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 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

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.

Excellus Web Page: https://www.excellusbcbs.com

*Participating Regions and Products[1]			
Central[2]:	MCD	CHP	COM
Northeast[3]:	MCD	CHP	COM
Western[4]:	MCD	CHP	COM

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

Region Definitions

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

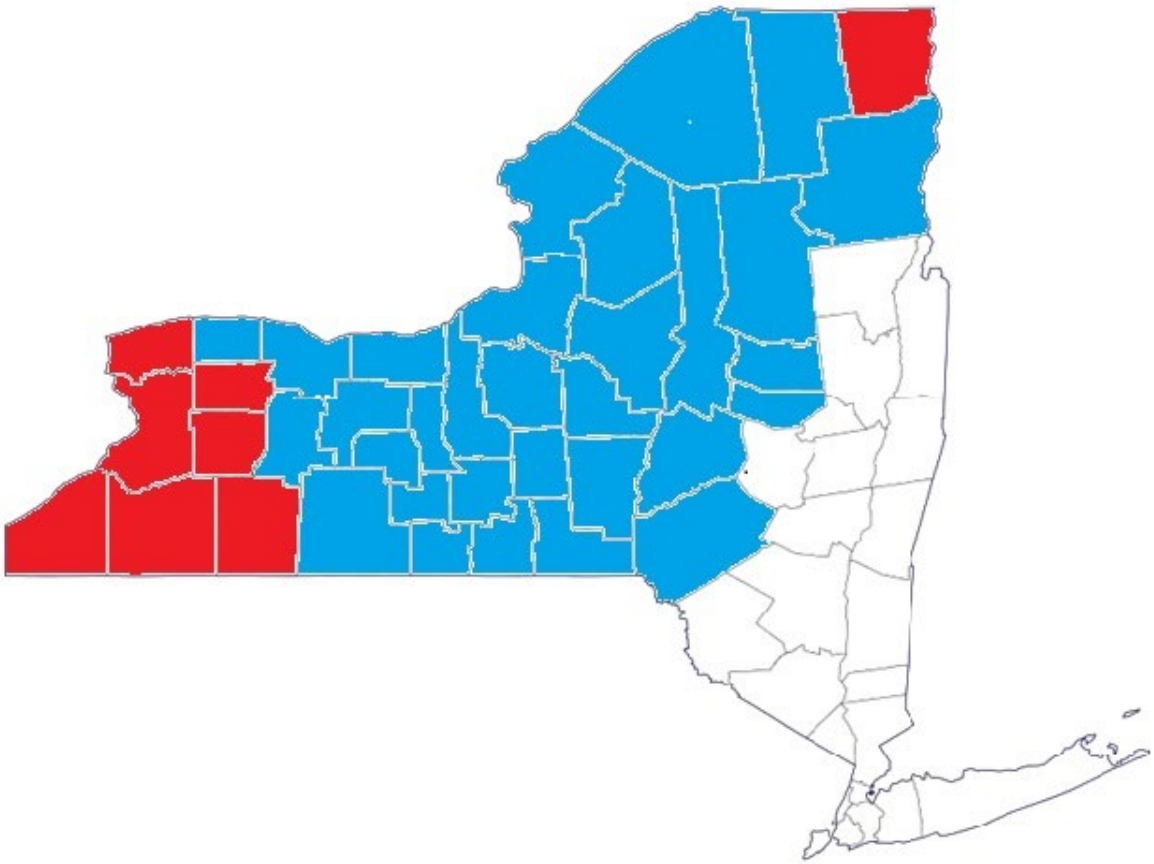
[1] Note that the HARP product line is available in all counties that serve the Medicaid population.

[2] Broome, Herkimer, and Oneida counties participate in MCD, CHP and COM. All other counties in the Central region participate in CHP and COM only.

[3] Excellus participates in CHP and COM in Clinton, Delaware, Essex, Franklin, Fulton, Hamilton and Montgomery counties. The MCO participates in MCD, CHP and COM in Otsego County.

[4] Allegany, Cattaraugus, Chautauqua, Genesee, Niagara and Wyoming counties participate in COM only. Chemung, Schuyler, and Steuben counties participate in CHP and COM only.

Figure 1: Excellus Map of Participating Counties



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

III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has increased from 2017 to 2018 by a rate of .7%. Excellus enrollment represents 3.9% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	166,408	168,074	169,223
% Change from Previous Year	-7.1%	1.0%	.7%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	3.8%	3.8%	3.9%

Data Source: NYS OHIP Medicaid DataMart

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

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

	2016	2017	2018
CHP	26,719	29,679	30,293
Commercial[1]	873,987	893,527	944,197

Data Source: NYSDOH OHIP Child Health Plus Program

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

Figure 2: Excellus Enrollment Trends—All Product Lines

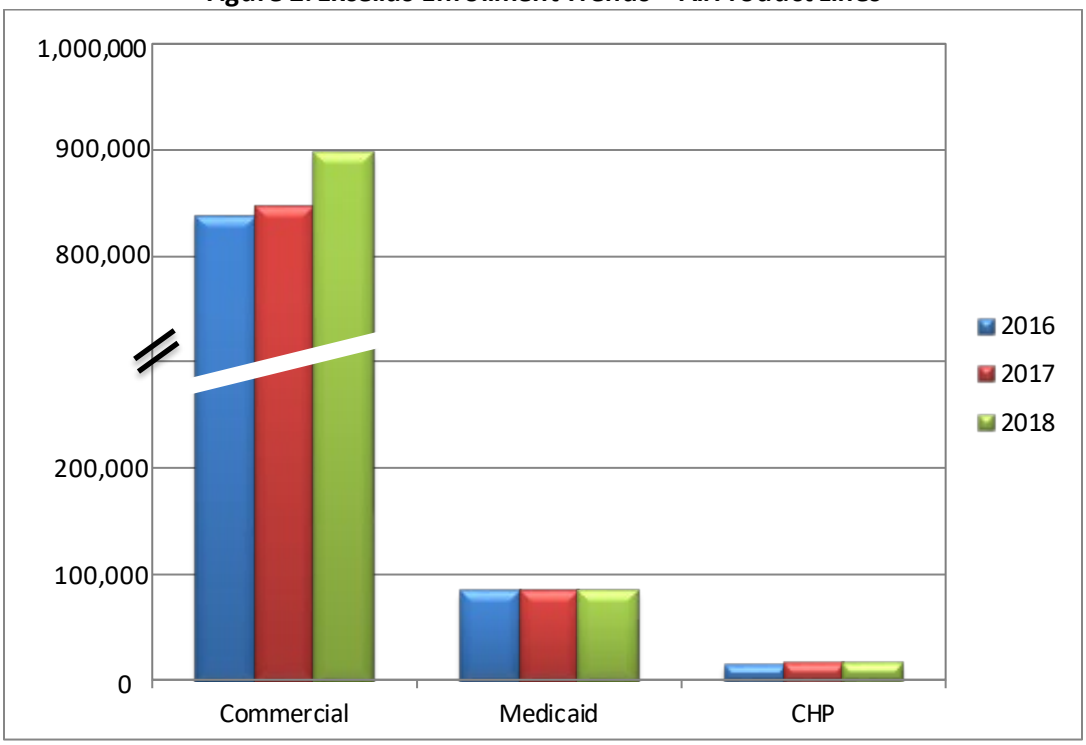


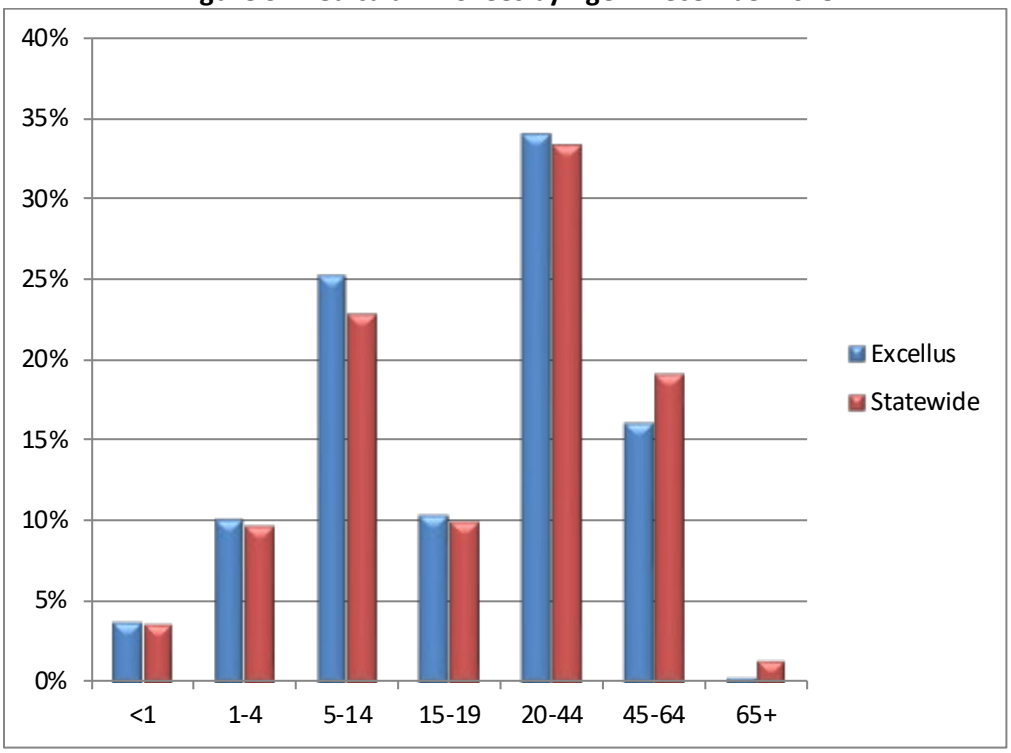
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. Members aged 20-44 year olds are the largest age group in Excellus' Medicaid membership.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	3155	3187	6342	3.8%	3.6%
1-4	8814	8301	17115	10.1%	9.7%
5-14	21917	20800	42717	25.3%	22.8%
15-19	8698	8744	17442	10.3%	9.9%
20-44	21529	36015	57544	34.1%	33.3%
45-64	12527	14672	27199	16.1% ▼	19.1%
65 and Over	206	336	542	0.3% ▼	1.4%
Total	76846	92055	168901		
Under 20	42584	41032	83616	49.5%	46.1%
Females 15-64		59431		35.2%	34.7%

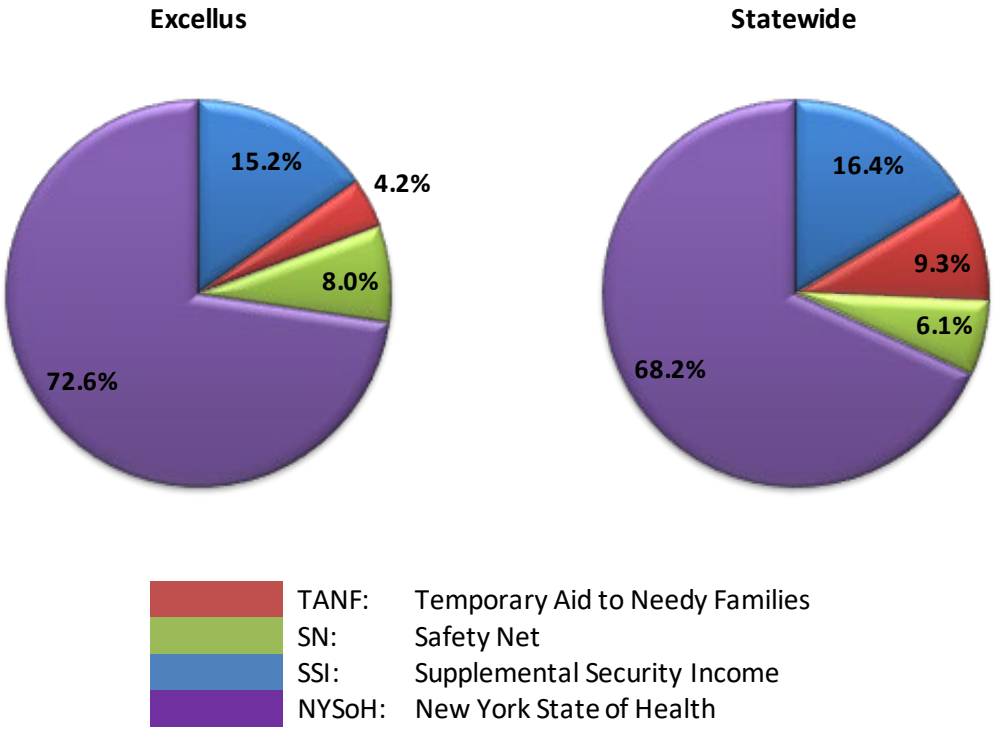
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. In 2018, the MCO's Medicaid product had 3 out of 6 measures with rates below the SWA. For detailed information regarding board certification of providers, please see *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[5].

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

	2016		2017		2018	
Provider Type	**Excellus**	**Statewide Average**	**Excellus**	**Statewide Average**	**Excellus**	**Statewide Average**
Medicaid/CHP						
Family Medicine	71%	71%	60% ▼	72%	59% ▼	74%
Internal Medicine	78%	75%	69% ▼	76%	68% ▼	76%
Pediatricians	71% ▼	78%	65% ▼	79%	64% ▼	80%
OB/GYN	84% ▲	75%	83% ▲	77%	82%	80%
Geriatricians	72%	63%	68%	63%	68%	63%
Other Physician Specialists	80% ▲	75%	77%	76%	76%	77%
Commercial						
Family Medicine	71%	74%	64% ▼	77%	60% ▼	72%
Internal Medicine	78% ▲	73%	69% ▼	77%	68% ▼	73%
Pediatricians	71% ▼	77%	69% ▼	79%	64% ▼	75%
OB/GYN	84% ▲	78%	87% ▲	79%	82% ▼	78%
Geriatricians	73%	63%	67%	69%	69%	66%
Other Physician Specialists	80% ▲	78%	77% ▼	79%	75% ▼	77%

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

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. In 2018, 3 out of 10 provider types had rates above the SWA.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	3,682	22.9%	19.5%
Pediatrics	822	5.1% ▲	3.8%
Family Practice	1,371	8.5% ▲	3.5%
Internal Medicine	1,441	9.0%	8.4%
Other PCPs	48	0.3% ▼	3.8%
OB/GYN Specialty[1]	728	4.5%	3.8%
Behavioral Health	2,133	13.3%	17.2%
Other Specialties	8,480	52.8% ▲	46.0%
Non-PCP Nurse Practitioners	35	0.2% ▼	8.7%
Dentistry	1,008	6.3%	4.9%
Total	16,066		

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

	Excellus			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	46:1	2,505	67:1	42:1	80,986	42:1
Pediatrics (Under age 20)	102:1			70:1		
OB/GYN (Females age 15-64)	82:1			59:1		
Behavioral Health	79:1			73:1		

Data Source: Derived ratios calculated from NYS OHIP Medicaid DataMart and NYS Provider Network Data System (PNDS).

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

The number of Medicaid PCPs with an "Open Panel" is presented in **Table 7** for the fourth quarters of 2016 through 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼. In 2018, Excellus' rate of Medicaid PCPs with an Open Panel was below the SWA.

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

	2016			2017			2018		
	Excellus		Statewide	Excellus		Statewide	Excellus		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
					Medicaid				
Providers with Open Panel	2,036	99.4 ▲	85.0	2,162	82.9	95.7	526	14.7 ▼	90.8

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

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

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

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
100	80	**80.0%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 71 providers (total number of providers who were compliant for participation (80), less total number of providers with closed panels (9)). Excellus performed above the threshold for all call types.

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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	7	7	100.0%
	Pediatrician	10	9	90.0%
	OB/GYN	6	6	100.0%
	Total Routine	**23**	**22**	**95.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	5	4	80.0%
	Pediatrician	9	5	55.6%
	OB/GYN	8	8	100.0%
	Total Non-Urgent	**22**	**17**	**77.3%**
After-Hours Access	Internist/Family Practitioner	7	5	71.4%
	Pediatrician	10	8	80.0%
	OB/GYN	9	9	100.0%
	Total After-Hours	**26**	**22**	**84.6%**

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

IV. Utilization

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

Encounter Data

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

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	Excellus	Statewide Average	Excellus	Statewide Average	Excellus	Statewide Average
PCPs and OB/GYNs	4.00	3.85	3.72	3.56	3.81	3.50
Specialty	2.14	2.45	1.96	2.30	1.92 ▼	2.33
Emergency Room	0.80 ▲	0.54	0.72 ▲	0.55	0.68	0.53
Inpatient Admissions	0.14	0.14	0.14	0.14	0.14	0.13
Dental	1.24	1.03	1.20	1.02	1.15	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a) (ii) of the Medicaid Managed Care and Family Health Plus Model Contract, MCOs must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone, or by mail, and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 11** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2016 through 2018, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. The MCO's rates have increased from 2017 to 2018.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	Excellus	SWA	Excellus	SWA	Excellus	SWA
	Medicaid					
Enrollee Health Screenings	27.1% ▲	12.5%	8.7%	12.7%	12.6%	13.2%

QARR Use of Services Measures

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

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)								
Visits	4,534	4,529	4,440	5,317	NV	4,044 ▼	4,082 ▼	4,209
ER Visits	716	653	613	492	NV	187	194	204
Inpatient ALOS								
Medicine	3.7	3.8	3.8	4.5	3.2	3.1 ▼	3.2 ▼	3.5
Surgery	6.2	6.0	6.4	7.0	4.0	3.8	3.8 ▼	4.4
Maternity	2.6 ▼	2.6 ▼	2.6 ▼	2.9	2.5	2.5 ▼	2.4 ▼	2.6
Total	3.9	3.9	4.0	4.4	3.3 ▼	3.2 ▼	3.2 ▼	3.6
Inpatient Utilization (PTMY)								
Medicine Cases	33	31	29	30	15	15 ▼	15	17
Surgery Cases	15	13	12	12	15	14 ▼	14 ▼	15
Maternity Cases	29	29	27	32	13	12	11	12
Total Cases	69	65	60	66	42	39 ▼	39 ▼	42

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

V. Performance Indicators

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

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

The HEDIS® Final Audit Report prepared for Excellus indicated that the MCO had no significant issues in any areas related to reporting. Excellus demonstrated compliance with all areas of Information Systems and all areas of Measure Determination required for successful HEDIS® reporting. The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well.

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

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[6]

Quality Indicators

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

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO's Medicaid product had 3 out of 14 rates above the SWA.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	90	94 ▲	94 ▲	**89**	91 ▲	84	89	**89**
WCC—BMI Percentile	86 ▲	90 ▲	89	**86**	81 ▲	83	92	**90**
WCC—Counseling for Nutrition	85 ▲	89 ▲	86	**83**	82	78	88	**87**
WCC—Counseling for Physical Activity	81 ▲	80 ▲	77	**74**	78 ▲	74	80	**80**
Childhood Immunizations—Combo 3	83 ▲	83 ▲	86 ▲	**73**	88 ▲	89	87	**84**
Lead Screening in Children	85	87	82 ▼	**89**	82	84 ▼	85	**88**
Adolescent Immunizations—Combo 2[2]		39	40	**43**		26	30	**31**
Adolescents—Alcohol and Other Drug Use[3]	76 ▲	71	76	**70**	72	76	77	**78**
Adolescents—Depression[3]	66	77 ▲	73	**67**	65 ▲	62	68	**69**
Adolescents—Sexual Activity[3]	70	69	74	**67**	70 ▲	71	74	**74**
Adolescents—Tobacco Use[3]	84 ▲	85 ▲	84 ▲	**74**	82 ▲	80	82	**82**
Breast Cancer Screening	64 ▼	65 ▼	67 ▼	**71**	77 ▲	78 ▲	78 ▲	**77**
Colorectal Cancer Screening	52 ▼	56 ▼	59	**63**	68	71	72	**71**
Chlamydia Screening (Ages 16-24)	61 ▼	59 ▼	59 ▼	**76**	50 ▼	50 ▼	51 ▼	**59**

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

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

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

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Excellus had 21% of their rates above the SWA.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	92 ▲	93 ▲	94 ▲	**91**	90 ▲	92	93	**93**
Spirometry Testing for COPD	44 ▼	43 ▼	40 ▼	**56**	41 ▼	42 ▼	41 ▼	**45**
Use of Imaging Studies for Low Back Pain	69 ▼	74 ▼	75	**77**	75 ▼	80	80	**80**
Pharmacotherapy Management for COPD—Bronchodilators	87	88	91	**89**	76	78	81	**80**
Pharmacotherapy Management for COPD—Corticosteroids	75 ▲	80	83 ▲	**76**	70	76	80	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	66	69	71	**71**	73 ▲	78 ▲	78 ▲	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	54	60	61	**59**	59 ▲	67 ▲	65 ▲	**63**
Asthma Medication Ratio (Ages 19-64)	60 ▲	60	60	**60**	80 ▲	83 ▲	82	**81**
Asthma Medication Ratio (Ages 5-18)	69 ▲	68 ▲	66	**68**	85 ▲	86	85	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	86	85	86	**80**	87	86	82	**83**
CDC—HbA1c Testing	85 ▼	89	89	**92**	93	92	93	**92**
CDC—HbA1c Control (<8%)	52	54	57	**60**	65	63	64	**61**
CDC—Eye Exam Performed	64	71	69	**67**	61	59	61	**63**
CDC—Nephropathy Monitor	86 ▼	91	89 ▼	**92**	89	88	88	**89**
CDC—BP Controlled (<140/90 mm Hg)	73 ▲	72 ▲	76 ▲	**66**	74 ▲	76 ▲	74 ▲	**69**
Drug Therapy for Rheumatoid Arthritis	89 ▲	90	82	**83**	89 ▲	87	85	**84**
Monitor Patients on Persistent Medications—Total Rate	87 ▼	87 ▼	87 ▼	**92**	84	84	84	**84**
Appropriate Treatment for URI	93 ▼	94 ▼	95	**95**	91 ▼	93	94	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	23 ▼	38 ▲	40 ▲	**36**	23 ▼	31 ▲	36 ▲	**34**
HIV Viral Load Suppression[2,3]	84 ▲	84 ▲	81 ▲	**77**				
Flu Shots for Adults (Ages 18-64)[4]	45	44						
Advising Smokers to Quit[4]	68	85						

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Smoking Cessation Medications[4]	49	54						
Smoking Cessation Strategies[4]	44	46						

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

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

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

[2] NYS-specific measure.

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

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Excellus' Medicaid product line had 4 out of 9 behavioral health measures with rates below the SWA.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	45 ▼	47 ▼	50 ▼	**53**	65	68 ▲	70 ▲	**68**
Antidepressant Medication Management—Effective Continuation Phase	32 ▼	35 ▼	38	**37**	50	54 ▲	56 ▲	**53**
Follow-Up Care for Children on ADHD Medication—Initiation	42 ▼	44 ▼	45 ▼	**59**	44	42	43	**45**
Follow-Up Care for Children on ADHD Medication—Continue	53 ▼	51 ▼	53 ▼	**66**	52	49	48	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	72 ▼	72 ▼	83 ▲	**74**	75	74	68	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	56 ▼	56 ▼	77 ▲	**63**	59	58	51	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	78 ▼	78 ▼	77 ▼	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	75	68	74	**80**				
Antipsychotic Medications for Schizophrenia	52 ▼	61	60	**63**				

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

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."* Performance indicators related to Utilization and Access to Care are included in this section[7].

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, 50% of Excellus utilization measures had rates below the SWA.

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

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	68 ▲	70 ▲	85 ▲	**82**
Well-Child Visits—3 to 6 Years	82 ▼	82 ▼	84 ▼	**86**
Adolescent Well-Care Visits	67 ▼	67 ▼	67	**68**
		Commercial		
Well-Child Visits—First 15 Months	88 ▲	89 ▲	94	**67**
Well-Child Visits—3 to 6 Years	85 ▼	85 ▼	87 ▼	**88**
Adolescent Well-Care Visits	62 ▼	63 ▼	64 ▼	**67**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). In 2018, Excellus' rates remained above the SWA for 60% of the measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Children & Adolescents' Access to PCPs (CAP)								
12-24 Months	99 ▲	99 ▲	99 ▲	**97**	98	98	98	**98**
25 Months-6 Years	94	94	94	**94**	94 ▼	94 ▼	95	**95**
7-11 Years	97	97	97	**97**	96 ▼	96 ▼	93 ▼	**97**
12-19 Years	96 ▲	97 ▲	96 ▲	**95**	94	95	95	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	87 ▲	87 ▲	87 ▲	**81**	94	94	94	**94**
45-64 Years	91 ▲	91 ▲	91 ▲	**89**	96	96	96	**96**
65+ Years	90	91	92	**91**	98 ▲	98 ▲	98 ▲	**97**
Access to Other Services								
Timeliness of Prenatal Care	89	92 ▲	92 ▲	**88**	95 ▲	95	93	**92**
Postpartum Care	67	63 ▼	69	**70**	89 ▲	83	84	**83**
Annual Dental Visit[2]	63 ▲	63 ▲	62 ▲	**61**				

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

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 15** presents prenatal care rates calculated by the NYSDOH for QARR 2015 through 2017 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	Excellus	ROS Average	Excellus	ROS Average	Excellus	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	5% ▲	7%	6%	7%	-	-
Prenatal Care in the First Trimester	76%	74%	76%	74%	76	75
Risk-Adjusted Primary Cesarean Delivery[1]	11%	14%	11%	13%	-	-
Vaginal Birth After Cesarean	16%	14%	16%	14%	-	-
Commercial						
Risk-Adjusted Low Birth Weight[1]	4%	4%	4%	4%	-	-
Prenatal Care in the First Trimester	89% ▲	88%	90% ▲	88%	89 ▲	88
Risk-Adjusted Primary Cesarean Delivery[1]	17% ▲	19%	17%	18%	-	-
Vaginal Birth After Cesarean	13%	11%	13%	11%	-	-

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

ROS: Rest of State

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

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. In MY 2014, 2016, and 2018 the CAHPS survey reported on child measures for Medicaid members. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). The MCO's rates have trended upwards for 42% of the measures for the Medicaid product line.

Table 16 CAHPS®—2014, 2016, 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA	Excellus	SWA
Flu Shots for Adults Ages 18-64							61	**52**	56	**52**	58	**56**
Advising Smokers to Quit							76	**84**	71	**80**	69	**81**
Getting Care Needed[1]	87	**83**	86	**85**	87	**84**	87	**88**	89	**88**	90	**89**
Getting Care Quickly[1]	91 ▲	**87**	91	**88**	91	**88**	90	**88**	91 ▲	**87**	91	**87**
Customer Service[1]	87	**82**	90	**86**	84	**86**	97 ▲	**88**	93	**89**	92	**91**
Coordination of Care[1]	77	**74**	76	**74**	80	**75**	84	**84**	81	**83**	91	**87**
Collaborative Decision Making[1]	54	**53**	82 ▲	**74**	77	**76**	83	**80**	79	**80**	79	**80**
Rating of Personal Doctor[1]	90	**89**	90	**90**	90	**90**	83	**84**	89	**86**	83	**86**
Rating of Specialist	86	**81**	81	**83**	86	**84**	79	**83**	85	**84**	80	**84**
Rating of Healthcare	88	**85**	88	**86**	90	**87**	78	**78**	81	**80**	76	**81**
Satisfaction with Provider Communication[1]	94	**93**	95 ▲	**93**	96 ▲	**93**	96	**96**	97	**96**	96	**96**
Wellness Discussion							74	**77**	73	**76**	76	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	64	**64**	74	**68**	66	**69**						
Rating of Health Plan -High Users	91 ▲	**84**	90	**85**	88	**84**	63	**68**	69	**68**	66	**72**
Overall Rating of Health Plan	86	**83**	90 ▲	**85**	88	**85**	66	**67**	68	**66**	62 ▼	**71**
Recommend Plan to Family/Friends												

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

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

Table 17 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Utilization and Access to Care measures reported annually in the New York State Managed Care Plan Performance Report. Thirty-nine measures were included for the Measurement Year (MY) 2018 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 2018, the MCO was required to follow up on no more than three measures from the D and F categories of the Matrix. If the MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow up.

Table 17: Quality Performance Matrix—Measurement Year 2018

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

Performance Improvement Project

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

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

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

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

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

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

Member-Focused Interventions:

- High-risk CM program targeted women referred to the Plan by their medical providers and through claims from pharmacy, prenatal medications, and pregnancy imaging studies.
- Promotion of birth spacing options was an integral component of the high-risk case management program.
- Member education and promotion of 17P for women at high risk. Once these women were identified, they were given education and support regarding the use of 17P.

Provider-Focused Interventions:

- Implementation of high-risk CM program from provider pregnancy referrals with claims extract.
- External provider meetings for discussion of project and obtain partnership with both medical record data pulls as well as providing physician advisory capacity for the project.
- Provider education fostering use of Pregnancy Referral Forms and relay to health plan electronically through integration in their EMR.
- Removal of prior authorization for 17P and network provider education.

MCO-Focused Interventions:

- High-risk CM enhancements - assessment for depression and tobacco prevalence screening.

Table 18 presents a summary of Excellus' 2017-2018 PIP. Excellus demonstrated an improvement for 9 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	70%	93%	90th percentile-QARR	Demonstrated improvement
Postpartum Care	67%	70%	90th percentile-QARR	Demonstrated improvement
Received at least one 17P injection	2%*	81%	10% increase annually	Demonstrated improvement from Interim to Final
Depression Screening**	100%	100%	90% compliance Yr. 1 95% compliance Remeasurement	Performance level was maintained
Tobacco Screening**	100%	100%	90% compliance Yr. 1 95% compliance Remeasurement	Performance level was maintained
Tobacco Screening Follow-Up**	29%	1%	90% compliance Yr. 1	Performance declined

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
			95% compliance Remeasurement	
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	2%	14%	5% increase per year	Demonstrated improvement
Age 15-20 years; within 60 days	20%	22%	5% increase per year	Demonstrated improvement
Age 21-44 years; within 3 days	1%	9%	5% increase per year	Demonstrated improvement
Age 21-44 years; within 60 days	13%	22%	5% increase per year	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	0%	0%	5% increase per year	Performance level was maintained
Age 15-20 years; within 60 days	0%	12%	5% increase per year	Demonstrated improvement
Age 21-44 years; within 3 days	0%	0.03%	5% increase per year	Performance level was maintained
Age 21-44 years; within 60 days	0%	7%	5% increase per year	Demonstrated improvement

* Method to determine 17P rates changed from 2016 to 2017 new data pull.
**Members from high-risk case management program.

Health Disparities

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

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

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

- To effectively identify at-risk members, Excellus developed population density maps which indicate the number of gaps in care, by HEDIS measure, for each zip code.
- Excellus creates monthly dashboards for all HEDIS measures by line of business to identify differences in health outcomes between the Medicaid population and other types of health care consumers. One difference identified by Excellus is in Breast Cancer Screening. The Medicaid member rates for 2018 were significantly lower than Commercial member rates. Interventions were created to increase the rates for Medicaid members.
- Excellus identifies gaps in quality of care for Medicaid subgroups. Members are identified as compliant or non-compliant for quality measures by specific categories such as HARP and Behavioral Health. Each measure member list is handled by the appropriate team at the MCO for outreach.
- By using density mapping, Excellus has noted higher rates of gaps in preventative care in specific urban zip codes where Vital Statistics data indicates higher rates of poverty. Transportation and availability of service providers have been noted as common barriers to care. Therefore, the MCO aims to collaborate with mobile units and community connection staff to connect members in these areas with preventative screening services.
- Excellus was successful in implementing interventions that reduced differences in health outcomes and improved the quality of care for MCO members identified with gaps in breast cancer screenings. Over a 2-week time period, in 2018, the MCO was able to close 103 Breast Cancer Screening gaps through a pilot collaboration with a mobile mammography unit. Members identified for this pilot resided within a 5-mile radius of the mobile unit's scheduled location and had 2 or more gaps in care. Excellus' community connection staff provided health education to hard to find members and assisted with engagement into care management, scheduling appointments and linking with transportation resources.

VI. Health Information Technology

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

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

- Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
- Use of telecommunications technologies
- Use of Electronic Health Records (EHR)
- Use of electronic internal registries
- Use of clinical risk group (CRG) or similar software
- Secure electronic transfer of member data between the MCO, its vendors, and network providers
- Electronic communication with providers
- Electronic communication with members
- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)[8]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

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

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

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Electronic communication with providers	100%
Secure electronic transfer of protected health information to patients and/or providers	100%
Future plans to implement HIT	77%
Use of clinical risk group (CRG) or similar software	100%
Use of telecommunications technologies	100%
Use of Electronic Health Records (EHR)	92%
Electronic communication with members	100%

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

Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	69%
Participation in a medical home pilot or program	46%
Use of electronic internal registries	46%
Participation in State, Federal or privately funded HIT initiatives	46%

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

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Use of secure email, fax, secure file transfer, and FTP

- Use of telecommunications technologies:
  - Use of outbound dialer and an IVR system to conduct HRA and chronic disease programs.
  - Implemented a telemedicine system that offers video conferencing for members to access a "virtual doctor visit".

- Use of Electronic Health Records (EHR):
  - Use of third-party data aggregator for EHR data combined with MCO claims data

- Use of clinical risk group (CRG) or similar software:
  - Use of software to risk-stratify members for case management outreach utilizing costs and gaps in care information
  - Use of a custom Artificial Intelligence Machine Learning predictive model to predict member utilization.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Via secure FTP, secure file transfer, fax, secure email, and web-based portal

- Electronic communication with providers:
  - Via FTP, secure file transfer, fax, and secure email

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Associated with Rochester RHIO to receive daily admit discharge and transfer (ADT) data
  - Excellus is in the testing phase of receiving data from HEALTHeLINK (Western NY RHIO)
  - Integration of immunization data from NYS Immunization Information System (NYSIIS) with claims and EHR data.

- Participation in a medical home pilot or program:
  - Support Patient-Centered Medical Home (PCMH) model
  - Support health information technology needs of the medical home model

- Future plans to implement HIT:
  - Initiation of the Systems Integration Project (SIP); a unified information platform to build an interconnected, person-centered system of support services for members. The SIP will establish connections between local health, education, and human services organizations to members seeking support.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

Excellus was in compliance with 11 of the 14 operational survey categories. The categories in which Excellus was not compliant were Organization and Management (4 citations), Quality Assurance (1 citation), and Utilization Review (3 citations). Excellus was in compliance in all of the focused review types in 2018.

Table 20: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability for routine and urgent visits; re-audits are performed when results are below 75%.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination, or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information—Web	Review of MCOs' web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listings of primary, specialty, and ancillary providers for the enrolled population.
Provider Participation—Directory	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCPs with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent "sick", and urgent appointments.
Other	Used for issues that 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 21: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	0
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	4	0
Prenatal Care	0	0
Quality Assurance	1	0
Service Delivery Network	0	0
Utilization Review	3	0
Total	**8**	**0**

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, Excellus had 58% of external appeals were upheld.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	14	19	8
Overturned in Part	0	0	0
Upheld	21	17	11
Medicaid Total	**35**	**36**	**19**
		CHP	
Overturned	0	1	1
Overturned in Part	0	0	0
Upheld	0	0	1
CHP Total	**0**	**1**	**2**

VIII. Strengths and Opportunities for Improvement[9]

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

Strengths

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

Strengths:

- In regard to the percentages of various provider types within the MCO's Medicaid provider network, Excellus has reported rates above the statewide average for the following provider types: Pediatrics, Family Practice, and Other Specialties.
- The MCO performed well in the 2018 Primary Care and OB/GYN Access and Availability Survey. The MCO demonstrated compliance for all call types.
- The MCO has shown an improvement in the rate of health screenings for new enrollees. In 2017 the MCO had a reported rate of 8.7% and in 2018 the reported rate is 12.6%.
- In regards to the HEDIS®/QARR Effectiveness of Care domain, the MCO's rates for *Childhood Immunization Status—Combination 3*, *Adolescent Preventive Care—Tobacco Use* and *Testing for Children with Pharyngitis* have been reported above the statewide average for at least three consecutive reporting years. The MCO's also had a reported rate above the statewide average for *Adult BMI Assessment* in 2018.
- 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 *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) and HIV Viral Load Suppression* measures.. Additionally, rates for, *Pharmacotherapy Management for COPD-Corticosteroids* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* were reported above the statewide average for 2018.
- In the HEDIS®/QARR Utilization domain, the MCO's rate for *Well-Child Visits in the First 15 Months of Life* has reported rates above the statewide average for at least three consecutive reporting years. ,
- In the HEDIS®/QARR Access to Care domain, the MCO's rates for the *Children and Adolescents' Access to PCPs-12-24 Months, Adults' Access to Preventive/Ambulatory Services-(20-44 Years and 45-64 Years)* and *Annual Dental Visit (Ages 2-20)*, measures are above the statewide average for at least three consecutive

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

reporting years. The MCO's rate for *Timeliness of Prenatal Care* was also reported above the statewide average for 2018.

- The MCO reported a rate above the statewide average for the *Satisfaction with Provider Communication* measure of the CAHPS® member satisfaction survey for 2018.

Opportunities for Improvement

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

Opportunities for Improvement:

- In regard to the provider network indicators, 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 board certification rates for *Family Medicine* and *Internal Medicine* were below the statewide average for 2018, as well. The MCO has also reported rates below the statewide average for the percentage of providers in its Medicaid network for the following provider types: Other PCPs and Non-PCP Nurse Practitioners. In regards to Medicaid PCPs with an open panel, the MCO reported rates below the statewide average in 2018.
- In regards to Medicaid encounters, the MCO reported rates below the statewide average for Specialists.
- 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, 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 *Lead Screening in Children* was reported below the statewide average for 2018.
- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO's rate for the *Annual Monitoring for Patients on Persistent Medications—Total Rate* measure has been reported below the statewide average for at least three consecutive reporting years. Additionally, the MCO's rate for the *Comprehensive Diabetes Care – Nephropathy Monitor* measure has a reported rate below the statewide average for 2018.
- 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, 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.*
- The MCO demonstrates an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 8 citations from the operational surveys related to Organization and Management, Quality Assurance and Utilization Review. *(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. With the rate for breast cancer screenings and chlamydia screenings in women consistently below the statewide average, the MCO should continuously evaluate current interventions to determine how effective these interventions are at targeting women's health needs. In addition to women's health needs, the MCO should continue to conduct measure-specific barrier analysis to determine factors preventing members from seeking or receiving screening and diagnostic testing, such as cultural barriers that prevent members from seeking

care, member education on when screenings are recommended, or lack of available appointment times, and develop targeted initiatives to address identified barriers.

- While the MCO's rates for behavioral health measures has trended upwards, the MCO's rates continue to fall below the statewide averages. The MCO should continue its previously launched initiatives for addressing measures related to Behavioral Health medication adherence. The member and provider incentives, and the use of telehealth are very promising interventions added in 2018. The MCO should consider monitoring the effectiveness of these interventions and modify as needed. The MCO should also consider the use of pharmacists to provide education to members regarding behavioral health mediations.
- The MCO should work to address the citations received during the operation survey. The MCO should ensure that all protocols are followed in regard to utilization reviews. Training sessions or refresher courses should be given regarding the policy and procedures for processing standard appeals. The MCO should also re-train its vendor management staff to ensure all employees are following the standard operating procedures when dealing with delegates. *[Note: Recommendation to address citations received was a recommendation in the previous year's report..]*

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** The MCO 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.]

  MCO Response: MCO has launched over 40 project teams since 2015 dedicated to process improvement efforts for individual quality metrics across all lines of business. Using PDSA methodology, a barrier analysis is conducted, and new interventions are planned, developed and tested to measure effectiveness. 2018 new innovative pilots to address barriers of transportation and access included: Vendor partnership for mailing of FIT Tests to members with gaps in colorectal cancer screening; Partnerships with providers in scheduling members to use mobile mammography units; and MCO directly contracted with a mobile health clinic vendor to meet members where they are and perform services such as Breast Cancer Screening, Hemoglobin A1C and FIT testing, in communities where higher percentages of gaps exist. Late in December 2018 a member incentive pilot was launched for Spirometry testing and will be continued in 2019. Additionally, the MCO is advancing the use of digital platforms and technology to promote preventive care through social media channels and interactive care management applications. A media campaign was also conducted through a local Spanish radio station where interviews were conducted with MCO staff to address language barriers and promote preventive care. Lastly, through a partnership with one local school and our dental vendor we conducted dental health screenings during a recent fall event.

- **2017 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.]

MCO Response: Previously launched initiatives for addressing measures related to Behavioral Health medication adherence have shown improvement in rates over time and will be continued. In addition to member outreach and letters from MCO staff, new initiatives to address BH gaps in care include Embedded Care Manager on psychiatric inpatient unit at hospitals with higher volume of MCO members. This model has shown success and has been expanded to an inpatient Substance Use Rehab facility. The member incentive program launched in late 2018 also included BH measures: Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications and Metabolic Monitoring for Children and Adolescents on Antipsychotics, which resulted in several calls to the plan by members who were unaware of the need for these screenings. Additional BH measures are being added incrementally to the member incentive in 2019 and 2020 including Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up Care for Children Prescribed ADHD Medication. Medicaid Managed Care members are now also able to utilize behavioral health services through telehealth. Excellus has partnered with the vendor, MDLIVE, as of 1/1/19 to provide telehealth services. Considerations in development include behavioral health provider incentives and focus groups to educate on behavioral health quality metrics and advance continuity and coordination of care between physical health and mental health practitioners.

- **2017 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.]

  MCO Response: Barriers identified through direct outreach to parents identified a knowledge gap in that school sports physicals do not include all the recommended screenings as a routine well child visit. A large media campaign was launched during summer months and runs periodically throughout the school year with animated messaging around the importance of annual well visits and differences between a well visit and a sports physical. Teams of staff conduct ongoing targeted outreach to members with gaps in well child visits and assist with securing appointments and setting up transportation if needed. Several staff who conduct outreach are 'virtually' embedded into provider practices and able to directly schedule appointments for members. In addition to outbound calls, when a member calls in to our member services department there is an alert on the member account which identifies gaps in care so the representative can offer another reminder and offer to assist in scheduling an appointment.

- **2017 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.]

  MCO Response:

  - The MCO now requires vendors that conduct utilization review to submit proof of their current New York State Department of Health (DOH) and/or Department of Financial Services (DFS) registration.

The UM Compliance Administrator verifies proof of DOH and/or DFS utilization review agent registration during each utilization review delegate's annual oversight audit. In addition, the MCO houses each utilization review Delegate's DOH and/or DFS registration information in its internal tracking system which triggers a reminder six months prior to each utilization review delegate's DOH and/or DFS registration renewal date. At that time, the UM Compliance Administrator contacts the utilization review delegate to remind them of the upcoming utilization review agent registration renewal, monitors the utilization review delegate's agent renewal process to insure timely completion, and ensures that the current renewal documents are added to our internal tracking system.

- Member Services staff have been re-trained on addressing written and verbal requests for information from members. Internal audits are conducted to ensure continued compliance.
- The MCO continues initiatives included in the prior year's response regarding improvements to our provider directories. In addition, the following new initiatives have been implemented:

o Auto dialer software is used to confirm provider telephone numbers.
o A provider info validator tool is used by the Provider Relations Staff when making office visits.
o Internal Data Flux reports are used to compare provider data collected via claims with the data currently housed in our internal systems.
o Routine internal audits are conducted to verify provider information is captured correctly in the MCO's systems.

IX. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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