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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

HEALTH INSURANCE PLAN OF GREATER NEW YORK, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

Health Insurance Plan of Greater New York, Inc. (HIP) is a regional, not-for-profit health services corporation that is licensed to operate a health maintenance organization (HMO). HIP serves Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Commercial (COM), and Medicare populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP and Commercial product lines.

EmblemHealth (HIP) Web Page: https://www.emblemhealth.com/

*Participating Regions and Products[1]			
Central[2]:			COM
Hudson Valley[3]:	MCD	CHP	COM
Long Island:	MCD	CHP	COM
Northeast[4]:			COM
New York City:	MCD	CHP	COM

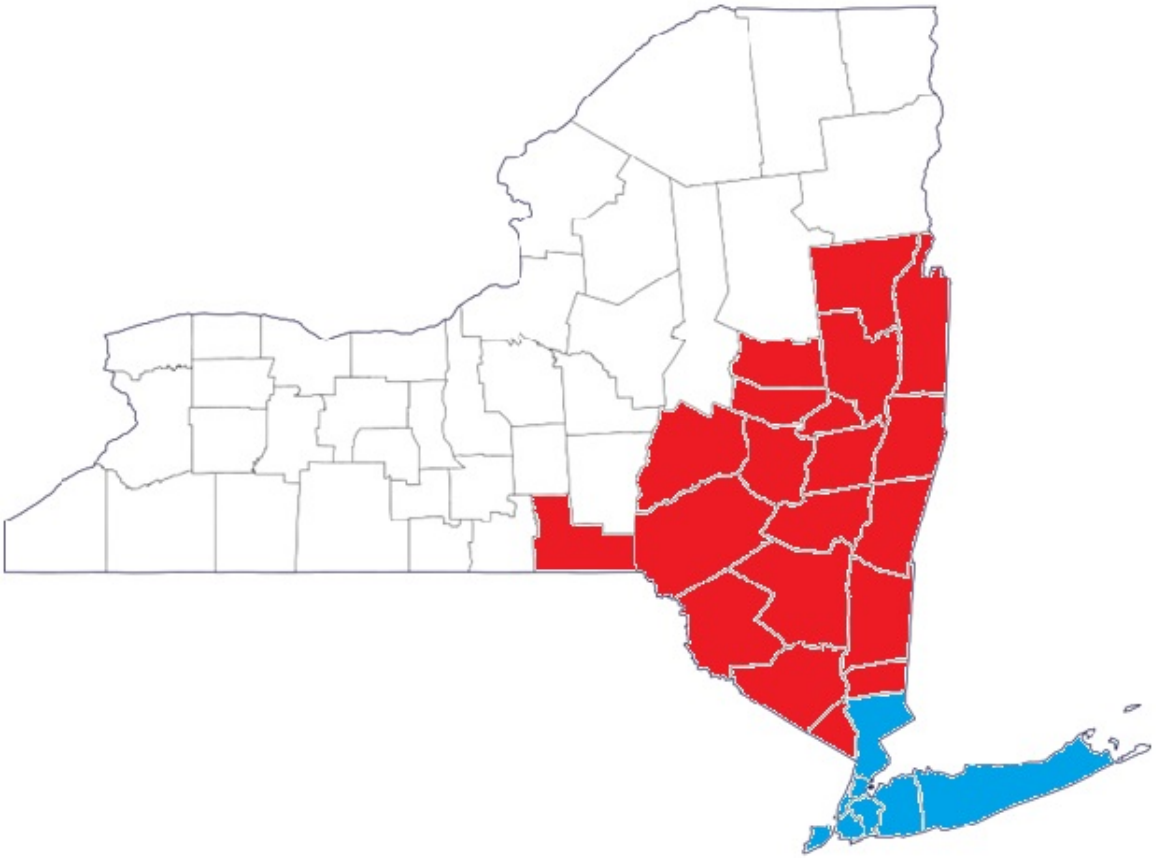
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

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

[1] Note that the HARP product line is available in all counties that serve the Medicaid population.
[2] EmblemHealth participates in Broome County only.
[3] EmblemHealth participates in COM only in all counties except Westchester. MCD, CHP and COM are offered in Westchester County.
[4] EmblemHealth participates in Albany, Columbia, Delaware, Fulton, Greene, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

Figure 1: HIP Map of Participating Counties



Note: Counties shaded in blue serve the Medicaid, CHP, and HARP populations, while the counties shaded in red serve the Commercial population only. The Commercial product line is also available in all counties in which the MCO operates.

III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has decreased from 2017 to 2018 by a rate of 8.0%. HIP's membership represents 3.0% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	168,855	141,780	130,406
% Change from Previous Year		-16.0%	-8.0%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	3.9%	3.2%	3.0%

Data Source: NYS OHIP Medicaid DataMart

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

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

	2016	2017	2018
CHP	10,803	10,437	10,219
Commercial	305,828	284,882	292,381

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: HIP Enrollment Trends—All Product Lines

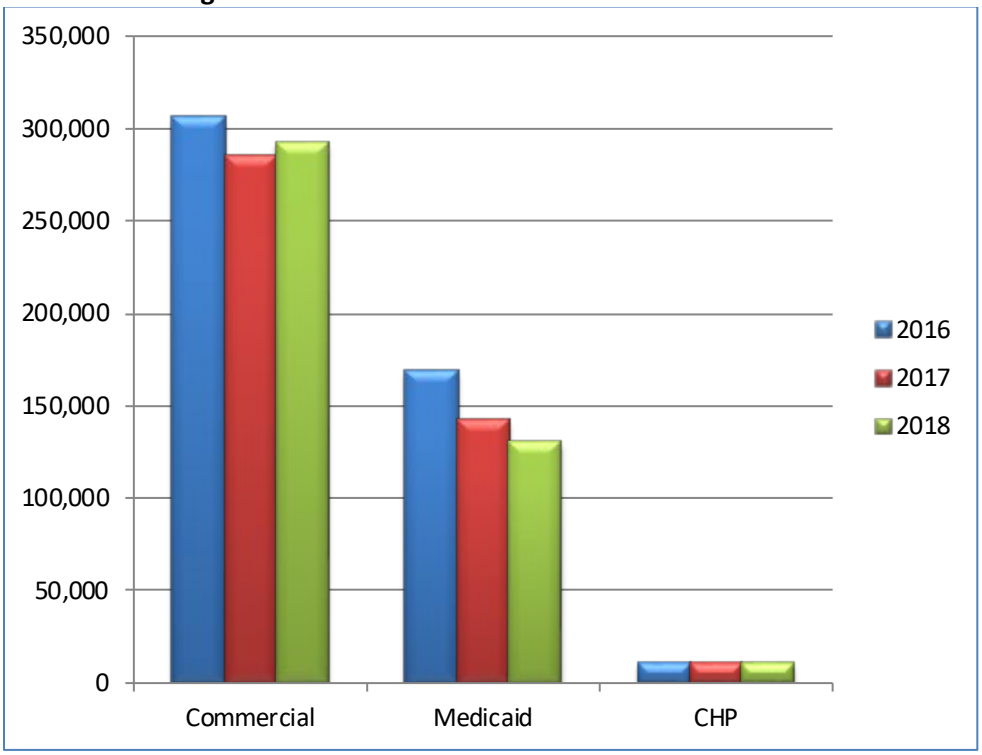


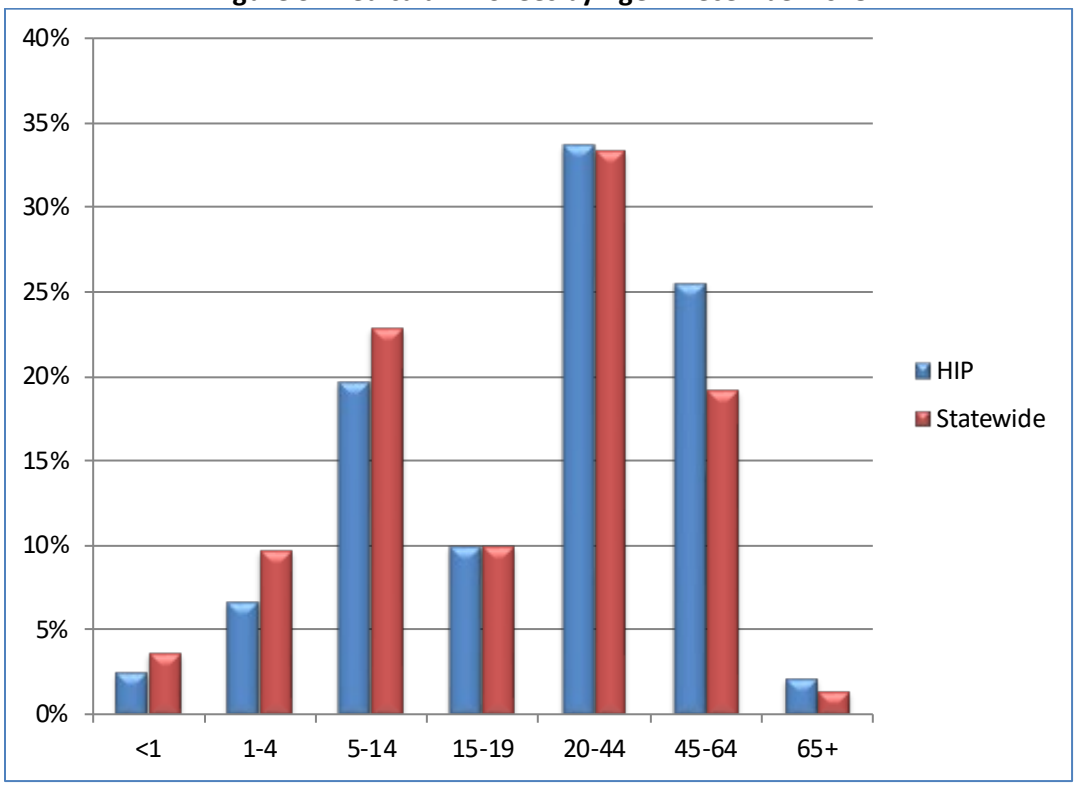
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average (SWA). In 2018, the MCO had rates below the SWA for 3 out of 6 age groups.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	1,671	1,565	3,236	2.5% ▼	3.6%
1-4	4,440	4,177	8,617	6.6% ▼	9.7%
5-14	13,170	12,266	25,436	19.6% ▼	22.8%
15-19	6,510	6,343	12,853	9.9%	9.9%
20-44	17,437	26,265	43,702	33.7%	33.3%
45-64	13,933	19,030	32,963	25.4% ▲	19.1%
65 and Over	910	1,886	2,796	2.2% ▲	1.4%
Total	58,071	71,532	129,603		
Under 20	25,791	24,351	50,142	38.7% ▼	46.1%
Females 15-64		51,638		39.8% ▲	34.7%

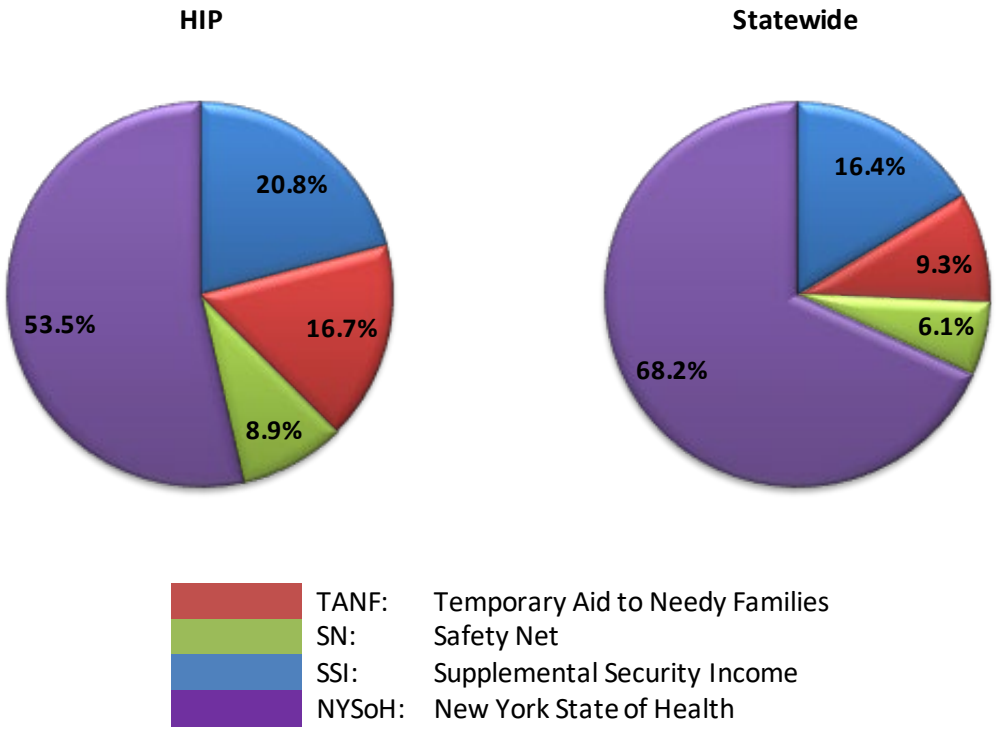
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



A breakdown of MCO membership by aid category, as reported by the NYSDOH for December 31, 2018, is shown in **Figure 3**.

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR Board Certification rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. For detailed information regarding board certification of providers, please see the All Plan Summary Report. In 2018, HIP's rates trended downwards for most provider types.

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

Provider Type	2016		2017		2018	
	HIP	Statewide Average	HIP	Statewide Average	HIP[1]	Statewide Average
Medicaid/CHP						
Family Medicine	66% ▼	71%	75%	72%	71%	74%
Internal Medicine	71% ▼	75%	75%	76%	72%	76%
Pediatricians	74% ▼	78%	76% ▼	79%	74%	80%
OB/GYN	72%	75%	74% ▼	77%	73%	80%
Geriatricians	68%	63%	72% ▲	63%	67%	63%
Other Physician Specialists	70% ▼	75%	75%	76%	74%	77%
Commercial						
Family Medicine	68% ▼	74%	76%	77%	73%	72%
Internal Medicine	71% ▼	73%	75% ▼	77%	72%	73%
Pediatricians	74% ▼	77%	78%	79%	76%	75%
OB/GYN	73% ▼	78%	77% ▼	79%	73%	78%
Geriatricians	65%	63%	69%	69%	65%	66%
Other Physician Specialists	71% ▼	78%	76% ▼	79%	75%	77%

[1]Level of significance was unaudited

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. HIP's rates for Pediatricians, OB/GYN specialists and Dentists were above the SWA in 2018.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	6,549	19.8	19.5
Pediatrics	1,737	5.3 ▲	3.8
Family Practice	1,108	3.4	3.5
Internal Medicine	3,309	10.0	8.4
Other PCPs	395	1.2 ▼	3.8
OB/GYN Specialty[1]	1,658	5.0 ▲	3.8
Behavioral Health	5,375	16.3	17.2
Other Specialties	14,331	43.4	46.0
Non-PCP Nurse Practitioners	1,810	5.5	8.7
Dentistry	3,328	10.1 ▲	4.9
Total	33,051		

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

	HIP			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	20:1	6,436	20:1	42:1	80,986	42:1
Pediatrics (Under age 20)	29:1			70:1		
OB/GYN (Females age 15-64)	31:1			59:1		
Behavioral Health	24:1			73:1		

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

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

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

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

	2016			2017			2018		
	HIP		Statewide	HIP		Statewide	HIP		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
					Medicaid				
Providers with Open Panel	5,815	97.9	85.0	5,987	97.9	95.7	6,366	98.9	90.8

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

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

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

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
50	34	**68%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 33 providers (total number of providers who were compliant for participation (34), less total number of providers with closed panels (1)). HIP performed above the threshold for Routine and After-Hours Access call types.

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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	6	6	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	**12**	**11**	**91.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	6	5	83.3%
	Pediatrician	4	3	75.0%
	OB/GYN	1	0	0.00%
	Total Non-Urgent	**11**	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	4	4	100.0%
	OB/GYN	2	1	50.0%
	Total After-Hours	**10**	**8**	**80.0%**

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

IV. Utilization

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

Encounter Data

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

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	HIP	Statewide Average	HIP	Statewide Average	HIP	Statewide Average
PCPs and OB/GYNs	3.91	3.85	3.73	3.56	3.40	3.50
Specialty	2.43	2.45	2.41	2.30	2.31	2.33
Emergency Room	0.47	0.54	0.49	0.55	0.44	0.53
Inpatient Admissions	0.15	0.14	0.14	0.14	0.14	0.13
Dental	0.85	1.03	0.77	1.02	0.79	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

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

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	HIP	SWA	HIP	SWA	HIP	SWA
	Medicaid					
Enrollee Health Screenings	22.4%	12.3%	46.8% ▲	12.7%	21.8%	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). 50% of HIP's rates for Use of Services measures have trended downwards in 2018.

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

	Medicaid/CHP				Commercial			
Measure	2016	2017	2018	2018 Statewide Average	2016	2017	2018	2018 Statewide Average
Outpatient Utilization (PTMY)								
Visits	5,198	5,054	4,709	5,317	4,527	4,430	4,290	4,209
ER Visits	450	392	387	492	261	232	216	204
Inpatient ALOS								
Medicine	4.7 ▲	4.6 ▲	4.4	4.5	4.5 ▲	4.6 ▲	4.3 ▼	3.5
Surgery	4.9 ▼	4.9 ▼	6.6	7.0	5.0	5.2	5.9 ▲	4.4
Maternity	3.0	3.1 ▲	3.2 ▲	2.9	3.2 ▲	3.2 ▲	3.2 ▲	2.6
Total	4.7 ▲	4.8	4.6	4.4	4.4 ▲	4.6 ▲	4.6 ▲	3.6
Inpatient Utilization (PTMY)								
Medicine Cases	28	26	37	30	23	21	26 ▲	17
Surgery Cases	21 ▲	20	15	12	16	16	15	15
Maternity Cases	5 ▼	5 ▼	20	32	11	10	11	12
Total Cases	67	63	67	66	49	46	50	42

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

V. Performance Indicators

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

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

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

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

HEDIS®/QARR Performance Measures

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

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

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

Quality Indicators

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

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, although the MCO had three rates below the SWA, 86% of the rates have trended upwards.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	89	77 ▼	81 ▼	**89**	82	77 ▼	86	**89**
WCC—BMI Percentile	80	77 ▼	81 ▼	**86**	74	71 ▼	80 ▼	**90**
WCC—Counseling for Nutrition	80	75 ▼	79	**83**	74	67 ▼	74 ▼	**87**
WCC—Counseling for Physical Activity	72	66 ▼	71	**74**	66 ▼	58 ▼	66 ▼	**80**
Childhood Immunizations—Combo 3	71	68 ▼	70	**73**	77	72 ▼	72 ▼	**84**
Lead Screening in Children	86	85	85	**89**	85	88	83 ▼	**88**
Adolescent Immunizations—Combo 2[2]		28 ▼	39	**43**		27	34	**31**
Adolescents—Alcohol and Other Drug Use[3]	75	68	71	**70**	72	57 ▼	65 ▼	**78**
Adolescents—Depression[3]	70 ▲	61	69	**67**	65	54 ▼	61 ▼	**70**
Adolescents—Sexual Activity[3]	77 ▲	65	66	**67**	69	55 ▼	61 ▼	**74**
Adolescents—Tobacco Use[3]	76	70	74	**74**	74	63 ▼	68 ▼	**82**
Breast Cancer Screening	70	67 ▼	67 ▼	**71**	75 ▲	74 ▼	72 ▼	**77**
Colorectal Cancer Screening	57	60	63	**63**	68	64	70	**71**
Chlamydia Screening (Ages 16-24)	76	75	76	**76**	79 ▲	76 ▲	75 ▲	**60**

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

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

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

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

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, 50% of HIP's Acute and Chronic Care rates trended upwards for the Medicaid product line.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	87 ▼	88 ▼	82 ▼	**91**	89	94	93	**93**
Spirometry Testing for COPD	49	50	51	**56**	52 ▲	48 ▲	51 ▲	**45**
Use of Imaging Studies for Low Back Pain	72 ▼	78	79	**77**	75	81	83 ▲	**80**
Pharmacotherapy Management for COPD—Bronchodilators	82	87	85	**89**	70	75	71	**80**
Pharmacotherapy Management for COPD—Corticosteroids	57 ▼	72	72	**76**	53 ▼	69	63 ▼	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	68	66	73	**71**	67	75	78	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	55	50 ▼	61	**59**	50	59	71	**63**
Asthma Medication Ratio (Ages 19-64)	59	58	73	**60**	73	78	75 ▼	**81**
Asthma Medication Ratio (Ages 5-18)	68 ▲	66	66	**68**	77	73 ▼	83	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	82	83	84	**80**	68 ▼	83	69 ▼	**83**
CDC—HbA1c Testing	92	91	91	**92**	91	91	90	**92**
CDC—HbA1c Control (<8%)	57	57	54 ▼	**60**	57 ▼	59 ▼	52 ▼	**61**
CDC—Eye Exam Performed	66	60 ▼	65	**67**	60	64	60	**63**
CDC—Nephropathy Monitor	93	93	93	**92**	92	91	90	**89**
CDC—BP Controlled (<140/90 mm Hg)	61	56 ▼	59 ▼	**66**	55 ▼	52 ▼	52 ▼	**69**
Drug Therapy for Rheumatoid Arthritis	83	84	86	**83**	74 ▼	80	82	**84**
Monitor Patients on Persistent Medications—Total Rate	91 ▼	91 ▼	89 ▼	**92**	88 ▲	87 ▲	85	**84**
Appropriate Treatment for URI	94	95	94	**95**	94	95	94	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	27 ▼	27 ▼	23 ▼	**36**	35 ▲	33	35	**34**
HIV Viral Load Suppression[2,3]	77	72	76	**77**				
Flu Shots for Adults (Ages 18-64)[4]	36	44			45	42 ▼	46 ▼	**56**
Advising Smokers to Quit[4]	85	80			80	78	78	**81**
Smoking Cessation Medications[4]	54	57			48	54	63	**62**
Smoking Cessation Strategies[4]	54	52			39	49	51	**55**

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

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

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

[2] NYS-specific measure.

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

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, HIP has shown improvement in 5 out of 9 behavioral health measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	54	52	53	**53**	64	61 ▼	65	**68**
Antidepressant Medication Management—Effective Continuation Phase	38	38	39	**37**	48	45 ▼	50	**53**
Follow-Up Care for Children on ADHD Medication—Initiation	65	65 ▲	63	**59**	51	63 ▲	48	**45**
Follow-Up Care for Children on ADHD Medication—Continue	72	76	80	**66**	*SS*	*SS*	*SS*	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	71 ▼	77	69 ▼	**74**	69 ▼	70 ▼	58 ▼	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	54 ▼	57	58 ▼	**63**	53 ▼	54 ▼	40 ▼	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	80	79	79	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	79	82	70	**80**				
Antipsychotic Medications for Schizophrenia	61	67	69	**63**				

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

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

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as "*the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).*" Performance indicators related to Utilization and Access to Care are included in this section[6].

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

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

Measure	2016	2017	2018	2018 Statewide Average
Medicaid/CHP				
Well-Child Visits—First 15 Months	65	66	77 ▼	**81**
Well-Child Visits—3 to 6 Year Olds	83 ▼	87 ▲	82 ▼	**86**
Adolescent Well-Care Visits	70 ▲	77 ▲	64 ▼	**81**
Commercial				
Well-Child Visits—First 15 Months	72 ▼	70 ▼	85 ▼	**94**
Well-Child Visits—3 to 6 Year Olds	83 ▼	80 ▼	83 ▼	**88**
Adolescent Well-Care Visits	62 ▼	61 ▼	63 ▼	**67**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). HIP had rates below the SWA for 75% of the age groups in the *Children and Adolescents' Access to PCPs*. The MCO also had rates below the SWA for 100% of the age groups in the *Access to Other Services* measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Children & Adolescents' Access to PCPs (CAP)								
12-24 Months	95% ▼	93% ▼	90 ▼	**97**	97% ▼	96% ▼	95 ▼	**98**
25 Months-6 Years	93% ▼	93% ▼	90 ▼	**94**	93% ▼	91% ▼	92 ▼	**95**
7-11 Years	96% ▼	96% ▼	96 ▼	**97**	95% ▼	94% ▼	95 ▼	**97**
12-19 Years	96%	95%	95	**95**	93% ▼	92% ▼	92 ▼	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	82% ▼	83% ▲	82 ▲	**81**	91% ▼	92% ▼	92 ▼	**94**
45-64 Years	89% ▼	89%	89	**89**	95% ▼	95% ▼	95 ▼	**96**
65+ Years	86% ▼	88% ▼	89 ▼	**91**	93% ▼	93% ▼	93 ▼	**97**
Access to Other Services								
Timeliness of Prenatal Care	88%	80% ▼	70 ▼	**88**	90%	83% ▼	72 ▼	**92**
Postpartum Care	63% ▼	61% ▼	56 ▼	**69**	73% ▼	61% ▼	67 ▼	**83**
Annual Dental Visit[2]	55% ▼	50% ▼	55 ▼	**61**				

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

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

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

NYSDOH-Calculated Prenatal Care Measures

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

Table 15: QARR Prenatal Care Rates—2015-2017

	Medicaid						Commercial					
	2015		2016		2017		2015		2016		2017	
Measure	HIP	Regional Average	HIP	Regional Average	HIP	Regional Average	HIP	Regional Average	HIP	Regional Average	HIP	Regional Average
NYC												
Risk-Adjusted Low Birth Weight[1]	8%	**6%**	6%	**6%**	-	**-**	6%	**6%**	7%	**6%**	-	**-**
Prenatal Care in the First Trimester	77%	**75%**	79%	**76%**	79	**75**	85% ▼	**87%**	86%	**85%**	86	**87**
Risk-Adjusted Primary Cesarean Delivery[1]	14%	**14%**	17%	**14%**	-	**-**	21%	**21%**	23%	**22%**	-	**-**
Vaginal Birth After Cesarean	20%	**18%**	20%	**18%**	-	**-**	12% ▼	**16%**	12%	**13%**	-	**-**
ROS												
Risk-Adjusted Low Birth Weight[1]	10%	**7%**	9%	**7%**	-	**-**	5%	**4%**	4%	**4%**	-	**-**
Prenatal Care in the First Trimester	80%	**74%**	75%	**74%**	75	**74**	85%	**88%**	84% ▼	**88%**	84 ▼	**88**
Risk-Adjusted Primary Cesarean Delivery[1]	19% ▼	**14%**	17%	**13%**	-	**-**	20%	**19%**	21%	**18%**	-	**-**
Vaginal Birth After Cesarean	11%	**14%**	11%	**14%**	-	**-**	4%	**11%**	4% ▼	**11%**	-	**-**

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

NYC: New York City; ROS: Rest of State

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

Member Satisfaction

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

Table 16: CAHPS®—2014, 2016, 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	HIP	SWA	HIP	SWA	HIP	SWA	HIP	SWA	HIP	SWA	HIP	SWA
Flu Shots for Adults Ages 18-64							44 ▼	**52**	45	**52**	46 ▼	**56**
Advising Smokers to Quit							92 ▲	**84**	80	**80**	78	**81**
Getting Care Needed[1]	84	**83**	86	**85**	82	**84**	76 ▼	**88**	77 ▼	**88**	76 ▼	**89**
Getting Care Quickly[1]	89	**87**	88	**88**	89	**88**	78 ▼	**88**	77 ▼	**87**	75 ▼	**87**
Customer Service[1]	76	**82**	83	**86**	85	**86**	81 ▼	**88**	81 ▼	**89**	84 ▼	**91**
Coordination of Care[1]	76	**74**	79	**74**	77	**75**	75 ▼	**84**	69 ▼	**83**	81	**87**
Collaborative Decision Making[1]	49	**53**	81 ▲	**74**	77	**76**	75 ▼	**80**	73 ▼	**80**	76	**80**
Rating of Personal Doctor[1]	91	**89**	92	**89**	90	**90**	82	**84**	77 ▼	**86**	84	**86**
Rating of Specialist	74	**81**	79	**83**	89	**84**	79	**83**	78 ▼	**84**	75 ▼	**84**
Rating of Healthcare	84	**85**	86	**86**	87	**87**	72 ▼	**78**	65 ▼	**80**	72 ▼	**81**
Satisfaction with Provider Communication[1]	93	**93**	95 ▲	**93**	94	**93**	93 ▼	**96**	91 ▼	**96**	95	**96**
Wellness Discussion							77	**77**	69 ▼	**76**	68 ▼	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	*SS*	**64**	58	**68**	SS	**69**						
Rating of Health Plan—High Users	81	**84**	81	**85**	82	**84**	68	**68**	67	**68**	61 ▼	**72**
Overall Rating Health Plan	78 ▼	**83**	81	**85**	79 ▼	**85**	69	**67**	63	**66**	63 ▼	**71**
Recommend Plan to Family/Friends												

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

SS: Sample size too small to report

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

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

Performance Improvement Project

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

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

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

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

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

HIP's 2017-2018 PIP topic was *"Perinatal Care"*. During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- Informed members of the Healthy Beginnings program through enrollment packages, website and mailings.
- Conducted 2 telephone assessments during the 1st trimester and then again mid-pregnancy; educational materials regarding pregnancy, depression, smoking cessation, and contraception options.
- Member outreach to the NY Smokers Quitline via direct mail and case management referrals.
- 24/7 nurse advice line provided to members.
- Case management provided education to members with high risk pregnancies, addressed medication reconciliation, smoking cessation, and depression screening

Provider-Focused Interventions:

- Newsletters sent to providers on medical policy requirements for 17P.
- Notification of Pregnancy form sent to providers.
- Member's case management care plan was sent to provider; contacted providers whose members had invalid telephone numbers to contact the member to engage her in the Healthy Beginnings program and/or case management.

MCO-Focused Interventions:

- Identification of high-risk pregnant women utilizing new data sources such as Notification of Pregnancy form, reports of antepartum admissions and discharges for undelivered potential high-risk pregnant members.
- Care Management's trigger list was updated to include additional criteria, such as more behavioral health factors and prior obstetrical history.

Table 18 presents a summary of HIP's 2017-2018 PIP. HIP demonstrated an improvement for 5 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	88%	70%		Performance declined
Postpartum Care	63%	56%		Performance declined
Received at least one 17P injection	8%	8%	25%	Performance level was maintained
Depression Screening	10%	19%	86%	Demonstrated improvement
Tobacco Screening	10%	18%	92%	Demonstrated improvement
Tobacco Screening Follow-Up	100%	23%	92%	Performance declined
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	12%	8%	25%	Performance declined
Age 15-20 years; within 60 days	50%	34%	60%	Performance declined
Age 21-44 years; within 3 days	9%	16%	20%	Demonstrated improvement
Age 21-44 years; within 60 days	29%	32%	45%	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	5%	1%	10%	Performance declined
Age 15-20 years; within 60 days	14%	4%	25%	Performance declined
Age 21-44 years; within 3 days	8%	9%	20%	Demonstrated improvement
Age 21-44 years; within 60 days	10%	10%	20%	Performance level was maintained

Health Disparities

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

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

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

- EmblemHealth conducted an annual population analysis to assess the needs and characteristics of the enrolled population including social determinants of health. The analysis was used to evaluate the current complex case management criteria, case management and population health program processes and resources compared to the needs identified and were used to determine if modifications to existing programming was needed to better meet the needs of the enrolled population.
- EmblemHealth implemented actions to address identified gaps in care and improve program and intervention effectiveness. EmblemHealth is responsive to its members' needs through promoting best practices within EmblemHealth through addressing cultural, linguistic, racial, gender, religious, sexual orientation and health literacy diversity and disparities by:
    - Improving communication and coordination of care through complex case management and interdisciplinary teams.
    - Promote self-management to members through ongoing case and disease management, EmblemHealth Neighborhood Care, and ACPNY.
    - Implemented a new software platform that addresses the Plan's data and different platform to address the Plan's clinical data. This also permits sharing data between the interdisciplinary team.
- A Member Satisfaction Survey was provided to members via telephonic IVR and e-blast with embedded webpage link. The survey was utilized to evaluate and address members' cultural, racial, ethnic, and linguistic needs and preferences. The survey results indicated that White/Caucasian followed by Black/ African American are the most prevalent race in members' responses. The overall satisfaction with practitioners understanding members' cultural, gender, racial, ethnic and language needs for Medicaid was 86% for primary care, 90% for specialists and 90% for Behavioral Health.
- EmblemHealth reviews HEDIS and QARR rates for various lines of business, including Medicaid, Commercial and Medicare. Data profiles are created for each line of business detailing rate disparities based on age, gender, and location. Profiles are reviewed by applicable staff that is tasked with developing interventions to address key disparities.
- Annually, the plan segments or stratifies its Medicaid members into subsets for targeted intervention.
- EmblemHealth monitors aspects of continuity and coordination of medical care and initiates actions as needed to improve continuity. During 2018, EmblemHealth continued monitoring transitions of care

between settings, including but not limited to deliveries that have a postpartum visit on or between 21 and 56 days after delivery. It was determined that there was a need for a continued and focused effort that reaches out to new mothers to educate them about the importance of a timely postpartum visit, as defined and measured by HEDIS and NYSQARR specifications. It was also determined that social determinants of health such as finance, family support/child care, food insecurities and inadequate transportation impacted whether some members received timely postpartum care. Some of the interventions that were implemented included:

  - Care Manager assistance with appointment set up for members, align and connect members to community resources, incorporate postpartum education to all Healthy Beginnings program
  - Mailing to all identified EmblemHealth pregnant members providing education regarding the importance of the postpartum appointment, member education and connect members with providers.
  - Care Management deployed a field-based Care Manager in the ACPNY practice sites. This was to provide face-to-face care management services to high-risk members associated with the ACPNY providers.

- EmblemHealth conducts research to determine barriers that prevent members from engaging in preventive services, managing chronic conditions, and improving their health. Barriers to care are also discussed during applicable committee and subcommittee meetings. Smaller workgroup meetings will be held if additional focus and analysis is required to develop interventions to remove identified barriers. Summary of key findings: HIP HEDIS 2019 (CY 2018) Medicaid and HARP rates for postpartum care remained below the Quality Assurance Reporting Requirements (QARR) 75th percentile for Medicaid and HARP while the Commercial rates although improved from the prior year were also below the Quality Compass benchmarks.
- EmblemHealth has implemented interventions that aim to reduce or eliminate differences in health outcomes and to improve the quality of care for its members. Some of these interventions are:
  - Member support using a language line, TTY line, member materials offered in different languages and a 24/7 access to online website which is translated to Chinese and Spanish.
  - EmblemHealth's Neighborhood Care centers provide members, AdvantageCare Physicians and the community at large with health and wellness services, care coordination and customer service within their neighborhoods. This face to face support reinforces a holistic approach to health and wellness and helps community members to take a more active role in their mental and physical wellbeing. Trained and friendly customer care navigators hired from the communities they service connect people to relevant healthcare and community resources.
  - In 2018, EmblemHealth engaged with CityBlock, a company that uses technology-enabled services to address the unmet health and social needs of urban populations.

VI. Health Information Technology

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

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

- Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
- Use of telecommunications technologies
- Use of Electronic Health Records (EHR)
- Use of electronic internal registries
- Use of clinical risk group (CRG) or similar software
- Secure electronic transfer of member data between the MCO, its vendors, and network providers
- Electronic communication with providers
- Electronic communication with members
- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange(HIE)[7]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

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

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

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

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

Health Information Technology	% of MCOs Reporting Use
Electronic communication with members	100%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	69%
Participation in a medical home pilot or program	46%
Use of electronic internal registries	46%
Participation in State, Federal or privately funded HIT initiatives	46%

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

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Use of member and provider portals that are protected by multi-factor authentication and encryption.

- Use of telecommunications technologies:
  - Use of inbound/outbound telecom and faxes to support different facets of the healthcare experience including but not limited to delivering health services and information that supports member care, health education, and administrative activities.
  - Members can make payments and update demographic information through telecom technology.

- Use of Electronic Health Records (EHR):
  - Utilizes EHRs to collect, report and share data.

- Use of clinical risk group (CRG) or similar software:
  - Utilize a CRG or similar software to predict member utilization or to identify members for care management.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Member data is shared electronically through electronic files transmitted to vendors via secure managed file transfers.

- Electronic communication with providers:
  - EmblemHealth utilizes the telephone (inbound/outbound), secure e-mail and secure web portals to communicate with providers and Revenue Cycle Management (RCM) companies to which work is outsourced.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - EmblemHealth did not indicate if there is any participation with a RHIO or HIE.

- Participation in a medical home pilot or program:
  - EmblemHealth did not indicate if there is any participation with a medical home pilot or program.

- Future plans to implement HIT:
  - EmblemHealth continues to evaluate opportunities to expand the use of Health Information Technology (HIT) for members and providers, as well as to improve data analysis and business processes.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

Regarding the focused reviews, HIP was in compliance with 13 of the 14 categories. The category in which HIP was not compliant was Organization and Management (2 citations). The MCO was in compliance for all of the operational survey categories in 2018.

Table 20: Focused Review Types

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

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

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Type	
Complaints and Grievances	0	0		
Credentialing	0	0		
Disclosure	0	0		
Family Planning	0	0		
HIV	0	0		
Management Information Systems	0	0		
Medicaid Contract	0	0		
Medical Records	0	0		
Member Services	0	0		
Organization and Management	0	2	Behavioral Health Claims	2
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	0	0		
Utilization Review	0	0		
Total	**0**	**2**		

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, HIP had 73% of external appeal decisions upheld.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	66	24	23
Overturned in Part	9	3	6
Upheld	109	71	77
Medicaid Total	**184**	**98**	**106**
		CHP	
Overturned	0	0	1
Overturned in Part	0	0	0
Upheld	1	0	0
CHP Total	**1**	**0**	**1**

VIII. Strengths and Opportunities for Improvement[8]

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

Strengths

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

Strengths:

- Regarding the percentages of various providers in EmblemHealth's Medicaid provider network, the MCO reported rates above the statewide average for the following provider types: Pediatrics, OB/GYN Specialty and Dentistry.
- The MCO performed well in the 2018 Primary Care and OB/GYN Access and Availability Survey for routine and after-hours call types.
- In the HEDIS®/QARR Access to Care domain, the MCO's rate for *Adults' Access to Preventative/Ambulatory Services for 20-44 Years* has reported a rate above the statewide average in 2018.
- In 2018, EmblemHealth performed various activities to address disparities in health outcomes and/or health care among its Medicaid population. EmblemHealth reported activities that target members, providers and the MCO's operations.

Opportunities for Improvement

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

Opportunities for Improvement:

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

- The MCO demonstrates an opportunity for improvement regarding providers having available appointments for non-urgent "sick" call types. The Primary Care and OB/GYN Access and Availability survey reported the MCO has an appointment rate of 72.7% for non-urgent "sick" call types.
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care domain. The MCO reported rates below the statewide average for the following measures: *Adult BMI Assessment, Weight Assessment and Counseling for Children and Adolescents—BMI Percentile, Breast Cancer Screening,* and *Appropriate Testing for Children with Pharyngitis*. *(Note: Adult BMI, WCC- BMI Percentile, Breast Cancer Screening* and *Appropriate Testing for Children with Pharyngitis were an opportunity for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Acute and Chronic Care domain. The MCO has reported a rate below the statewide average for at least three consecutive reporting years for *Annual Monitoring for Patients on Persistent Medications—Total Rate*. Additionally, rates for *Comprehensive Diabetes Care—HbA1c Control (<8%),* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* were reported below the statewide average for 2018. *(Note: Annual Monitoring for Patients on Persistent Medications—Total Rate and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis were opportunities for improvement in the previous year's report.)*
- In regards to the HEDIS®/QARR Behavioral Health domain, EmblemHealth has rates below the statewide average for the *Follow-Up After Hospitalization for Mental Illness-30 Days and Follow-Up After Hospitalization for Mental Illness-7 Days* measures.
- In 2018, the MCO had reported rates below the statewide average for all measures in the HEDIS®/QARR Utilization domain.
- The MCO continues to demonstrate an opportunity for improvement in the HEDIS®/QARR Access to Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Postpartum Care* and *Annual Dental Visit (Ages 2-20),* as well as the following age groups of the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* measures: *12-24 Months, 25 Months-6 Years, 7-11 Years,* and *65+ Years*. The MCO's rate for *Timeliness of Prenatal Care* was below the statewide average for 2018, as well. *(Note: Children and Adolescents' Access to Primary Care Practitioners, Adults' Access to Preventive/ Ambulatory Health Services—65+ Years, Postpartum Care, and Annual Dental Visit (Ages 2-20) were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regard to member satisfaction. The MCO has reported a rate below the statewide average for the *Overall Rating of Health Plan* measure.

Recommendations:

- The MCO should consider creating a process that identifies providers who did not meet the necessary access and availability requirements for non-urgent appointments. The MCO should consider including education on the appointment availability requirements with the outreach efforts made by the EmblemHealth Quality Provider Engagement team. Appointments should be scheduled within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated. The MCO should also consider including reminders in existing provider newsletters on the importance of appointment timeframes.
- Although the MCO has shown improvements in the screening measures for the HEDIS®/QARR Effectiveness of Care domain, the MCO continues to perform below average for some measures. The MCO should continue with its current strategy to improve performance in HEDIS®/QARR measures. The MCO should provide continuous training on the organization's HEDIS®/QARR goals to all staff members, vendors and providers who engage members.
- The MCO continues to perform below average for measures in the HEDIS®/QARR Acute and Chronic Care domain regarding diabetes care and monitoring of patients with persistent medications. The MCO should

consider providing member education on diabetes management during the in-home diabetic testing appointments. The use of evidence based self-management programs can also be beneficial to the Medicaid population. In regards to the annual monitoring of patients with persistent medications, the MCO should continue with its efforts to engage providers within ACPNY and Cityblock IPA. The MCO should also include smaller practices with a high volume of Medicaid members in the outreach efforts made by the EmblemHealth Quality Provider Engagement team.

- The MCO should conduct a root cause analysis to identify the cause for the decrease in rates for the *Follow-Up After Hospitalization for Mental Illness-30 Days* and *Follow-Up After Hospitalization for Mental Illness-7 Days* measures. The MCO should consider developing communications educating mental health professionals within the Medicaid network.
- The MCO should continue to work to improve its rates for the HEDIS®/QARR Access to Care measures for children and adolescents as all measures performed below average in 2018. The MCO should consider developing a comprehensive intervention strategy aimed at improving access to primary care as well as preventive care for this population. *[Repeat recommendation.]*

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** The MCO should continue its efforts to improve HEDIS®/QARR and CAHPS® measures that consistently perform below average through a thorough evaluation of the effectiveness of its current strategy. The MCO should also consider implementing a more active strategy, rather than focusing strongly on an education campaign, that could include initiatives such as in-home screenings for diabetics or community events where members can receive check-ups, prenatal or postpartum visits, or preventive screenings and immunizations. [Repeat recommendation.]

  MCO Response: EmblemHealth continues to improve its performance in HEDIS®/QARR measures. EmblemHealth uses targeted processes and methodology for conducting and evaluating quality improvement activities. This includes using baseline measurement, root cause analysis, development and implementation of appropriate interventions, and re-measurement to determine the impact of interventions utilizing valid statistical analyses. EmblemHealth continues to monitor HEDIS®/QARR rates monthly to identify lower-than-anticipated performance and implements interventions as needed. Performance, goals and indicators are monitored through the quality committee structure and senior leadership steering committees. EmblemHealth makes HEDIS®/QARR reports available to staff involved in specific performance improvement activities as well as those departments whose work impacts measurements.

  EmblemHealth continues to engage more members and providers in the quality process as well as broaden its multifaceted intervention strategy. During an evaluation, we identified opportunities to take a more active approach in engaging our members and providers. EmblemHealth partnered with vendors to conduct in-home diabetic testing and dental screenings at community events and at EmblemHealth's Neighborhood Care locations. EmblemHealth deployed a field-based initiative wherein EmblemHealth Care Managers are either embedded into one of the thirty-eight AdvantageCare Physicians of New York (ACPNY) practices and/or visits members, including pregnant members; in the community, in their home, or at one of the ten EmblemHealth Neighborhood Care locations. Care Managers encourage members to

drop in for guidance and assistance in activities such as making appointments, arranging transportation and addressing social determinants of health at any of our Neighborhood Care locations. EmblemHealth also partners with Cityblock, IPA, to engage the Medicaid population in Health Home care management to connect the members to wellness check-ups and provide wrap around care. Utilizing their community health workers to meet members in the community to assist in driving the health outcomes. Field-based care management programs are known to have higher engagement rates than traditional telephonic programs.

EmblemHealth has Quality Health Navigators who help members find a doctor, schedule an appointment, as well as connect members to customer service to change account information. The Quality Health Navigators also provide telephonic outreach to educate members and encourage them to go for their preventive care visits.

Additionally, EmblemHealth created a Quality Provider Engagement team to collaborate with provider groups. The team meets with providers to share gaps in care reports, identify provider's patients due for services, practitioner-provider report cards, provide education and best practices information, discuss HEDIS®/QARR measures, access and availability standards and other quality related information. The Quality Provider Engagement team communicates regularly with providers to follow-up on gaps in care report usage, to determine the number of members who completed services, and to respond to provider-specific questions regarding HEDIS®/QARR measures, including providing codes providers can use to submit.

- **2017 Recommendation:** The MCO should continue to work to improve its rates for the HEDIS®/QARR Access to Care measures for children and adolescents that continue to perform below average. As the MCO also struggles with certain preventive care measures for children and adolescents, the MCO should consider developing a comprehensive intervention strategy aimed at improving access to primary care as well as preventive care for this population. [Repeat recommendation.]

  MCO Response: EmblemHealth continues to work on improvements in its preventive care and access to care measures for children and adolescents that continue to perform below average. Key interventions include but are not limited to; a member incentive program encouraging parents/guardians to take their child(ren) for their annual well-visit and dental care, a primary care provider incentive program, partnering with provider groups, and educational/reminder mailings and calls.

  EmblemHealth conducts annual studies on network adequacy, appointment availability and 24-hour access. An analysis of member satisfaction surveys showed that member dissatisfaction seems to flow from members' inability to secure access to services due to provider access and availability. Providers who were found non-compliant with appointment availability and after-hours access were outreached and educated. Since 2017, EmblemHealth expanded its ACPNY office locations to increase members' access to care.

- **2017 Recommendation:** The MCO should work to address the issues identified in the focused review surveys. First, the MCO should re-train its Member Services staff on appropriate procedures for responding to members' requests for information. Next, the MCO should ensure that policies and procedures are followed when required to notify the NYSDOH of a change in staffing. Lastly, the MCO should continue its efforts to improve the accuracy of the information in the provider directories to improve access and availability of care. [Repeat recommendation.]

MCO Response: EmblemHealth works diligently to address the performance challenges that are noted in the operational and focused review surveys. EmblemHealth continually reviews processes and implements strategies to improve EmblemHealth's compliance with New York State's Structure and Operation Standards. EmblemHealth is committed to fully meeting all standards.

EmblemHealth monitors member and provider telephone service standards. EmblemHealth's Customer Service leadership addresses the barriers and opportunities with actions that are taken throughout the year. Weekly meetings are held to detect trends, track results and identify issues. Data from after-call surveys are reviewed weekly to ensure that the member's questions are being addressed, the customer service representative followed procedures, members are provided accurate information, customer service advocates remained legally compliant and were accountable for quality and accuracy in resolving the issues. An example of customer service being accountable for quality and accuracy in resolving member issues is a member being reminded to get a new referral from his/her primary care provider if a referral for a certain number of visits is ending. Members Services staff are re-trained on appropriate procedures as necessary to ensure they are responding to members' requests for information. Additionally, EmblemHealth's Customer Service department instituted knowledge quizzes to assess Member Services staff's knowledge, as well as modified several training documents to re-educate Member Services staff to access critical member communications during member calls.

EmblemHealth complies with all relevant Article 44 laws including Part 98 of the New York Code of Rules and Regulations. EmblemHealth recognizes that to operate as a managed care organization, it must provide the New York State Department of Health with information about its board and its officers. To remain compliant with this requirement, EmblemHealth has implemented a policy highlighting its internal process which states written notice will be provided to the New York State Department of Health upon the departure, resignation, or termination of any officer, member of the board, medical director or any key employee as otherwise defined/determined by EmblemHealth along with the identity of the individual.
Additionally, EmblemHealth will provide written notice to New York State Department of Health of the hiring of an individual to replace any officer, member of the board, medical director or any key employee as otherwise defined/determined by EmblemHealth along with the identity of the individual. This process is monitored closely by EmblemHealth's Vice President, Deputy General Counsel and Assistant Corporate Secretary, or a designee of either.

EmblemHealth is committed to on-going activities to improve the accuracy of its provider directories. Actions taken as a response to the 2016 recommendation are still in place. EmblemHealth staff conducts educational outreach with providers' office staff to update demographic information which includes but not limited to; office hours, after hours coverage procedures, confirming primary care provider or specialist functions, panels opened/closed for primary care providers, and network participation. Additionally, EmblemHealth has training videos on its provider portal to educate providers and office staff on updating demographic information and recognizing network participation when scheduling appointments. Quarterly, electronic reminders are sent to providers to update demographic information in the secure provider portal, by fax, and email, in addition to reminders included in the monthly training webinars, the annual notification to providers, newsletters and in other correspondence, where appropriate. Each year, EmblemHealth audits a random sample of providers to confirm after-hours access and compliance with appointment scheduling time frames. Letters are sent to all audited providers with copies of the access and availability standards and directory accuracy reminders.

EmblemHealth staff contacts entities delegated for credentialing with current network participation to share with its providers. To ensure the accuracy of EmblemHealth's paper and web directories, an internal audit process to pre-screen credentialing applications for providers requesting participation in EmblemHealth's network was implemented. If through the audit process any information is inaccurate, the credentialing application is rejected, and the provider is asked to resubmit the application with correct information.

IX. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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