

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

EXTERNAL QUALITY REVIEW
TECHNICAL REPORT FOR:
EXCELLUS HEALTH PLAN, INC.

Reporting Year 2014

Published August 2016

Table of Contents

I. About This Report	1
II. MCO Corporate Profile	2
III. Enrollment and Provider Network	3
ENROLLMENT	3
PROVIDER NETWORK	5
PRIMARY CARE AND OB/GYN ACCESS AND AVAILABILITY SURVEY – 2014	8
IV. Utilization	11
ENCOUNTER DATA	11
QARR USE OF SERVICES MEASURES	12
V. Quality Indicators	13
VALIDATION OF PERFORMANCE MEASURES	13
SUMMARY OF HEDIS® 2015 INFORMATION SYSTEM AUDIT™	13
QARR ACCESS TO/AVAILABILITY OF CARE MEASURES	17
NYSDOH-CALCULATED QARR PRENATAL CARE MEASURES	18
MEMBER SATISFACTION	19
QUALITY PERFORMANCE MATRIX ANALYSIS – 2014 MEASUREMENT YEAR	20
NYSDOH QUALITY INCENTIVE	22
PERFORMANCE IMPROVEMENT PROJECT	23
VI. Deficiencies and Appeals	25
COMPLIANCE WITH NYS STRUCTURE AND OPERATION STANDARDS	25
VII. Strengths and Opportunities for Improvement	28
VIII. Appendix	38
REFERENCES	38

List of Tables

- Table 1: Enrollment: Medicaid – 2012-20143
- Table 2: Enrollment: Other Product Lines – 2012-20143
- Table 3: Medicaid Membership Age and Gender Distribution – December 20144
- Table 4: Medicaid Providers by Specialty – 2014 (4th Quarter)5
- Table 5: Ratio of Enrollees to Medicaid Providers – 2014 (4th Quarter)6
- Table 6 HEDIS®/QARR Board Certification Rates – 2012-20147
- Table 7: Provider Network: Access and Availability Survey – Region Details – 2014.....9
- Table 8: Provider Network: Access and Availability Survey Results – 2014..... 10
- Table 9: Medicaid Encounter Data – 2012-2014..... 11
- Table 10: QARR Use of Services – 2012-2014 12
- Table 11: QARR MCO Performance Rates – 2012-2014..... 15
- Table 12: QARR Access to/Availability of Care Measures – 2012-2014 17
- Table 13: QARR Prenatal Care Measures – 2011-2013 18
- Table 14: Child CAHPS® – 2012 and 2014 19
- Table 15: Quality Performance Matrix – 2014 Measurement Year 21
- Table 16: Quality Incentive – Points Earned – 2012-2014 22
- Table 17: Quality Incentive – Measures and Points Earned – 2014 23
- Table 18: Performance Improvement Project – 2013-2014..... 24
- Table 19: Focused Review Types 26
- Table 20: Summary of Citations 27

List of Figures

Figure 1: Enrollment Trends – All Product Lines3

Figure 2: Medicaid Enrollees by Age – December 2014.....4

Acronyms Used in This Report

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

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs 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.

The technical reports are individualized reports on the Managed Care Organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2014 External Quality Review (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 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: health plan corporate structure, enrollment data, provider network information, encounter data summaries, and PQI/compliance/satisfaction/quality points and incentive.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, and Deficiencies and Appeals. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP), Family Health Plus (FHP), and Commercial product lines. For some measures, including QARR 2015 (MY 2014), 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 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 has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR 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 that 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 report is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2014.

II. MCO Corporate Profile

Excellus Health Plan, Inc. (Excellus) is a regional, not-for-profit health maintenance organization (HMO) that services Medicaid (MCD), Child Health Plus (CHP), 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 for Excellus.

- Plan ID: 1390598
- DOH Area Office: RAO
- Corporate Status: HMO
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: January 1, 1998
- Product Lines: Medicaid, Child Health Plus, Commercial, and Medicare
- Contact Information: 165 Court Street
Rochester, NY 14647
(877) 253-4797
- NCQA Accreditation Status as of 08/31/14: Medicaid – Commendable; Commercial – Scheduled; Medicare – Excellent
- Medicaid Dental Benefit Status: Provided

Participating Counties and Products

Allegany:	COM			Broome:	COM	MCD	CHP	Cattaraugus:	COM		
Cayuga:	COM		CHP	Chautauqua:	COM			Chemung:	COM		CHP
Chenango:	COM		CHP	Clinton:	COM		CHP	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

III. Enrollment and Provider Network

ENROLLMENT

Table 1 displays enrollment for the MCO’s Medicaid product line for 2012, 2013, and 2014, as well as the percent change from the previous year. Enrollment has decreased from 2013 to 2014 by a rate of 11.2%. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 1** trends enrollment for all product lines.

Table 1: Enrollment: Medicaid – 2012-2014

	2012	2013	2014
Number of Members	162,989	193,598	171,931
% Change From Previous Year		18.8%	-11.2%

Data Source: MEDS II

Table 2: Enrollment: Other Product Lines – 2012-2014

	2012	2013	2014
FHP¹	21,627	21,881	-
Commercial²	26,256	22,737	720,983
CHP	38,933	34,706	28,393

¹ In RY 2014, the MCO discontinued its Family Health Plus product line.

² Commercial enrollment total for RY 2014 represents the HMO and PPO product lines combined.

Figure 1: Enrollment Trends – All Product Lines

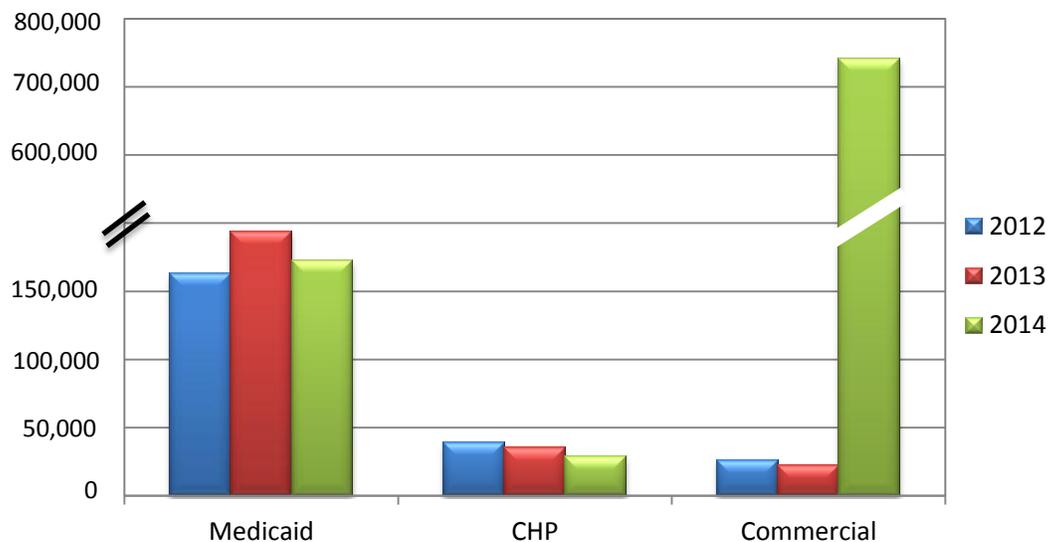
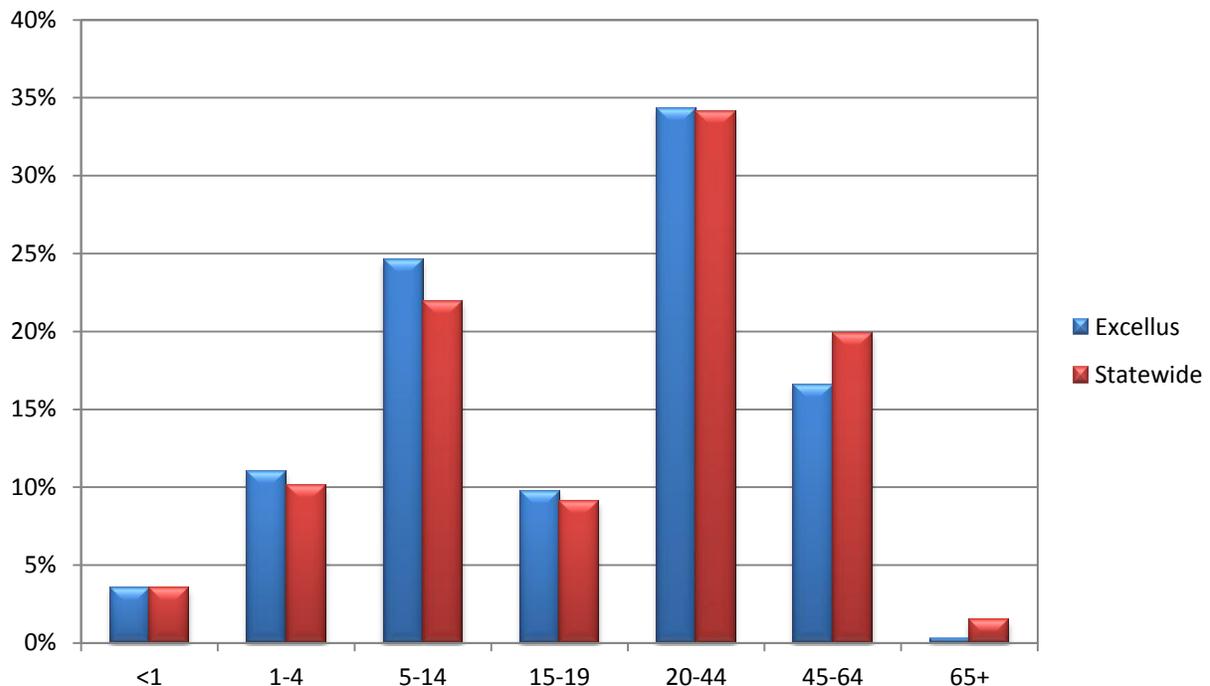


Table 3 and **Figure 2** display a breakdown of the MCO’s enrollment by age and gender as of December 31, 2014, for the Medicaid product line. The table also indicates whether the MCO’s rate is above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 3: Medicaid Membership Age and Gender Distribution – December 2014

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	3,171	2,873	6,044	3.5%	3.5%
1-4	9,671	9,271	18,942	11.0%	10.1%
5-14	21,796	20,510	42,306	24.6%	22.0%
15-19	8,258	8,337	16,595	9.7% ▲	9.1%
20-44	21,512	37,496	59,008	34.3%	34.1%
45-64	12,961	15,511	28,472	16.6% ▼	19.9%
65 and Over	232	332	564	0.3% ▼	1.5%
Total	77,601	94,330	171,931		
Under 20	42,896	40,991	83,887	48.8%	44.6%
Females 15-64		61,344		35.7%	36.1%

Figure 2: Medicaid Enrollees by Age – December 2014



PROVIDER NETWORK

Table 4 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2014 in comparison to the statewide percentages. For this table, MCO percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Table 4: Medicaid Providers by Specialty – 2014 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	2,715	10.6% ▼	19.8%
Pediatrics	647	2.5% ▼	4.5%
Family Practice	1,108	4.3%	3.9%
Internal Medicine	946	3.7% ▼	8.9%
Other PCPs	14	0.1% ▼	2.5%
OB/GYN Specialty¹	1,052	4.1%	4.1%
Behavioral Health	2,247	8.7% ▼	19.6%
Other Specialties	14,314	55.7% ▲	43.6%
Non-PCP Nurse Practitioners	10	0.0% ▼	5.7%
Dentistry	969	3.8%	6.2%
Unknowns	4,401	17.1% ▲	0.9%
Total	25,708		

Data Source: HCS

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

Table 5 displays the ratio of enrollees to providers for the MCO’s Medicaid product line. Statewide data are also included. For this table, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Table 5: Ratio of Enrollees to Medicaid Providers – 2014 (4th Quarter)

	Excellus	Statewide
	Ratio of Enrollees to Providers	Median Ratio of Enrollees to Providers ¹
Primary Care Providers	63:1	47:1
Pediatricians (Under Age 20)	130:1	95:1
OB/GYN (Females Age 15-64)	58:1	42:1
Behavioral Health	77:1	56:1

Data Source: Derived Medicaid ratios calculated from MEDS II enrollment data and HCS provider data.

¹ The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers.

Table 6 displays HEDIS®/QARR Board Certification rates for 2012 through 2014 of providers in the MCO's network in comparison to the statewide averages. The table also indicates whether the MCO's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 6 HEDIS®/QARR Board Certification Rates – 2012-2014

Provider Type	2012 ¹		2013		2014	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
Medicaid/CHP						
Family Medicine	80%	78%	79%	78%	75%	77%
Internal Medicine	83%	80%	83% ▲	78%	81% ▲	77%
Pediatricians	82%	81%	79%	80%	77%	80%
OB/GYN	79%	74%	81%	78%	86% ▲	75%
Geriatricians	74%	70%	74%	69%	72%	64%
Other Physician Specialists	84% ▲	78%	82% ▲	78%	83% ▲	76%
Commercial						
Family Medicine	79%	79%	79%	79%	74% ▼	79%
Internal Medicine	82% ▲	79%	83% ▲	78%	81%	79%
Pediatricians	82%	81%	79%	81%	77% ▼	82%
OB/GYN	80%	77%	81%	78%	83% ▲	79%
Geriatricians	75%	69%	75%	67%	73%	68%
Other Physician Specialists	84% ▲	78%	82% ▲	77%	83% ▲	79%

¹ For RY 2012, rates reflect the Medicaid product line only.

PRIMARY CARE AND OB/GYN ACCESS AND AVAILABILITY SURVEY – 2014

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

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee's request, while non-urgent "sick" office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a "live voice" representing the named provider is reached or if the named provider's beeper number is reached.

A random sample of 240 provider sites was selected from each region in which the MCO operated and provided primary care as a Medicaid and/or Family Health Plus benefit. Of these 240 provider sites, 120 were surveyed for routine appointments, 80 were surveyed for non-urgent "sick" appointments, and 40 were surveyed for after hours access. For MCOs with less than the 240 available provider sites, all providers were selected.

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

Table 7 displays the seven regions in New York State, as well as the MCOs operating in each region that offered primary care and obstetrics/gynecological benefits to its Medicaid members at the time of the survey.

Table 7: Provider Network: Access and Availability Survey – Region Details – 2014

Region Name	Counties	MCOs Operating in Region
Region 1: Buffalo	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming	Excellus Health Plan, Inc.; Fidelis Care New York; HealthNow New York, Inc.; Independent Health Association, Inc.; MVP Health Plan, Inc.; and Univera Community Health, Inc.
Region 2: Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates	Excellus Health Plan, Inc.; Fidelis Care New York; and MVP Health Plan, Inc.
Region 3: Syracuse	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins	Capital District Physicians’ Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; SCHC Total Care, Inc.; and UnitedHealthcare Community Plan
Region 4: Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington	Capital District Physicians’ Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 5: New Rochelle	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Health Insurance Plan of Greater New York; Hudson Health Plan, Inc.; MVP Health Plan, Inc.; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 6: New York City	Bronx, Kings, New York, Queens, and Richmond	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Amida Care, Inc.; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; MetroPlus Health Plan, Inc.; MetroPlus Health Plan, Inc. Special Needs Plan; UnitedHealthcare Community Plan; VNS Choice SelectHealth; and WellCare of New York, Inc.
Region 7: Long Island	Nassau and Suffolk	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; and UnitedHealthcare Community Plan

Table 8 displays the MCO’s Primary Care and OB/GYN Access and Availability results for 2014. The MCO met the 75% threshold for after hours calls in Regions 1, 2, and 4.

Table 8: Provider Network: Access and Availability Survey Results – 2014

Region	Call Type	Excellus	Region Average
Regions 1 & 2	Routine	59.1%	57.9%
	Non-Urgent “Sick”	46.6%	52.3%
	After Hours Access	75.0%	69.8%
Region 3	Routine	64.0%	61.8%
	Non-Urgent “Sick”	45.7%	57.4%
	After Hours Access	64.0%	72.2%
Region 3	Routine	65.5%	68.6%
	Non-Urgent “Sick”	63.2%	60.2%
	After Hours Access	90.9%	80.4%

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 9 displays selected Medicaid encounter data for 2012 through 2014. The MCO's rates for these periods are also compared to the statewide averages. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Table 9: Medicaid Encounter Data – 2012-2014

	Encounters (PMPY)					
	2012		2013		2014	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
PCPs and OB/GYNs	4.31	4.24	4.26	4.45	4.20	4.36
Specialty	2.00	2.04	2.05	1.90	1.99	1.94
Emergency Room	0.80	0.60	0.80 ▲	0.60	1.17	2.11
Inpatient Admissions	0.14	0.15	0.14	0.14	0.13	0.15
Dental – Medicaid	1.05	1.03	1.58 ▲	1.00	1.24 ▲	1.03
Dental – FHP	1.11	1.12	1.79 ▲	1.04	1.26 ▲	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 percentiles. **Table 10** lists the Use of Services rates for the selected product lines for 2012 through 2014. 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 10: QARR Use of Services – 2012-2014

Measure	Medicaid/CHP				Commercial			
	2012 ¹	2013	2014	2014 Statewide Average	2012	2013	2014	2014 Statewide Average
Outpatient Utilization (PTMY)								
Visits	4,764	4,683	4,550	5,366	4,629	4,170	4,035	4,264
ER Visits	838	735	664	555	216	186	180	185
Inpatient ALOS								
Medicine	3.0 ▼	3.5 ▼	3.8	4.3	3.2 ▼	3.3	3.6 ▼	3.9
Surgery	4.1 ▼	5.3	6.4	6.4	3.9 ▼	4.0 ▼	4.4	5.0
Maternity	2.5 ▼	2.6 ▼	2.6 ▼	2.8	2.7	2.6 ▼	2.6	2.8
Total	3.1 ▼	3.6 ▼	4.0	4.2	3.3 ▼	3.4 ▼	3.6 ▼	4.0
Inpatient Utilization (PTMY)								
Medicine Cases	43	38	37	40	21	19	17	20
Surgery Cases	20	18	16	13	19	18	17	16
Maternity Cases	47	41	34	36	12	13	14 ▲	11
Total Cases	97	84	76	79	50	49	45	47

PTMY: Per Thousand Member Years

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

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

V. Quality Indicators

To measure the quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including HEDIS®/QARR 2015 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 for several measures to the NYSDOH. 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® 2015 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA).

For measurement year (MY) 2014, the methodology for reporting performance measure rates was modified. Previously, Medicaid and Child Health Plus were reported separately; however, for QARR 2015 (MY 2014), rates for these populations were combined, following HEDIS® methodology (summing numerators and denominators from each population). Although the data presented in this report for MY 2012 are Medicaid only (unless otherwise specified), trend analysis has been applied over the time period 2012 through 2014, as the effect of combining the CHP and Medicaid populations was determined to be negligible through an analysis of historical QARR data.

The results of each MCO's HEDIS® 2015 Compliance Audit™ are summarized in its Final Audit Report (FAR).

SUMMARY OF HEDIS® 2015 INFORMATION SYSTEM AUDIT™

As part of the HEDIS® 2015 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, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® 2015 Final Audit Report (FAR) prepared for Excellus indicated that the MCO had no significant problems in any area related to reporting. The MCO demonstrated compliance with all areas of the Information Systems and all areas of measure determination required for successful HEDIS®/QARR reporting.

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

Excellus passed Medical Record Review for the four measures validated, as well as for exclusions. The MCO was able to report all measures for all product lines.

Table 11 displays QARR performance rates for Measurement Years 2012, 2013, and 2014, as well as the statewide averages (SWAs). 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 Notes for Table 11

R: Rotated measure.

NR: Not reported.

NP: Dental benefit not provided.

FY: First-Year Measure, MCO-specific rates not reported.

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

Table 11: QARR MCO Performance Rates – 2012-2014

Measure	Medicaid/CHP				Commercial			
	2012 ¹	2013	2014	2014 SWA	2012	2013	2014	2014 SWA
Follow-up Care for Children on ADHD Meds – Continue	45 ▼	54 ▼	47 ▼	67	48	47	42	44
Follow-up Care for Children on ADHD Meds – Initial	39 ▼	44 ▼	41 ▼	58	44	42	42	42
Adolescents – Alcohol and Other Drug Use	R	64	R	R	R	72 ▲	R	R
Adolescents – Depression	R	59	R	R	R	65 ▲	R	R
Adolescents – Sexual Activity	R	64	R	R	R	65 ▲	R	R
Adolescents – Tobacco Use	R	68	R	R	R	77 ▲	R	R
Adolescent Immunization – Combo	70	72	R	R	83 ▲	72	R	R
Adolescent Immunization – HPV	FY	25	25	28	FY	20 ▲	20 ▲	16
Adult BMI Assessment	75	83	R	R	83 ▲	82 ▲	R	R
Flu Shots for Adults (Ages 18-64)		47	R	R		53	61 ▲	52
Advising Smokers to Quit	R	84	R	R	86	74 ▼	76	84
Follow-up After Hospitalization for Mental Illness – 30 Days	75	70 ▼	78	78	86 ▲	77 ▲	75	72
Follow-up After Hospitalization for Mental Illness – 7 Days	61	50 ▼	59	63	73 ▲	60 ▲	57	57
Antidepressant Medication Management – Continue	39	34	32 ▼	35	57	49	49	48
Antidepressant Medication Management – Acute Phase	52	49	46 ▼	50	71	66 ▲	65	64
Drug Therapy for Rheumatoid Arthritis	87	80	86	81	91 ▲	88	89 ▲	86
Appropriate Meds for People with Asthma (Ages 19-64)	81	80	81 ▲	78	93 ▲	92 ▲	90 ▲	89
Appropriate Meds for People with Asthma (Ages 5-18)	91 ▲	91 ▲	90 ▲	85	98 ▲	96 ▲	96 ▲	93
Asthma Medication Ratio (Ages 19-64)	FY	56	57 ▲	53	FY	81 ▲	79 ▲	76
Asthma Medication Ratio (Ages 5-18)	FY	75 ▲	69 ▲	61	FY	85 ▲	85 ▲	80
Use of Imaging Studies for Low Back Pain	77	75 ▼	74	77	81 ▲	79 ▲	79	78
Persistence of Beta-Blocker Treatment After a Heart Attack	83	89	79	86	87	85	88	84
Avoidance of Antibiotics for Adults with Acute Bronchitis	15 ▼	17 ▼	18 ▼	28	14 ▼	17 ▼	19 ▼	24
Chlamydia Screening (Ages 16-24)	64 ▼	59 ▼	59 ▼	72	47 ▼	48 ▼	47 ▼	57
Colon Cancer Screening	R	48 ▼	R	R	R	64	R	R
Dental Visit (Ages 19-21)	42	42	44	43				
Annual Dental Visits (Ages 2-18)	NP	61	63 ▲	60				
Diabetes BP Controlled (<140/90 mm Hg)	R	71	R	R	R	72 ▲	R	R
Diabetes HbA1c below 8%	R	51 ▼	R	R	R	66 ▲	R	R
Diabetes Eye Exam	R	64	R	R	R	57	R	R

¹For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

Table 11: QARR MCO Performance Rates – 2012-2014 (continued)

Measure	Medicaid/CHP				Commercial			
	2012 ¹	2013	2014	2014 SWA	2012	2013	2014	2014 SWA
Diabetes Nephropathy Monitor	R	78 ▼	R	R	R	84	R	R
Diabetes HbA1c Test	R	85 ▼	R	R	R	91	R	R
HIV – Engaged in Care	87	88 ▲	69 ▼	81				
HIV – Syphilis Screening	63	61 ▼	61 ▼	73				
HIV – Viral Load Monitoring	74	75	73	71				
Childhood Immunization – Combo 3	R	77	R	R	R	86 ▲	R	R
Lead Testing	R	76 ▼	R	R	R	83 ▲	R	R
Breast Cancer Screening	60 ▼	65 ▼	67 ▼	71	76 ▲	76 ▲	77 ▲	74
Smoking Cessation Medications	R	62	R	R	67	47	49	57
Medical Management for People with Asthma 50% (Ages 19-64)	69	61 ▼	61 ▼	66	73	71	69	69
Medical Management for People with Asthma 50% (Ages 5-18)	55 ▲	59 ▲	51	50	64 ▲	59 ▲	56	55
Smoking Cessation Strategies	R	58 ▲	R	R	51	35 ▼	44	50
Monitor Patients on Persistent Medications – Combined	87 ▼	88 ▼	89 ▼	92	81 ▼	81 ▼	83 ▼	84
Pharmacotherapy Management for COPD – Bronchodilator	89	89	88	88	83	77	80	79
Pharmacotherapy Management for COPD – Corticosteroid	77	77	78	75	68	75	80	76
Testing for Pharyngitis	82 ▼	83 ▼	84 ▼	88	89	85 ▼	85 ▼	87
Diabetes Monitoring for Schizophrenia	FY	71	74	78				
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	FY	83	81	82				
Antipsychotic Meds for Schizophrenia	FY	58	57	61				
Spirometry Testing for COPD	35 ▼	35 ▼	39 ▼	53	45 ▼	41 ▼	40 ▼	49
Treatment for Upper Respiratory Infection	91 ▼	88 ▼	90 ▼	93	91	88 ▼	90 ▼	91
Well-Child Visits – First 15 Months	71	77 ▲	74 ▲	66	94 ▲	90 ▲	87 ▲	84
Well-Child Visits – 3 to 6 Year Olds	70 ▼	78 ▼	82 ▼	84	87 ▲	85	84 ▼	85
Well-Care Visits for Adolescents	49 ▼	60 ▼	63 ▼	65	63 ▲	61 ▼	58 ▼	61
Children BMI	R	77	R	R	R	80 ▲	R	R
Children Counseling for Nutrition	R	74	R	R	R	80 ▲	R	R
Children Counseling for Physical Activity	R	69	R	R	R	77 ▲	R	R

¹For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

QARR ACCESS TO/AVAILABILITY OF CARE MEASURES

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care, and dental services for selected product lines. **Table 12** displays the Access to/Availability of Care measures for Measurement Years 2012 through 2014. 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 MCOs for that measure (indicated by ▼).

Table 12: QARR Access to/Availability of Care Measures – 2012-2014

Measure	Medicaid/CHP				Commercial			
	2012 ¹	2013	2014	2014 SWA	2012	2013	2014	2014 SWA
Children and Adolescents' Access to PCPs (CAP)								
12 – 24 Months	98% ▲	99% ▲	99% ▲	97%	99% ▲	99% ▲	98%	98%
25 Months – 6 Years	90% ▼	94%	95%	94%	97% ▲	96% ▲	95% ▼	95%
7 – 11 Years	95% ▼	97% ▲	97%	97%	99% ▲	98% ▲	96% ▼	97%
12 – 19 Years	92%	96% ▲	96% ▲	94%	96% ▲	95% ▲	93% ▼	94%
Adults' Access to Preventive/Ambulatory Services (AAP)								
20 – 44 Years	87% ▲	88% ▲	87% ▲	84%	97% ▲	95% ▲	95% ▲	94%
45 – 64 Years	90%	91% ▲	92% ▲	91%	98% ▲	97% ▲	97% ▲	96%
65+ Years	92%	93%	93%	90%	98% ▲	98% ▲	98% ▲	97%
Access to Other Services								
Timeliness of Prenatal Care	91%	R	91% ▲	88%	96% ▲	R	91%	89%
Postpartum Care	70%	R	71%	69%	89% ▲	R	85% ▲	75%
Annual Dental Visit²	42% ▼	60%	62% ▲	58%				

R: Rotated measure

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

² For the Annual Dental Visit measure, the Medicaid/FHP age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-CALCULATED QARR PRENATAL CARE MEASURES

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, as well as 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. **Table 13** presents prenatal care rates calculated by the NYSDOH for QARR 2011 through 2013. In addition, the table indicates if the MCO's rate was significantly better than the average (indicated by ▲) or whether the MCO's rate was significantly worse than the average (indicated by ▼).

Table 13: QARR Prenatal Care Measures – 2011-2013

Measure	2011		2012		2013	
	Excellus	ROS Average	Excellus	ROS Average	Excellus	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight ¹	7%	7%	6%	7%	6%	7%
Prenatal Care in the First Trimester	74% ▲	71%	74%	71%	77% ▲	72%
Risk-Adjusted Primary Cesarean Delivery ¹	15%	15%	14%	15%	15%	15%
Vaginal Birth After Cesarean	12%	11%	14%	11%	12%	12%
Commercial						
Risk-Adjusted Low Birth Weight ¹	5%	5%	4% ▲	5%	4% ▲	4%
Prenatal Care in the First Trimester	90% ▲	86%	90%	87%	90% ▲	87%
Risk-Adjusted Primary Cesarean Delivery ¹	22% ▲	25%	22% ▲	24%	22% ▲	24%
Vaginal Birth After Cesarean	7%	6%	9%	8%	14% ▲	10%

¹ A low rate is desirable for this measure.

ROS: Rest of State

MEMBER SATISFACTION

In 2014, the CAHPS® survey for child Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Surveys were administered to parents/caretakers of Medicaid enrollees aged 0-17 years. **Table 14** displays the question category, the MCO's rates, and statewide averages for Measurement Year 2014. The table also indicates whether the MCO's rate was significantly better than the statewide average (SWA) (indicated by ▲) or whether the MCO's rate was significantly worse than the SWA (indicated by ▼).

Table 14: Child CAHPS® – 2012 and 2014

	Medicaid			
	2012		2014	
	Excellus	Statewide Average	Excellus	Statewide Average
Coordination of Care ¹	79 ▲	74	77	74
Getting Care Needed ¹	82	78	87	83
Satisfaction with Provider Communication ¹	95 ▲	93	94	93
Customer Service ¹	89	85	87	82
Collaborative Decision Making ¹	90	87	54	53
Getting Information	89 ▲	82	91	89
Rating of Healthcare	90 ▲	83	88	85
Rating of Personal Doctor ¹	90	88	94 ▲	88
Getting Care Quickly ¹	92 ▲	86	91 ▲	87
Rating of Counseling	70	63	64	64
Overall Rating of Health Plan	84	82	86	83
Rating of PCP	90	89	90	89
Rating of Specialist	83	78	86	81
Access to Specialized Services ¹	70	71	79	76

¹ These indicators are composite measures.

QUALITY PERFORMANCE MATRIX ANALYSIS – 2014 MEASUREMENT YEAR

Table 15 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. Twenty-eight measures were selected for the 2014 Measurement Year (MY) Quality Performance Matrix, which include combined measures for 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 Managed Care Organizations through a percentile ranking.

For the MY 2012 Quality Performance Matrix, the NYSDOH made modifications in order to focus on those measures in need of the most improvement statewide. For previous measurement years, the cell category (A-F) was determined by the year-over-year trend of the measure (vertical axis) and by any significant difference from the statewide average (horizontal axis). For the 2012 MY, the matrix was reformatted to maintain the year-over-year evaluation on the vertical axis, but to evaluate the MCO's performance based on a percentile ranking on the horizontal axis. The new percentile ranking was partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. The 2012 matrix included only those measures for which the 2011 Medicaid statewide average was less than a predetermined benchmark; however, for MY 2014, additional measures were included to provide MCOs with a broader overview of quality performance, and further assist MCOs in identifying and prioritizing quality improvement.

With the issuance of the 2008 MY Matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY Matrix, MCOs were required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO had more than three measures reported in the F category, the MCO was required to submit root cause analyses and plans of action on all measures reported in the F category. For the MY 2014 Matrix, this requirement was modified, requiring the MCO to submit a maximum of three root cause analyses and plans of action, regardless of the number of measures reported in the F category. Beginning with MY 2008, if an 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 15: Quality Performance Matrix – 2014 Measurement Year

Trend *	Percentile Ranking		
	0 to 49%	50 to 89%	90 to 100%
	C	B	A Drug Therapy for Rheumatoid Arthritis
No Change	D Antidepressant Medication Management-Acute Phase Antipsychotic Meds for Schizophrenia Appropriate Testing for Pharyngitis Asthma Medication Ratio (Ages 19-64) Avoid Antibiotics for Adults with Acute Bronchitis Breast Cancer Screening Cervical Cancer Screening Chlamydia Screening (Ages 16-24) Controlling High Blood Pressure Diabetes Monitoring for Schizophrenia Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds FU After Hospitalization for Mental Illness-7 Days FU for Child on ADHD Meds-Initial Medical Mgmt for People with Asthma 50% (Ages 19-64) Spirometry Testing for COPD Use of Imaging Studies for Low Back Pain Well-Care Visits for Adolescents Well-Child Visits-3 to 6 Year Olds	C Annual Dental Visits (Ages 2-18) Asthma Medication Ratio (Ages 5-18) Medical Mgmt for People with Asthma 50% (Ages 5-18) Pharmacotherapy Mgmt for COPD-Corticosteroid Postpartum Care	B Well-Child Visits-First 15 Months (5+ visits)
	F HIV-Engaged in Care Persistence of Beta-Blocker Treatment after a Heart Attack Frequency of Ongoing Prenatal Care	D	C

NYSDOH QUALITY INCENTIVE

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. Points earned are derived from an algorithm that considers QARR 2015 (MY 2014) rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores, and compliance information from MY 2012 and MY 2013. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCO qualifies for. For 2014, there were four levels of incentive awards that could be achieved by MCOs based on the results. **Table 16** displays the points the MCO earned from 2012 to 2014, as well as the percentage of the financial incentive that these points generated based on the previous measurement year's data. **Table 17** displays the measures that were used to calculate the 2014 incentive, as well as the points the MCO earned for each measure.

Table 16: Quality Incentive – Points Earned – 2012-2014

	2012		2013		2014	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
Total Points (150 Possible Points)	52	78.4	66	80.8	59.5	73.8
PQI Points (20 Possible Points)	10	9.9	4.8	6.9	20	6.9
Compliance Points (-20 Possible Points)	-4	-5.3	-6	-5.4	-2	-4
Satisfaction Points (30 Possible Points)	15	15.9	20	15.9	15	16.3
Quality Points¹ (100 Possible Points)	31	57.9	47	63.4	26.5	54.5
Percentage of Financial Incentive Earned	0%		15%		25%	

¹Quality Points presented here are normalized.

Table 17: Quality Incentive – Measures and Points Earned – 2014

Measure	MCO Points
PQI	20.0
Adult Prevention Composite PQI (10 points)	10.0
Pediatric Composite PDI (10 points)	10.0
Compliance (-4 points, except where noted)	-2.0
MEDS	0.0
MMCOR	0.0
QARR	0.0
Provider Directory (-2 points)	-2.0
Member Services	0.0
Satisfaction (10 points each)	15.0
Rating of Health Plan (CAHPS®)	5.0
Getting Care Needed (CAHPS®)	5.0
Customer Service and Information (CAHPS®)	5.0
Quality (3.84 points each, except where noted)	16.8
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.0
Antidepressant Medication Management—Effective Acute Phase Treatment	0.0
Appropriate Testing for Pharyngitis	0.0
Asthma Medication Ratio (Ages 5-18) (1.92 points)	1.44
Asthma Medication Ratio (Ages 19-64) (1.92 points)	0.0
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	0.0
Breast Cancer Screening	0.0
Cervical Cancer Screening	0.0
Chlamydia Screening (Ages 16-24)	0.0
Comprehensive Care for People Living with HIV/AIDS—Engaged in Care	0.0
Controlling High Blood Pressure	0.0
Diabetes Monitoring for People with Diabetes and Schizophrenia	0.0
Diabetes Screen for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	0.0
Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis	3.84
Follow-Up After Hospitalization for Mental Illness Within 7 Days	0.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	0.0
Medication Management for People with Asthma 50% Days Covered (Ages 5-18) (1.92 points)	0.96
Medication Management for People with Asthma 50% Days Covered (Ages 19-64) (1.92 points)	0.0
Persistence of Beta-Blocker Treatment After a Heart Attack	0.0
Pharmacotherapy Management of COPD Exacerbation—Corticosteroid	2.88
Use of Imaging Studies for Low Back Pain	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0
Annual Dental Visit (Ages 2-18)	1.92
Frequency of Ongoing Prenatal Care	0.0
Postpartum Care	1.92
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	3.84
Well-Child & Preventive Care Visits in 3 rd , 4 th , 5 th , & 6 th Year of Life	0.0
Well-Care Visits for Adolescents	0.0
Total Normalized Quality Points¹	26.5
Total Points Earned	59.5

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

¹ Quality Points were normalized before being added to the total points earned. The points each MCO earned for each quality measure were aggregated and converted to normalized quality points. Quality points were normalized in order to control for a difference in base points, as not every MCO could earn points for each measure due to small sample sizes (less than 30 members).

PERFORMANCE IMPROVEMENT PROJECT

Each MCO is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating MCO- and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, MCOs and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to 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) 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 validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

Excellus' 2013-2014 PIP topic is *"The impact of planned interventions with comorbid conditions of schizophrenia and diabetes in a pilot study with managed Medicaid enrollees"*. Throughout the conduct of the PIP, the MCO implemented the following interventions:

- Developed an Integrated Care Management team to promote internal consistency with the member and provider interventions.
- Continuously monitored the need for active interventions, which are triggered by gaps in care (medication and treatment adherence).
- Created Provider educational material to promote best practices for metabolic screening and monitoring with the use of antipsychotic medications.
- Specialized Care Manager (SCM) identified gaps in care and educated members and families on annual testing, medication adherence, and links to primary and mental health care and community resources.

Table 18 presents a summary of Excellus' 2013-2014 PIP.

Table 18: Performance Improvement Project – 2013-2014

Indicators	Results
HEDIS® Diabetes Screen for Schizophrenia or Bipolar Disorder for People Using Antipsychotic Medications	Performance level maintained.
HEDIS® Diabetes Monitoring for People with Diabetes and Schizophrenia	Performance level maintained.
HEDIS® Adherence to Antipsychotic Medications for People with Schizophrenia	Performance level maintained.

VI. Deficiencies and Appeals

COMPLIANCE WITH NYS STRUCTURE AND OPERATION STANDARDS

This section of the report examines deficiencies identified by the NYSDOH in operational and focus 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 in **Table 20**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO is 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/recredentialing, 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 MCO to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in **Table 19**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 20 reflects the total number of citations for the most current operational survey of the MCO, which ended in 2014, as well as from the focused reviews conducted in 2014. 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 have multiple citations.

Excellus was in compliance with 10 of 14 categories. The categories in which Excellus was not in compliance were Organization and Management (3 citations), Quality Assurance (1 citation), Service Delivery Network (9 citations), and Utilization Review (10 citations).

Table 19: 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 (Medicaid Encounter Data Set)	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.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information – Web	Review of MCO’s web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listing of primary, specialty, and ancillary providers for 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 (Quality Assurance Reporting Requirements)	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.

AO: Area Office

HCS: Health Commerce System

SOD: Statement of Deficiency

Table 20: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances		
Credentialing		
Disclosure		
Family Planning		
HIV		
Management Information Systems		
Medicaid Contract		
Medical Records		
Member Services		
Organization and Management		3
<i>Provider Directory Information</i>		<i>2</i>
<i>Provider Participation—Directory</i>		<i>1</i>
Prenatal Care		
Quality Assurance		1
<i>Access and Availability</i>		<i>1</i>
Service Delivery Network		9
<i>Provider Directory Information</i>		<i>1</i>
<i>Provider Participation—Directory</i>		<i>8</i>
Utilization Review	10	
Total	10	13

VII. Strengths and Opportunities for Improvement¹

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 healthcare 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 received an NCQA rating of “Commendable” for its Medicaid product line.
- The 2015 HEDIS® Final Audit Report revealed no significant issues and the MCO was able to report all required QARR rates.
- The MCO earned PQI, compliance, satisfaction, and quality points that qualified it for 25% of the available financial incentive. The MCO continues to demonstrate improvement in this area.
- In regard to the Primary Care Access and Availability Survey, the MCO met the established 75% threshold for after hours access in Regions 1, 2, and 4.
- The MCO reported an above average rate for at least three consecutive reporting years for the HEDIS®/QARR measure *Use of Appropriate Medications for People with Asthma (Ages 5-18)*. The MCO's rates were also above average for the following HEDIS®/QARR measures: *Use of Appropriate Medications for People with Asthma (Ages 19-64)*, *Asthma Medication Ratio (Ages 19-64)*, *Asthma Medication Ratio (Ages 5-18)*, *Annual Dental Visits (Ages 2-18)*, and *Well-Child Visits—First 15 Months of Life*.
- In regard to access to primary care, the MCO's rates were above the 90th percentile for the HEDIS®/QARR measures *Children and Adolescents' Access to PCPs* and *Adults' Access to Preventive/Ambulatory Services* for the following age groups: 12-24 months, 12-19 years, 20-44 years, and 45-64 years.
- In regard to member satisfaction, the MCO reported above average rates for two child CAHPS® measures: *Rating of Personal Doctor* and *Getting Care Quickly*.

Opportunities for Improvement

- In regard to the Primary Care Access and Availability Survey, the MCO demonstrates an opportunity for improvement. The MCO failed to meet the established 75% threshold for routine and non-urgent “sick” appointments in all regions in which the MCO operates.
- The MCO continues to demonstrate an opportunity for improvement in regard to its overall HEDIS®/QARR performance, as it has reported below average rates for at least three consecutive reporting years for the following HEDIS®/QARR measures: *Follow-Up Care for Children Prescribed ADHD Medications—Continuation Phase*, *Follow-Up Care for Children Prescribed ADHD Medications—Initiation Phase*, *Avoidance of Antibiotics for Adults with Acute Bronchitis*, *Chlamydia Screening (Ages 16-24)*, *Breast Cancer Screening*, and *Annual Monitoring for Patients on Persistent Medications—Combined Rate*.

¹ 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.

Appropriate Testing for Pharyngitis, Spirometry Testing for COPD, Appropriate Treatment for Upper Respiratory Infection, Well-Child Visits—3 to 6 Year Olds, and Well-Care Visits for Adolescents. The MCO also reported below average rates for the following HEDIS®/QARR measures: *Antidepressant Medication Management—Effective Continuation Phase Treatment, Antidepressant Medication Management—Effective Initiation Phase Treatment, HIV—Engaged in Care, HIV—Syphilis Screening, and Medication Management for People with Asthma 50% of Days Covered (Ages 19-64).* (Note: *Follow-Up Care for Children Prescribed ADHD Medications, Avoidance of Antibiotics for Adults with Acute Bronchitis, HIV—Syphilis Screening, Breast Cancer Screening, Medication Management for People with Asthma 50% of Days Covered (Ages 19-64), Annual Monitoring for Patients on Persistent Medications—Combined Rate, Appropriate Testing for Pharyngitis, Spirometry Testing for COPD, Appropriate Treatment for Upper Respiratory Infection, Well-Child Visits—3 to 6 Year Olds, and Well-Care Visits for Adolescents* were opportunities for improvement in the previous year’s report.)

- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYS structure and operation standards. The MCO received 23 citations, including 10 operational citations and 13 focused review citations related to Organization and Management, Quality Assurance, Service Delivery Network, and Utilization Review. (Note: compliance with NYS structure and operation standards was an opportunity for improvement in the previous year’s report.)

Recommendations

- In order to ensure its members have access to appropriate care, and that the MCO continues to receive a percentage of the financial incentive, the MCO should continue to work to improve poorly performing HEDIS®/QARR measures. As the MCO continues to struggle with several measures related to appropriate care for respiratory conditions, the MCO should consider a more targeted member intervention strategy, in addition to targeting Emergency Departments for interventions. [*Repeat recommendation.*]
- The MCO should continue to work to address the issues identified in the operational and focused surveys. As many of the MCO’s citations are related to the provider directory, the MCO should work to ensure the information presented in the provider directories is accurate and up-to-date. [*Repeat recommendation.*]

Response to Previous Year’s Recommendations

- **2013 Recommendation:** To ensure members receive appropriate care and that the plan continues to qualify for a percentage of the available financial incentive, the plan should continue with the initiatives described in the plan’s response to the previous year’s recommendation. The plan should continue to routinely assess the effectiveness of its HEDIS®/QARR strategy and modify it as needed.

MCO Response:

- 1. The Health Plan (HP) continues to monitor and work to improve HEDIS/QARR measures and evaluates the effectiveness of the initiatives.**

In 2014 the HP continues to assess the Effectiveness of the HEDIS/QARR strategy interventions and modify it as needed.

- Several focus groups were created to perform in-depth review of the Quality Measures that are below the State Wide Average. The Groups performed Root Cause Analysis and formulated Plan, Do, Study, Act (PDSA) steps to improve scores.
- The Health Plan (HP) designated a committee to pursue concerns with data integrity identified through the root cause analysis for specific measures continues its work. The Committee continues to focus on well child measures, follow up care for children prescribed ADHD medication measures, and the HIV measure.

The following programs were in place to enhance provider performance:

1. Pediatric Quality Incentive Pilot Program

The primary focus of the Pediatric Quality Incentive Program is to have our members undergo a comprehensive well-care visit. Most age-appropriate preventive screenings are provided at a well-care visit. The measurement periods for the incentive program are July 1, 2014 to December 31, 2014, then January 1 through December 31 for calendar year 2015 and for each subsequent calendar year. The incentive is performance-based and will be initiated by claims submitted for the delivery of services. The incentive payment is \$20 per patient and is based on completed qualified comprehensive well visits and will be awarded biannually.

2. Embedded Practice Model

The HP continues to engage in the Embedded Practice Model in 14 high volume practices across all regions. Most of the practices allow access to their EMR, allowing embedded staff to assist with scheduling appointments for well child visits, preventive screenings, and wellness services as well as assess billing practices for coding accuracy.

3. Make Quality Pay Program (MQPP)

The HP care management vendor developed the Make Quality Pay Program (MQPP) and was launched in 8 counties (Monroe, Wayne, Livingston, Ontario, Seneca, Yates, and Broome). The program encompassed all of the QARR clinical quality measures.

- Launched in July 2014
- 40 unique practices/groups are engaged
- Covering 70+ locations
- Engaging approximately 150,000 members (85% of MMC/CHP membership)
- Providers receive quarterly gap reports and progress reports

4. Gap Reports

2013 Gap reports were hand delivered by the Provider Outreach Team to a subset of providers. The Gap Report program was modified to only target providers in counties that did not qualify for the MQPP or the PQIP (qualification criteria of having 500 Medicaid/CHP members or greater).

Measures included were: Well Child (all three), Lead Screening, Mammography, Cervical Cancer Screening, Cardiac Disease (LDL screening), and Diabetes Composite.

Gap Reports encompassed open gaps for third and fourth quarter of 2013.

Physician feedback was compiled (majority of feedback was positive, some concern around members who are auto assigned, offices stated information was helpful).

Please see outcomes graph below.

Outcomes for 2013 Gap Reports (For the Well Child results, all three WC measures are combined)

EHP East GAP Provider Outcomes							
Measures	Provider Count	Location Count	PCP Count	Pre Count	Post Count	Member Improvement	% Improvement
Well							
Child	17	36	158	2975	1007	1968	66.2%
Lead	14	25	69	229	49	180	78.6%
Mammo	16	37	140	1111	541	570	51.3%

Pap	17	39	157	2887	1324	1563	54.1%
Cardiac							
LDL	14	30	89	243	141	102	42.0%
Diab							
Micro	14	29	111	430	231	199	46.3%
Diab Eye	15	34	107	404	223	181	44.8%
Diab A1C	12	24	57	110	52	58	52.7%
Diab LDL	13	26	89	203	104	99	48.8%
Total	17	40	182	8592	3672	4920	57.3%

Summary

1. EHP East providers showed an overall 57.3% improvement across all GAP measures
2. Lead had the biggest improvement with over 70% increases in compliance.
3. EHP East providers had over 40% improvement rates in all 9 measures
4. EHP East included a total of 17 Providers, 40 different locations and a total of 182 PCP's while

The HP continues to prioritize the measures in which we have reported below average rates for at least three consecutive years including:

Current Process Assessment: Adolescent Well-Care Visits

Current Process Assessment: Well Child 3,4,5,6 yo.

- A. AWC and WC34 is a focus measure within the Embedded Practice Model.
 - Continue to build trusted working relationships with providers in the community.
 - Developing quarterly productivity and compliance summaries for the practices.
 - Developing a provider experience survey.
 - Intervention will continue in 2015, AWC Score increased by 1.58% in 2014.
- B. AWC and WC34 is a focus measure in Pediatric Quality Incentive Pilot Program (PQIP).
 - Launched in August 2014.
 - Internal discussions around expanding the program to encompass more members.
 - Consideration to increasing the dollar amount of the incentive based on feedback from the providers.
 - In addition to education specific to the quality measures, providers receive quarterly gap reports and progress reports.
 - Intervention will continue in 2015, 2014 outcomes to be reported next report.
- C. AWC and WC34 is a focus measure in the MQPP.
 - Intervention will continue in first half of 2015, 2014 outcomes to be reported next report.
- D. AWC is a focus measure on the HP 2013 Gap reports and were hand delivered by the Provider Outreach Team

- Gap reports are accompanied by an education tool the HP developed; QIS sheets (Quality Information Sheets) that provide an explanation of the quality measure, the recommended coding, as well as some tips relative to recommended documentation in the medical record.
 - Data is supportive of Gap Report activity continuing in 2014.
- E. HP Member outreach
- HP staff engaged in telephonic member outreach to remind parents/guardians of the need for adolescent well child visits.
 - Claims indicated a 7% greater compliance rate than those who did not have any phone call made.
 - Telephonic outreach activity data supports positive outcomes and will continue next year.
- F. Follow through on internal data integrity concerns.
- Measure requires PCP to be rendering provider.
 - Concern internally when a facility bills, not capturing the rendering provider information in the right repository that then feeds our HEDIS data collection tool.

Current Process Assessment: HIV/AIDS Comprehensive Care

- A. HIV/AIDS Comprehensive Care is included in the MQPP.
- B. Distribution of gap reports to high volume providers ensuring all HIV confidentiality laws are followed.
- C. Follow through on internal data integrity concerns (as mentioned above).

Current Process Assessment: Follow up Care for Children Prescribed ADHD Medication: Initiation Phase

- A. The Follow up Care for Children Prescribed ADHD Medication: Initiation Phase is included in MQPP.
- B. The HP performs provider and member outreach when children have filled an initial prescription for ADHD medication.
 - Provider Outreach team sends a letter to prescribing providers reminding them of the recommended follow up appointment dates for each member.
- C. Case Management outreaches to parent/guardian to educate and to ensure follow up appointments have been scheduled.
 - HP has seen improvement, initiative will continue.
 - HP has identified a potential data integrity concern with the place of service for psychiatric centers not being captured correctly on claims. This root cause analysis is a work in progress.

Current Process Assessment: Annual Monitoring for Patients on Persistent Medications—Combined Rate

- A. The Annual Monitoring for Patients on Persistent Medications is a measure included in the MQPP.
- B. The HP performs member outreach for members who are taking an ACE/ARB, diuretic, or digoxin and anticonvulsants and have not yet had the appropriate blood test in the specified time frame.
 - During the 3rd and 4th quarter of the RY a letter was sent to the member explaining the need for the blood test and that Lifetime Health Care (LTHC), a home care agency, will be contacting them to set up an appointment to have the blood drawn in his/her home.
 - The HP assists LTHC in obtaining a physician order for the blood work and set up an appointment for the blood draw.

- There were operational challenges in the implementation that delayed the launch until November 2014.
- Outcomes of this initiative have not yet been measured.

Current Process Assessment: Appropriate Testing for Pharyngitis

Current Process Assessment: Appropriate Treatment for Upper Respiratory Infection (URI)

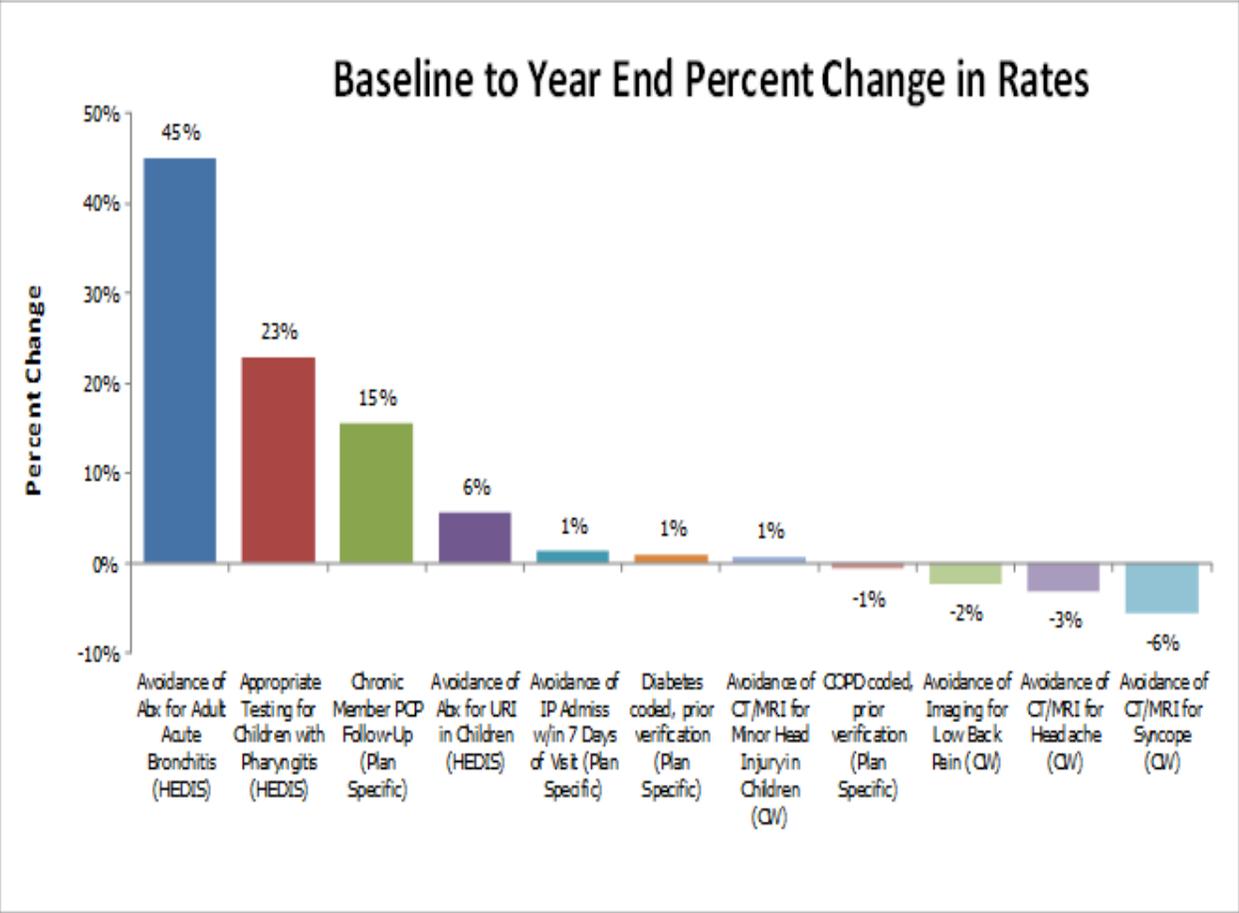
- A. The measures are included in the PQIP and MQPP programs.
- B. The HP created an initiative to engage Emergency Departments in improving performance on this measure through education.
 - ED report was developed to increase transparency of quality measures.
 - Opportunity identified for improved coding and billing practices and care decisions.
 - Target goal was to move the measure to the next quartile of measure performance.
 - Program included 94% of the targeted hospitals.
 - Testing rates improved by 23% for pharyngitis.
 - Testing rates improved by 6% for URI.
 - See graph below for ED reporting outcomes.

Current Process Assessment: Use of Imaging Studies for Low Back Pain

- A. Root cause analysis of this measure indicated that 53% of the claims for the members that received imaging for low back pain less than 6 weeks following the diagnosis came from Emergency Departments.
- B. The HP created an initiative to engage Emergency Departments in improving performance on this measure through education.
 - HP continues to work on other opportunities for improved provider performance.
 - See graph below for ED reporting outcomes.

Current Process Assessment: Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis

- A. This measure is included in the PQIP and MQPP.
- B. The HP created an initiative to engage Emergency Departments in improving performance on this measure through education.
 - There was an improvement of 45% for those facilities engaged for avoidance of antibiotics for adults with acute bronchitis.
- C. The HP's root cause analysis identified that providers are billing the diagnosis code for Acute Bronchitis while the medical record indicated that the member had pre-existing bronchitis indicating that a different diagnosis code should have been used.
 - The HP provided education worksheets to providers.
 - Ongoing monitoring indicates improvements in this measure.



Current Process Assessment: Breast Cancer Screening

- A. In 2013, the HP sent a member mailing to all members overdue for a mammography screening, placed calls to members in medium and high risk categories. In 2013, the HP also distributed gap reports to high volume PCP providers.
 - This outreach accounts for a 51% improvement for the members included; however, there remains a significant volume of membership that still needs to be reached.
 - The HP will continue to provide gap reports.
- B. The HP care management vendor launched a pilot program in which they secured entire days at 2 large radiology practices.
 - 1st event: 200 members contacted, scheduled 16 appointments, and had 12 complete the mammogram. (75% success rate)
 - 2nd event: 217 members contacted, scheduled 13 appointments, and had 9 members complete the mammogram. (69% success rate)
 - 3rd event: 220 members contacts, scheduled 15 appointments, and 10 members completed the mammogram. (67% success rate.)
 - Members attending scheduled appointments were given a \$25 gift card and entered into a drawing for a \$50 gift card.
 - This intervention will continue.

Current Process Assessment: Cervical Cancer Screening

- A. This measure is included in the MQPP.
- B. The HP provides Gap reports to providers with education material.
 - Through on-going monitoring, the HP has not seen improvement in this measure and continues to seek improvement opportunities.

Current Process Assessment: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

- A. This measure is included in the MQPP.
- B. On a monthly basis, the HP reviews reports of members with a COPD diagnosis but no evidence of a spirometry test. The HP works with LTHC agency to obtain a physician order and perform spirometry testing in the member's home. Through on-going monitoring, the HP has seen improvement in this measure.
- C. This initiative will continue.

Current Process Assessment: Use of Appropriate Medications for People with Asthma

- A. This measure is included in the MQPP.
- B. The HP identifies members that have a diagnosis of asthma with no corresponding pharmacy claim for an appropriate asthma medication. The HP contacts impacted members to verify diagnosis and assist with obtaining any needed medication. Through ongoing monitoring, the HP has seen improvement in this measure.
 - This initiative will continue.
- C. The HP initiated a letter to providers for members with an asthma diagnosis but no claim for an asthma medication. This has not been successful in getting provider feedback. The HP will modify the letter and expand to other asthma measures.

Current Process Assessment: Lead Screening in Children

- A. This measure is included in the PQIP and MQPP programs.
- B. The HP's root cause analysis of this measure indicated that our members were indeed receiving the lead testing, but were missing having the test done by the age of 2.
 - Telephonic member outreach is performed ensuring the reminder call to the member's parent/guardian is made well before the child turns two.
 - Provider Outreach also sends a letter to the provider offices seeking their assistance in getting the members in prior to that second birthday. The letter indicates the member that is requiring the test and the date of the member's 2nd birthday.
 - Monthly (administrative) monitoring of this measure indicates the HP is trending in the right direction and this intervention will continue.

Current Process Assessment: Comprehensive Diabetes Care

- A. This measure is included in the MQPP.
- B. The HP's Root Cause analysis indicated that the weakest score is the Dilated Retinal Exam component of this measure. HP verified that retail eye centers were billing appropriately but such centers indicated that members are not disclosing their diabetes diagnosis. The HP focused outreach on high volume ophthalmology practices and provided gap reports to those practices.

- The outcomes data indicated that 21% of the sample population received his/her DRE exam as a result of the gap reports.
- The HP's intent to continue exploring and expanding interventions to include the other reporting criteria elements of this measure.

Current Process Assessment: Prenatal and Post-partum Care, Postpartum care total

- A. This measure is included in the MQPP.
- B. The HP's Root Cause Analysis indicated that the weakest part of this measure is with the post-partum compliance. The HP Case Management team performs member outreach encouraging and facilitating the scheduling of timely post-partum appointments.

Other Program offered by the Health Plan to improve QARR measures include:

Care Management Programs include:

- The program manages members with Complex and Non-Complex Case Management needs, including chronic, behavioral health, or prenatal care needs. The Case Manager, after conducting a comprehensive assessment, develops an individualized care plan, coordinates and collaborates with internal care management programs, providers, and community resources to ensure member needs are met and they have the ability to overcome barriers to receiving health care services by linking with needed resources, such as transportation. Care gaps are identified and efforts are made to educate members on the importance of preventive care and assist with scheduling appointments when appropriate.
- Care management efforts are collaborative and include outreach to community practitioners (i.e. Health Homes), medical providers, and social agencies to provide quality and comprehensive health care to members in an integrated manner.

Disease Management Programs include:

- Members with chronic conditions such as Diabetes, Asthma, or Coronary Artery Disease may be eligible for participation in Disease Management programs which provide telephonic outreach, education, and support services to promote member adherence to treatment guidelines, prevent disease complications, and optimize functional status. Identification of eligible members and stratification according to severity is based on a predictive modeling tool (MedAi). MedAi utilizes evidence based medicine, HEDIS specifications, medical and pharmacy claims, demographics, regional variances, and motivational risk to assign an overall member risk score. Interventions are tailored based on risk and include informational mailings, newsletters, and/or gap mailings for low risk members. High risk members will also receive Case Management that includes care coordination, chronic condition education, comprehensive assessment, and individualized interventions based on the member's needs along with a disease-specific educational booklet.
- **2013 Recommendation:** The plan should continue to work to address the problems noted in the focused surveys. [*Repeat recommendation.*]

MCO Response:

Access and Availability

New Initiatives:

- HP created and distributed a new desk top tool for provider office staff which includes access and availability requirements including rules and timeframes for scheduling appointments. This information was also posted to the HP's website.
- HP created IVR Messaging with Access and Availability requirements that play when providers call HP provider services telephone line.

Current Processes:

- HP staff provides education on Access and Availability requirements during provider office visits and schedules targeted visits to provider offices that fail any survey. Access & Availability standards are also reviewed during Quarterly Provider Office Seminars.
- HP's quarterly Provider Newsletter includes articles reminding providers of the Access & Availability standards as well as reminders for offices to timely notify the Plan of any changes to practice demographic information. This communication is emailed to all providers and then posted to the web for reference. HP conducts telephonic "secret shopper" surveys using methodologies consistent with the IPRO surveys. Interventions for non-compliant providers include written notification of non-compliance, contact from the Plan's Medical Director to discuss barriers to access of care, follow up education for provider staff, and referral for credentialing review for continued non-compliance.
- HP contracts with a vendor to perform provider verification calls to ensure HP has correct demographic information.

Member Services

New Initiatives:

- HP continues to education and test member services staff and routinely reviews reference materials to improve accuracy and clarity.
- HP adopted more efficient procedures for handling all correspondence.

Current Process:

- HP conducts secret shopping calls of member services staff for understanding of covered benefits and proper handling of requested member materials.

VIII. Appendix

REFERENCES

A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
 - Managed Care Plan Directory, Accessed August 31, 2015
 - NCQA Accreditation website, <http://hprc.ncqa.org>, Accessed August 31, 2015

B. Enrollment/Provider Network

1. Enrollment

- NYSDOH OMC Membership Data, 2012-2014
- Enrollment by Age and Gender Report as of December 2014
- Enrollment Status by Aid Category and County as of December 2014
- Enrollment Status Report, December 2014

2. Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, December 2014
- QARR Measurement Year, 2012-2014
- NYSDOH Primary Care Access and Availability Survey, 2014

C. Utilization

1. Encounter Data

- MMC Encounter Data System, 2012-2014

2. QARR Use of Services

- QARR Measurement Year, 2012-2014

D. Quality Indicators

1. Summary of HEDIS® Information Systems Audit™ Findings

- 2014 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors

2. QARR Data

- Performance Category Analysis, Quality Performance Matrix (2014 Measurement Year)
- QARR Measurement Year, 2012-2014

3. CAHPS® 2014 Data

- QARR Measurement Year, 2014

4. Quality/Satisfaction Points and Incentive

- Quality/Satisfaction Points and Incentive, 2012-2014

5. Performance Improvement Project

- 2013-2014 PIP Report

E. Deficiencies and Appeals

1. Summary of Deficiencies

- MMC Operational Deficiencies by Plan/Category, 2014
- Focus Deficiencies by Plan/Survey Type/Category, 2014