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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

FIDELIS CARE NEW YORK
[NEW YORK STATE CATHOLIC HEALTH PLAN, INC.]

Reporting Year 2017

FINAL REPORT

Published April 2019

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Acronyms Used in This Report

ALOS:	*Average Length of Stay*
AO:	*Area Office*
CFR:	*Code of Federal Regulations*
CHP:	*Child Health Plus*
CMS:	*Centers for Medicare and Medicaid Services*
COM:	*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:	*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*
OHIP:	*Office of Health Insurance Programs*
OPMC:	*Office of Professional Medical Conduct*
OP:	*Optimal Practitioner Contact*
OQPS:	*Office of Quality and Patient Safety*
PCP:	*Primary Care Practitioner/Provider*
PHSP:	*Prepaid Health Services Plan*
PIP:	*Performance Improvement Project*
PIHP:	*Prepaid Inpatient Health Plan*
PNDS:	*Provider Network Data System*
POC:	*Plan of Corrective Action*
PMPY:	*Per Member Per Year*
PTMY:	*Per Thousand Member Years*
PQI:	*Prevention Quality Indicator*
Q1:	*First Quarter (Jan.—March)*
Q2:	*Second Quarter (Apr.—June)*
Q3:	*Third Quarter (July—Sept.)*
Q4:	*Fourth Quarter (Oct.—Dec.)*
QARR:	*Quality Assurance Reporting Requirements*
ROS:	*Rest of State*
RY:	*Reporting Year*
SN:	*Safety Net*
SOD:	*Statement of Deficiency*
SS:	*Small Sample (less than 30)*
SSI:	*Supplemental Security Income*
SWA:	*Statewide Average*
TANF:	*Temporary Aid to Needy Families*
TR:	*Technical Report*
UR:	*Utilization Review*

I. About This Report

Purpose of This Report

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

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

History of the New York State Medicaid Managed Care Program

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

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

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

Scope of This Report

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

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

Structure of This Report

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

Section VII of this report provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's report. The MCO was given the opportunity to describe current 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 2017.

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

II. MCO Corporate Profile

Fidelis Care New York (Fidelis) is a statewide, not-for-profit prepaid health services plan (PHSP) that serves Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), and Managed Long-Term Care (MLTC) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

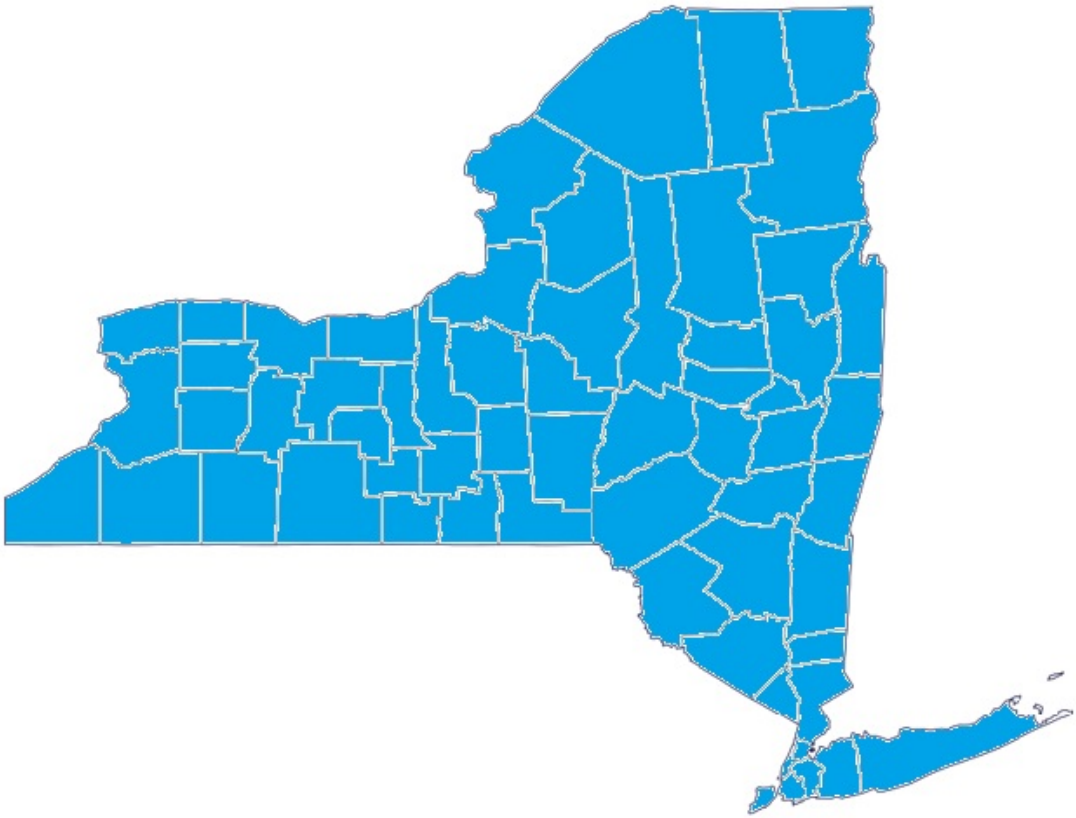
- Plan ID: 2060193
- DOH Area Office: MARO, WRO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: November 3, 1993
- Product Line(s): Medicaid (MCD), Child Health Plus (CHP), Managed Long-Term Care (MLTC), Health and Recovery Plan (HARP), Fully Integrated Duals Advantage (FIDA), Medicaid Advantage Plus (MAP), and Medicaid Advantage
- Contact Information: 95-25 Queens Blvd.
  Rego Park, NY 11374
  (718) 896-6500
- NCQA Accreditation Rating[2] (as of 10/15/18): Medicaid—Accredited
- Medicaid Dental Benefit Status: Mandatory

Participating Counties and Products

Albany:	MCD	CHP	HARP	**Allegany:**	MCD	CHP	HARP	**Bronx:**	MCD	CHP	HARP
Broome:	MCD	CHP	HARP	**Cattaraugus:**	MCD	CHP	HARP	**Cayuga:**	MCD	CHP	HARP
Chautauqua:	MCD	CHP	HARP	**Chemung:**	MCD	CHP	HARP	**Chenango:**	MCD	CHP	HARP
Clinton:	MCD	CHP	HARP	**Columbia:**	MCD	CHP	HARP	**Cortland:**	MCD	CHP	HARP
Delaware:	MCD	CHP	HARP	**Dutchess:**	MCD	CHP	HARP	**Erie:**	MCD	CHP	HARP
Essex:	MCD	CHP	HARP	**Franklin:**	MCD	CHP	HARP	**Fulton:**	MCD	CHP	HARP
Genesee:	MCD	CHP	HARP	**Greene:**	MCD	CHP	HARP	**Hamilton:**	MCD	CHP	HARP
Herkimer:	MCD	CHP	HARP	**Jefferson:**	MCD	CHP	HARP	**Kings:**	MCD	CHP	HARP
Lewis:	MCD	CHP	HARP	**Livingston:**	MCD	CHP	HARP	**Madison:**	MCD	CHP	HARP
Monroe:	MCD	CHP	HARP	**Montgomery:**	MCD	CHP	HARP	**Nassau:**	MCD	CHP	HARP
New York:	MCD	CHP	HARP	**Niagara:**	MCD	CHP	HARP	**Oneida:**	MCD	CHP	HARP
Onondaga:	MCD	CHP	HARP	**Ontario:**	MCD	CHP	HARP	**Orange:**	MCD	CHP	HARP
Orleans:	MCD	CHP	HARP	**Oswego:**	MCD	CHP	HARP	**Otsego:**	MCD	CHP	HARP
Putnam:	MCD	CHP	HARP	**Queens:**	MCD	CHP	HARP	**Rensselaer:**	MCD	CHP	HARP
Richmond:	MCD	CHP	HARP	**Rockland:**	MCD	CHP	HARP	**Saratoga:**	MCD	CHP	HARP
Schenectady:	MCD	CHP	HARP	**Schoharie:**	MCD	CHP	HARP	**Schuyler:**	MCD	CHP	HARP
Seneca:	MCD	CHP	HARP	**St. Lawrence:**	MCD	CHP	HARP	**Steuben:**	MCD	CHP	HARP
Suffolk:	MCD	CHP	HARP	**Sullivan:**	MCD	CHP	HARP	**Tioga:**	MCD	CHP	HARP
Tompkins:	MCD	CHP	HARP	**Ulster:**	MCD	CHP	HARP	**Warren:**	MCD	CHP	HARP
Washington:	MCD	CHP	HARP	**Wayne:**	MCD	CHP	HARP	**Westchester:**	MCD	CHP	HARP
Wyoming:	MCD	CHP	HARP	**Yates:**	MCD	CHP	HARP		MCD	CHP	HARP

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

Figure 1: Fidelis Map of Participating Counties



III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2015, 2016, and 2017, as well as the percent change from the previous year. Enrollment has increased from 2016 to 2017 by a rate of 4.5%. Fidelis' membership represents 27.9% 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—2015-2017

	2015	2016	2017
Number of Members	1,137,895	1,168,283	1,220,700
% Change from Previous Year		2.7%	4.5%
Statewide Total[1]	4,593,911	4,349,457	4,378,153
% of Total Medicaid Enrollment	24.8%	26.9%	27.9%

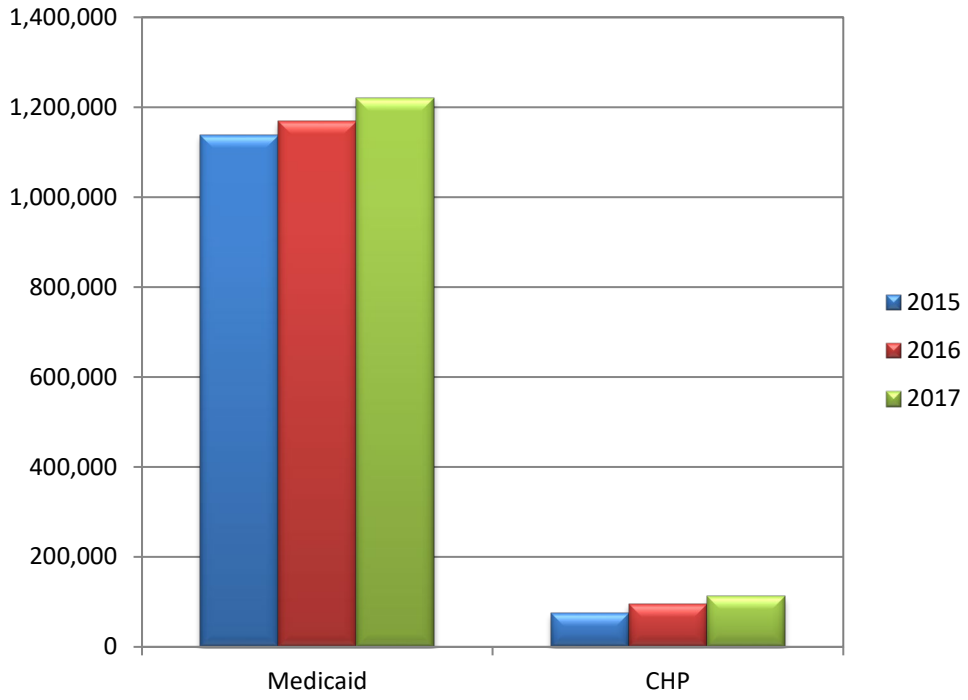
Data Source: MEDS II

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

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

	2015	2016	2017
CHP	75,583	95,403	112,613

Figure 2: Fidelis Enrollment Trends—All Product Lines



Provider Network

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

Network Adequacy Standards

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

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

Appointment Availability/Timeliness Standards

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

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

Travel Time and Distance Standards

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

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

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

Board Certification

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

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

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

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

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

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

Provider Type	2015		2016		2017	
	Fidelis	Statewide Average	Fidelis	Statewide Average	Fidelis	Statewide Average
Medicaid/CHP						
Family Medicine	84% ▲	77%	81% ▲	71%	81% ▲	72%
Internal Medicine	83% ▲	76%	81% ▲	75%	81% ▲	76%
Pediatricians	86% ▲	79%	84% ▲	78%	86% ▲	79%
OB/GYN	80% ▲	76%	80% ▲	75%	81% ▲	77%
Geriatricians	61%	63%	63%	63%	60%	63%
Other Physician Specialists	76%	76%	77% ▲	75%	79% ▲	76%

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

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

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

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

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

IV. Utilization

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

Encounter Data

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

Table 4: Medicaid Encounter Data—2015-2017

	Encounters (PMPY)					
	2015		2016		2017	
	Fidelis	Statewide Average	Fidelis	Statewide Average	Fidelis	Statewide Average
PCPs and OB/GYNs	5.21 ▲	4.12	3.85	3.85	3.63	3.56
Specialty	0.96 ▼	1.92	2.60	2.45	2.57	2.30
Emergency Room	0.50	0.54	0.50	0.54	0.53	0.55
Inpatient Admissions	0.12	0.14	0.14	0.14	0.14	0.14
Dental	1.16	0.99	1.16	1.03	1.15	1.02

Data Source: MEDS II
PMPY: Per Member Per Year

QARR Use of Services Measures

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

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

Measure	Medicaid/CHP			
	2015	2016	2017	2017 Statewide Average
Outpatient Utilization (PTMY)				
Visits	6,059 ▲	5,979 ▲	5,852 ▲	5,302
ER Visits	540	559	505	512
Inpatient ALOS				
Medicine	3.9	3.8	3.8	4.4
Surgery	5.4	5.4	5.5	6.2
Maternity	2.6	2.7	2.7 ▼	2.9
Total	3.8	3.8	3.8 ▼	4.3
Inpatient Utilization (PTMY)				
Medicine Cases	34	35	33	32
Surgery Cases	15	16	16	14
Maternity Cases	31	33	33	33
Total Cases	72	75	73	71

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).

Validation of Performance Measures

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

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

Summary of HEDIS® 2018 Information System Audit™

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

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

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

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

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

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

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

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

HEDIS®/QARR Performance Measures

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

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

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

Quality Indicators

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

Effectiveness of Care

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

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

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

COPD: Chronic Obstructive Pulmonary Disease

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

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

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

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

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

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Adult BMI Assessment	92	92 ▲	88	**86**
WCC—BMI Percentile	75	81	87	**84**
WCC—Counseling for Nutrition	76	84 ▲	84	**83**
WCC—Counseling for Physical Activity	73	75 ▲	74	**73**
Childhood Immunizations—Combo 3	71	71	74	**75**
Lead Screening in Children	86	82 ▼	88	**88**
Adolescent Immunizations—Combo 2[2]			37	**41**
Adolescents—Alcohol and Other Drug Use[3]	68	73	67	**67**
Adolescents—Depression[3]	57	61	59	**61**
Adolescents—Sexual Activity[3]	62	72	64	**65**
Adolescents—Tobacco Use[3]	76	81 ▲	73	**71**
Breast Cancer Screening	72	71	71	**71**
Colorectal Cancer Screening	61	57	61	**62**
Chlamydia Screening (Ages 16-24)	71 ▼	72 ▼	72 ▼	**74**
Testing for Children with Pharyngitis	91 ▲	93 ▲	93 ▲	**91**
Spirometry Testing for COPD	59 ▲	53	59 ▲	**55**
Use of Imaging Studies for Low Back Pain	73 ▼	67 ▼	72 ▼	**77**
Flu Shots for Adults (Ages 18-64)[4]	35 ▼	35 ▼	37 ▼	**42**
Advising Smokers to Quit[4]	69 ▼	69 ▼	84	**80**
Smoking Cessation Medications[4]	46 ▼	46 ▼	56	**59**
Smoking Cessation Strategies[4]	43	43	51	**51**

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

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

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

[3] NYS-specific measure.

[4] CAHPS® measure.

Acute and Chronic Care

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

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

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

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

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

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

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

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Pharmacotherapy Management for COPD—Bronchodilators	88	84	89	**88**
Pharmacotherapy Management for COPD—Corticosteroids	76	72 ▲	79 ▲	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	67	70 ▲	72 ▲	**69**
Medication Management for People with Asthma 50% (Ages 5-18)	56 ▲	59 ▲	61 ▲	**57**
Asthma Medication Ratio (Ages 19-64)	59 ▲	61 ▲	63 ▲	**57**
Asthma Medication Ratio (Ages 5-18)	68 ▲	70 ▲	73 ▲	**64**
Persistence of Beta-Blocker Treatment After a Heart Attack	86	92 ▲	92 ▲	**85**
CDC—HbA1c Testing	91	93	91	**91**
CDC—HbA1c Control (<8%)	61	61 ▲	64 ▲	**59**
CDC—Eye Exam Performed	65	67	72 ▲	**67**
CDC—Nephropathy Monitor	92	94	94	**93**
CDC—BP Controlled (<140/90 mm Hg)	70	68	59	**61**
Drug Therapy for Rheumatoid Arthritis	86 ▲	82	84	**83**
Monitor Patients on Persistent Medications—Total Rate	93 ▲	93 ▲	93 ▲	**92**
Appropriate Treatment for URI	95 ▲	96 ▲	96 ▲	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	31	35 ▲	36 ▲	**34**
HIV Viral Load Suppression[2,3]		76	76	**77**

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

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

[2] NYS-specific measure.

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

Behavioral Health

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

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

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

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

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

Measure	Medicaid/CHP			
	2015	2016	2017	2017 SWA
Antidepressant Medication Management—Effective Acute Phase	52	53 ▲	54 ▲	**52**
Antidepressant Medication Management—Effective Continuation Phase	36	37	38	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	61 ▲	59	59	**58**
Follow-Up Care for Children on ADHD Medication—Continue	69	67	67	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	85 ▲	80 ▲	79 ▲	**78**
Follow-Up After Hospitalization for Mental Illness—7 Days	71 ▲	66 ▲	63	**62**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	84 ▲	83	82	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	80	82	81	**81**
Antipsychotic Medications for Schizophrenia	62	63	64	**62**

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access to/Timeliness Indicators

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

Utilization

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

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

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

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

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

Measure	2015	2016	2017	2017 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	62 ▼	63 ▼	66 ▼	**68**
Well-Child Visits—3 to 6 Year Olds	82 ▼	83 ▼	84 ▼	**85**
Adolescent Well-Care Visits	63 ▼	67 ▼	66 ▼	**68**

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

Access to Care

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

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

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

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

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

Measure	Medicaid/CHP			
	2015	2016	2017	2017 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	97% ▲	98% ▲	98% ▲	**96%**
25 Months-6 Years	94% ▲	95% ▲	95% ▲	**94%**
7-11 Years	97%	97%	97%	**97%**
12-19 Years	95%	95%	96% ▲	**95%**
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	84% ▲	84% ▲	82%	**82%**
45-64 Years	90% ▲	90%	90%	**90%**
65+ Years	91%	91% ▲	92% ▲	**91%**
Access to Other Services				
Timeliness of Prenatal Care	91% ▲	90%	90%	**88%**
Postpartum Care	71%	72%	73%	**71%**
Annual Dental Visit[2]	61% ▲	62% ▲	62% ▲	**60%**

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

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

NYSDOH-Calculated Prenatal Care Measures

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

Table 8: QARR Prenatal Care Measures

Measure	2014		2015		2016	
	Fidelis	Regional Average	Fidelis	Regional Average	Fidelis	Regional Average
NYC						
Risk-Adjusted Low Birth Weight[1]	7%	6%	7%	6%	7%	6%
Prenatal Care in the First Trimester	73%	75%	77% ▲	75%	77%	76%
Risk-Adjusted Primary Cesarean Delivery[1]	13%	15%	14%	14%	15%	14%
Vaginal Birth After Cesarean	15% ▲	18%	22%	18%	22%	18%
ROS						
Risk-Adjusted Low Birth Weight[1]	6%	7%	7%	7%	7%	7%
Prenatal Care in the First Trimester	76% ▲	74%	74%	74%	74%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	15%	13%	13%	14%	12%	13%
Vaginal Birth After Cesarean	20%	13%	15%	14%	15%	14%

NYC: New York City; ROS: Rest of State

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

Member Satisfaction

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

Table 9: CAHPS®—2013, 2015, 2017

Measure	2013		2015		2017	
	Fidelis	Statewide Average	Fidelis	Statewide Average	Fidelis	Statewide Average
			Medicaid			
Flu Shots for Adults Ages 18-64	46	**44**	35 ▼	**40**	37 ▼	**42**
Advising Smokers to Quit	79	**78**	69 ▼	**80**	84	**80**
Getting Care Needed[1]	78	**78**	78	**79**	80	**79**
Getting Care Quickly[1]	77	**78**	76	**80**	80	**78**
Customer Service[1]	81	**82**	85	**84**	86	**86**
Coordination of Care[1]	74	**78**	73 ▼	**80**	75	**81**
Collaborative Decision Making[1]	49	**48**	73 ▼	**79**	82	**80**
Rating of Personal Doctor[1]	77	**78**	78	**80**	81	**81**
Rating of Specialist	72	**76**	75	**80**	80	**80**
Rating of Healthcare	71	**71**	69 ▼	**75**	78	**77**
Satisfaction with Provider Communication[1]	88	**89**	90	**91**	93	**91**
Wellness Discussion	65 ▼	**71**	65	**68**	81 ▲	**72**
Getting Needed Counseling/Treatment	67	**70**	71	**74**	70	**69**
Rating of Counseling/Treatment	60	**61**	56	**64**	57	**60**
Rating of Health Plan—High Users	74	**77**	70	**77**	77	**80**
Overall Rating of Health Plan	75	**76**	71 ▼	**76**	77	**76**
Recommend Plan to Family/Friends	93	**92**	91	**93**	94 ▲	**92**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2017

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

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

Table 10: Quality Performance Matrix—Measurement Year 2017

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

NYSDOH Quality Incentive

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

Table 11: Quality Incentive Points Earned—2015-2017

	2015		2016		2017	
	Fidelis	Statewide Average	Fidelis	Statewide Average	Fidelis	Statewide Average
Total Points *(150 Possible Points)*	93.7	75.2	128.0	92.5	111.8	87.9
PQI Points *(20 Possible Points)*	5.0	6.9	10.0	7.3	10.0	7.3
Compliance Points *(-20 Possible Points)*	-6.0	-3.6	-2.0	-2.3	-8.0	-7.2
Satisfaction Points *(30 Possible Points)*	10.0	20.0	20.0	15.7	15.0	15.7
Bonus Points *(6 Possible Points)*			6.0	6.0	6.0	6.0
Quality Points[1] *(100 Possible Points)*	84.7	56.0	94.0	66.4	88.8	66.1
Financial Incentive Award Designation[2]	Tier 2		Tier 1		Tier 2	

[1] Quality points presented here are normalized.

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

Table 12: Quality Incentive Measures and Points Earned—2017

Measure	MCO Points
PQI (10 points each)	**10.0**
Adult Prevention Quality Overall Composite (PQI 90)	5.0
Pediatric Quality Overall Composite (PDI 90)	5.0
Compliance (-4 points each, except where noted)	**-8.0**
MMCOR	0.0
MEDS	0.0
QARR	0.0
Access/Availability *(-2 points)*	-2.0
Provider Directory *(-2 points)*	-2.0
Member Services	-4.0
Satisfaction (10 points each)	**15.0**
Rating of Health Plan	5.0
Getting Care Needed	5.0
Customer Service	5.0
Bonus Points (6 points)	**6.0**
Telehealth Plan	6.0
Quality (3.33 points each)	**65.768**
Annual Dental Visit (Ages 2-18)	1.665
Antidepressant Medication Management	3.33
Breast Cancer Screening	2.498
Cervical Cancer Screening	1.665
Chlamydia Screening	1.665
Childhood Immunization Status—Combination 3	0.00
Colorectal Cancer Screening	2.498
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	3.33
Comprehensive Diabetes Care—Received All Tests	3.33
Controlling High Blood Pressure	3.33
Flu Shots for Adults	0.00
Immunizations for Adolescents—Combination 2	3.33
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3.33
Medical Assistance with Tobacco Cessation (Composite Rate)	1.665
Medication Management for People with Asthma (Ages 5-64)	3.33
Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	1.665
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	3.33
Weight Assessment and Counseling for Children and Adolescents	1.665
Well-Child Visits in the First 15 Months of Life—Five or More Visits	1.665
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1.665
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2.498
Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications	1.665
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	3.33
Follow-Up After Emergency Department Visit for Mental Illness—7 Days	3.33
Follow-Up After Hospitalization for Mental Illness—7 Days	3.33
Follow-Up for Children Prescribed ADHD Medication	1.665
Metabolic Monitoring for Children and Adolescents on Antipsychotics	0.00
Timeliness of Prenatal Care	2.498
Postpartum Care	2.498
HIV Viral Load Suppression	0.00
Total Normalized Quality Points[1]	**88.8**
Total Points Earned	**111.8**

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

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

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

Performance Improvement Project

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

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

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

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

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

Fidelis' 2017-2018 PIP topic was *"Improving Perinatal Care and Reducing Preterm Birth"*. During 2017, the MCO implemented the following interventions:

Member-Focused Interventions:

- Members will be categorized into three groups in order to target specific interventions tailored for their situation. "Arm A" will include members referred to the High Risk OB Team and were identified as having a history of preterm birth. "Arm B" will include members referred to the High Risk OB Team for positive screenings for depression, substance abuse, and/or tobacco use. "Arm C" will include members who screened positive for smoking but do not have any other high risk factors.
- Members in "Arm A" will receive the following targeted interventions:
    - Assessment of member history of preterm birth;
    - Advice and assistance to consult their provider on the benefits and authorization of 17P, and assess the members' access to 17p;
    - Referral to BabyCare Case Management; and
    - Mailing of a "No Contact" letter after three unsuccessful attempts at outreach.
- Members in "Arm B" will receive the following targeted interventions:
    - Assessment of depression, substance use, and/or tobacco use status;
    - Advice and assistance to consult their provider on the benefits of depression management, abstaining from drugs/alcohol during pregnancy, and quitting smoking and cessation counseling;
    - Referrals and follow up with Behavioral Health Case Management for care coordination; and
    - Mailing of a "No Contact" letter after three unsuccessful attempts at outreach.
- Members in "Arm C" will receive the following targeted interventions:
    - Assessment of tobacco use;
    - Advice and assistance to consult their provider on the benefits of quitting smoking and cessation counseling;
    - Case management, including advice to quit, assistance with the creation of a quit plan, establishment of milestones, benefits information, referrals to the Quitline for smoking cessation counseling, and ongoing monthly support and follow-up;
    - Educational materials for perinatal care and prevention of preterm births, a resource guide, and referrals to smoking cessation counseling classes in the members' area; and
    - Mailing of a "No Contact" letter after three unsuccessful attempts at outreach.

Provider-Focused Interventions:

- Educational materials will be mailed to high-volume OB/GYN and Family Practitioners with information on the requirement of performing comprehensive risk assessments; standardized valid tools to monitor and evaluate pregnancy-related risk factors; specific diagnostic codes to use for billing for screening services and 17P prescriptions; guidelines on how counseling for members; details on benefits covered by the MCO; and a checklist of fields required in the referral form to help with early identification of high-risk pregnant members.
- Letters will be mailed to OB/GYN and Family Practitioners that include members' prenatal care plans, along with a request that the members receive the required referral and counseling services, and education on the tools and processes to use for screening for depression, along with tobacco and alcohol assessments and the use of appropriate billing codes.
- All educational materials will be posted to the MCO's provider website for providers to access the information online.
- Propose to collaborate with Provider Relations to identify and target the top OB/GYN and Family Practitioners providing services to the high-risk population and provide ongoing education on all necessary information.

MCO-Focused Interventions:

- Update CCA to create reportable fields that capture and track data for early identification of preterm births from different data sources, along with other indicators relevant for perinatal case management.
- Develop educational materials and communication strategies for OB/GYNs and Family Practitioners.

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

Table 13: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Use of 17p	21.6%		31.4%	
Depression Screening	34.1%		39.1%	
Substance Use Screening	73.9%		78.9%	
Screening for Tobacco Use	77.4%		82.4%	
Follow-Up for Positive Tobacco Use Screening	78.4%		83.4%	

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

VI. Structure and Operation Standards[6]

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

Fidelis was in compliance with 11 of the 14 categories. The categories in which Fidelis was not compliant were Disclosure (3 citations), Organization and Management (4 citations), and Service Delivery Network (2 citations).

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

Table 14: Focused Review Types

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

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

Table 15: Summary of Citations

Category	Operational Citations[1]	Focused Review Citations
Complaints and Grievances		0
Credentialing		0
Disclosure		3
Member Services Phone Calls		*1*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Family Planning		0
HIV		0
Management Information Systems		0
Medicaid Contract		0
Medical Records		0
Member Services		0
Organization and Management		4
Access and Availability		*2*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Prenatal Care		0
Quality Assurance		0
Service Delivery Network		2
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Utilization Review		0
Total	**—**	**9**

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

VII. Strengths and Opportunities for Improvement[7]

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

Strengths:

- The MCO has reported rates above the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *Family Medicine, Internal Medicine, Pediatricians,* and *OB/GYN*. Additionally, the *Board Certification* rate for *Other Physician Specialists* was reported above the statewide average for 2017.
- In the HEDIS®/QARR Effectiveness of Care domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for *Appropriate Testing for Children with Pharyngitis*, while the MCO's rate was above the statewide average for 2017 for *Use of Spirometry Testing in the Assessment and Diagnosis of COPD.*
- The MCO performed well for the HEDIS®/QARR Acute and Chronic Care domain. Rates for the following measures have been reported above the statewide average for at least three consecutive reporting years: *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18), Asthma Medication Ratio (Ages 19-64), Asthma Medication Ratio (Ages 5-18), Annual Monitoring for Patients on Persistent Medications—Total Rate,* and *Appropriate Treatment for Children with Upper Respiratory Infection.* Additionally, rates for the following measures were reported above the statewide average for 2017: *Pharmacotherapy Management of COPD Exacerbation—Corticosteroids, Medication Management for People with Asthma 50% of Days Covered (Ages 19-64), Persistence of Beta-Blocker Treatment After a Heart Attack, Comprehensive Diabetes Care—HbA1c Control (<8.0%), Comprehensive Diabetes Care—Eye Exam (Retinal) Performed,* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.*
- In the HEDIS®/QARR Behavioral Health domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for the *Follow-Up After Hospitalization for Mental Illness—30 Days* measure, while the MCO's rate for *Antidepressant Medication Management—Effective Acute Phase Treatment* was above the statewide average for 2017.
- In the domain of Access to Care, the MCO has reported rates above the statewide average for at least three consecutive reporting years for the *12-24 Months* and *25 Months-6 Years* age groups of the HEDIS®/QARR *Children and Adolescents' Access to Primary Care Practitioners* measure, as well as the *Annual Dental Visit (Ages 2-20)* measure. Additionally, rates for *Children and Adolescents' Access to Primary Care Practitioners—12-19 Years* and *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* were reported above the statewide average for 2017.
- The MCO reported rates above the statewide average on the 2017 CAHPS® member satisfaction survey for *Wellness Discussion* and *Recommend Plan to Family/Friends.*

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

Opportunities for Improvement:

- The MCO continues to demonstrate 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 *Chlamydia Screening in Women (Ages 16-24), Use of Imaging Studies for Low Back Pain,* and *Flu Shots for Adults (Ages 18-64)* measures. *(Note: Chlamydia Screening in Women (Ages 16-24), Use of Imaging Studies for Low Back Pain, and Flu Shots for Adults (Ages 18-64) were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in regard to well-care visits for children and adolescents. The MCO's rates for *Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits* have been reported below the statewide average for at least three consecutive reporting years. *(Note: Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; and Adolescent Well-Care Visits were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 9 citations from the focused review surveys related to Disclosure, Organization and Management, and Service Delivery Network. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO should continue to work to improve the HEDIS®/QARR measures that consistently perform below average. The MCO should evaluate its current initiatives for effectiveness and modify its strategy where necessary. *[Repeat recommendation.]*
- The MCO should conduct thorough population-specific barrier analyses to inform intervention strategies aimed at improving well-child visit rates. Additionally, the MCO should consider conducting county- or region-specific barrier analyses for these measures to identify if there is a region that is performing lower than the others and target interventions for that region. *[Repeat recommendation.]*
- The MCO should continue to work to address issues identified in the focused review surveys. First, the MCO should re-train its Member Services staff to ensure all staff members are aware of proper procedures when responding to members' requests for information. Second, the MCO should continue its efforts to improve the information included in its provider directories to ensure accuracy of provider data and to ensure members have appropriate access to care. *[Repeat recommendation.]*

Response to Previous Year's Recommendations:

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

- **2016 Recommendation:** Fidelis should work with its vendor to ensure that all required HEDIS®/QARR measures are properly coded so that the MCO is able to report all required rates.

  MCO Response: Fidelis continued to work closely with its HEDIS®/QARR software vendor, General Dynamics (GDIT). GDIT committed to more frequent client updates, more resources dedicated to quality control, and to increase development resources. In January 2018, General Dynamics' clinical software division was sold to Verscend, Inc. The CEO Verscend communicated to Fidelis the need to improve quality control and to increase development resources for the old General Dynamics software. Fidelis was above to submit all measures in HEDIS® 2018 (reporting year 2017) on time and the software passed all audit requirements.

- **2016 Recommendation:** As the MCO did not meet the 75% compliance threshold for most of the call types included in the Primary Care and OB/GYN Access and Availability Survey, Fidelis should take steps to ensure that providers in its network are aware of and understand the timeliness standards for appointment availability and that all providers in the network have appropriate after-hours access.

  MCO Response: Fidelis Care implemented its Plan of Correction related to the Primary Care and OB/GYN Access and Availability Survey and continued to educate providers on the timeliness and access standards. Fidelis Care initiated the following activities: referenced/published access and availability standards in sections three and four of the provider manual; provider tip sheet created specifically outlining all of the access and availability standards (available on Fidelis Care's public website); published articles in the Fidelis Provider Bulletin concerning access and availability requirements; the inclusion of access and availability standards on each monthly Primary Care Provider membership roster; reinforcement of the access and availability standards during all meetings with providers and during site visits by Fidelis Care's Provider Relations staff; availability of all information on Fidelis Care's website and in the Provider Manual. As required, Fidelis Care administers yearly access and availability surveys and has demonstrated significant improvement in its scores. Providers identified as not compliant at the time of the survey are educated on access and availability standards.

- **2016 Recommendation:** The MCO should continue to work to improve the HEDIS®/QARR rates that consistently perform below average. As several of these measures are related to access to primary and preventive care for children and adolescents, the MCO should conduct a thorough barrier analysis for these populations to determine factors that prevent members from seeking or receiving primary care visits and develop interventions to address identified barriers. *[Repeat recommendation.]*

  MCO Response: In accordance to the Mission of Fidelis Care to promote health through quality, accessible care and services for all, Fidelis Care has implemented multiple initiatives to continuously improve HEDIS®/QARR and CAHPS® measure rates that perform below the statewide average (SWA). Fidelis Care continues to focus on both statewide campaigns and regionally focused initiatives to improve the Plan's HEDIS®/QARR performance.

  1. **HEDIS®/QARR Improvement Efforts:** Strategies employed to improve the Plan's HEDIS®/QARR measure performance include supplemental database, print media, educational visits with providers, and member/provider outreach. Initiatives to improve the HEDIS®/QARR measure rates were bundled into multi-measure projects as well as measure specific projects.

  2. **HEDIS®/QARR Project Sponsors Work Group:** The Work Group meets weekly to work on all aspects of HEDIS®/QARR including: monthly rate report analysis, planned outreach and incentive opportunities targeting providers and members, and identifies and addresses status of supporting technical components. The group is designed as a cross-departmental approach to quality improvement and includes representation from pharmacy, clinical services, behavioral health, quality management, vendor delegation and oversight, provider relations, IT and communications. Findings and activities of this group are reported to the QARR Steering Committee.

  3. **QARR Steering Committee:** The Committee meets weekly and is made up of Fidelis Care Executive Leadership who provide guidance on key issues, objectives, and decisions. The work of the Project Sponsors team is used to inform the committee members via monthly rate report analysis and significant HEDIS®/QARR updates and initiatives. HEDIS®/QARR measure reports are calculated monthly and presented to the Committee. Weekly meetings are held to monitor the effectiveness of

interventions to assure that the measures below the SWA thresholds improve over time and the measures above the SWA are maintained.

4. **HEDIS®/QARR Noncompliance Reports/Fail Lists:** Monthly rate reports are generated which support targeted outreach to providers and members. Individual provider non-compliance reports are posted to the provider portal monthly to help providers identify patients in need of services and to encourage compliance. A letter version of the non-compliance reports are mailed to providers every other month as additional support. Clinical Services utilize monthly fail lists to focus phone outreach, encouraging member compliance and when necessary and/or requested to assist in appointment scheduling.

5. **Member and Provider Outreach:** Member outreach includes outbound calls to encourage members to adhere to quality preventative measures such as colorectal and breast cancer screening, well child/adolescent care and immunizations. Member outreach was also conducted to identify potential gaps in behavioral health care treatment and services.

   Provider outreach includes provider mailings with focused prospective reports in addition to routine report cards and non-compliance reports so that providers can take action to ensure members receive preventive care services. Provider site visits are also conducted as a part of the outreach. The Plan's Provider Quality Specialists (PQS) continue to conduct site visits to review report cards, discuss specific measures such as colorectal cancer screening; well-child/adolescent care and immunizations; chlamydia screening.

6. **Focused HEDIS®/QARR Improvement Projects:**

   <u>Colorectal Cancer Screening (COL) and Breast Cancer Screening (BCS) Improvement Projects</u>
   Ongoing collaborative partnership with the NYSDOH for improving the COL and BCS rates in the Adirondack/North Country counties. The targeted interventions included: member outreach with co-branded educational materials, reminder letters and phone calls; provider education through a professional conference and provider site visits by the Plan's PQS providing educational printed materials aimed at improving screening rates. Despite the Plan's collaborative partnership and improvement initiatives with the NYSDOH along with additional member/provider improvement efforts, the Plan rates for COL and BCS are below SWA.

   <u>Adult Smoking Cessation Improvement Project</u>
   Following the Performance Improvement Project in 2016 there were continued initiatives to target smoking cessation on multiple levels that included: enhanced identification of smokers; member and provider education to support the utilization of smoking cessation benefits, a smoking cessation resource guide was created and uploaded to the provider portal and Fidelis website. The Plan demonstrated marked improvement in the following two measures: 91) Advising Smokers to Quit with a rate of 69.31 (MY 2015) to a rate of 83.87 (MY 2017) that is above the SWA of 79.80; (2) Discussing Smoking Cessation Strategies with a rate of 43.43 (MY 2015) to a rate of 50.79 (MY 2017) that is above the SWA of 50.63. The Plan also demonstrated improvement in Discussing Smoking Cessation Medications with a rate of 46.08 (MY 2015) to a rate of 56.45 (MY 2017) that is below the SWA of 59.43. The Plan will include strategies for continued improvement with focus on achieving the SWA for Discussing Smoking Cessation Medications by developing an action plan with implementation of improvement initiatives.

   <u>Flu Shots for Adults Improvement Project</u>

The Flu Shot for Adults (ages 18-64) interventions include: promotion on the phone tree hold message, provided member education to raise awareness and encourage receiving the flu shot in newsletters and on the fidelis.org website. Additionally, the Plan provided flu shot clinics in NYC where 64% of attendees had not previously received a flu shot. The Plan demonstrated improvement in the Flu Shot for Adults rate from 35.22 (MY 2015) to 36.91 (MY 2017) that is below SWA. The Plan will include strategies for continued improvement with focus on achieving the SWA for Flu Shot for Adults by developing an action plan with implementation of improvement initiatives.

Quality Performance Matrix

The below table outlines the 2017 Quality Performance Matrix measures and activities

Program Goal: Improve QARR measures quality of care performance:			
Implementation Activities			
Measure	***Baseline**	**Goal**	**Result (2017 MY)**
1. Chlamydia Screening (Ages 21-24)	Benchmark—2016 MY SWA 75.92% Baseline 73.32% (2016 MY)	Achieve Medicaid 50th percentile compliance rate of 75.2%.	73.76% Result increase over baseline/below goal
2. Childhood Immunization Status (Combo 3)	Benchmark—2016 MY SWA 74.42% Baseline 70.56% (2016 MY)	Improve Childhood Immunization Status (Combo 3) above the SWA to 75%.	74.21% Result increased over baseline/below goal
3. Use of Imaging Studies for Low Back Pain	Benchmark—2016 MY SWA 77.87% Baseline 66.83% (2016 MY)	Achieve Medicaid 50th percentile compliance rate of 71.9%.	72.33% Goal met
Root cause (summary): Root cause analysis revealed factors contributing to the measures low performance; factors include: policies, people, provisions, and or other.			
Key barriers (summary): Chlamydia Screening Ages 21-24 (barriers: people, provisions), CIS Combo 3 (barriers: people, provisions), Use of Imaging Studies for Low Back Pain (barriers: people, provisions)			
Corrective Action (summary): All corrective action plans proposed were implemented in support of addressing the identified barriers.			
Next Steps (summary): Continue to assess effectiveness of corrective actions and monitor measure performance. Evaluate results for continued improvement.			

1. The Chlamydia Screening in Women (21-24 years) (CHL) rate did not met the goal. However, there has been a noted year over year improvement since MY 2014. Implemented interventions included: provider outreach was conducted for providers with low compliance rates; targeted education and communications for provider groups based on region with focus on quality improvement is ongoing with support from the Provider Relations staff. The CHL (21-24 years) targeted measure improvement

will be continued in the upcoming year. The project team will evaluate interventions to determine best practice for ongoing/new interventions.

2. The Childhood Immunization Status (Combo 3) rate did not meet the goal but has demonstrated a marked improvement. Implemented interventions included: provider outreach was conducted for providers with low compliance rates with focus on low performing regions; targeted education and communications for parents/caregivers of children at birth through 2 years of age with monthly reminder postcards sent 9 months prior to the child's second birthday. The project team will evaluate interventions to determine best practice for ongoing/new interventions and will develop/implement improvement initiatives to improve the Adolescent Immunizations (Combo 2) rate in the upcoming year.

3. The Use of Imaging Studies for Low Back Pain (LBP) exceeded the goal. Implemented interventions included: LBP noncompliance analysis and outreach to high volume providers who over utilize imaging studies (not consistent with the recommended guidelines), provider education regarding imaging study recommended guidelines through a LBP announcement and Tip Sheet on the Fidelis Provider Portal. Monitoring and evaluation of measure performance will continue in the upcoming year.

- **2016 Recommendation:** Fidelis should continue to work to address the issues identified in the operational and focused review surveys. The MCO should take steps to ensure that all MCO and delegated vendor Utilization Review materials and notification letters contain the correct information and required language. Additionally, the MCO should continue its efforts to improve the accuracy of the information included in the provider directories, as well as members' access to timely appointments. *[Repeat recommendation.]*

  MCO Response: Fidelis Care regularly monitored the implementation of the Plan of Correction submitted to the New York State Department of Health related to utilization review materials and notification letters. The issues identified in the operational reviews were corrected and did not reoccur during the focused review. Fidelis implemented the new utilization review determination notices (438 Mega Rule) in 2018. Fidelis Care's Vendor Oversight Department regularly monitors vendor compliance with utilization review and notices on a weekly basis.

  Fidelis Care continues work to improve the accuracy of the information included in the provider directories. The online attestation process, by which our providers can attest to the accuracy of the information in the directories is not available all year and is promoted quarterly. In 2018, this promotion was expanded to include the Fidelis Care phone tree, so that providers who call Fidelis Care are also aware of the attestation process. A provider data quality project has also been formed, with the team leveraging other sources of information such as LexisNexis and CAQH to verify the accuracy of the information in our directories. Provider Relations has conducted education on the importance of maintaining accurate provider demographic information and included an article in the Provider Bulletin, 2018 volume 4 issue 3.

VIII. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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