
WCC—Counseling for Physical Activity	64 ▼	67 ▼	72	**74**
Childhood Immunizations—Combo 3	73	67 ▼	72	**73**
Lead Screening in Children	89	88	89	**89**
Adolescent Immunizations—Combo 2[2]		42	42	**43**
Adolescents—Alcohol and Other Drug Use[3]	63	61	62	**70**
Adolescents—Depression[3]	56	53	64	**67**
Adolescents—Sexual Activity[3]	64	58	59 ▼	**67**
Adolescents—Tobacco Use[3]	65 ▼	62 ▼	67	**74**
Breast Cancer Screening	71	73 ▲	72 ▲	**71**
Colorectal Cancer Screening	60	61	58 ▼	**63**
Chlamydia Screening (Ages 16-24)	75 ▲	77 ▲	78 ▲	**76**

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

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

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

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

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). While HealthPlus' rates have trended upwards for most measures, 20% of their rates were below the SWA in 2018.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	89	90 ▼	90 ▼	**91**
Spirometry Testing for COPD	54	56	53	**56**
Use of Imaging Studies for Low Back Pai	84 ▲	83 ▲	82	**77**
Pharmacotherapy Management for COPD—Bronchodilators	87	85	93	**89**
Pharmacotherapy Management for COPD—Corticosteroids	68	71	75	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	63 ▼	69	70	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	52	54 ▼	59	**59**
Asthma Medication Ratio (Ages 19-64)	51 ▼	52 ▼	54 ▼	**60**
Asthma Medication Ratio (Ages 5-18)	67 ▲	65	67	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	81	82	80	**80**
CDC—HbA1c Testing	93	91	92	**92**
CDC—HbA1c Control (<8%)	56	54	56	**60**
CDC—Eye Exam Performed	65	63	64	**67**
CDC—Nephropathy Monitor	95 ▲	93	92	**92**
CDC—BP Controlled (<140/90 mm Hg)	66	54 ▼	61 ▼	**66**
Drug Therapy for Rheumatoid Arthritis	83	82	83	**83**
Monitor Patients on Persistent Medications—Total Rate	92	93 ▲	92	**92**
Appropriate Treatment for URI	94	93 ▼	94 ▼	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	35 ▲	34	36	**36**
HIV Viral Load Suppression[2,3]	73 ▼	73	74	**77**
Flu Shots for Adults (Ages 18-64)[4]	47 ▲	39		
Advising Smokers to Quit[4]	74	76		
Smoking Cessation Medications[4]	51	52		
Smoking Cessation Strategies[4]	49	45		

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

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

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

[2] NYS-specific measure.

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

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	48	53	53	**53**
Antidepressant Medication Management—Effective Continuation Phase	35	38	38	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	68 ▲	66 ▲	58	**59**
Follow-Up Care for Children on ADHD Medication—Continuation	79 ▲	74	66	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	76	77	73	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	61	60	62	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	82	84	84	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	85	80	78	**80**
Antipsychotic Medications for Schizophrenia	61	63	62	**63**

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."* Performance indicators related to Utilization and Access to Care are included in this section[5].

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

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

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	64	66 ▼	81 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	86 ▲	86 ▲	87 ▲	**86**
Adolescent Well-Care Visits	70 ▲	72 ▲	71 ▲	**68**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). The MCO continues to have rates above the SWA for all age groups in the Children and Adolescents' Access to PCP. The MCO demonstrates an opportunity for improvement in Adult's Access to Preventative/Ambulatory and Other Services.

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

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	97	97 ▲	98 ▲	**97**
25 Months-6 Years	96 ▲	95 ▲	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 ▼	81 ▼	81	**81**
45-64 Years	89 ▼	88 ▼	88 ▼	**89**
65+ Years	89	90 ▼	90 ▼	**91**
Access to Other Services				
Timeliness of Prenatal Care	90	87	83 ▼	**88**
Postpartum Care	71	73	71	**70**
Annual Dental Visit[2]	61 ▲	59 ▼	59 ▼	**61**

[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 15** presents prenatal care rates calculated by the NYSDOH for QARR 2015 through 2017 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	Empire BCBS HealthPlus	Regional Average	Empire BCBS HealthPlus	Regional Average	Empire BCBS HealthPlus	Regional Average
			NYC			
Risk-Adjusted Low Birth Weight[1]	7%	6%	6%	6%	-	-
Prenatal Care in the First Trimester	78% ▲	75%	80% ▲	76%	80 ▲	75
Risk-Adjusted Primary Cesarean Delivery[1]	16% ▼	14%	14%	14%	-	-
Vaginal Birth After Cesarean	15%	18%	15%	18%	-	-
			ROS			
Risk-Adjusted Low Birth Weight[1]	9%	7%	13% ▼	7%	-	-
Prenatal Care in the First Trimester	74%	74%	74%	74%	74	75
Risk-Adjusted Primary Cesarean Delivery[1]	15%	14%	17%	13%	-	-
Vaginal Birth After Cesarean	13%	14%	13%	14%	-	-

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

NYC: New York City; ROS: Rest of State

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

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018 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 ▼). The MCO's rates have trended upwards for 33% of the measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average	Empire BCBS HealthPlus	Statewide Average
			Medicaid			
Getting Care Needed[1]	76	**83**	84	**85**	81	**84**
Getting Care Quickly[1]	82 ▼	**87**	88	**88**	82 ▼	**88**
Customer Service[1]	85	**82**	85	**86**	82	**86**
Coordination of Care[1]	72 ▼	**74**	74	**74**	67	**75**
Collaborative Decision Making[1]	48	**53**	67 ▼	**74**	74	**76**
Rating of Personal Doctor[1]	89	**89**	88	**89**	89	**90**
Rating of Specialist	86	**80**	84	**83**	75	**84**
Rating of Healthcare	85	**85**	84	**86**	86	**87**
Satisfaction with Provider Communication[1]	91	**93**	93	**93**	93	**93**
Rating of Counseling/Treatment	71	**64**	71	**68**	63	**69**
Rating of Health Plan—High Users	79	**84**	83	**85**	88	**84**
Overall Rating of Health Plan	82	**83**	86	**85**	84	**85**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

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

Performance Improvement Project

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

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

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

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

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

In 2018 Empire BCBS HealthPlus continued with the PIP topic *"Perinatal Care: A collaborative approach to improve maternal health outcomes"*. The MCO implemented the following interventions:

Member-Focused Interventions:

- Pregnant members identified as positive for tobacco use were educated on NYS Smokers Quitline and provided assistance to complete and submit registration form. Members identified as smokers received Health Crowd text messages to promote smoking cessation.
- Mailed brochures covering family life planning, optimal birth spacing, and contraceptive options to all members identified as pregnant.
- Maternal-Child Health Workshops: Conducted outreach to members at various sites including hospitals, FQHCs, WIC centers, Health Plan Community Service Centers, and provider offices.
- Referrals to High Risk OBCM: Messages included education and screening for depression and smoking cessation through IVR calls, texts, app, and website. High Risk OBCM was alerted to members who triaged as Urgent or High based upon IVR screener responses for follow up.

Provider-Focused Interventions:

- Quarterly fax blast to all OB/GYN Providers covering the four focus areas of this PIP included CPT billing guidance.
- 17P Authorization Process Provider Alert Letter: The information was faxed to providers of members identified as pregnant through IVR Screener and OB Screener calls to educate and reinforce 17P authorization process. High Risk OBCM team also made calls to providers.
- Quarterly visits with 17 OB/GYN targeted provider groups were conducted by OBCM to discuss comprehensive perinatal services and to highlight the four focus areas of the PIP.
- Collaboration between EBCBS OBCM and NYU Lutheran Women's Health Services: Quarterly visits to promote bilateral referrals with focus on high-risk pregnant members and providing care coordination for those exhibiting signs of depression and/or screened positive for tobacco use.

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 conducted education workshops in English/Spanish/Chinese at hospitals, FQHCs, WIC centers, CSCs and provider offices. Members were educated on the four focus areas of the PIP.

Table 18 presents a summary of Empire BCBS HealthPlus' 2017-2018 PIP. HealthPlus demonstrated an improvement for 6 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	90%	83%	95%	Performance declined
Postpartum Care	71%	71%	76%	Performance level was maintained
Received at least one 17P injection	*	80%	26%	Demonstrated improvement
Depression Screening	46%	**	51%	Performance declined
Tobacco Screening	56%	**	61%	Demonstrated improvement
Tobacco Screening Follow-Up	57%	**	62%	Demonstrated improvement
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	5%	2%	10%	Performance declined
Age 15-20 years; within 60 days	39%	13%	44%	Performance declined
Age 21-44 years; within 3 days	7%	7%	12%	Performance level was maintained
Age 21-44 years; within 60 days	33%	9%	37%	Performance declined
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	1%	2%	6%	Demonstrated improvement
Age 15-20 years; within 60 days	10%	11%	15%	Demonstrated improvement
Age 21-44 years; within 3 days	0.06%	2%	5%	Demonstrated improvement
Age 21-44 years; within 60 days	7%	7%	12%	Performance level was maintained

*Baseline not calculated for 17P.
*Final rate not calculated for depression screening or tobacco measures.

Health Disparities

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

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

HealthPlus reported that the following activities were performed in 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- HealthPlus conducts analyses and studies to understand, identify and characterize the population and at – risk characteristics to understand population health needs and programming efforts. As a result of these analyses the MCO implemented the following programs:
    - Maternal and child services case management program.
    - Early and periodic screening, diagnostic, and treatment outreach program.
    - Disease Management Program
    - Post discharge case management program
    - Complex case management program
- HealthPlus conducts an assessment of health care disparities using administrative HEDIS measures by evaluating both race/ethnicity and language stratification. Of the scored measures, identified statistically significant disparities and measures with largest gaps to attain parity with non-Hispanic whites were identified; no limitation on denominator size. Measures related to respiratory conditions and behavioral health disparities were most prevalent with the African American membership. For Asian American members, measures identified with greatest disparities included: MMA > 51-64 50%, 50% Total Rate, CDC > A1c Poor Control, W15 > 1, 2, 3, 4, and 5 Visits, and IET > Initiation Rate. For Hispanic members measures identified with greatest disparities included: AMR > 5-11, 12-18, 19-50, 51-64, MMA > 12-18 50%, 51-64 50%, 50%, Total Rate, 12-18 75%, 19-50 75%, CAP > 12-19y, Total Rate, and W15 > 1, 2, and 3 Visits.

  The MCO provides appropriate translation services and staff are available to speak with members on the phone that request language and translation services. Text messages are also provided in additional languages.
- The MCO reviews and assesses for gaps in quality of care for their Medicaid members and subgroups.
- In 2018, the MCO provided assistance on coding and documentation with providers to better assess members' needs better. Additionally the Plan is undertaking a creation of a social determinants of health (SDoH) program to provide support to various social concerns (e.g. car seats and baby supplies to expecting moms, food bank support, nutritional guidance support). The MCO developed clinical programs that will start in 2019 to target the SDoH.

- HealthPlus works to assess and develop programming aimed to reduce/eliminate differences in health status/outcomes and improve quality of care for members with at risk characteristics. In 2018, the MCO completed a 2 - year performance improvement project focused on maternal health and outcomes with a focus to mitigate psychosocial risk factors, decrease preterm labor and recurrent births while increasing the member's quality of life and satisfaction with health plan services.

  Provider and member interventions focused on education, outreach and collaboration and included:

  a. Providers: face-to-face visits, alert faxes, phone calls
  b. Members: introducing and completing an OB Screener assessment, Maternal Child Health Workshops and education program over phone and text during pregnancy ("My Advocate" program), Family Planning Brochure dissemination, OB High Risk Case Mgmt, Health Crowd texting educational messages

  HealthPlus saw an improvement in the focus areas and will continue to work on education and outreach efforts to improve outcomes for pregnant members.

  In an effort to address literacy needs of diverse members, Empire's Multicultural Health Strategy team supported enhancements to two member-facing initiatives:

  Medicaid EPSDT Program
  During 2018, the MCO's Multicultural Health Strategy team worked extensively on updating the mailers, email, and text message campaigns to improve reading ease and facilitate understanding. The goal is to have the updated member material go live in 2019, after the required approval process is completed.

  Medicaid Asthma Outreach Program
  Empire's Pharmacy team supported development of a new introductory letter to improve reading ease and facilitate understanding of critical components of appropriate asthma management. The goal is to have the updated member material go live in 2019, after the required State approval process is completed.

VI. Health Information Technology

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

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

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

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

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

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

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

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

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

HealthPlus has indicated that it performs the following HIT-related activities:

- Secure electronic transfer of protected health information to patients and/or providers:
  - Utilizes text messaging.
  - Use of an IVR system.
  - Use of secure fax and email.
  - Use of secure FTP sites.

- Use of telecommunications technologies:
  - Utilizes text messaging.
  - Telephonically via IVR and live calls to members.
  - Use of a 24 hour nurse health telephone service and a Telehealth service.

- Use of Electronic Health Records (EHR):
  - EMR/EHR data is collected from providers via monthly, quarterly and annual data feeds and via direct remote connection.

- Use of clinical risk group (CRG) or similar software:
  - Utilizes Treo risk management software to predict member utilization and identify members for case management.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Via secure FTP.

- Electronic communication with providers:
  - Use of Secure FTP and secure fax..

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Participates with HIXNY

- Participation in a medical home pilot or program:
  - The MCO does not participate in a medical home pilot or program..

- Future plans to implement HIT:
    - The MCO is reviewing opportunities to partner and engage in other HIT activities.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

For the operation review, HealthPlus was in compliance with 10 of the 14 categories. The categories in which the MCO was not compliant were Disclosure (1 citations), Organization and Management (3 citations), Service Delivery Network (2 citations), and Utilization Review (2 citations). For the focused reviews, HealthPlus was in compliance with 12 of the 14 categories. The category in which the MCO was not compliant was Organization and Management (2 citations).

Table 20: Focused Review Types

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

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

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Type	
Complaints and Grievances	0	0		
Credentialing	0	0		
Disclosure	1	0		
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	3	2	Contracts	2
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	2	0		
Utilization Review	2	0		
Total	**8**	**2**		

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, HealthPlus upheld 60% of external appeals.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	255	133	178
Overturned in Part	25	16	18
Upheld	275	235	295
Medicaid Total	**555**	**384**	**491**
		CHP	
Overturned	0	2	12
Overturned in Part	0	0	0
Upheld	2	1	8
CHP Total	**2**	**3**	**20**

VIII. Strengths and Opportunities for Improvement[7]

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

Strengths

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

Strengths:

- In regards to the provider network, Empire BCBS HealthPlus has shown an improvement in board certification rates for the following provider types: *Internal Medicine, Pediatricians, OB/GYN* and *Other Physician Specialists*. The MCO also has rates above the statewide average for the quantity of OB/GYN providers and other specialists in the MCO's Medicaid network. The MCO provides a network of primary care providers that is available and accessible to members for routine and non-urgent "sick" appointments. The MCO had an appointment rate of 100% for Internist/Family Practitioner, Pediatrician and OB/GYN provider types.
- In regards to the HEDIS®/QARR Effectiveness of Care domain, the MCO has reported a rate above the statewide average for the *Chlamydia Screening in Women (Ages 16-24)* and *Breast Cancer Screening* measures.
- In regard to the Access/Timeliness Indicators, the MCO's rates for HEDIS®/QARR *Well-Child Visits for 3 to 6 Year Olds and Adolescent Well-Care Visits have* reported rates above the statewide average for at least three consecutive reporting years, while the rate for *Well-Child Visits in the First 15 Months* was above the statewide average for 2018. The MCO's rates for HEDIS®/QARR *Children and Adolescents' Access to PCPs* have reported rates above the statewide average for at least three consecutive reporting years for the following age groups: 25 months-6 years, 7-11 years and 12-19 years old. The reported rate for 12-24 months was above the statewide average for 2018.
- In regard to the 2017 QARR Prenatal Care rates, the MCO's rate for *Prenatal Care in the First Trimester* was significantly better than the regional average.

[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.

- The MCO's rates for the QARR Use of Services domain remained below the statewide average for the following measures: *Outpatient Utilization: ER Visits, Inpatient Utilization: Medicine Cases, Surgery Cases* and *Total Cases.*
- In 2018, Empire BCBS HealthPlus had a focused review as part of the monitoring of compliance with structure and operation standards. The MCO did not have any citations as a result of the focused review.

Opportunities for Improvement

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

Opportunities for Improvement:

- The MCO demonstrates an opportunity for improvement with after-hours access to Internist/Family Practitioner, Pediatrician and OB/GYN provider types. The 2018 Primary Care and OB/GYN Access and Availability Survey results reflected an appointment rate of 62.1% for after-hours access.
- The MCO has reported rates below the statewide average for the member utilization of PCPs and OB/GYNs.
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care domain. In 2018, the MCO reported rates below the statewide average for *WCC-BMI Percentile, Adolescents—Sexual Activity, Colorectal Cancer Screening and Testing for Children with Pharyngitis.*
- 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 reporting years for the *Asthma Medication Ratio (Ages 19-64)* measure, while rates for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg),* and *Appropriate Treatment for URI* were reported below the statewide average for 2018.
- The MCO continues to demonstrate opportunities for improvement in regard to access to care for adults. The MCO has reported rates below the statewide average for the *Adults' Access to Preventive/Ambulatory Health Services* measure for both *45-64 Years* and *65+ Years.* Additionally, rates for *Timeliness of Prenatal Care and Annual Dental Visit* were reported below the statewide average for 2018.
- The MCO demonstrates an opportunity for improvement in regard to member satisfaction. The MCO reported rates below the statewide average for *Getting Care Quickly* for the 2018 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 8 citations from the operational survey related to Disclosure, Organization and Management, Service Delivery Network, and Utilization Review. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement regarding denial of claims for Medicaid and CHP members. The MCO has an increase from 384 external appeals in 2017 to 491 external appeals in 2018. Of the 491 cases, 178 were overturned and 18 were partially overturned.

Recommendations:

- With the MCO's after-hours appointment rate for primary care and OB/GYN providers below the 75% threshold, Empire BCBS HealthPlus should initiate a process of identifying providers who do not meet the necessary access and availability requirements. The MCO should provide education on the after-hours appointment timeframe requirements and monitor the identified providers. Provider education can be done during the existing onsite provider visits to review quality measure performance. The MCO should also consider including reminders in existing provider communications such as newsletters and fax blasts on the importance of having after-hours availability.
- While the MCO has demonstrated improvements with the provider network indicators, the rate of adult members accessing preventative services has consistently performed below statewide averages. The MCO should look at barriers preventing providers from conducting these services, such as lack of cultural competency, time during well-visits, or improper coding. The MCO should also look at barriers preventing members from accessing these services, such as transportation concerns or work schedule conflicts with office hours. The MCO has had improvements with child and adolescent well-care visits and implemented similar interventions with the adult population but did not have the same results. The MCO should consider evaluating these outcomes and enhance the current interventions that target the preventive care needs for the adult population.
- The MCO should continue to 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.]*

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** 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.]

  MCO Response: Empire Blue Cross Blue Shield HealthPlus continually evaluates intervention strategies for all measures, conducts detailed analyses of our performance on HEDIS/QARR and CAHPS measures and have cross-functional Work Groups dedicated to the following clinical areas: Access to Care, Respiratory, Chronic Conditions, Women's Health, Behavioral Health, HIV, Pharmacy and CAHPS. Each Work Group has representation from our Clinical, Quality Management, Member Services, Provider Relations, Data Analytics as well as Marketing and Community Relations. These workgroups all report to Senior Leadership both at the local health plan and corporate level.

  During MY2018, the following interventions were implemented to address the opportunities for improvement identified when comparing health plan performance, at least monthly, with the statewide averages:

  • Text message reminders for well visits and measure specific service gaps (English, Spanish)
  • Enhanced clinic days at Provider sites and Empire Community Service 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 and telephonic outreach/education during pregnancy and post delivery
• Member telephonic outreach/education to address all open care gaps throughout the year and care coordination
• 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
• Collaboration between Quality Management, Provider Relations and Marketing for joint onsite Provider visits for outreach/education purposes and to address 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 (CHWs) to conduct home visits for asthma triggers in the home environment and other member needs as indicated

In MY 2018, the Plan 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 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:
    o Quality of Care
    o Access
    o Attitude and Service
    o Billing and Financial Issues
    o 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 quality improvement initiatives
• To address getting needed care, health plan members received annual birthday and overdue service WellVisit reminders via texts and calls; in addition, the plan provided 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 displays preventive health information, and plan services on the Member Portal of the plan's website
• The health plan continued offering a member Incentive program to encourage member preventive health screenings 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/QARR performance measures. The Health Plan will continue tracking outcomes to meet the goal of exceeding the statewide 50th percentile or greater benchmarks for all measures.

- **2017 Recommendation:** The MCO should investigate the performance of preventive care measures for children and adolescents in comparison to 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 preventing providers from conducting these services, such as time during well-visits or improper or missing coding.

  MCO Response: Empire Blue Cross Blue Shield HealthPlus conducts detailed analyses of our performance on the preventive care measures to identify barriers related to Child and Adolescent preventive care measures and Access to Care performance disparity. The Plan reviews and implements education and interventions with members and providers to promote the utilization of preventive care services for our members and provides guidelines for services that can be conducted during visits, in accordance to both general and member specific needs that are identified.

  Empire's Prevention and Access to Care Work Group which consists of representatives from our Clinical, Quality Management, Member Services, Provider Relations, Data Analytics, Marketing and Community Relations conducted barrier review and implemented a series of interventions including the following:

  - Monthly Work Group review includes continued monitoring of provider performance for those providers who have members with access to care compliance and lower QARR performance for coding review and education opportunities

  For Providers, the Plan conducted the following in MY 2018 to address child and adolescent health gaps in care:
  • Onsite provider visits to review quality measure performance including Well-Visits, chronic care services and the importance of PCPs building a relationship with all assigned members
  • Distributed gaps in care lists and quality report cards to PCPs to identify members who have outstanding care gaps
  • Partnered 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 and user outreach for appropriate services
  • Disseminated co-branded mailings in partnership with PCPs with large member panels to encourage members to contact their PCPs for preventive well visits
  • Developed and shared Provider Webinar series to provide education on primary education needs including care gaps review, ensuring appropriate documentation needs and improvement, ICD 10 coding, patient screening
  • Review Immunization and Lead Registry data from providers to review opportunities for additional education.

  For members, the Plan conducted the following interventions in MY 2018 to address preventive care needs for Child and Adolescent health:
  • Text message reminders for Well-Visits and measure specific service gaps
  • Phone calls and educational mailings to educate and remind parents and guardians of service needs through the year, as well as care coordination as needed

• Enhanced clinic days at Provider sites and Empire Community Service Centers to address gaps for Well-Visits
•Maternity baby shower events for expecting mothers and telephonic outreach/education during pregnancy and post-delivery
Member Newsletters, which are translated into 5 languages: English, Spanish, Chinese, Arabic and Russian that included Preventive Health Tips Sheet as well as educational articles; in addition, a Teen Member Newsletter was mailed to all households with teen members covering adolescent health information and resources both at the health plan and in the community
• Annual post card outlining care needs for children and adolescents
• The Health Plan displays preventive health information, and plan services on the Member Portal of the plan's website which is available to members and parents/guardians
• The Health Plan continued offering a member Incentive program to encourage member preventive and chronic care services

- **2017 Recommendation:** 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 implementing new initiatives. [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 Quality, Clinical, Member Services, Provider Relations, Marketing and Community Relations and Data Analytics teams implemented a series of interventions including the following in MY 2018:

  For members:
  • 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 Exams, well-visits and Breast Cancer Screening
  • Home visits for Diabetes care gaps
  • Disseminated co-branded mailings in partnership with PCPs with large member panels to encourage members to contact their PCPs for preventive well visits
  • Member education regarding the availability of urgent care centers
  • The Health Plan continued to produce and disseminate Member Newsletters which are translated into 5 languages: English, Spanish, Chinese, Arabic and Russian that discuss access, benefits, education and number for members to outreach to the Plan for assistance in scheduling appointments and connecting members to care
  • The Health Plan displays preventive health information, and plan services on the Member Portal of the plan's website
  • The Health Plan continued offering a member Incentive program to encourage member preventive health screenings and chronic care services.

  For Providers, the Plan implemented the following in 2018:
  • Distributing gaps in care lists and quality report cards to PCPs to identify members who have outstanding care gaps

• Developed and shared Provider Webinar series to provide education on primary education needs including care gaps review, ensuring appropriate documentation needs and improvement, ICD 10 coding, patient screening
• 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
• 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
• Monitoring progress versus performance goals for Provider Access and Availability specifically to identify access issues for Family & General Practice, Internist and Pediatricians
• Empire Provider Solutions team also conducts bi-annual access and availability surveys of network providers to assess provider compliance with NYS DOH appointment availability standards

Additionally, the Plan completed the following in 2018 and continues to:
• Track, monitor, and trend member complaints related to access to care
• Analyze Member complaints/grievances and appeals 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 and Access to Care
• Analyze 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 will continue reviewing barriers to care and its impact, developing interventions to address those barriers and tracking outcomes to meet the goal of exceeding the statewide 50th percentile benchmarks for all measures.

- **2017 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 of members' access to care to ensure that there is not a negative impact. [Repeat recommendation.]

  MCO Response: What has the MCO done or planned to do to address the recommendation? Starting 2020, there will be a team dedicated to the enhancement of the NY AOD Surveys to include increasing the response rate of the providers in the NY market. The focus of this team will be to work directly with providers that fail to responds to the initial survey request as to ensure that we are able to obtain accurate and up to date provider demographic information.
  - What are the expected outcomes or goals of the actions to be taken? The goal will be to obtain a 90% or greater response rate from all active providers who are actively participating.
  - When and how will this be accomplished? To accomplish the goals, the team will use the following methods to obtain responses to the surveys:
    - An initial awareness communication will be delivered to providers advising them of the pending survey delivery
    - Surveys will be delivered to providers by email or fax starting Q1 2020
    - Providers who fail to respond within the first 30 days will be sent an follow up survey
      - Survey will reinforce the importance of the survey
    - Providers who fail to respond to within 30 days will then be contacted via phone

        - Providers will be afforded the opportunity to review and walk through the updates on the phone with the associate
        - Providers will also have the option to forward the completed survey directly to the associate for expedited processing
- What is the MCO's process for monitoring the actions to determine their effectiveness? Weekly reports will be generated that will provide insight into those providers that have yet to respond to the survey.

IX. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
  - QARR Measurement Year 2018
- *CAHPS® 2018:*
  - QARR Measurement Year 2018
- *Performance Improvement Project:*
  - 2018-2019 PIP Reports

E. Structure and Operations

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