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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

EXCELLUS HEALTH PLAN, INC.

Reporting Year 2017

FINAL REPORT

Published April 2019

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

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

History of the New York State Medicaid Managed Care Program

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

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

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

Scope of This Report

In accordance with federal regulations, the technical report summarizes the results of the 2017 EQR to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified survey vendor and technical assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the

following: MCO corporate structure, enrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction/quality points and incentive, and deficiencies and citations summaries[1].

Structure of This Report

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

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

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

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

II. MCO Corporate Profile

Excellus Health Plan, Inc. (Excellus) is a regional, not-for-profit health maintenance organization (HMO) that serves Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Commercial (COM), and Medicare populations. Excellus utilizes three DBAs: Upstate HMO, Univera Healthcare HMO, and Excellus Health Plan, Inc. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP and Commercial product lines.

- Plan ID: 1390598
- DOH Area Office: CAO
- Corporate Status: HMO
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: January 1, 1998
- Product Line(s): Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Commercial (COM), and Medicare
- Contact Information: 165 Court Street
  Rochester, NY 14647
  (877) 253-4797
- NCQA Accreditation Rating[2] (as of 10/15/18): Commercial and Medicaid—Commendable
- Medicaid Dental Benefit Status: Mandatory

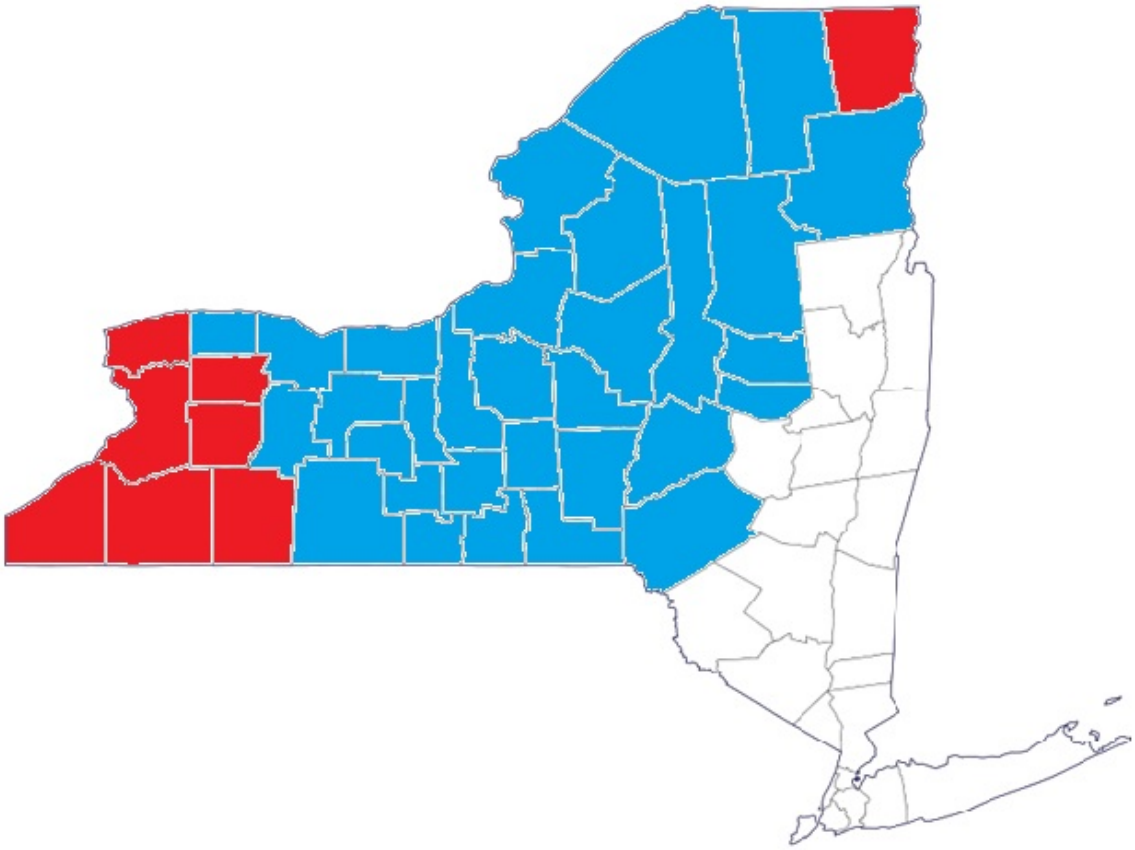
Participating Counties and Products[1]

Allegany:	COM			**Broome:**	COM	MCD	CHP	**Cattaraugus:**	COM		
Cayuga:	COM		CHP	**Chautauqua:**	COM			**Chemung:**	COM		CHP
Chenango:	COM		CHP	**Clinton:**	COM			**Cortland:**	COM		CHP
Delaware:	COM		CHP	**Erie:**	COM			**Essex:**	COM		CHP
Franklin:	COM		CHP	**Fulton:**	COM		CHP	**Genesee:**	COM		
Hamilton:	COM		CHP	**Herkimer:**	COM	MCD	CHP	**Jefferson:**	COM		CHP
Lewis:	COM		CHP	**Livingston:**	COM	MCD	CHP	**Madison:**	COM		CHP
Monroe:	COM	MCD	CHP	**Montgomery:**	COM		CHP	**Niagara:**	COM		
Oneida:	COM	MCD	CHP	**Onondaga:**	COM		CHP	**Ontario:**	COM	MCD	CHP
Orleans:	COM	MCD	CHP	**Oswego:**	COM		CHP	**Otsego:**	COM	MCD	CHP
Schuyler:	COM		CHP	**Seneca:**	COM	MCD	CHP	**St. Lawrence:**	COM		CHP
Steuben:	COM		CHP	**Tioga:**	COM		CHP	**Tompkins:**	COM		CHP
Wayne:	COM	MCD	CHP	**Wyoming:**	COM			**Yates:**	COM	MCD	CHP

[1] The HARP product line is available in all counties that serve Medicaid (MCD).

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

Figure 1: Excellus Map of Participating Counties



Note: Counties shaded in blue serve the Medicaid and/or Child Health Plus populations, while counties shaded in red serve the Commercial population only. The Commercial product line is available in all participating counties.

III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2015, 2016, and 2017, as well as the percent change from the previous year. Enrollment has increased from 2016 to 2017 by a rate of 1.0%. Excellus' membership represents 3.8% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2015-2017

	2015	2016	2017
Number of Members	179,128	166,408	168,074
% Change from Previous Year		-7.1%	1.0%
Statewide Total[1]	4,593,911	4,349,457	4,378,153
% of Total Medicaid Enrollment	3.9%	3.8%	3.8%

Data Source: MEDS II

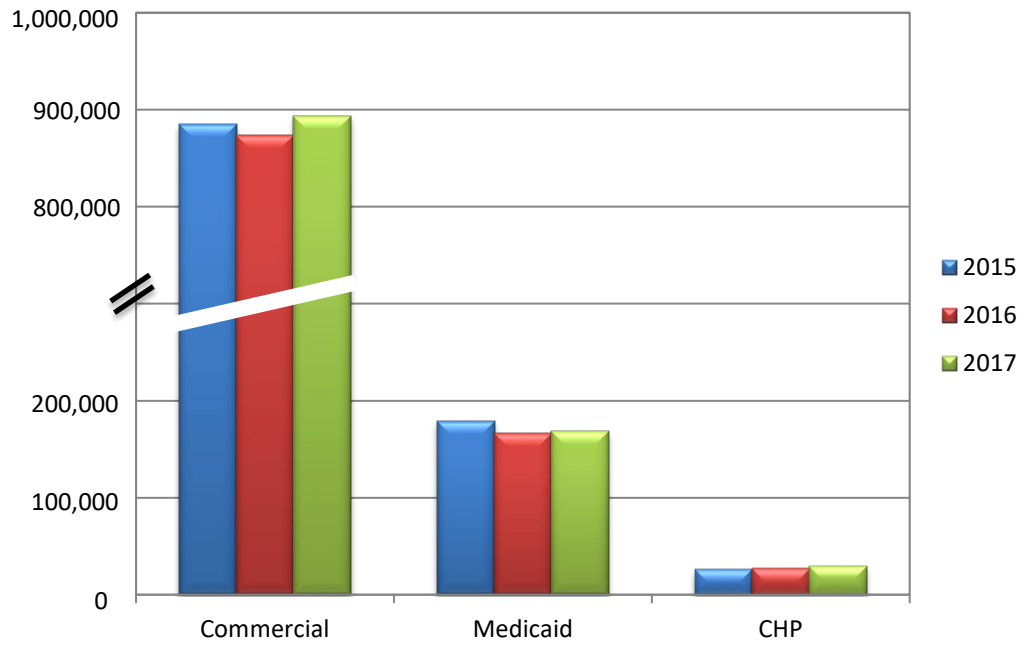
[1] The statewide totals include MCOs that were operational during the measurement year, but did not have enough members to report sufficient data.

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

	2015	2016	2017
CHP	25,722	26,719	29,679
Commercial[1]	885,106	873,987	893,527

[1] Commercial enrollment totals represent the HMO and PPO product lines combined.

Figure 2: Excellus Enrollment Trends—All Product Lines



Provider Network

This section of the report examines the MCO's provider network through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey[3]. This section also includes an overview of network adequacy standards.

Network Adequacy Standards

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

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

Appointment Availability/Timeliness Standards

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

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

Travel Time and Distance Standards

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

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

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

Board Certification

Board certification ensures physicians meet rigorous criteria. In order to maintain an "active" board certification, providers must have evidence of professional standing, commitment to lifelong learning and self-assessment, cognitive expertise, and evaluation of practice performance. The American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) member boards require participation in a program of ongoing maintenance of certification[4].

The quality of the providers participating in an organization's network has a significant effect on the overall quality of care delivered to members. As a result, purchasers and consumers want information that helps them assess the quality of an organization's physicians, though HEDIS® *Board Certification* does not directly measure the quality of every provider in an organization. The changing scope of medical information, increased public concern for the need to recredential physicians, and evidence that knowledge and skills of practicing physicians decays over time motivated specialty boards to limit the duration of certificates[5]. To date, all ABMS member boards have agreed to issue time-limited certificates that necessitate subsequent re-certification, usually at intervals of 10 years or less.

Board certification shows what percentage of the organization's physicians have sought and obtained board certification. While there are valid reasons why physicians may not have done this, and board certification alone is not a guarantee of quality, certification provides a baseline established by standardized, specialty-specific competency testing. HEDIS®/QARR *Board Certification* rates represent the percentage of physicians in the MCO's provider network that are board-certified in their specialty. **Table 3** displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2015 through 2017, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average.

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

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

Table 3: HEDIS®/QARR Board Certification Rates—2015-2017

Provider Type	2015		2016		2017	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
Medicaid/CHP						
Family Medicine	74%	77%	71%	71%	60% ▼	72%
Internal Medicine	80% ▲	76%	78%	75%	69% ▼	76%
Pediatricians	74% ▼	79%	71% ▼	78%	65% ▼	79%
OB/GYN	84% ▲	76%	84% ▲	75%	83% ▲	77%
Geriatricians	68%	63%	72%	63%	68%	63%
Other Physician Specialists	81% ▲	76%	80% ▲	75%	77%	76%
Commercial						
Family Medicine	74%	76%	71%	74%	64% ▼	77%
Internal Medicine	80%	78%	78% ▲	73%	69% ▼	77%
Pediatricians	74% ▼	79%	71% ▼	77%	69% ▼	79%
OB/GYN	84%	80%	84% ▲	78%	87% ▲	79%
Geriatricians	68%	65%	73%	63%	67%	69%
Other Physician Specialists	81%	79%	80% ▲	78%	77% ▼	79%

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

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Primary Care and OB/GYN Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid Managed Care Contract. The survey evaluates the availability of routine and non-urgent "sick" office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after-hours access.

Section 15.2 of the Medicaid Managed Care Contract outlines the timeliness standards for various types of services. For routine office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(vi) states *"Routine, non-urgent, preventive appointments… within four (4) weeks of request."* For non-urgent "sick" office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(v) states that appointments must be scheduled *"…within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated."* Note that the timeliness standard for these types of appointments excludes weekends and holidays. The timeliness standard for prenatal appointments with OB/GYN providers is stated in Section 15.2(a)(ix) as follows: *"…within three (3) weeks during the first trimester, within two (2) weeks during the second trimester, and within one (1) week during the third trimester."*

As noted previously, the Survey also assesses MCO compliance with standards for after-hours access. Section 15.3 of the Contract outlines requirements for providers for 24-hour access to care for members. Section 15.3(a) states *"The Contractor must provide access to medical services and coverage to Enrollees, either directly or through their PCPs and OB/GYNs, on a twenty-four (24) hour, seven (7) days a week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends."* The Contract also states, in Section 15.3(b), that MCOs can satisfy this requirement *"…by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after-hours "on-call" telephone resources to members with medical problems."* For the purposes of the Survey, after-hours access is considered compliant if a "live voice" representing the named provider is reached or if the provider's beeper number is reached.

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

IV. Utilization

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

Encounter Data

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

Table 4: Medicaid Encounter Data—2015-2017

	Encounters (PMPY)					
	2015		2016		2017	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
PCPs and OB/GYNs	3.83	4.12	4.00	3.85	3.72	3.56
Specialty	2.04	1.92	2.14	2.45	1.96	2.30
Emergency Room	0.73 ▲	0.54	0.80 ▲	0.54	0.72 ▲	0.55
Inpatient Admissions	0.12	0.14	0.14	0.14	0.14	0.14
Dental	1.16	0.99	1.24	1.03	1.20	1.02

Data Source: MEDS II
PMPY: Per Member Per Year

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 5** lists the Use of Services rates for 2015 through 2017, as well as the statewide averages for 2017. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

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

	Medicaid/CHP				Commercial			
Measure	**2015**	**2016**	**2017**	**2017 Statewide Average**	**2015**	**2016**	**2017**	**2017 Statewide Average**
Outpatient Utilization (PTMY)								
Visits	4,515	4,534	4,529	5,302	4,003	NV	4,044 ▼	4,211
ER Visits	665	716	653	512	179	NV	187	204
Inpatient ALOS								
Medicine	3.7 ▼	3.7	3.8	4.4	3.2	3.2	3.1 ▼	3.7
Surgery	6.3	6.2	6.0	6.2	4.2	4.0	3.8	4.2
Maternity	2.6 ▼	2.6 ▼	2.6 ▼	2.9	2.5	2.5	2.5 ▼	2.7
Total	3.9	3.9	3.9	4.3	3.4 ▼	3.3 ▼	3.2 ▼	3.7
Inpatient Utilization (PTMY)								
Medicine Cases	34	33	31	32	15	15	15 ▼	17
Surgery Cases	16	15	13	14	16	15	14 ▼	16
Maternity Cases	30	29	29	33	13	13	12	11
Total Cases	71	69	65	71	42	42	39 ▼	43

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

NV: Not valid. The MCO reported invalid data for the measure.

V. Performance Indicators

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

Validation of Performance Measures

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data to the NYSDOH for several measures. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of the MCO's HEDIS® 2018 Compliance Audit™ are summarized in its Final Audit Report (FAR).

For Measurement Year (MY) 2013, the methodology for reporting performance measures was modified. Previously, Medicaid and Child Health Plus (CHP) were reported separately; however, since MY 2013, and for the most recent reporting period of QARR 2018 (MY 2017), rates for these populations were combined following HEDIS® methodology (summing numerators and denominators from each population). Trend analyses were applied over the time period, as the effect of combining the CHP and Medicaid product lines was determined to be negligible through an analysis of historical QARR data.

Summary of HEDIS® 2018 Information System Audit™

As part of the HEDIS® 2018 Compliance Audit™, auditors assessed the MCO's compliance with NCQA standards in the six designated information system categories, as follows:

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

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

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

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

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

measures for all applicable product lines. The MCO passed Medical Record Review for all five measures validated, as well as for exclusions.

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

HEDIS®/QARR Performance Measures

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

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

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

Quality Indicators

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

Effectiveness of Care

This domain of measures includes various indicators which are used to measure preventive care and screenings for several health issues. These indicators are used to evaluate how well the MCO provided these services for their enrollees. The following table describes the measures included in the Effectiveness of Care domain.

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

Effectiveness of Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday.
HEDIS®	Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
HEDIS®	Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.
HEDIS®	Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
HEDIS®	Appropriate Testing for Children with Pharyngitis (CWP)	The percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
HEDIS®	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.
HEDIS®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
CAHPS®	Flu Vaccinations for Adults Ages 18-64 (FVA)	The percentage of members 18-64 years of age who received an influenza vaccine between July 1 of the measurement year and the date when the CAHPS® 5.0H survey was completed.
CAHPS®	Advising Smokers and Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
CAHPS®	Discussing Cessation Medications	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
CAHPS®	Discussing Cessation Strategies	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods and strategies during the measurement year.
NYS-specific[2]	Adolescent Preventive Care (ADL)	The percentage of adolescents ages 12-17 who had at least one outpatient visit with a PCP or OB/GYN practitioner during the measurement year and received assessment, counseling, or education in the following four components of care: 1) risk behaviors and preventive actions associated with sexual activity; 2) depression; 3) risks of tobacco usage; and 4) risks of substance use, including alcohol.

COPD: Chronic Obstructive Pulmonary Disease

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

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

Table 6a displays the HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Effectiveness of Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the

MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

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

	Medicaid/CHP				Commercial			
Measure	**2015**	**2016**	**2017**	**2017 SWA**	**2015**	**2016**	**2017**	**2017 SWA**
Adult BMI Assessment	93	90	94 ▲	**86**	84 ▲	91 ▲	84	**86**
WCC—BMI Percentile	80	86 ▲	90 ▲	**84**	81 ▲	81 ▲	83	**84**
WCC—Counseling for Nutrition	80	85 ▲	89 ▲	**83**	81 ▲	82	78	**81**
WCC—Counseling for Physical Activity	72	81 ▲	80 ▲	**73**	76 ▲	78 ▲	74	**75**
Childhood Immunizations—Combo 3	79 ▲	83 ▲	83 ▲	**75**	84 ▲	88 ▲	89	**86**
Lead Screening in Children	84	85	87	**88**	79	82	84 ▼	**89**
Adolescent Immunizations—Combo 2[2]			39	**41**			26	**27**
Adolescents—Alcohol and Other Drug Use[3]	61	76 ▲	71	**67**	71 ▲	72	76	**74**
Adolescents—Depression[3]	49 ▼	66	77 ▲	**61**	57 ▲	65 ▲	62	**68**
Adolescents—Sexual Activity[3]	62	70	69	**65**	73 ▲	70 ▲	71	**68**
Adolescents—Tobacco Use[3]	81 ▲	84 ▲	85 ▲	**71**	79 ▲	82 ▲	80	**78**
Breast Cancer Screening	67 ▼	64 ▼	65 ▼	**71**	77 ▲	77 ▲	78 ▲	**77**
Colorectal Cancer Screening	49 ▼	52 ▼	56 ▼	**62**	63	68	71	**69**
Chlamydia Screening (Ages 16-24)	60 ▼	61 ▼	59 ▼	**74**	48 ▼	50 ▼	50 ▼	**58**
Testing for Children with Pharyngitis	88	92 ▲	93 ▲	**91**	87	90 ▲	92	**92**
Spirometry Testing for COPD	46 ▼	44 ▼	43 ▼	**55**	41 ▼	41 ▼	42 ▼	**45**
Use of Imaging Studies for Low Back Pain	74	69 ▼	74 ▼	**77**	79	75 ▼	80	**80**
Flu Shots for Adults (Ages 18-64)[4]	41	41	48 ▲	**42**	52	56	54	**53**
Advising Smokers to Quit[4]	83	83	81	**80**	74	71	77	**83**
Smoking Cessation Medications[4]	60	60	65	**59**	50	49	57	**62**
Smoking Cessation Strategies[4]	54	54	49	**51**	50	51	59	**56**

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

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

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2017, *Combination 2* is reported, as it includes the HPV component.

[3] NYS-specific measure.

[4] CAHPS® measure.

Acute and Chronic Care

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

Acute and Chronic Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement period and who were dispensed appropriate medications.
HEDIS®	Medication Management for People with Asthma (MMA)	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medication, and remained on an asthma controller medication for at least 50% of their treatment period.
HEDIS®	Asthma Medication Ratio (AMR)	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year.
HEDIS®	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.
HEDIS®	Comprehensive Diabetes Care (CDC)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c testing; HbA1c control (<8.0%); eye exam (retinal) performed; medical attention for nephropathy; and BP control (<140/90 mm Hg).
HEDIS®	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
HEDIS®	Annual Monitoring for Patients on Persistent Medications—Total Rate (MPM)	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
HEDIS®	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	The percentage of children 3 months-18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.
HEDIS®	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	The percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.
NYS-specific[2]	HIV Viral Load Suppression	The percentage of Medicaid enrollees confirmed HIV-positive who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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

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

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

Table 6b displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

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

	Medicaid/CHP				Commercial			
Measure	**2015**	**2016**	**2017**	**2017 SWA**	**2015**	**2016**	**2017**	**2017 SWA**
Pharmacotherapy Management for COPD—Bronchodilators	89	87	88	**88**	82	76	78	**80**
Pharmacotherapy Management for COPD—Corticosteroids	83 ▲	75 ▲	80	**76**	81 ▲	70	76	**77**
Medication Management for People with Asthma 50% (Ages 19-64)	65	66	69	**69**	70	73 ▲	78 ▲	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	53	54	60	**57**	61 ▲	59 ▲	67 ▲	**63**
Asthma Medication Ratio (Ages 19-64)	58 ▲	60 ▲	60	**57**	79 ▲	80 ▲	83 ▲	**81**
Asthma Medication Ratio (Ages 5-18)	69 ▲	69 ▲	68 ▲	**64**	85 ▲	85 ▲	86	**84**
Persistence of Beta-Blocker Treatment After a Heart Attack	89	86	85	**85**	89	87	86	**88**
CDC—HbA1c Testing	87 ▼	85 ▼	89	**91**	92	93	92	**91**
CDC—HbA1c Control (<8%)	50 ▼	52	54	**59**	62	65	63	**63**
CDC—Eye Exam Performed	66	64	71	**67**	62	61	59	**63**
CDC—Nephropathy Monitor	89 ▼	86 ▼	91	**93**	90	89	88	**90**
CDC—BP Controlled (<140/90 mm Hg)	66	73 ▲	72 ▲	**61**	69 ▲	74 ▲	76 ▲	**69**
Drug Therapy for Rheumatoid Arthritis	89 ▲	89 ▲	90	**83**	89 ▲	89 ▲	87	**86**
Monitor Patients on Persistent Medications—Total Rate	87 ▼	87 ▼	87 ▼	**92**	83 ▼	84	84	**84**
Appropriate Treatment for URI	93 ▼	93 ▼	94 ▼	**95**	90 ▼	91 ▼	93	**93**
Avoidance of Antibiotics for Adults with Acute Bronchitis	18 ▼	23 ▼	38 ▲	**34**	18 ▼	23 ▼	31 ▲	**30**
HIV Viral Load Suppression[2,3]		84 ▲	84 ▲	**77**				

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.

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 otherwise noted.

[2] NYS-specific measure.

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

Behavioral Health

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

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

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

Table 6c displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

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

Measure	Medicaid/CHP				Commercial			
	2015	2016	2017	2017 SWA	2015	2016	2017	2017 SWA
Antidepressant Medication Management—Effective Acute Phase	46 ▼	45 ▼	47 ▼	**52**	64	65	68 ▲	**67**
Antidepressant Medication Management—Effective Continuation Phase	32 ▼	32 ▼	35 ▼	**37**	49	50	54 ▲	**52**
Follow-Up Care for Children on ADHD Medication—Initiation	46 ▼	42 ▼	44 ▼	**58**	43	44	42	**44**
Follow-Up Care for Children on ADHD Medication—Continue	55 ▼	53 ▼	51 ▼	**66**	49	52	49	**52**
Follow-Up After Hospitalization for Mental Illness—30 Days	80	72 ▼	72 ▼	**78**	74 ▲	75	74	**76**
Follow-Up After Hospitalization for Mental Illness—7 Days	64	56 ▼	56 ▼	**62**	58	59	58	**61**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	79 ▼	78 ▼	78 ▼	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	70 ▼	75	68	**81**				
Antipsychotic Medications for Schizophrenia	55 ▼	52 ▼	61	**62**				

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.

Utilization

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

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

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

Table 7a displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Utilization domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

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

Measure	2015	2016	2017	2017 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	70 ▲	68 ▲	70 ▲	**68**
Well-Child Visits—3 to 6 Years	83 ▼	82 ▼	82 ▼	**85**
Adolescent Well-Care Visits	63 ▼	67 ▼	67 ▼	**68**
		Commercial		
Well-Child Visits—First 15 Months	87 ▲	88 ▲	89 ▲	**87**
Well-Child Visits—3 to 6 Years	83 ▼	85 ▼	85 ▼	**86**
Adolescent Well-Care Visits	59 ▼	62 ▼	63 ▼	**66**

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

Access to Care

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

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

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

Table 7b displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Access to Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼).

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

Measure	Medicaid/CHP				Commercial			
	2015	2016	2017	2017 SWA	2015	2016	2017	2017 SWA
Children & Adolescents' Access to PCPs (CAP)								
12-24 Months	99% ▲	99% ▲	99% ▲	**96%**	98%	98%	98%	**98%**
25 Months-6 Years	94%	94%	94%	**94%**	94% ▼	94% ▼	94% ▼	**95%**
7-11 Years	97% ▲	97%	97%	**97%**	95% ▼	96% ▼	96% ▼	**97%**
12-19 Years	96% ▲	96% ▲	97% ▲	**95%**	93% ▼	94%	95%	**95%**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	87% ▲	87% ▲	87% ▲	**82%**	94% ▲	94%	94%	**94%**
45-64 Years	91% ▲	91% ▲	91% ▲	**90%**	96% ▲	96%	96%	**95%**
65+ Years	91%	90%	91%	**91%**	98% ▲	98% ▲	98% ▲	**96%**
Access to Other Services								
Timeliness of Prenatal Care	89%	89%	92% ▲	**88%**	92%	95% ▲	95%	**94%**
Postpartum Care	65% ▼	67%	63% ▼	**71%**	85% ▲	89% ▲	83%	**83%**
Annual Dental Visit[2]	61% ▲	63% ▲	63% ▲	**60%**				

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

Table 8: QARR Prenatal Care Rates—2014-2016

Measure	2014		2015		2016	
	Excellus	ROS Average	Excellus	ROS Average	Excellus	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	6%	7%	5% ▲	7%	6%	7%
Prenatal Care in the First Trimester	76% ▲	74%	76%	74%	76%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	10% ▲	13%	11%	14%	11%	13%
Vaginal Birth After Cesarean	18% ▲	13%	16%	14%	16%	14%
Commercial						
Risk-Adjusted Low Birth Weight[1]	4%	4%	4%	4%	4%	4%
Prenatal Care in the First Trimester	90% ▲	87%	89% ▲	88%	90% ▲	88%
Risk-Adjusted Primary Cesarean Delivery[1]	17% ▲	19%	17% ▲	19%	17%	18%
Vaginal Birth After Cesarean	13%	12%	13%	11%	13%	11%

ROS: Rest of State

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

Member Satisfaction

In 2017, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 9** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2013, 2015, and 2017. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼).

Table 9: CAHPS®—2013, 2015, 2017

Measure	Medicaid						Commercial					
	2013		2015		2017		2013		2015		2017	
	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA
Flu Shots for Adults Ages 18-64	47	**44**	41	**40**	48 ▲	**42**	53	**49**	52	**48**	54	**53**
Advising Smokers to Quit	84	**78**	83	**80**	81	**80**	74 ▼	**84**	74	**80**	77	**83**
Getting Care Needed[1]	83 ▲	**78**	86 ▲	**79**	82	**79**	92 ▲	**88**	91	**89**	87	**87**
Getting Care Quickly[1]	84 ▲	**78**	84 ▲	**80**	79	**78**	89	**87**	87	**86**	87	**86**
Customer Service[1]	81	**82**	87	**84**	83	**86**	84	**86**	95 ▲	**89**	85	**88**
Coordination of Care[1]	82	**78**	80	**80**	81	**81**	85	**83**	85	**84**	87	**84**
Collaborative Decision Making[1]	49	**48**	80	**79**	79	**80**	45	**47**	80	**79**	82	**81**
Rating of Personal Doctor[1]	76	**78**	80	**80**	83	**81**	84	**84**	84	**84**	84	**85**
Rating of Specialist	76	**76**	85	**80**	79	**80**	81	**82**	81	**84**	87	**84**
Rating of Healthcare	73	**71**	78	**75**	84 ▲	**77**	85 ▲	**78**	83 ▲	**77**	78	**79**
Satisfaction with Provider Communication[1]	91	**89**	92	**91**	92	**91**	96	**94**	95	**96**	96	**95**
Wellness Discussion	71	**71**	71	**68**	74	**72**	73	**77**	71	**77**	72	**75**
Getting Needed Counseling/ Treatment	69	**70**	82	**74**	70	**69**						
Rating of Counseling/ Treatment	62	**61**	59	**64**	66	**60**						
Rating of Health Plan—High Users	84 ▲	**77**	83	**77**	85	**80**	69	**66**	73	**68**	74	**71**
Overall Rating of Health Plan	78	**76**	82 ▲	**76**	80	**76**	66	**66**	64	**65**	69	**69**
Recommend Plan to Family/Friends	94	**92**	95 ▲	**93**	93	**92**						

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] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2017

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

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

Table 10: Quality Performance Matrix—Measurement Year 2017

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Monitoring Diabetes—Received All Tests	**A**
No Change	**D** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Antidepressant Medication Management—Effective Acute Phase Treatment Antidepressant Medication Management—Effective Continuation Phase Treatment Breast Cancer Screening Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Meds Follow-Up After Hospitalization for Mental Illness—7 Days Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase Engagement of Alcohol and Other Drug Dependence Treatment—Total Rate Initiation of Alcohol and Other Drug Dependence Treatment—Total Rate Management Diabetes Outcomes—HbA1c Control (<8.0%) Metabolic Monitoring for Children and Adolescents on Antipsychotics Use of Spirometry Testing in the Assessment and Diagnosis of COPD Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Postpartum Care	**C** Adolescent Immunizations (Combo 2) Annual Dental Visits (Ages 2-18) Cervical Cancer Screening Colon Cancer Screening Controlling High Blood Pressure Follow-Up After Emergency Department Visit for Mental Illness—7 Days Medication Management for People with Asthma 50% of Days Covered (Ages 5-64) Statin Therapy for Patients with Cardiovascular Disease—Adherence Weight Assessment for Children and Adolescents—BMI Percentile Weight Assessment for Children and Adolescents—Counseling for Nutrition Timeliness of Prenatal Care	**B** Childhood Immunization Status (Combo 3) Medication Management for People with Asthma 75% of Days Covered (Ages 5-64) Weight Assessment for Children and Adolescents—Counseling for Physical Activity Well-Child Visits in the First 15 Months of Life (5+ Visits) HIV Viral Load Suppression
↓	**F** Discussing Smoking Cessation Strategies Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	**D** Advising Smokers to Quit	**C** Discussing Smoking Cessation Medications Flu Shots for Adults (Ages 18-64)

NYSDOH Quality Incentive

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. The NYSDOH Office of Health Insurance Programs (OHIP) calculated the quality incentive using an algorithm which considers the following data elements: QARR data, the most recent Medicaid CAHPS® results, PDI 90 Overall Quality Composite and PQI 90 Preventive Quality Composite, and regulatory compliance information from MY 2015 and MY 2016. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCO qualified for. MCOs can earn 100 points for quality measures, 30 points for satisfaction measures, 20 points for PDI/PQI measures, and up to 6 points for approved telehealth plans. A maximum of 20 points may be subtracted from the MCO's total points based on compliance measures, as well. The total points are normalized to a 100-point scale to determine the MCO's final score. MCOs are then placed into one of five tiers to determine the incentive award. The highest performing MCOs are placed in Tier 1, while the lowest performing MCOs are placed in Tier 5. Tiers are based on the percentage of total points earned, and MCOs must meet or exceed the tier threshold to be eligible for the incentive award. **Table 11** displays the points the MCO earned from 2015 to 2017, as well as the tier of incentive awards the MCO achieved based on the previous measurement year's data. **Table 12** displays the measures that were used to calculate the 2017 incentive, as well as the points the MCO earned for each measure.

Table 11: Quality Incentive Points Earned—2015-2017

	2015		2016		2017	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
Total Points *(150 Possible Points)*	83.4	75.2	83.7	92.5	92.2	87.9
PQI Points *(20 Possible Points)*	12.5	6.9	7.5	7.3	5.0	7.3
Compliance Points *(-20 Possible Points)*	-2.0	-3.6	-2.0	-2.3	-8.0	-7.2
Satisfaction Points *(30 Possible Points)*	25.0	20.0	20.0	15.7	15.0	15.7
Bonus Points *(6 Possible Points)*			6.0	6.0	6.0	6.0
Quality Points[1] *(100 Possible Points)*	47.9	56.0	52.2	66.4	74.2	66.1
Financial Incentive Award Designation[2]	Tier 2		Tier 3		Tier 3	

[1] Quality points presented here are normalized.

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

Table 12: Quality Incentive Measures and Points Earned—2017

Measure	MCO Points
PQI (10 points each)	**5.0**
Adult Prevention Quality Overall Composite (PQI 90)	0.0
Pediatric Quality Overall Composite (PDI 90)	5.0
Compliance (-4 points each, except where noted)	**-8.0**
MMCOR	0.0
MEDS	0.0
QARR	0.0
Access/Availability *(-2 points)*	-2.0
Provider Directory *(-2 points)*	-2.0
Member Services	-4.0
Satisfaction (10 points each)	**15.0**
Rating of Health Plan	5.0
Getting Care Needed	5.0
Customer Service	5.0
Bonus Points (6 points)	**6.0**
Telehealth Plan	6.0
Quality (3.33 points each)	**54.945**
Annual Dental Visit (Ages 2-18)	1.665
Antidepressant Medication Management	0.00
Breast Cancer Screening	0.00
Cervical Cancer Screening	1.665
Chlamydia Screening	0.00
Childhood Immunization Status—Combination 3	3.33
Colorectal Cancer Screening	1.665
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	0.00
Comprehensive Diabetes Care—Received All Tests	2.498
Controlling High Blood Pressure	2.498
Flu Shots for Adults	3.33
Immunizations for Adolescents—Combination 2	3.33
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3.33
Medical Assistance with Tobacco Cessation (Composite Rate)	2.498
Medication Management for People with Asthma (Ages 5-64)	3.33
Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	2.498
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.00
Weight Assessment and Counseling for Children and Adolescents	2.498
Well-Child Visits in the First 15 Months of Life—Five or More Visits	3.33
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	0.0
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1.665
Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications	0.00
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	3.33
Follow-Up After Emergency Department Visit for Mental Illness—7 Days	3.33
Follow-Up After Hospitalization for Mental Illness—7 Days	3.33
Follow-Up for Children Prescribed ADHD Medication	0.00
Metabolic Monitoring for Children and Adolescents on Antipsychotics	0.00
Timeliness of Prenatal Care	2.498
Postpartum Care	0.00
HIV Viral Load Suppression	3.33
Total Normalized Quality Points[1]	**74.2**
Total Points Earned	**92.2**

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

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

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

Performance Improvement Project

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

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

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may be categorized as infrequent conditions or services, and also exist for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special needs place them at high risk. The State may select the MCO's study topic(s), or topics may be selected based on enrollee input. While MCOs have the option to select a study topic of their choosing, they are encouraged to participate collaboratively with other MCOs in conducting their PIPs. The common-themed PIP chosen for Reporting Years 2017-2018 was Perinatal Care and Pre-term Births.

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

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

Excellus' 2017-2018 PIP topic was *"Improving Maternal and Infant Health Outcomes in a Medicaid Managed Care Plan"*. During 2017, the MCO implemented the following interventions:

Member-Focused Interventions:

- Internal review of member guidebook to enhance member educational messaging regarding pregnancy and postpartum care, plus well-child visits and immunizations.
- Quarterly baby showers held in various communities for the purpose of member education and as an opportunity to provide access to community resources to women and their families.

Provider-Focused Interventions:

- Implementation of the Smart Start for Your Baby (SSFB) Case Management from provider pregnancy referrals and claims extracts.
- External provider meetings for discussion of the PIP and to obtain partnerships for medical record data pulls and providing physician advisory capacity.
- Provider education related to the use of Pregnancy Referral Forms relayed electronically through integration with providers' EMRs.
- Discussions with physician groups and hospital systems for suggestions to improve postpartum compliance through possible opportunities with discharge planning.

MCO-Focused Interventions:

- SSFB enhancements to include behavioral risk assessment for depression and tobacco use.
- Internal prenatal and postpartum workgroup focused on identifying process improvements for the HEDIS® Prenatal and Postpartum Care and Frequency of Ongoing Prenatal Care measures.
- Discussions with community agencies serving cultural groups.

Table 13 presents a summary of Excellus' 2017-2018 PIP.

Table 13: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Postpartum Care	64.8%		90th percentile	
Frequency of Ongoing Prenatal Care >81%	89.0%		90th percentile	
17P Utilization	1.8%		N/A[1]	
Depression Screening	100.0%		100.0%	
Smoking Screening	100.0%		100.0%	
Most or Moderately Effective Contraception within 3 days of delivery(Ages 15-20)	2.2%		5% increase	
Most or Moderately Effective Contraception within 3 days of delivery(Ages 21-44)	1.3%		5% increase	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 15-20)	20.2%		5% increase	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 21-44)	13.5%		5% increase	
LARC within 3 days of delivery(Ages 15-20)	0.0%		5% increase	
LARC within 3 days of delivery(Ages 21-44)	0.0%		5% increase	
LARC within 60 days of delivery(Ages 15-20)	0.0%		5% increase	
LARC within 60 days of delivery(Ages 21-44)	0.0%		5% increase	

LARC: Long-Acting Reversible Contraceptive

[1] Goal will be finalized after a new data pull, as the method to determine the rates changed from the baseline year.

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

VI. Structure and Operation Standards[6]

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

Excellus was in compliance with 10 of the 14 categories. The categories in which Excellus was not compliant were Complaints and Grievances (2 citations), Disclosure (2 citations), Organization and Management (5 citations), and Service Delivery Network (5 citations).

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

Table 14: Focused Review Types

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

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

Table 15: Summary of Citations

Category	Operational Citations[1]	Focused Review Citations
Complaints and Grievances		2
Access and Availability		*1*
Member Services Phone Calls		*1*
Credentialing		0
Disclosure		2
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Family Planning		0
HIV		0
Management Information Systems		0
Medicaid Contract		0
Medical Records		0
Member Services		0
Organization and Management		5
Access and Availability		*1*
Contracts		*2*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Prenatal Care		0
Quality Assurance		0
Service Delivery Network		5
Access and Availability		*1*
Provider Directory Information		*2*
Provider Participation—Directory		*2*
Utilization Review		0
Total	—	**14**

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

VII. Strengths and Opportunities for Improvement[7]

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

Strengths:

- The MCO has reported a rate above the statewide average for at least three consecutive reporting years for HEDIS®/QARR *Board Certification* for *OB/GYN*.
- The MCO performed well in the HEDIS®/QARR Effectiveness of Care domain. The MCO's rates for *Childhood Immunization Status—Combination 3* and *Adolescent Preventive Care—Tobacco Use* have been reported above the statewide average for at least three consecutive reporting years. Additional measures for which the MCO's rates were above the statewide average for 2017 include the following: *Adult BMI Assessment, Weight Assessment and Counseling for Children and Adolescents—BMI Percentile, Weight Assessment and Counseling for Children and Adolescents—Counseling for Nutrition, Weight Assessment and Counseling for Children and Adolescents—Counseling for Physical Activity, Adolescent Preventive Care—Depression, Appropriate Testing for Children with Pharyngitis,* and *Flu Shots for Adults (Ages 18-64)*.
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for the *Asthma Medication Ratio (Ages 5-18)* measure. Additionally, rates for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* and *HIV Viral Load Suppression* were reported above the statewide average for 2017.
- The MCO performed well in regard to the HEDIS®/QARR Access/Timeliness Indicators. The MCO's rates for *Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Annual Dental Visit (Ages 2-20)* have been reported above the statewide average for at least three consecutive reporting years, as have the rates for the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* measures: *12-24 Months, 12-19 Years, 20-44 Years,* and *45-64 Years*. The MCO's rate for *Timeliness of Prenatal Care* was also reported above the statewide average for 2017.
- The MCO reported a rate above the statewide average for the *Rating of Healthcare* measure of the CAHPS® member satisfaction survey for 2017.

Opportunities for Improvement:

- The MCO has reported a rate below the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *Pediatricians.* The MCO's rates for *Family Medicine* and *Internal Medicine* were below the statewide average for 2017, as well.

[7] This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement", rather than "Strengths" and "Weaknesses", as indicated in federal regulations.

- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Breast Cancer Screening, Colorectal Cancer Screening, Chlamydia Screening in Women (Ages 16-24),* and *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.* Additionally, the MCO's rate for *Use of Imaging Studies for Low Back Pain* was reported below the statewide average for 2017. *(Note: Breast Cancer Screening, Colorectal 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 were opportunities for improvement in the previous year's report.)*
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO's rates for *Annual Monitoring for Patients on Persistent Medications—Total Rate* and *Appropriate Treatment for Children with Upper Respiratory Infection* have been reported below the statewide average for at least three consecutive reporting years. *(Note: Annual Monitoring for Patients on Persistent Medications—Total Rate and Appropriate Treatment for Children with Upper Respiratory Infection were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in regard to HEDIS®/QARR Behavioral Health measures. The MCO's rates have been reported below the statewide average for at least three consecutive reporting years for the following measures: *Antidepressant Medication Management—Effective Acute Phase Treatment, Antidepressant Medication Management—Effective Continuation Phase Treatment, Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase, Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase,* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications.* Additionally, the MCO's rates for *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days* were reported below the statewide average for 2017. *(Note: Antidepressant Medication Management, Follow-Up Care for Children Prescribed ADHD Medication, Follow-Up After Hospitalization for Mental Illness, and Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications were opportunities for improvement in the previous year's report.)*
- In regard to HEDIS®/QARR Access/Timeliness Indicators, the MCO has reported rates below the statewide average for at least three consecutive reporting years for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits*. Additionally, the MCO's rate for *Postpartum Care* was reported below the statewide average for 2017. *(Note: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Adolescent Well-Care Visits were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 14 citations from the focused review surveys related to Complaints and Grievances, Disclosure, Organization and Management, and Service Delivery Network. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO continues to struggle with several screening and diagnostic measures. The MCO should conduct a thorough, measure-specific barrier analysis to determine factors preventing members from seeking or receiving these screenings, such as members not knowing appropriate ages to receive these screenings, fear of pain/discomfort or positive test results, or lack of available appointment times, and develop targeted initiatives to address identified barriers. *[Repeat recommendation.]*
- As the MCO continues to struggle to improve behavioral health measures, the MCO should continue its pilot initiative noted in the MCO's response to the previous recommendation, evaluate the interventions

associated with this pilot for effectiveness, and modify the pilot as needed. The MCO should also consider including more active initiatives, as most of the related initiatives are passive in nature (i.e., mailings, telephonic outreach). The MCO could consider the feasibility of home-based therapy options for follow-up care and diabetes screens as a potential intervention. *[Repeat recommendation.]*

- The MCO should conduct thorough barrier analysis for the HEDIS®/QARR *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures, as the MCO continues to struggle to improve rates. Based on the barrier analysis, the MCO should implement targeted, proactive initiatives in order to ensure members are able to receive appropriate well-care visits. *[Repeat recommendation.]*
- The MCO should work to address the citations received during the focused review surveys. First, the MCO should ensure that all protocols are followed in regard to renewing contracted vendors. Second, the MCO should re-train its Member Services staff to ensure all staff members follow policy and procedure when dealing with member requests. Last, the MCO should continue to identify ways to improve the accuracy of information included in provider directories and develop proactive initiatives that do not cause the providers undue fatigue. *[Repeat recommendation.]*

Response to Previous Year's Recommendations:
Note: The responses below are taken directly from the MCO and are not edited for content.

- **2016 Recommendation:** Excellus should take steps to ensure that its vendor properly programs all HEDIS®/QARR measure specifications in order to address the issues noted in the HEDIS® Final Audit Report.

  MCO Response: The National Committee for Quality Assurance (NCQA) certifies software vendors HEDIS® measures annually. Additionally, HEDIS® Licensed Organization Audit Firms annually review Quality Assurance Reporting Requirements (QARR) measures with software vendors for valid rate calculation. Software vendors determine pertinent file layout in accordance of measure calculations which are then programmed by our Plan. During the HEDIS® 2017 final rate review and subsequent validation, it was noted the software did not conform to the organizations bundled billing practices for emergency department visits when a patient is admitted or stays more than one day, as it had in prior years, causing most emergency room services to be significantly overstated. Upon further validation, the findings impacted the Emergency Department Utilization (EDU) and Ambulatory Care (AMB) for commercial and Medicare resulting in a biased reported rate. NCQA determined measure re certification was not appropriate given the timing in the process. Medicaid results were not impacted. The MCO conducts a robust review of the HEDIS® software annually and validates measure results monthly. If irregularities are noted, the MCO addresses the results with the vendor, and if necessary, requests guidance from NCQA.

- **2016 Recommendation:** Since the MCO did not meet the 75% compliance threshold for most call types included in the Primary Care and OB/GYN Access and Availability Survey, Excellus should ensure that all providers in its network understand the accessibility requirements for timely access to appointments and are abiding by those requirements, in addition to ensuring providers have appropriate after-hours access.

  MCO Response: Providers are reminded of access and availability requirements through quarterly postings in the MCO's provider newsletter. Additional education is provided as noted below.

  Ongoing MCO Initiative (the following processes are in place and will continue):

- The MCO's Quarterly Provider Newsletters include reminders for provider offices to timely report any changes.
- The MCO has implemented a process that requires all provider offices who have failed an Access and Availability survey to complete a formal Plan of Correction. Provider offices are afforded three months to implement the Plan of Correction after which the MCO will re-test the provider. If the provider fails a 2nd time, an MCO Medical Director sends a letter to the failed provider addressing the issue and the severity of being out of compliance with the Access and Availability Standards. The MCO continues to survey identified providers on a quarterly basis to ensure continued compliance until such time it is determined that no further monitoring is necessary.
- The MCO contracts with an external vendor (live voice) for data cleansing to identify updated addresses and telephone numbers for plan providers.
- The MCO has continued "robo" calls using the Customer Care phone system to verify whether provider phone numbers are active. This occurs twice annually and has proven to be a great success in identifying and eliminating non-working provider phone numbers.
- The MCO runs quarterly reports to identify providers that have not submitted claims in the previous three months. Identified providers are contacted to verify the accuracy of the provider information maintained by the MCO.
- MCO Provider Relations Staff reviews provider information with office staff during each on-site office visit and during Fall Provider Seminars. Provider Relations works closely with any practices that have previously been found to be noncompliant with Access and Availability standards to bring the practice into compliance.
- MCO Provider Relations also conducts monthly orientation for new provider staff which includes a component on Access and Availability Standards.
- The MCO includes Access and Availability Audit performance in its Value Based Payment arrangements.

- **2016 Recommendation:** As the MCO continues to struggle with several HEDIS®/QARR measures, the MCO should routinely evaluate current initiatives for effectiveness and remove or enhance them when necessary. Additionally, as many of these measures are related to behavioral health care, the MCO should assess barriers specific to mental health, such as embarrassment or stigma, side effects of medications, and which providers prescribe these medications the most often, and address those barriers with targeted interventions. *[Repeat recommendation.]*

  MCO Response: Annually, the MCO completes a comprehensive review of the quality program and the effectiveness of activities. This includes a review of the overall program description to ensure it remains current and is in alignment with the program's strategic direction. In addition, data is used to evaluate overall effectiveness of the various activities focused on driving a level of excellence in quality, safety, and clinical care for the members. On an annual basis, the MCO develops an organization wide action plan to assure that performance is optimized to improve the quality ratings program. Using the *RACI* model, which identifies staff that are responsible for executing the activities and milestones, individual staff accountable for each initiative, staff that need to be consulted, and staff that need to be informed to align activities across multiple departments. Outcomes are tracked quarterly. The results of all initiatives on the action plan are reported up through MCO's board of directors.

  The MCO conducts a robust evaluation of measure results based on data and clinical expertise to identify priority interventions and drive measure improvement. HEDIS®/QARR measures are monitored on a monthly basis and trended over time. If rates are trending below the SWA or are noted to be trending downward, a project team may be launched to take a closer look at the data and all current interventions

to evaluate their effectiveness. When initiatives are determined to be ineffective, the project team develops alternate interventions which are piloted and measured for effectiveness. If successful, pilots are implemented across all regions and other lines of business to improve the health of all members. When interventions are found to be no longer relevant or ineffective, they are discontinued. The MCO's Quality Monitoring Committee provides ongoing monitoring of project team progress and intervention outcomes.

Using this method, the MCO launched the Antidepressant Medication Management (AMM) Pilot in 2017. Behavioral Health Case Management (BH CM) staff receives a weekly report of members who have received a new diagnosis of major depression and a new prescription for an antidepressant medication and a weekly report of members who are non-compliant with their first refill at 40 days after their initial fill. Letters are sent to members who were on the initial fill report. Members on the non-compliant report receive 2 member calls and 2 member letters, and the prescriber received a call, and a letter. Member calls are performed by BH case managers who aim to educate members, understand any barriers, and develop a plan to help the member with compliance. Non-compliant member outreach revealed that members often reported having had side effects and being told by the prescriber to take lower dosages of medication, so it appeared that they were not compliant, but they were compliant at this lower dosage. Members having difficulty filling their medications are offered home delivery. In order to assure continuity and coordination of care, prescribers are notified by phone or letter of members who had not refilled their antidepressant medications.

The MCO launched similar pilots for follow-up appointments for children prescribed ADHD medications, schizophrenia measures (SSD, SMD, SAA), and transition of care processes after hospital admission for psychiatric admissions.

- **2016 Recommendation:** The MCO should continue its strategy to address the citations it received in relation to provider directory accuracy and monitor its initiatives for continued effectiveness. Additionally, the MCO should ensure policies and procedures are followed when initiating or terminating a contract with a vendor or provider. *[Repeat recommendation.]*

  MCO Response:

  Ongoing MCO Initiatives

  Sutherland Outbound Calls—The MCO hired a vendor, Sutherland Global Services, to perform outbound calls to providers inquiring about several pieces of key demographic information, ensuring accuracy of Plan data and making updates if needed. These calls began in October 2013 and are ongoing. To date, several thousand offices have been called throughout service area, resulting in information updates where needed, including termination of providers no longer practicing at a location. Given the duration of time these calls have been performed, provider offices are increasingly fatigued from the calls and some are requesting the vendor discontinue calls to their practices. Therefore the MCO is to finish the current call campaign concluding in June 2019 and implement new measures outlined below to continue data accuracy initiatives.

  Returned Mail—All returned mail related to provider address information is reviewed by Provider File Management team. Information is compared to demographic information contained in MCO IT systems. Discrepancies are addressed through outbound calls to provider offices to validate and/or update demographic information.

Quality Office Demographic Audits—The Quality Office team performs a random, statistically valid audit of the provider records. Provider information is added and/or updated as necessary. The Provider File Management leadership creates action plans to address any trends identified in the accuracy of provider information.

Data Compare Reports—A series of reports are run comparing MCO provider data across systems to identify any inconsistencies. Reports are prioritized based on critical fields (HPN requirements and deficiency reports would be a factor in prioritization). These reports are then assigned to staff to validate errors exist, and ensure all corrections are made. In addition, the information gleaned from these reports is used to evaluate root cause of the errors and if current programs are in place to address root cause issues and if not, to implement process changes to address the root cause. Each month report trends are reviewed to determine progress and discuss root cause and resolution.

Five or More Location Calls—MCO staff calls practitioners who are listed as providing services at five (5) or more locations as past research indicates providers are seldom practicing at that many locations. As a result of these calls, over a thousand incorrectly listed locations have been removed from the directory.

Panel Status Calls—MCO vendor calls offices to confirm panel status.

New Initiatives

Competitive Analysis—The MCO compares the provider information against provider information reported by primary competitors in the market to identify discrepancies. MCO staff will then make follow-up calls to providers with discrepancies in their information to validate and/or correct the information.

VIII. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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