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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

Capital District Physicians' Health Plan, Inc. (CDPHP) is a regional, not-for-profit health maintenance organization (HMO). The plan serves the Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Commercial (COM), and Medicare populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP and Commercial product lines.

CDPHP Web Page: https://www.cdphp.com/

*Participating Regions and Products[1]			
Central[2]:	MCD	CHP	COM
Hudson Valley[3]:		CHP	COM
Northeast:	MCD	CHP	COM

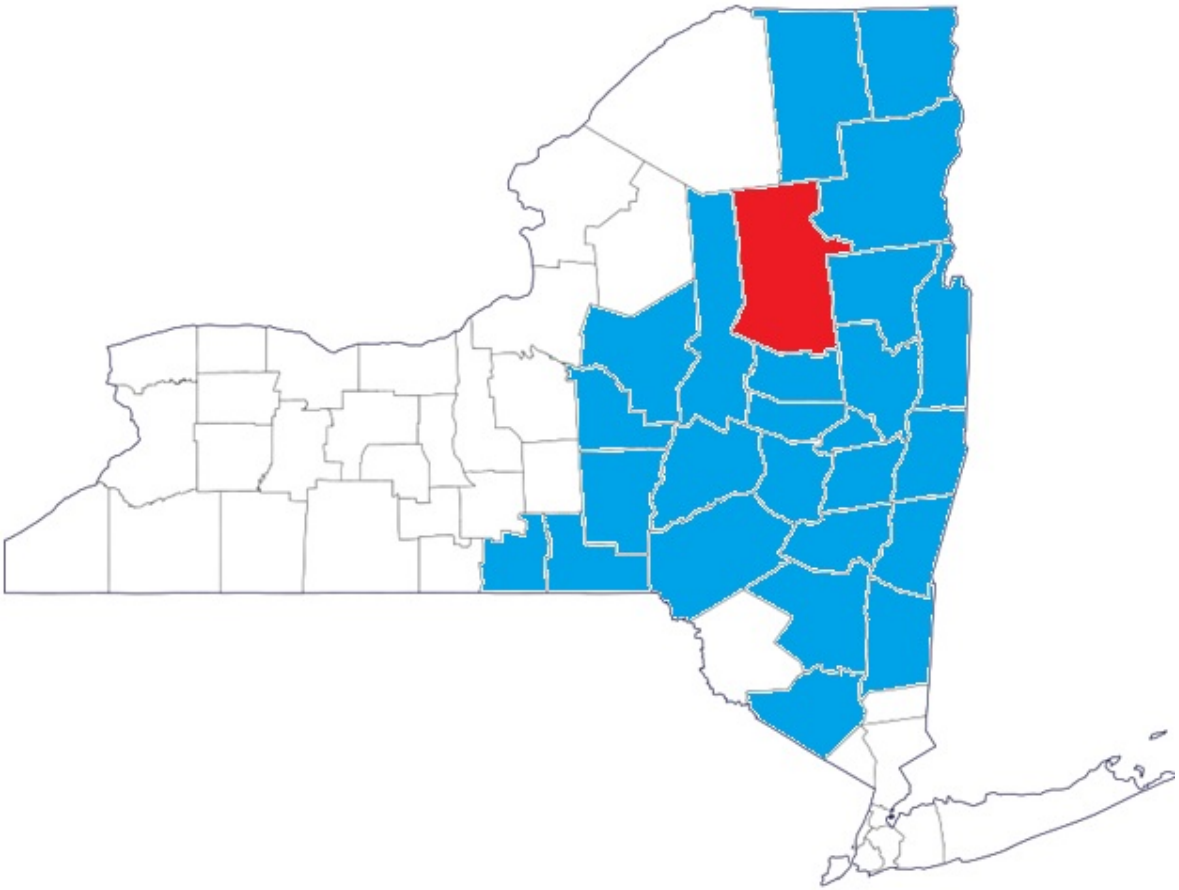
* Please contact the plan directly to confirm the plan participation counties.

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] Note that the HARP product line is available in all counties that serve the Medicaid population.
[2] CDPHP only participates in Broome, Chenango, Herkimer, Madison, Oneida and Tioga counties.
[3] CDPHP only participates in Duchess, Orange and Ulster counties.

Figure 1: CDPHP Map of Participating Counties



Note: Counties shaded in blue serve the Medicaid and/or Child Health Plus populations, while the county shaded in red serves the Commercial population only. The Commercial product line is also available in counties serving Medicaid and/or CHP, while the HARP product line is available in all counties that serve Medicaid.

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 .8%. CDPHP enrollment represents 1.9% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	85,544	82,147	81,452
% Change from Previous Year	-11.3%	-4.0%	-.8%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	2.0%	1.9%	1.9%

Data Source: NYS OHIP Medicaid DataMart

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

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

	2016	2017	2018
CHP	12,479	12,987	13,057
Commercial	96,117	91,924	88,078

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: CDPHP Enrollment Trends—All Product Lines

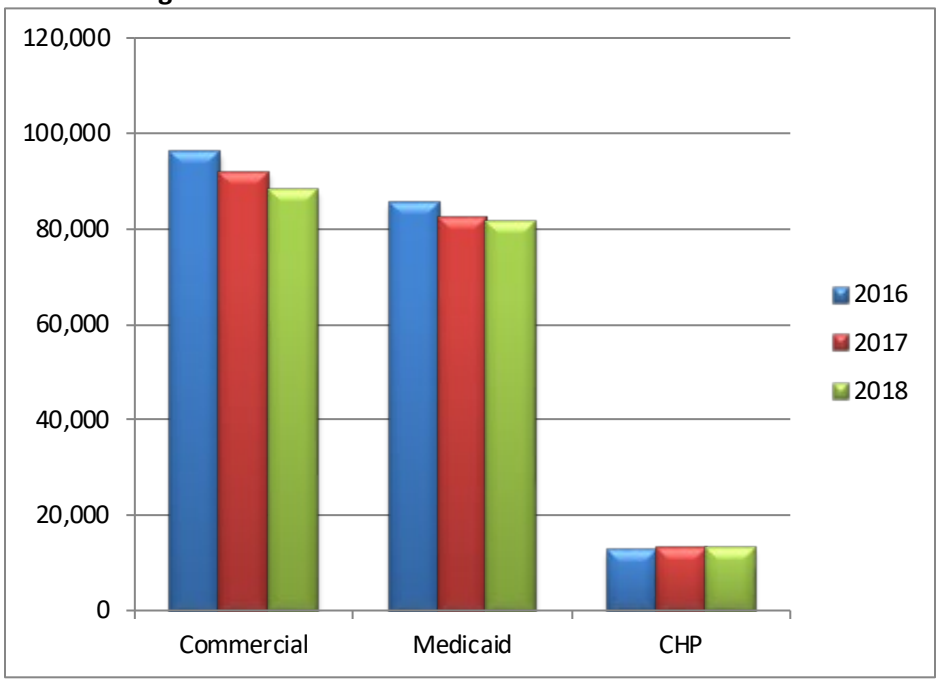


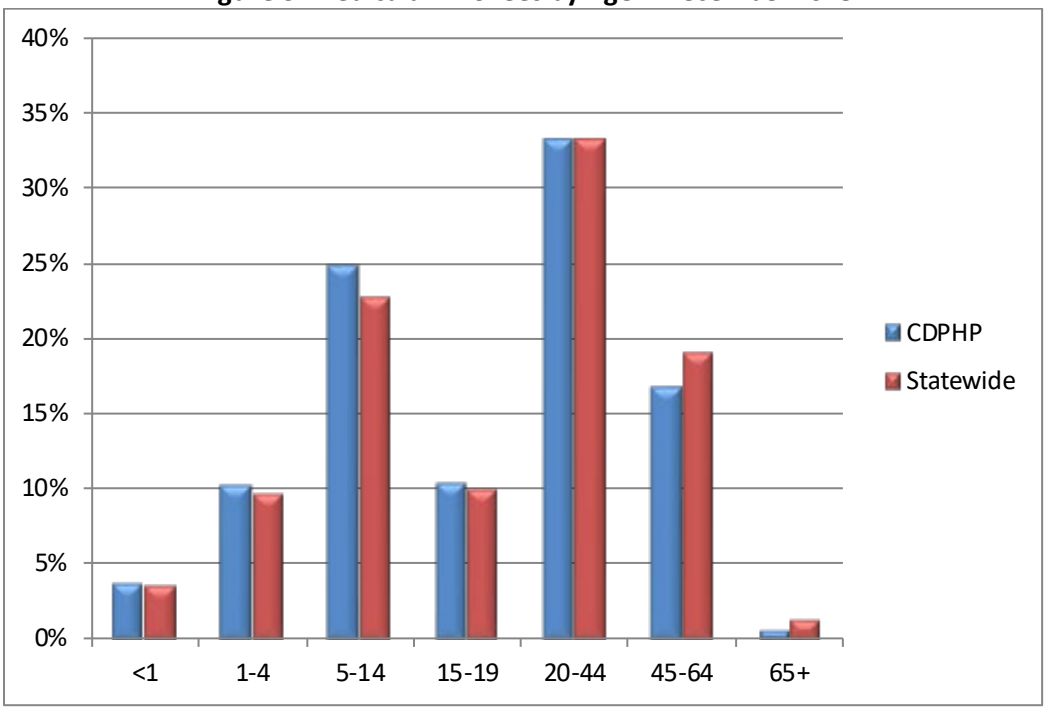
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. Members under the age of 20 are the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

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	1,567	1,446	3,013	3.7%	3.6%
1-4	4,240	4,077	8,317	10.2%	9.7%
5-14	10,388	9,850	20,238	24.9%	22.8%
15-19	4,257	4,180	8,437	10.4%	9.9%
20-44	9,954	17,118	27,072	33.3%	33.3%
45-64	6,286	7,343	13,629	16.8%	19.1%
65 and Over	204	293	497	0.6% ▼	1.4%
Total	**36,896**	**44,307**	**81,203**		
Under 20	20,452	19,553	40,005	49.3%	46.1%
Females 15-64		28,641		35.3%	34.7%

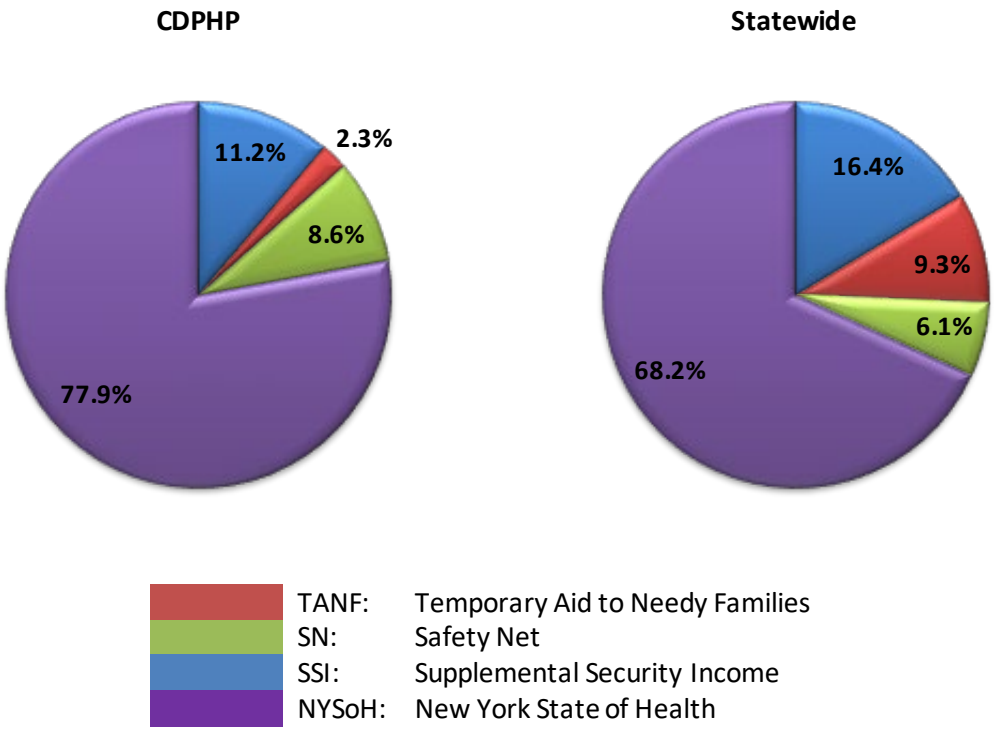
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

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, CDPHP's Medicaid product line had an improvement in 2 out of 6 measures. 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*[4].

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

	2016		2017		2018	
Provider Type	**CDPHP**	**Statewide Average**	**CDPHP**	**Statewide Average**	**CDPHP***	**Statewide Average**
Medicaid/CHP						
Family Medicine	86% ▲	71%	85% ▲	72%	86%	74%
Internal Medicine	81% ▲	75%	80%	76%	80%	76%
Pediatricians	81%	78%	82%	79%	81%	80%
OB/GYN	74%	75%	74%	77%	73%	80%
Geriatricians	68%	63%	65%	63%	66%	63%
Other Physician Specialists	78% ▲	75%	79% ▲	76%	79%	77%
Commercial HMO						
Family Medicine	86% ▲	74%	85% ▲	77%	89%	72%
Internal Medicine	82% ▲	73%	81% ▲	77%	83%	73%
Pediatricians	83% ▲	77%	83%	79%	83%	75%
OB/GYN	76%	78%	76%	79%	75%	78%
Geriatricians	68%	63%	66%	69%	66%	66%
Other Physician Specialists	78%	78%	80%	79%	74%	77%

*Level of significance was unaudited in MY 2018.

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

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. In 2018, the rate for family practice providers was above the statewide average.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	3,084	22.1%	19.5%
Pediatrics	597	4.3%	3.8%
Family Practice	939	6.7% ▲	3.5%
Internal Medicine	736	5.3% ▼	8.4%
Other PCPs	812	5.8%	3.8%
OB/GYN Specialty[1]	547	3.9%	3.8%
Behavioral Health	1,963	14.0%	17.2%
Other Specialties	6,796	48.6%	46.0%
Non-PCP Nurse Practitioners	1,364	9.8%	8.7%
Dentistry	219	1.6%	4.9%
Total	**13,973**		

Data Source: NYS Provider Network Data System (PNDS)

[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)

	CDPHP			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	26:1	2,523	32:1	42:1	80986	42:1
Pediatrics (Under age 20)	67:1			70:1		
OB/GYN (Females age 15-64)	52:1			59:1		
Behavioral Health	41:1			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 less 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 ▼.

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

	2016			2017			2018		
	CDPHP		Statewide	CDPHP		Statewide	CDPHP		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
					Medicaid				
Providers with Open Panel	2097	93.7	85.0	2839	94.6	95.7	3031	99.9	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" telephone resources to members with medical problems."* For the purposes of the Survey, after-hours access is considered compliant if a "live voice" representing the named provider is reached or if the provider's beeper number is reached.

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

Table 8: displays the CDPHP 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
50	31	**62%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 29 providers (total number of providers who were compliant for participation (31), less total number of providers with closed panels (2)).

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	3	2	66.7%
	Pediatrician	3	3	100.0%
	OB/GYN	3	2	66.7%
	Total Routine	**9**	**7**	**77.8%**
Non-Urgent "Sick"	Internist/Family Practitioner	1	1	100.0%
	Pediatrician	6	3	50.0%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**10**	**7**	**70.0%**
After-Hours Access	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	3	2	66.7%
	OB/GYN	3	3	100.0%
	Total After-Hours	**10**	**8**	**80.0%**

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

IV. Utilization

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

Encounter Data

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

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	CDPHP	Statewide Average	CDPHP	Statewide Average	CDPHP	Statewide Average
PCPs and OB/GYNs	4.38	3.85	3.98	3.56	3.86	3.50
Specialty	2.46	2.45	2.29	2.30	2.22	2.33
Emergency Room	0.93 ▲	0.54	1.04 ▲	0.55	1.02 ▲	0.53
Inpatient Admissions	0.11	0.14	0.10	0.14	0.11	0.13
Dental	1.01	1.03	0.99	1.02	1.00	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 ▼. CHPHP's rates were above the statewide average for three consecutive years.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	CDPHP	SWA	CDPHP	SWA	CDPHP	SWA
	Medicaid					
Enrollee Health Screenings	32.1% ▲	12.3%	32.1% ▲	12.7%	31.6% ▲	13.2%

QARR Use of Services Measures

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

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)								
Visits	5,839	4,980	5,037	5,317	5,013 ▲	4,733	4,791	4,209
ER Visits	758 ▲	654	583	492	266 ▲	254 ▲	235 ▲	204
Inpatient ALOS								
Medicine	4.3 ▼	3.7	3.4 ▼	4.5	3.8	3.9	3.5	3.5
Surgery	6.0	6.3	5.9 ▼	7.0	4.6	4.8	4.6	4.4
Maternity	2.8	2.7	2.7	2.9	3.0	2.9	2.8	2.6
Total	4.3	4.2	3.9	4.4	3.9	4.0	3.8	3.6
Inpatient Utilization (PTMY)								
Medicine Cases	43	33	32	30	22	22	19	17
Surgery Cases	21	21 ▲	19	12	18	18	17	15
Maternity Cases	30	30	29	32	11	12 ▲	12	12
Total Cases	85	76	71	66	50	51	46	42

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

V. Performance Indicators

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

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

The HEDIS® Final Audit Report prepared for CDPHP indicated that the MCO had no significant issues in any areas related to reporting. CDPHP 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.

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

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[5]

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.

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

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

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	97 ▲	96 ▲	97 ▲	**89**	93 ▲	92 ▲	97 ▲	**89**
WCC—BMI Percentile	87 ▲	86	94 ▲	**86**	92 ▲	91 ▲	98 ▲	**90**
WCC—Counseling for Nutrition	83	83	89 ▲	**83**	91 ▲	91 ▲	95 ▲	**87**
WCC—Counseling for Physical Activity	77 ▲	75	85 ▲	**73**	88 ▲	87 ▲	92 ▲	**80**
Childhood Immunizations—Combo 3	82 ▲	79	80 ▲	**73**	87 ▲	88	89 ▲	**84**
Lead Screening in Children	83 ▼	83 ▼	86	**89**	91 ▲	89	91	**88**
Adolescent Immunizations—Combo 2[2]		31 ▼	36 ▼	**43**		30	28	**31**
Adolescents—Alcohol and Other Drug Use[3]	71	72	81 ▲	**70**	79 ▲	82	91 ▲	**78**
Adolescents—Depression[3]	72 ▲	66	80 ▲	**67**	72 ▲	78 ▲	85 ▲	**70**
Adolescents—Sexual Activity[3]	66	58	75 ▲	**67**	72	74	84 ▲	**74**
Adolescents—Tobacco Use[3]	79	78	93 ▲	**74**	82 ▲	84	95 ▲	**82**
Breast Cancer Screening	64 ▼	65 ▼	65 ▼	**71**	80 ▲	79 ▲	79 ▲	**77**
Colorectal Cancer Screening	56	53 ▼	54 ▼	**63**	73 ▲	76 ▲	75 ▲	**71**
Chlamydia Screening (Ages 16-24)	67 ▼	67 ▼	70 ▼	**76**	69 ▲	69 ▲	71 ▲	**59**

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

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

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

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2017, *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 ▼). In 2018, the MCO's Medicaid product line had 25% of their rates below the SWA.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	90	91	92	**91**	94 ▲	93	96 ▲	**93**
Spirometry Testing for COPD	33 ▼	36 ▼	35 ▼	**56**	42	42	47	**45**
Use of Imaging Studies for Low Back Pain	70 ▼	71 ▼	69 ▼	**77**	77	78	74 ▼	**80**
Pharmacotherapy Management for COPD—Bronchodilators	88	84	89	**89**	68	83	84	**80**
Pharmacotherapy Management for COPD—Corticosteroids	79 ▲	78	81	**76**	82 ▲	81	83	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	61 ▼	67	63 ▼	**71**	74	76	77	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	54	59	65 ▲	**59**	62	67	63	**63**
Asthma Medication Ratio (Ages 19-64)	58	61	53 ▼	**60**	83 ▲	85	86 ▲	**81**
Asthma Medication Ratio (Ages 5-18)	67	68	69	**68**	86	84	84	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	89	86	88	**80**	89	85	92	**83**
CDC—HbA1c Testing	91	89	91	**92**	93	93	93	**92**
CDC—HbA1c Control (<8%)	55	60	56	**60**	70 ▲	69 ▲	70 ▲	**61**
CDC—Eye Exam Performed	65	69	68	**67**	65 ▲	68 ▲	68 ▲	**63**
CDC—Nephropathy Monitor	91	91	90	**92**	93 ▲	91	95 ▲	**89**
CDC—BP Controlled (<140/90 mm Hg)	74 ▲	74 ▲	76 ▲	**66**	75 ▲	74 ▲	81 ▲	**69**
Drug Therapy for Rheumatoid Arthritis	83	84	85	**83**	94 ▲	89	90 ▲	**84**
Monitor Patients on Persistent Medications—Total Rate	89 ▼	88 ▼	89 ▼	**92**	87 ▲	87 ▲	87 ▲	**84**
Appropriate Treatment for URI	94	94	96 ▲	**95**	95 ▲	95	96	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	33	36	43 ▲	**36**	34 ▲	38 ▲	38 ▲	**34**
HIV Viral Load Suppression[2,3]	83	84	84	**77**				
Flu Shots for Adults (Ages 18-64)[4]	35 ▼	42			57 ▲	58	59	**56**
Advising Smokers to Quit[4]	82	81			86	89	90 ▲	**81**
Smoking Cessation Medications[4]	59	64			69 ▲	69	70	**62**
Smoking Cessation Strategies[4]	49	53			61 ▲	63	62	**55**

Note: Rows shaded in grey indicate that the measure is not required to be reported for the Commercial product line.
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 ▼). In 2018, CDPHP's rates decreased in 3 out of 9 behavioral health measures.

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

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Antidepressant Medication Management—Effective Acute Phase	52	54	54	**53**	67	66	69	**68**
Antidepressant Medication Management—Effective Continuation Phase	35	37	39	**37**	51	53	53	**53**
Follow-Up Care for Children on ADHD Medication—Initiation	53 ▼	51 ▼	47 ▼	**59**	59 ▲	49	52	**45**
Follow-Up Care for Children on ADHD Medication—Continue	61	59	53 ▼	**66**	74 ▲	53	57	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	84 ▲	84 ▲	70	**74**	87 ▲	83 ▲	69	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	70 ▲	68 ▲	34 ▼	**63**	77 ▲	71 ▲	51	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	83	81	79	**84**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	85	85	86	**80**				
Antipsychotic Medications for Schizophrenia	60	62	60	**63**				

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

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[6].

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, CDPHP 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	68	63 ▼	85 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	78 ▼	83 ▼	85	**86**
Adolescent Well-Care Visits	65 ▼	66 ▼	68	**68**
		Commercial		
Well-Child Visits—First 15 Months	93 ▲	92 ▲	98 ▲	**94**
Well-Child Visits—3 to 6 Year Olds	92 ▲	91 ▲	94 ▲	**88**
Adolescent Well-Care Visits	74 ▲	73 ▲	75 ▲	**67**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). In 2018, 70% of Access to Care measures had rates above the SWA for CDPHP's Medicaid product line.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Children and Adolescents' Access to PCPs (CAP)								
12-24 Months	98 ▲	98 ▲	98 ▲	**97**	99	100 ▲	100 ▲	**98**
25 Months-6 Years	94	94	95 ▲	**94**	98 ▲	98 ▲	98 ▲	**95**
7-11 Years	98 ▲	97	97	**97**	99 ▲	99 ▲	99 ▲	**97**
12-19 Years	96 ▲	96 ▲	94 ▲	**95**	98 ▲	98 ▲	98 ▲	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	87 ▲	86 ▲	86 ▲	**81**	95 ▲	95 ▲	95 ▲	**94**
45-64 Years	91	91 ▲	91 ▲	**89**	98 ▲	98 ▲	97 ▲	**96**
65+ Years	93	90	90	**91**	97	98 ▲	98 ▲	**97**
Access to Other Services								
Timeliness of Prenatal Care	89	91	94 ▲	**88**	96 ▲	96	98 ▲	**92**
Postpartum Care	72	68	68	**70**	90 ▲	93 ▲	88	**83**
Annual Dental Visit[2]	59 ▼	60	63 ▲	**61**				

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

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Birth Statistics 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. 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	
	CDPHP	ROS Average	CDPHP	ROS Average	CDPHP	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	5%	7%	7%	7%		
Prenatal Care in the First Trimester	74%	74%	74%	74%	74%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	13%	14%	13%	13%		
Vaginal Birth After Cesarean	18%	14%	18%	14%		
Commercial						
Risk-Adjusted Low Birth Weight[1]	4%	4%	5%	4%		
Prenatal Care in the First Trimester	88%	88%	88%	88%	88%	88%
Risk-Adjusted Primary Cesarean Delivery[1]	19%	19%	17%	18%		
Vaginal Birth After Cesarean	19%	11%	19%	11%		

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

ROS: Rest of State

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

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). In 2018, 3 out of 12 measures had rates above the SWA for the MCO's Medicaid product line.

Table 16: CAHPS®—2014, 2016, and 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	CDPHP	SWA	CDPHP	SWA	CDPHP	SWA	CDPHP	SWA	CDPHP	SWA	CDPHP	SWA
Flu Shots for Adults Ages 18-64							58 ▲	**52**	57 ▲	**52**	59	**56**
Advising Smokers to Quit							87	**84**	86	**80**	90 ▲	**81**
Getting Care Needed[1]	89 ▲	**83**	91 ▲	**85**	88	**84**	91 ▲	**88**	92 ▲	**88**	94 ▲	**89**
Getting Care Quickly[1]	91 ▲	**87**	92 ▲	**88**	92 ▲	**88**	92 ▲	**88**	91 ▲	**87**	87	**87**
Customer Service[1]	82	**82**	84	**86**	93 ▲	**86**	90	**88**	92	**89**	91	**91**
Coordination of Care[1]	72	**74**	69	**74**	77	**75**	84	**84**	87	**83**	89	**87**
Collaborative Decision Making[1]	54	**53**	81 ▲	**74**	80	**76**	85 ▲	**80**	83	**80**	83	**80**
Rating of Personal Doctor[1]	91	**89**	94 ▲	**89**	91	**90**	89 ▲	**84**	89 ▲	**85**	90 ▲	**86**
Rating of Specialist	80	**81**	87	**83**	82	**84**	88 ▲	**83**	83	**84**	91 ▲	**84**
Rating of Healthcare	86	**85**	87	**86**	90	**87**	85 ▲	**78**	86 ▲	**80**	88 ▲	**81**
Satisfaction with Provider Communication[1]	94	**93**	94	**93**	97 ▲	**93**	97 ▲	**96**	96	**96**	97	**96**
Wellness Discussion							84 ▲	**77**	77	**76**	78	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	60	**64**	59	**68**	78	**69**						
Rating of Health Plan—High Users	87	**84**	91	**85**	86	**84**	82 ▲	**68**	79 ▲	**68**	89 ▲	**72**
Overall Rating of Health Plan	87 ▲	**83**	87	**85**	88	**85**	82 ▲	**67**	78 ▲	**66**	85 ▲	**71**
Recommend Plan to Family/Friends												

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

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Weight Assessment for Children and Adolescents - Counseling for Nutrition Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	**A** Weight Assessment for Children and Adolescents - BMI Percentile Weight Assessment for Children and Adolescents - Counseling for Physical Activity
No Change	**D** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Adolescent Immunization (Combo2) Asthma Medication Ratio (Ages 5-64) Breast 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 Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Medication Management for People with Asthma 75% Days Covered (Ages 5-64) Use of Spirometry Testing in the Assessment and Diagnosis of COPD Postpartum Care	**C** Annual Dental Visits (Ages 2-18) Antidepressant Medication Management-Effective Acute Phase Treatment Antidepressant Medication Management-Effective Continuation Phase Treatment Cervical Cancer Screening Childhood Immunization Status (Combo 3) Controlling High Blood Pressure 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) Metabolic Monitoring for Children and Adolescents on Antipsychotics Monitoring Diabetes - Eye Exams Statin Therapy for Patients with Cardiovascular Disease - Adherent Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits) Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Viral Load Suppression	**B** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days Timeliness of Prenatal Care
↓	**F**	**D**	**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, CDPHP's continued with the PIP topic *"Improving Perinatal Care and Reducing Adverse pregnancy outcomes for CDPHP's mainstream Medicaid population"*. The following interventions were continued from 2017 and some were implemented in 2018:

Member-Focused Interventions:

- Educate members regarding CDPHP's Smoke Free program, which will offer enhanced benefits for counseling and medications. The program will also offer pregnancy-tailored coaching and tools appropriate to the members' stage of pregnancy.
- Provided smoking cessation programs through the Roswell Park Cancer Institute.

Provider-Focused Interventions:

- Partner with providers for early identification of candidates for progesterone therapy.
- Educate providers regarding CDPHP's Smoke Free program through provider newsletters and the provider portal.
- Conduct OB/GYN Network Provider meeting for a comprehensive discussion about the PIP expectations and goals in the four target areas. The MCO received feedback from participating providers on barriers in each of the four areas and will develop further interventions to implementation and continuation of provider educational visits in 2018.
- CDPHP visited OB/GYN practices and provided education on existing pregnancy programs, case management options (medical and BH), and the CDPHP tobacco cessation pogram.

MCO-Focused Interventions:

- Create a provider survey.
- Update and distribute editable versions of the NYSDOH/OMH *Fact Sheet for Care Providers: Understanding Maternal Depression* with CDPHP resources for referrals and support and disseminate to network providers.
- Draft Mom2Be promotional materials for members that include information on family planning and disseminate materials to Mom2Be members and target population pre-conception.
- Collaborated with Healthy Schenectady Families to assist with identifying pregnant members, provide additional support services and increase the number of maternal risk assessments and referrals to case management.
- Modified existing case management software to assist with capturing the necessary data for the PIP interventions.

Table 18 presents a summary of CDPHP's 2017-2018 PIP. CDPHP demonstrated an improvement for 3 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	89%	93%	Baseline + 5%	Demonstrated improvement
Postpartum Care	72%	68%	Baseline + 5%	Performance declined
Received at least one 17P injection	20%	17%	Baseline + 5%	Performance declined
Depression Screening	23%*	79%	Baseline + 5%	Performance increased from baseline to interim but then declined from Interim to Final
Tobacco Screening	96%	79%	Baseline + 5%	Performance declined
Tobacco Screening Follow-Up				Plan did not measure or report results
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	3%	3%	Baseline + 5%	Performance level was maintained
Age 15-20 years; within 60 days	43%	37%	Baseline + 5%	Performance declined
Age 21-44 years; within 3 days	8%	9%	Baseline + 5%	Demonstrated improvement
Age 21-44 years; within 60 days	40%	35%	Baseline + 5%	Performance declined
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	0%	0%	Baseline + 5%	Performance level was maintained
Age 15-20 years; within 60 days	5%	5%	Baseline + 5%	Performance level was maintained
Age 21-44 years; within 3 days	0%	0.14%	Baseline + 5%	Performance level was maintained
Age 21-44 years; within 60 days	4%	5%	Baseline + 5%	Demonstrated improvement

LARC: Long-Acting Reversible Contraception

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.

CDPHP 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:

- CDPHP's data analytics team identifies and analyzes the membership for health disparities, social determinants of health, as well as epidemiologic analysis. In 2018, the health plan focused on identifying membership based on poverty, educational attainment and food access. Predictive modeling software was used to analyze disease prevalence and the contribution of individual chronic conditions to future risk. An interactive dashboard was created to display risk variables overlaid with diseases by LOB, age, gender, race, ethnicity, and BH risk status, which allows the plan to describe risk across relevant subpopulations.

  CDPHP identified members in the HARP and Medicaid/CHP lines of business to be below the FPL. Hispanic and African-American members have a higher percentage of living below the FPL than other groups. This indicates that poverty as a social determinant of health is more prevalent in the state programs. It also disproportionately impacts Hispanic and African-American members when compared to non-Hispanic members and other races.

  Across all LOBs, CDPHP identified black or African-American people have lower educational attainment, with 39–43 percent having a high school degree or lower, compared to just 32–38 percent for Asian members and 35–40 percent (except HARP) for white members.

  As it relates to food access, CDPHP estimates that the HARP LOB has the greatest percentage of low income-low access (LI-LA) individuals (11 percent) and Medicaid/CHP the second greatest (9 percent). Within State Programs, low food access is less associated with Hispanic ethnicity, with no difference noted between Hispanic and non-Hispanic members. The greatest percentage of members impacted by LI-LA was noted among the native Hawaiian or other Pacific Islander in the HARP population (25 percent), which is likely driven by the small number of members in this subpopulation.

  CDPHP identified notable differences in disease prevalence by race or ethnicity. Members of Asian race have higher prevalence of hypertension, osteoarthritis, hyperlipidemia, CKD, diabetes, and CAD. However, when prevalence is stratified by both age and race, Asians continue to have high hypertension rates when

compared to other races. Close to 40 percent of Asians ages 45 to 54 have hypertension, while just 34 percent of white members in the same age range have hypertension. Members of the black race have higher prevalence of hypertension and asthma, but a similar or lower prevalence of all other diseases shown above. It is unlikely that age can account for any of this difference, because the black or African-American population is younger when compared to other races. When investigating the prevalence of hypertension stratified by both race and age, black or African-American individuals have a higher prevalence of hypertension at all age ranges when compared to white members. Members of Hispanic ethnicity have higher prevalence of hypertension, asthma, obesity, depression, back degenerative conditions, osteoarthritis, ADD/ADHD, CKD, diabetes, and breast cancer, but lower rates of anxiety and tobacco use.

- In 2018, CDPHP implemented a multi-faceted approach for targeted member outreach and engagement efforts specifically in regards to specific conditions. The results of the quality and population health focused initiatives are evaluated and reported annually in a comprehensive program evaluation, which also incorporates learnings/recommendations for succeeding calendar years. The outcomes by program are extensive and too numerous to describe in this response.
- In 2018, CDPHP continued its partnership with Whitney M. Young for Whitney on Wheels, which uses Whitney Young's state-of-the art mobile health unit at locations designated by CDPHP to provide enhanced access to physicals, immunizations and other important services to Medicaid members at convenient locations in Albany and Troy. CDPHP also continued its partnership with Whitney Young Health to hold monthly events targeting women's health services at their Federally Qualified Health Center (FQHC) in Albany, with designated appointment slots for CDPHP members. Services included well women exams, cervical cancer screenings, and prescriptions for mammograms. Whitney Young's Troy health center was added on as a new location for women's health events in 2018.
- CDPHP implemented the below interventions to reduce or eliminate differences in health outcomes and to improve the quality of care for members identified with at-risk characteristics;
    a. Mom 2 Be Program: As a part of CDPHPs Mom 2 Be program, post-partum outreach is conducted to Medicaid members who have delivered at one of three participating hospitals in the area. Outreach is made within 7 to 10 days post-delivery to discuss the benefits of attending a post-partum visit and to offer members assistance in scheduling their post-partum appointment. Staff also offers information about community resources, transportation and breastfeeding in an effort to optimize post-partum care and health outcomes for mom and baby.
    b. Healthy Neighborhood: CDPHP's Healthy Neighborhood is a community-based initiative that is aimed at improving health outcomes and reducing gaps in care in targeted communities by providing ongoing support and access to health and wellness resources. In 2018, CDPHP partnered with 4 local community organizations to offer community members a variety of services, including health and social service information, free health screenings, and activities promoting healthy eating and exercise for adults and children. CDPHP expanded the Healthy Neighborhood series in 2018 to include 2 new sites located within low-income urban neighborhoods in Albany and Troy.
    c. Community Health Project (CHP): CDPHP maintains contracts with two community based organizations to provide outreach to targeted Medicaid members via trained community health workers. This initiative targets areas within the Capital District and surrounding counties with high concentrations of CDPHP's Medicaid membership to engage members with gaps in care and/or underutilization of preventive health services. For 2018 project results, please refer to the table below.
    d. Homeless Management Information System Outreach Initiative: Recognizing that homelessness is a key social determinant of health, CDPHP partners with a local administrator of the Homelessness Management Information System (HMIS), which is a database utilized by

homeless/housing service providers that receive HUD funding. This initiative provides a regular data feed to CDPHP's outreach team on CDPHP Medicaid members utilizing shelters, housing programs, drop-in centers, etc. in Albany, Schenectady, Rensselaer and Saratoga counties. This data allows CDPHP's care management team to outreach and engage a segment of the population that is at higher risk for experiencing chronic health conditions, mental health and substance use issues.

e. Community Based Case Management: CDPHP embeds nurse case managers, outreach and enrollment staff at community based locations frequented by low-income individuals and families in order to provide care management and ensure linkage to appropriate plan resources. This includes free community meal programs (i.e. "soup kitchens"), drop-in centers, shelters and local public housing authority sites. Additionally, CDPHP began embedding community advocates at new community sites during 2018. These non-clinical staff provides care coordination for preventive care needs and serve as a pipeline for identifying members in need of medical or behavioral health case management, pharmacy support or social work interventions and make appropriate referrals to the CDPHP Care Team.
f. Smoke Free: CDPHP partners with Roswell Park Cancer Institute to offer CDPHP Smoke-Free, a no-cost, individualized phone-based counseling program. Participants receive telephonic sessions with a specialized quit coach, as well as nicotine replacement therapy. In 2018, 116 Medicaid members participated in the program making up almost half of member enrollment.

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)[7]
- 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%
Use of telecommunications technologies	100%
Use of Electronic Health Records (EHR)	92%

[7] 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.

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 are not included in results.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Secure email is used when sharing protected information with patients.
  - Use of a provider portal, FTP and secure email are used with providers.

- Use of telecommunications technologies:
  - Use of Telvox calls to provide information to members to support efforts to close gaps in care.
  - Online and telephonic health education programs and shared-decision making tools.
  - Text4baby app for pregnant women and new moms provides appointment reminders and educational information regarding pregnancy.
  - Health information provided through CDPHP's "Daily Dose" blog shared on social media outlets.

- Use of Electronic Health Records (EHR):
  - EHR access is achieved with certain providers based upon a remote access agreement and primarily used to assist in chart retrieval surrounding certain HEDIS measures.

- Use of clinical risk group (CRG) or similar software:
  - Use of predictive model software with Evidenced Based Medicine (EBM) symmetry algorithms to proactively identify high-risk members for inclusion in the case management program.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Via secure FTP to individually defined third parties as needed.

- Electronic communication with providers:
  - Via secure website and secure email.

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

- Participation in a medical home pilot or program:
  - Support data integration and support of EHR deployment for CDPHP's Enhanced Primary Care Program.

- Future plans to implement HIT:
  - The health plan did not indicate any future plans to implement HIT.

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 a 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. CDPHP did not have any deficiencies issued for the operational and focused reviews completed in 2018.

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
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	0
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	0	0
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	0	0
Utilization Review	0	0
Total	0	0

Note: No deficiencies were issued to the MCO in 2018.

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, CDPHP had 56% of external appeals overturned and 41% were overturned partially.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	11	9	15
Overturned in Part	0	1	1
Upheld	8	9	11
Medicaid Total	**19**	**19**	**27**
		CHP	
Overturned	0	1	3
Overturned in Part	0	0	0
Upheld	1	0	0
CHP Total	**1**	**1**	**3**

VIII. Strengths and Opportunities for Improvement[8]

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 2018, the MCO has reported rates that are above the statewide average (3.5%) for family practice providers (6.7%).
- CDPHP has reported rates above the statewide average for three consecutive reporting years in regards to Medicaid enrollees receiving health screenings within thirty (30) days of enrollment.
- In the HEDIS®/QARR Effectiveness of Care domain, CDPHP has reported rates above the statewide average for at least three consecutive reporting years for the *Adult BMI Assessment* measure. In 2018, CDPHP also has reported rates above the statewide average for the following measures: *WCC – BMI Percentile, WCC – Counseling for Nutrition, WCC – Counseling for Physical Activity, Childhood Immunizations – Combo 3, Adolescents – Alcohol and Other Drug Use, Adolescents – Depression, Adolescents – Sexual Activity,* and *Adolescents – Tobacco Use.*
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO has reported rates statistically better than the statewide average for the following measures: *Medication Management for People with Asthma 50% (Ages 5-18), Appropriate Treatment for URI* and *Avoidance of Antibiotics for Adults with Acute Bronchitis.* The MCO has reported rates statistically better than the statewide average for three consecutive reporting years for the *Comprehensive Diabetes Care- Blood Pressure Controlled (<140/90mm Hg)*measure.
- In the HEDIS®/QARR Utilization domain, the MCO's performance for all three measures showed an improvement from 2017 to 2018. The *Well-Child Visits – First 15 Months* measure has a reported rate of 85% which is statistically better than the statewide average of 81%.
- CDPHP performed well in the HEDIS®/QARR Access to Care domain. CDPHP has reported rates above the statewide average for at least three consecutive reporting years for the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to*

[8] 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.

Preventive/Ambulatory Health Services measures: *12-24 Months, 12-19 Years,* and *20-44 Years*. The MCO also reported rates above the statewide average for the *25 Months – 6 Years* and *45-64 Years* age groups for 2018. In regards to access to other services, the MCO reported rates above the statewide average for the *Timeliness of Prenatal Care* and *Annual Dental Visit* measures.

- In regards to the CAHPS® member satisfaction survey, the MCO has reported rates above the statewide average for at least three consecutive survey cycles for the Getting Care Needed measure. Additional measures for which the MCO reported rates above the statewide average for the 2018 survey cycle include: Customer Service and Satisfaction with Provider Communication.
- In the QARR Use of Services domain, the MCO reported rates for Inpatient Average Length of Stay that was lower than 90% of all rates for the *Medicine* and *Surgery* measures.

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 regards to the MCO's Medicaid provider types, Internal Medicine providers had a rate of 5.3%, which is below the statewide average of 8.4%.
- The MCO demonstrates an opportunity for improvement in regard to appointment availability and after-hours access to providers. The total rate for the routine call type is 77.8% and for the non-urgent call type the rate was 70.0%.
- The MCO demonstrated several opportunities for improvement within the HEDIS®/QARR Effectiveness of Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Breast Cancer Screening, Chlamydia Screening in Women (Ages 16-24), Use of Spirometry Testing in the Assessment and Diagnosis of COPD,* and *Use of Imaging Studies for Low Back Pain*. Additionally, the MCO's rates for *Adolescent Immunizations – Combo 2* and *Colorectal Cancer Screening* were reported below the statewide average for 2018.
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO's rates for *Annual Monitoring for Patients on Persistent Medications—Total Rate* has been reported below the statewide average for at least three consecutive reporting years. Additionally, the MCO's rates for *Medication Management for People with Asthma 50% (Ages 19-64),* and *Asthma Medication Ratio (Ages 19-64)* were reported below the statewide average for 2018.
- In the HEDIS®/QARR Behavioral Health domain, the MCO's rate for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* have been reported below the statewide average for at least three consecutive reporting years. The MCO's rates for the *Follow-Up Care for Children on ADHD Medication – Continue* and *Follow-Up After Hospitalization for Mental Illness-7 Days* were below the statewide average for 2018.

Recommendations:

- The MCO should consider creating a process that identifies providers who did not meet the necessary access and availability requirements for routine and non-urgent appointments. The MCO should focus on educating providers on the appointment timeframe requirements. Routine appointments should be scheduled within four (4) weeks of request and non-urgent "sick" appointments should be scheduled within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated. The provider outreach can be done face-to-face or telephonically during routine visits by the provider representatives. The MCO

should also consider including reminders in existing provider newsletters on the importance of appointment timeframes.

- The MCO continues to struggle with improving rates for measures in the HEDIS®/QARR Effectiveness of Care domain. The MCO should continue with its efforts to improve the reliability and validity testing regarding data collection, sampling, and analysis for HEDIS®, QARR, and Enhanced Primary Care (EPC) performance metrics. The MCO should utilize these quality improvements to identify and implement interventions that target preventative health screenings. The MCO's rates for Access to Care measures are at or above statewide benchmarks; therefore, the MCO should investigate barriers to care with this in consideration.
- The MCO's rates for the HEDIS®/QARR Acute and Chronic Care domain reflect rates that are below the statewide average for the measures regarding asthma medications for adult members. The MCO should consider the use of pharmacists in their outreach to members. Pharmacists can be utilized to educate members on the importance of refilling their prescriptions and providing assistance on how and when to use the medications. The MCO can also consider collaborating with a community based organization (CBO) that outreaches to members face-to-face to assist with asthma education.
- The MCO should investigate reasons behind its poor performance in the measures that had rates below the statewide average in the HEDIS®/QARR Behavioral Health domain. The MCO should conduct thorough, population-specific barrier analyses to determine factors preventing members from following up with care, such as transportation issues, appointment availability issues, or the network adequacy for behavioral health providers.

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.

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

- **2017 Recommendation:** The MCO continues to struggle with improving rates for certain screening, diagnostic, and monitoring measures. The MCO should continue to conduct barrier analyses to determine factors that are preventing members from seeking or receiving these types of services. Additionally, the MCO should consider conducting geographic analysis for each measure to determine if there are specific areas or counties of service driving the MCO's rates down. The MCO should also consider the fact that while these measures are opportunities for improvement, the MCO's rates for Access to Care measures are at or above statewide benchmarks; therefore, the MCO should investigate barriers to care with this in consideration. *[Repeat recommendation.]*

  MCO Response: CDPHP continues to evaluate all HEDIS® and QARR measures that perform below average as well as those that have excellent performance. The quality enhancement department working with corporate analytics, the quality informatics staff enhanced the HEDIS® data processing and reporting and gap lists data corrections process to positively impact HEDIS® rates and national ratings. In addition, they improved interim HEDIS® reports (MY 2018) to run an actionable gap list to help move low performing practitioners on high impact HEDIS® measures, particularly our Enhanced Primary Care (EPC) practices, within the measurement year. The analytical data warehouse (ADW) continues to improve the efficiency of data analysis. Corporate analytics staff expertise in statistical analysis and utilization of other advance statistical tools continues to improve the QM program accuracy, reliability, and validity testing regarding data collection, sampling, and analysis for our HEDIS®, QARR, and Enhanced Primary Care (EPC) performance metrics; Network GeoAccess

reporting, Practitioner to Member Ratio Analysis reporting, practitioner gap lists, and practitioner quality performance profiling. All departments participate in the ongoing quality improvement process through active involvement in the internal team structure, which forms the mechanism to link quality management activities with other management functions. Internal team structure supports ad hoc end-to-end quality improvement efforts through the continuous quality improvement model of W. Edwards Deming's Plan-Do-Study-Act (PDSA) and monitors clinical and service quality through established quality indicators, which are reported quarterly to QMC and the board of directors.

- **2017 Recommendation:** The MCO should conduct age-specific barrier analyses for the three well-care visit measures that are performing below average. The MCO should identify barriers specific to each age group and develop targeted, proactive initiatives in order to get members in to see their providers for their well-visits.

  MCO Response: In 2018, CDPHP addressed a plan of correction for the Medicaid and Child Health Plus (CHP) lines of business to improve our HEDIS and NYS QARR rate with well child visits between the 3rd and 6th year of life (W34). A performance goal was set to increase the percentage of CDPHP members 3-6 years of age who had one or more well child visits with a primary care provider during the measurement year. A multidisciplinary team was formed, comprised of a medical director, quality improvement nurse, physician engagement quality educator, community engagement team members, and representatives from corporate analytics and communications. This team performed a root cause analysis and mapped out interventions aimed at improving CDPHP rates for well care visits in the 3rd, 4th, 5th and 6th years of life with the short-term goal of improving from 78.25 percent to meet or exceed the state wide 50th percentile rate of 82.77 percent, and a long-term goal of meeting and/or exceeding the state wide 90th percentile rate of 87.28 percent.

  One initiative implemented for this goal was to identify Medicaid and CHP members between the ages of three to six who did not complete an annual well child exam. Overall, 1938 Medicaid and CHP members received an incentive letter to complete their well child exam with a 24 percent gap closure rate. 1,585 of these members also received a Televox phone call, with 18 percent of those phone calls resulting in a completed call. Completed calls include those who answered the Televox call and listened to the whole message. Those with a completed Televox call, in addition to the incentive mailing, did not have a better gap closure rate when compared to the cohort that only received the incentive mailing. This may imply that a Televox call may not be a useful intervention for this particular measure when members are already receiving an incentive offer in the mail. In comparison, when evaluating the control group, there was a decrease in the gap closure rate for the cohort that did not receive any type of communication or incentive offerings. 198 Medicaid and CHP members were included in this control group with only 10 percent of these members completing their preventative exam, therefore supporting the effectiveness of the mailing campaign.

- **2017 Recommendation:** The MCO should take steps to address the citations received through the operational and focused review surveys. First, the MCO should ensure that the Utilization Review and Complaints and Grievances documents, both internally and through its vendors, contain the required information and follow the regulatory timeframes for filing appeals. Second, the MCO should review and, if necessary, revise its procedures for credentialing and re-credentialing providers so that all providers are appropriately vetted. Last, the MCO should continue its efforts to increase the accuracy of the information included in the provider directories, and should consider a proactive initiative in order to check the accuracy of provider information. *[Repeat recommendation.]*

MCO Response: In the state's survey, compliance issues were identified for two of CDPHP's contracted vendors, for radiology and dental. CDPHP's contract with the radiology vendor ended as of December 31, 2018. As it relates to its dental vendor, CDPHP, both prior to and following the survey, found their performance to be inconsistent. CDPHP required the vendor to review its policies and procedures and submit a plan of correction for the state's findings. CDPHP performs 100% quality review of all appeals denials and performs sample reviews for all initial denials. The vendor has made progress in meeting quality expectations, but has not achieved the level of success needed for CDPHP to roll back its determination-level oversight. CDPHP's will continue this high level of oversight with this contractor throughout the term of its agreement with CDPHP. Other minor issues with UM procedures were also identified, which were rectified by CDPHP following acceptance of the plan of correction by DOH.

With respect to the credentialing finding (i.e., one provider file was re-credentialed late), CDPHP's root cause analysis concluded this issue was caused by human error. To ensure ongoing compliance and reduce human error in the credentialing process, a new query was created to run on a weekly basis to validate that all files have been verified within the correct timeframe and that appropriate attachments are included with each file. This step has resolved any human error in the credentialing and re-credentialing processes.

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