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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

INDEPENDENT HEALTH ASSOCIATION, 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

Independent Health Association, Inc. (IHA) is a regional, not-for-profit health maintenance organization (HMO). The plan's Medicaid product name is MediSource. The plan 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.

IHA Web Page: https://www.independenthealth.com

*Participating Regions and Products[1]			
Western[2]:	MCD	CHP	COM

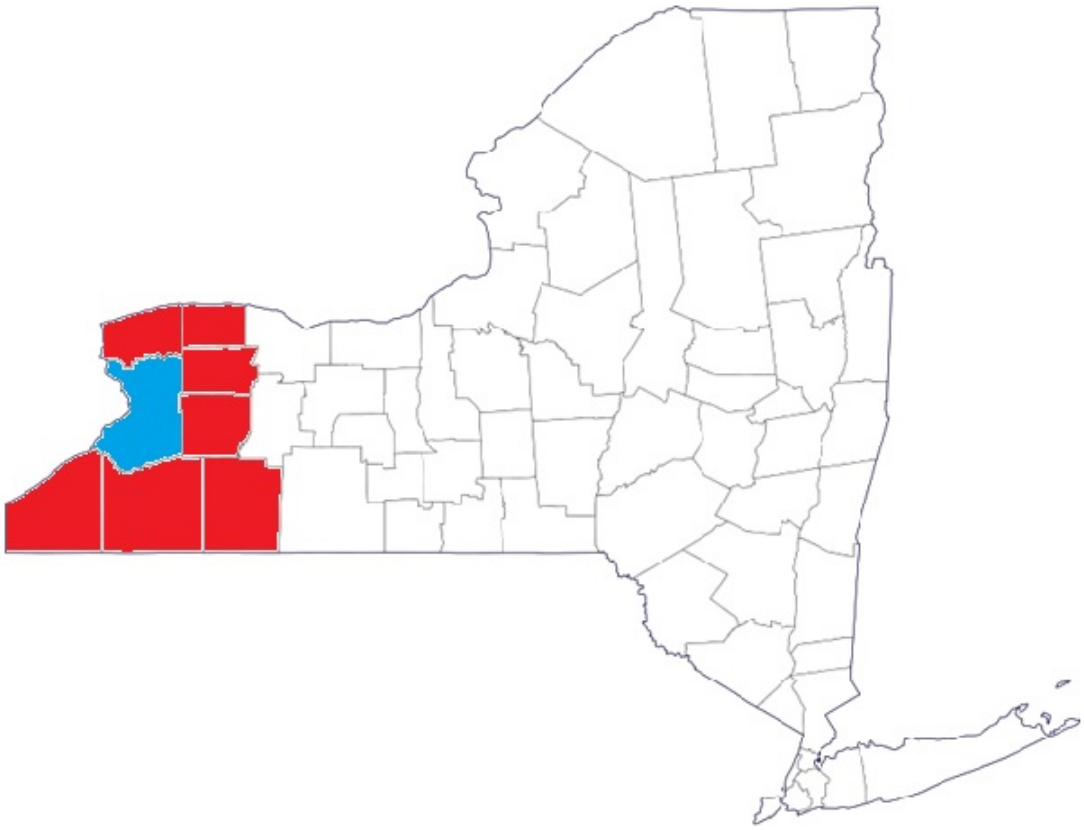
* Please contact the plan directly to confirm the plan participation counties.

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]IHA offers COM only in Allegany, Cattaraugus, Chautauqua, Genesee, Orleans and Wyoming counties. IHA offers CHP and Com only in Niagara County. In Erie county CHP, COM, HARP and MCD are offered.

Figure 1: IHA Map of Participating Counties



Note: Counties shaded in red serve the Commercial population only. IHA's Medicaid, CHP, and HARP products are only available in Erie County, shaded in blue. The CHP product line is also available in Niagara County.

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 7.4%. IHA's membership represents 1.3% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product line carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	60,952	59,212	55,109
% Change from Previous Year	-19.5%	-2.9%	-7.4%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	1.4%	1.3%	1.3%

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	4,516	5,188	5,572
Commercial	127,935	125,997	116,376

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: IHA Enrollment Trends—All Product Lines

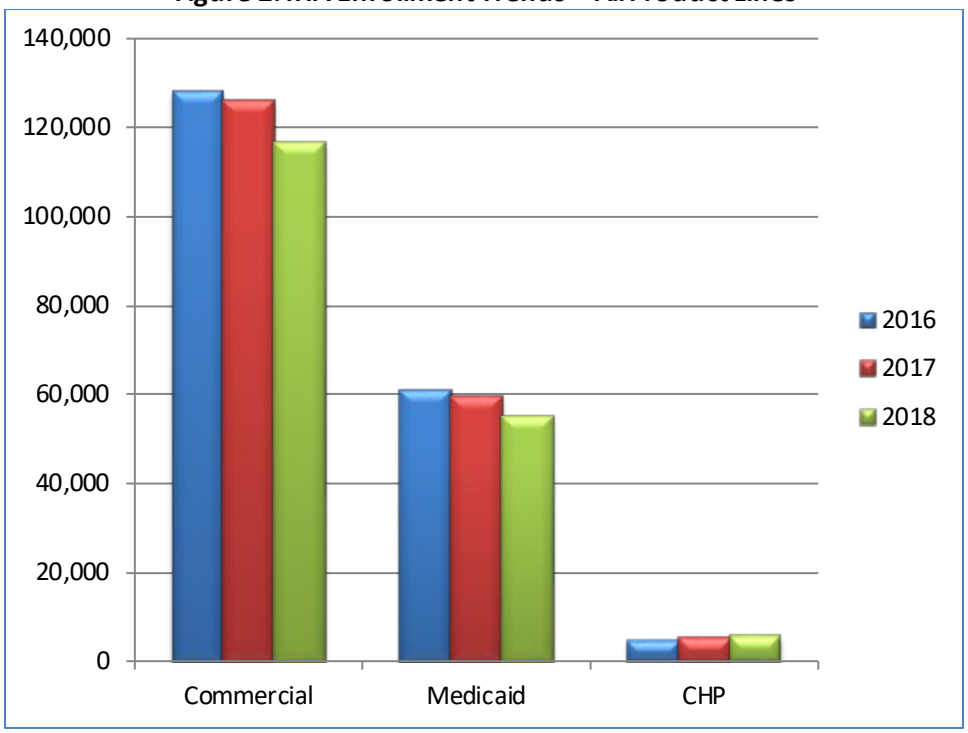


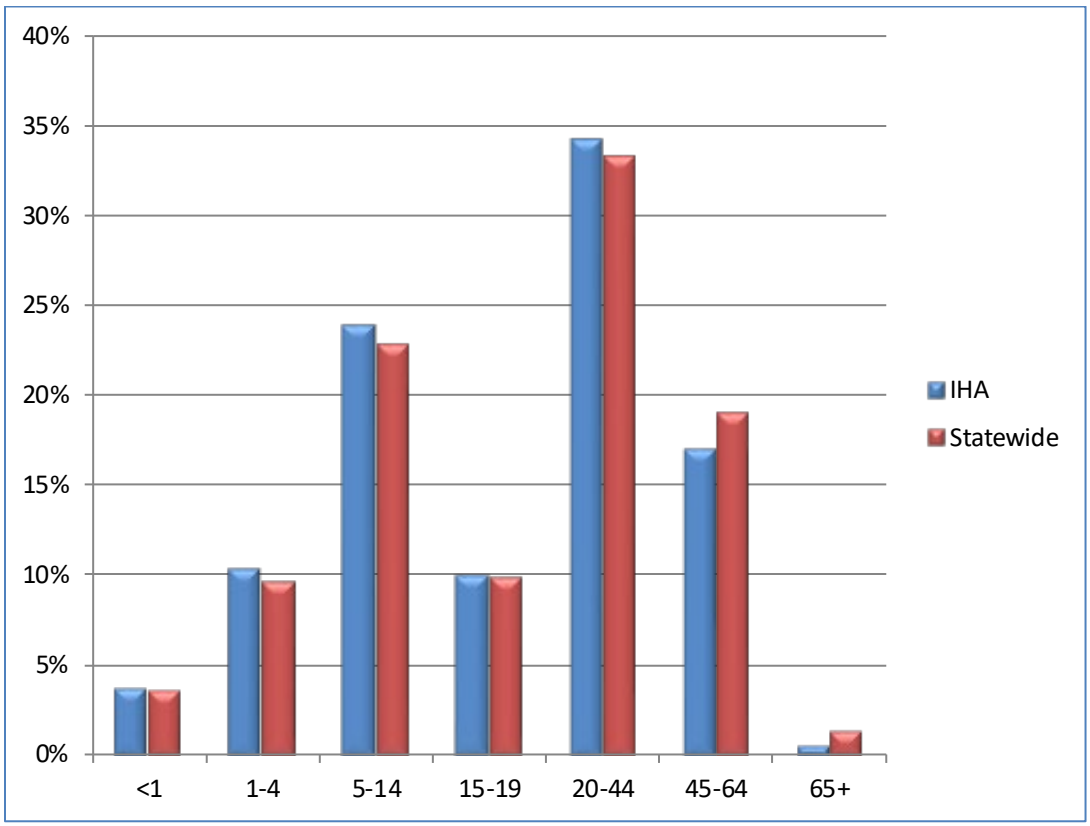
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. The MCO's rate for members aged 65 and over is below the statewide average.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	1,084	987	2,071	3.8%	3.6%
1-4	2,901	2,856	5,757	10.5%	9.7%
5-14	6,795	6,364	13,159	23.9%	22.8%
15-19	2,664	2,866	5,530	10.0%	9.9%
20-44	6,992	11,865	18,857	34.2%	33.3%
45-64	4,220	5,184	9,404	17.1%	19.1%
65 and Over	124	178	302	0.5% ▼	1.4%
Total	24,780	30,300	55,080		
Under 20	13,444	13,073	26,517	48.1%	46.1%
Females 15-64		19,915		36.2%	34.7%

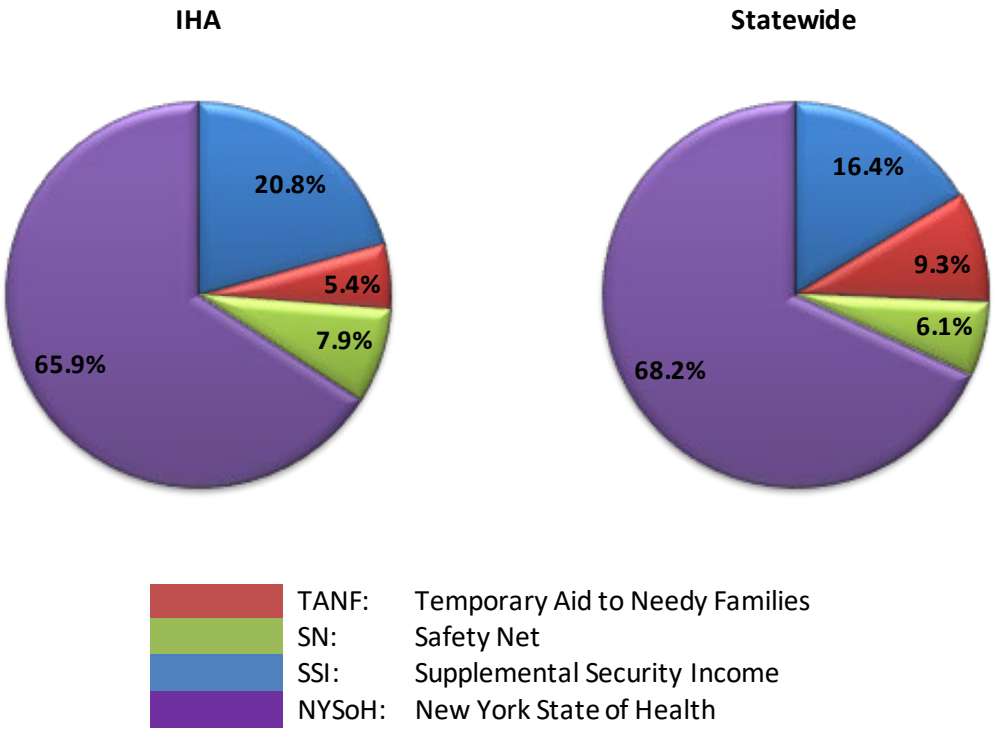
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

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

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

	2016		2017		2018	
Provider Type	**IHA**	**Statewide Average**	**IHA**	**Statewide Average**	**IHA[1]**	**Statewide Average**
Medicaid/CHP						
Family Medicine	84% ▲	71%	82% ▲	72%	87%	74%
Internal Medicine	73%	75%	73%	76%	73%	76%
Pediatricians	81%	78%	82%	79%	82%	80%
OB/GYN	80%	75%	80%	77%	80%	80%
Geriatricians	53%	63%	*SS*	63%	48%	63%
Other Physician Specialists	84% ▲	75%	84% ▲	76%	85%	77%
Commercial						
Family Medicine	84% ▲	74%	82%	77%	87%	72%
Internal Medicine	74%	73%	73% ▼	77%	73%	73%
Pediatricians	81%	77%	82%	79%	82%	75%
OB/GYN	80%	78%	80%	79%	81%	78%
Geriatricians	53%	63%	*SS*	69%	50%	66%
Other Physician Specialists	84% ▲	78%	84% ▲	79%	85%	77%

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

[1]Level of significance was unaudited.

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

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. The largest provider specialty type was Other Specialties, with 57.1% of the total MCO panel in 2018.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	856	13.9%	19.5%
Pediatrics	228	3.7%	3.8%
Family Practice	324	5.3%	3.5%
Internal Medicine	279	4.5% ▼	8.4%
Other PCPs	25	0.4% ▼	3.8%
OB/GYN Specialty[1]	217	3.5%	3.8%
Behavioral Health	312	5.1% ▼	17.2%
Other Specialties	3,506	57.1% ▲	46.0%
Non-PCP Nurse Practitioners	847	13.8%	8.7%
Dentistry	405	6.6%	4.9%
Total	6,143		

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. The MCO's rate of enrollees to Behavioral Health providers had a rate above the statewide average.

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

	IHA			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	64:1	1,036	53:1	42:1	80,986	42:1
Pediatrics (Under age 20)	116:1			70:1		
OB/GYN (Females age 15-64)	92:1			59:1		
Behavioral Health	177:1 ▲			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 ▼. The MCO rates for Medicaid PCPs with an Open Panel decreased from 2016 to 2018.

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

	2016			2017			2018		
	IHA		Statewide	IHA		Statewide	IHA		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
					Medicaid				
Providers with Open Panel	554	64.2 ▼	85.0	494	60.8	95.7	512	61.8	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). 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 is conducted.

Table 8: displays the IHA 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	39	**78%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 35 providers (total number of providers who were compliant for participation (39), less total number of providers with closed panels (4)). The MCO performed above the threshold for Routine 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	4	100.0%
	Pediatrician	4	3	75.0%
	OB/GYN	3	3	100.0%
	Total Routine	**11**	**10**	**90.9%**
Non-Urgent "Sick"	Internist/Family Practitioner	5	5	100.0%
	Pediatrician	4	2	50.0%
	OB/GYN	2	1	50.0%
	Total Non-Urgent	**11**[2]	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	5	3	60.0%
	OB/GYN	4	3	75.0%
	Total After-Hours	**12**	**8**	**66.7%**

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

[2] Final sample less excluded providers. Two (2) providers were excluded because the surveys could not be completed.

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 ▼. The MCO's rate for Specialty encounters was below the statewide average in 2018.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	IHA	Statewide Average	IHA	Statewide Average	IHA	Statewide Average
PCPs and OB/GYNs	4.17	3.85	4.15	3.56	4.15	3.50
Specialty	2.09	2.45	1.99	2.30	1.92 ▼	2.33
Emergency Room	0.68	0.54	0.65	0.55	0.63	0.53
Inpatient Admissions	0.42 ▲	0.14	0.41 ▲	0.14	0.35 ▲	0.13
Dental	1.11	1.03	1.14	1.02	1.15	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

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

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	IHA	SWA	IHA	SWA	IHA	SWA
	Medicaid					
Enrollee Health Screenings	20.8%	12.5%	21.0%	12.7%	22.6% ▲	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). The MCO's Medicaid/CHP product line had a rate above the statewide average for 1 out of 10 measures 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	4,373	4,234 ▼	4,130 ▼	5,317	4,201	4,188	4,197	4,209
ER Visits	731 ▲	692 ▲	572	492	217	226	212	204
Inpatient ALOS								
Medicine	4.1	3.9	3.9	4.5	3.9	4.0	3.8	3.5
Surgery	6.9	7.1	7.3	7.0	4.2	4.6	5.0	4.4
Maternity	2.9	2.9	2.9	2.9	2.7	2.8	2.8	2.6
Total	4.5	4.3	4.4	4.4	3.7	4.0	4.0	3.6
Inpatient Utilization (PTMY)								
Medicine Cases	39	41 ▲	37	30	17	19	17	17
Surgery Cases	21	19	18	12	17	18	16	15
Maternity Cases	32	35	35	32	12	12	13	12
Total Cases	83	85 ▲	80 ▲	66	44	47	44	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 2019 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 IHA indicated that the MCO had no significant issues in any areas related to reporting. IHA 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 six measures validated, as well.

IHA 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.[4]

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.

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had 6 out of 14 measures with a reported rate above the SWA.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	93 ▲	93 ▲	96 ▲	**89**	89 ▲	94 ▲	91	**89**
WCC—BMI Percentile	91 ▲	90 ▲	93 ▲	**86**	94 ▲	95 ▲	96 ▲	**90**
WCC—Counseling for Nutrition	88 ▲	89 ▲	88 ▲	**83**	92 ▲	94 ▲	97 ▲	**87**
WCC—Counseling for Physical Activity	81 ▲	85 ▲	85 ▲	**74**	88 ▲	91 ▲	95 ▲	**80**
Childhood Immunizations—Combo 3	81 ▲	81 ▲	83 ▲	**73**	89 ▲	91 ▲	90 ▲	**84**
Lead Screening in Children	88	91 ▲	93 ▲	**87**	95 ▲	94 ▲	97 ▲	**88**
Adolescent Immunizations—Combo 2[2]		38	35 ▼	**43**		27	31	**31**
Adolescents—Alcohol and Other Drug Use[3]	79 ▲	85 ▲	79 ▼	**70**	83 ▲	90 ▲	91 ▲	**78**
Adolescents—Depression[3]	79 ▲	81 ▲	77 ▼	**67**	81 ▲	86 ▲	87 ▲	**70**
Adolescents—Sexual Activity[3]	77 ▲	86 ▲	75 ▼	**67**	82 ▲	86 ▲	84 ▲	**74**
Adolescents—Tobacco Use[3]	85 ▲	89 ▲	85 ▼	**74**	86 ▲	88 ▲	90 ▲	**82**
Breast Cancer Screening	68 ▼	69	71	**71**	76 ▲	77	78 ▲	**77**
Colorectal Cancer Screening	49 ▼	53 ▼	57 ▼	**63**	69	70	75	**71**
Chlamydia Screening (Ages 16-24)	69 ▼	70 ▼	72 ▼	**76**	61	61 ▲	63 ▲	**59**

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 regards to the Medicaid/CHP product line, the MCO had rates below the SWA for 20% of the measures in 2018.

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	91	95 ▲	94 ▲	**91**	95 ▲	96 ▲	96 ▲	**93**
Spirometry Testing for COPD	39 ▼	42 ▼	42 ▼	**56**	50	51 ▲	49	**45**
Use of Imaging Studies for Low Back Pain	67 ▼	69 ▼	70 ▼	**77**	79 ▲	85 ▲	83 ▲	**80**
Pharmacotherapy Management for COPD—Bronchodilators	85	93	89	**89**	67	88	85	**80**
Pharmacotherapy Management for COPD—Corticosteroids	71	85 ▲	80	**76**	66	83	77	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	60 ▼	63 ▼	70	**71**	69	70 ▼	74	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	44 ▼	42 ▼	50 ▼	**59**	47 ▼	49 ▼	54 ▼	**63**
Asthma Medication Ratio (Ages 19-64)	62	62	55	**60**	79	79	81	**81**
Asthma Medication Ratio (Ages 5-18)	71 ▲	69	75 ▲	**68**	84	84	86	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	91	97	87	**80**	96 ▲	94	88	**83**
CDC—HbA1c Testing	90	88 ▼	92	**92**	91	92	92	**92**
CDC—HbA1c Control (<8%)	63 ▲	60	61	**60**	68 ▲	71 ▲	68 ▲	**61**
CDC—Eye Exam Performed	63	64	65	**67**	66 ▲	68 ▲	68 ▲	**63**
CDC—Nephropathy Monitor	93	92	93	**92**	93 ▲	93 ▲	93 ▲	**89**
CDC—BP Controlled (<140/90 mm Hg)	71 ▲	69 ▲	72 ▲	**66**	76 ▲	79 ▲	72	**69**
Drug Therapy for Rheumatoid Arthritis	76	80	79	**83**	82 ▼	85	83	**84**
Monitor Patients on Persistent Medications—Total Rate	88 ▼	88 ▼	88 ▼	**92**	85 ▲	85 ▲	85	**84**
Appropriate Treatment for URI	93	95	96	**95**	91	90 ▼	92	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	27	26 ▼	30	**36**	21 ▼	24 ▼	23 ▼	**34**
HIV Viral Load Suppression[2,3]	76	79	84	**77**				
Flu Shots for Adults (Ages 18-64)[4]	41	41			54	49	65 ▲	**56**
Advising Smokers to Quit[4]	76	78			79	83	90 ▲	**81**

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Smoking Cessation Medications[4]	62	63			60	61	67	**62**
Smoking Cessation Strategies[4]	51	53			52	54	50	**55**

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

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

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

[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, the MCO's Medicaid/CHP product line had a rate above the SWA for 1 out of 9 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	47	49	50	**53**	66	67	71	**68**
Antidepressant Medication Management—Effective Continuation Phase	35	35	36	**37**	49	51	56	**53**
Follow-Up Care for Children on ADHD Medication—Initiation	51 ▼	50 ▼	49 ▼	**59**	40	48	42	**45**
Follow-Up Care for Children on ADHD Medication—Continue	56	70	56	**66**	45	59	49	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	76	78	80	**74**	84 ▲	82	58 ▼	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	51 ▼	60	79 ▲	**63**	68 ▲	65	41 ▼	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	76 ▼	78	81	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	64	86	75	**80**				
Antipsychotic Medications for Schizophrenia	60	57	63	**63**				

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

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.[5]

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 ▼). The MCO's Medicaid/CHP product line had rates statistically better than the SWA for 2 out of 3 measures in this domain.

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	88 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	83	86	86	**86**
Adolescent Well-Care Visits	67 ▼	68	70 ▲	**68**
		Commercial		
Well-Child Visits—First 15 Months	93 ▲	92 ▲	98 ▲	**94**
Well-Child Visits—3 to 6 Year Olds	91 ▲	93 ▲	94 ▲	**88**
Adolescent Well-Care Visits	74 ▲	75 ▲	78 ▲	**67**

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

[5] 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 ▼). The MCO's Medicaid/CHP product line had rates above the SWA for 40% of the measures.

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

	Medicaid/CHP				Commercial			
Measure	2016	2016	2018	2018 SWA	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)								
12-24 Months	99 ▲	99 ▲	99 ▲	**97**	100 ▲	100 ▲	100 ▲	**98**
25 Months-6 Years	94	94	94	**94**	98 ▲	97 ▲	98 ▲	**95**
7-11 Years	97	97	97	**97**	99 ▲	99 ▲	99 ▲	**97**
12-19 Years	95	95	96	**95**	97 ▲	97 ▲	100 ▲	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	84 ▲	84 ▲	85 ▲	**81**	95 ▲	95 ▲	95 ▲	**94**
45-64 Years	90	89	90 ▲	**89**	96	97 ▲	97 ▲	**96**
65+ Years	85	85 ▼	90	**91**	98 ▲	98 ▲	98 ▲	**97**
Access to Other Services								
Timeliness of Prenatal Care	93 ▲	87	88	**88**	97 ▲	98 ▲	100 ▲	**92**
Postpartum Care	66 ▼	66 ▼	69	**70**	91 ▲	94 ▲	88	**83**
Annual Dental Visit[2]	66 ▲	69 ▲	69 ▲	**61**				

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

[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. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	IHA	ROS Average	IHA	ROS Average	IHA	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	7%	7%	7%	7%	-	-
Prenatal Care in the First Trimester	70% ▼	74%	75%	74%	75	75
Risk-Adjusted Primary Cesarean Delivery[1]	11%	14%	12%	13%	-	-
Vaginal Birth After Cesarean	14%	14%	14%	14%	-	-
Commercial						
Risk-Adjusted Low Birth Weight[1]	6% ▼	4%	5%	4%	-	-
Prenatal Care in the First Trimester	81% ▼	88%	81% ▼	88%	81 ▼	88
Risk-Adjusted Primary Cesarean Delivery[1]	21%	19%	18%	18%	-	-
Vaginal Birth After Cesarean	9%	11%	9%	11%	-	-

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

ROS: Rest of State

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

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. 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 ▼). In 2018, the MCO's Medicaid/CHP product line had rates above the statewide average for 25% of the measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	IHA	SWA	IHA	SWA	IHA	SWA	IHA	SWA	IHA	SWA	IHA	SWA
Flu Shots for Adults Ages 18-64							50	**52**	54	**52**	65 ▲	**56**
Advising Smokers to Quit							87	**84**	79	**80**	90 ▲	**81**
Getting Care Needed[1]	89 ▲	**83**	86	**85**	85	**84**	90	**88**	93 ▲	**88**	93 ▲	**89**
Getting Care Quickly[1]	91 ▲	**87**	91	**88**	89	**88**	90	**88**	90	**87**	89	**87**
Customer Service[1]	85	**82**	92 ▲	**86**	91 ▲	**86**	90	**88**	93 ▲	**89**	92	**91**
Coordination of Care[1]	76	**74**	71	**74**	73	**75**	85	**84**	86	**83**	88	**87**
Collaborative Decision Making[1]	54	**53**	75	**74**	84 ▲	**76**	82	**80**	82	**80**	83	**80**
Rating of Personal Doctor[1]	85 ▼	**89**	87	**89**	90	**90**	81	**84**	90 ▲	**86**	86	**86**
Rating of Specialist	89 ▲	**81**	84	**83**	82	**84**	78	**83**	81	**84**	84	**84**
Rating of Healthcare	85	**85**	88	**86**	90	**87**	80	**78**	84 ▲	**80**	83	**81**
Satisfaction with Provider Communication[1]	93	**93**	93	**93**	94	**93**	96	**96**	97	**96**	95	**96**
Wellness Discussion							84 ▲	**77**	83 ▲	**76**	81	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	62	**64**	71	**68**	66	**69**						
Rating of Health Plan—High Users	82	**84**	94 ▲	**85**	81	**84**	81 ▲	**68**	73	**68**	76	**72**
Overall Rating of Health Plan	87 ▲	**83**	91 ▲	**85**	90 ▲	**85**	74 ▲	**67**	72 ▲	**66**	72	**71**
Recommend Plan to Family/Friends												

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

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

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

IHA's 2017-2018 PIP topic was *"Improving Maternal and Infant Outcomes in Western New York"*. During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- General and targeted member education and outreach regarding postpartum contraception, including information on birth spacing, risks of preterm birth, depression, and tobacco use.

Provider-Focused Interventions:

- Provide general education and reminders to OB providers ensuring awareness of the prior authorization process for 17P, depression screening for prenatal members, birth spacing, and the importance of tobacco screening and industry-recognized tobacco cessation.
- Targeted physician education and counseling provided based on practice patterns of non-compliance with the outcome measures below the baseline rate.

MCO-Focused Interventions:

- Policy development and the improvement of health plan processes, including better identification of high-risk members to trigger more accurate and timelier member outreach and provider collaboration.

Table 18 presents a summary of IHA's 2017-2018 PIP. The MCO demonstrated an improvement for 10 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	**93%**	**88%**	92%	Performance declined
Postpartum Care	**66%**	**69%**	73%	Demonstrated improvement
Received at least one 17P injection	**15%**	**60%**	9.3%	Demonstrated improvement
Depression Screening*	**80%**	**74%**	83%	Demonstrated improvement from Interim to Final
Tobacco Screening*	**88%**	**92%**	23%	Performance declined from Interim to Final
Tobacco Screening Follow-Up*	**67%**	**38%**	24%	Performance declined from Interim to Final
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	**9%**	**9%**	10%	Performance level was maintained
Age 15-20 years; within 60 days	**42%**	**47%**	44%	Demonstrated improvement
Age 21-44 years; within 3 days	**10%**	**11%**	8%	Demonstrated improvement
Age 21-44 years; within 60 days	**40%**	**41%**	39%	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	**0%**	**2%**	3%	Demonstrated improvement
Age 15-20 years; within 60 days	**7%**	**10%**	21%	Demonstrated improvement
Age 21-44 years; within 3 days	**0%**	**1%**	3%	Demonstrated improvement
Age 21-44 years; within 60 days	**5%**	**7%**	17%	Demonstrated improvement

*Baseline measurement of depression screening, tobacco screening, and tobacco follow up was based on review of full prenatal records. Interim and final measurements were derived from incomplete records (missing social work notes, consultations, and referrals) and rates may be under-reported.

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.

IHA did not report on any activities performed in 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.

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)[6]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

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

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

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

[6] 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
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.

IHA has not indicated that it performed any HIT-related activities:

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

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

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

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

Regarding IHA's operational review; IHA was in compliance with 12 of the 14 categories. The categories in which IHA was not compliant were Organization and Management (4 citations) and Utilization Review (3 citations). Regarding IHA's focused review; IHA was in compliance with 13 of the 14 categories. The category in which IHA was not compliant was Organization and Management (2 citations).

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	4	2	Behavioral Health Claims	2
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	0	0		
Utilization Review	3	0		
Total	**7**	**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, 73% of the MCO's external appeals were upheld.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	8	1	3
Overturned in Part	2	0	0
Upheld	4	3	8
Medicaid Total	**14**	**4**	**11**
		CHP	
Overturned	0	0	0
Overturned in Part	0	0	0
Upheld	1	0	0
CHP Total	**1**	**0**	**0**

VIII. Strengths and Opportunities for Improvement[7]

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

Strengths

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

Strengths:

- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO had a total appointment rate above the threshold for Routine call types.
- The MCO's rate for health screenings for new enrollees had a rate (22.6%) above the statewide average in 2018.
- The MCO performed well in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO's rates have been reported above the statewide average for at least three consecutive reporting years for *Adult BMI Assessment, Weight Assessment and Counseling for Children and Adolescents—(BMI Percentile, Counseling for Nutrition and Counseling for Physical Activity),* and *Childhood Immunizations – Combo 3.* The MCO's rates were also reported above the statewide average in 2018 for *Lead Screening in Children.*
- In the domain of Effectiveness of Care: Acute and Chronic Care, the MCO reported rates above the statewide average for three consecutive years for *Comprehensive Diabetes Care – Blood Pressure Controlled (<140/90 mm Hg)*. The MCO also had rates above the statewide average in 2018 for Testing for Children with Pharyngitis and Asthma Medication Ratio (Ages 5-18).
- In regards to the HEDIS®/QARR Behavioral Health domain, the MCO's rate for *Follow-Up After Hospitalization for Mental Illness – 7 Days* was above the statewide average.
- In regards to the Access/Timeliness indicators, the MCO has reported rates for at least three consecutive reporting years for the *Children and Adolescents' Access to Primary Care Practitioners—12-24 Months, Adults' Access to Preventive/Ambulatory Health Services—20-44 Years,* and *Annual Dental Visit (Ages 2-20)* measures. The MCO also had reported rates above the statewide average in 2018 for following measures: Well-Child Visits – First 15 Months, Well-Child Visits – 3 to 6 Year Olds, and Adults' Access to Preventative/Ambulatory Services--46-65 Years.

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

- The MCO performed well on the 2018 CAHPS® member satisfaction survey. The MCO has reported a rate above the statewide average for at least three consecutive survey cycles for the *Overall Rating of Health Plan* measure. Additional measures for which the MCO reported rates above the statewide average on the 2018 survey include *Customer Service,* and *Collaborative Decision Making*.

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:

- The MCO demonstrates an opportunity for improvement with the ratio of enrollees to Behavioral Health specialists. The MCO had a rate above the statewide average which indicates fewer providers per enrollee.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO's appointment rates were below the 75% threshold for Non-Urgent "sick" and After-Hours Access call types.
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Colorectal Cancer Screening* and *Chlamydia Screening in Women (Ages 16-24).* The MCO also had rates below the statewide averages for the following measures: *Adolescents Immunizations-Combo 2*, *Adolescents-Alcohol and Other Drug Use, Adolescents-Depression, Adolescents-Sexual Activity,* and *Adolescents-Tobacco Use. (Note: Colorectal Cancer Screening* and *Chlamydia Screening in Women (Ages 16-24) were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Spirometry Testing for COPD, Use of Imaging Studies for Low Back Pain, Medication Management for People with Asthma 50% of Days Covered (Ages 5-18),* and *Annual Monitoring for Patients on Persistent Medications—Total Rate*. (*Note: Medication Management for People with Asthma 50% of Days Covered and Annual Monitoring for Patients on Persistent Medications—Total Rate was opportunities for improvement in the previous year's report.)*
- The MCO has reported a rate below the statewide average for at least three consecutive years for the HEDIS®/QARR Behavioral Health measure *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. *(Note: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regards to the QARR Prenatal Care domain. The MCO's rate for *Prenatal Care in the First Trimester* was below the statewide average for three consecutive years (2015-2017).
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 9 citations from the operational and focused review surveys related to Organization and Management and Utilization Review. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- Substance use and mental health issues affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[8] In 2018, the MCO's low rate of Behavioral Health specialists (5.1%) could have influenced its high ratio of enrollees to Behavioral Health providers (177:1). The MCO should make all efforts to contract with additional Behavioral Health providers or consider collaborating with a community based organization (CBO) that provides education and treatment for behavioral health conditions. The MCO should also conduct a root cause analysis to identify the source for the consistent poor performance on the HEDIS®/QARR *Follow-Up Care for Children on ADHD Medication – Initiation* measure. Some barriers could be provider network inadequacies, appointment availability conflicts with parent/guardian work schedules, or cultural factors regarding mental health.
- With the MCO's appointment rate below the 75% threshold for Primary Care and OB/GYN providers during Non-Urgent "sick" and After-Hours Access calls, the MCO should develop a process to identify providers who did not meet the requirements. The MCO should offer education on the access and availability standards to the identified providers. Ongoing reminders to providers can be given through existing provider communications such as; quarterly provider newsletters and fax blasts.
- Although the MCO's rates for *Colorectal Cancer Screening* and *Chlamydia Screening (Ages 16-24)* have trended upwards, the rates remained below the statewide average in 2018. The MCO should continue with its current interventions with a focus on member initiatives. In regards to the QARR Adolescent Preventative Care Measures, in 2018 the MCO saw a decline in performance for all measures. The MCO should investigate the cause of this decline as the previous years' rates were above the statewide averages. Possible barriers to consider are; MCO organizational changes, provider appointment availability, or provider education on these screenings. The MCO should continuously evaluate its current interventions to identify barriers to accessing preventative screenings.
- The MCO continues to struggle to improve rates related to acute and chronic care. The MCO should continue with its current interventions targeting members with asthma, as the MCO's rates for medication management has improved but still remains below the statewide average. The MCO should consider utilizing Pharmacists to provide member and provider outreach regarding chronic conditions such as COPD, asthma, and patients on persistent medications.
- The MCO should continue with the steps taken to address the identified issues in the different categories in which citations were noted in the 2018 operational and focused review surveys. The MCO should focus on Utilization Review notices sent to members and the management of delegates such as Beacon and HealthPlex. *[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 continues to struggle to improve several measures related to preventive screenings and diagnostic tests. The MCO should evaluate the impact the initiatives of mobile mammography units and FIT kits is having on closing these gaps in care to determine if they are helping members receive appropriate and timely screenings. Additionally, the MCO should determine barriers that affect providers' protocols when deciding which diagnostic tests are appropriate at a given time and implement interventions to address these barriers. *[Repeat recommendation.]*

[8] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

MCO Response: Independent Health agrees with this recommendation that it should evaluate its strategy to assess member barriers to preventative screenings and care as well as follow-up for chronic conditions. Since 2016, Independent Health has launched several performance improvement projects to increase our performance in specific areas of opportunity. Many of these initiatives have positively impacted performance measures for prevention and chronic disease management. Areas of focus for 2020 include:

1. PCP Gaps in Care closure through the Provider Portal: Independent Health will support the fourth year of its Medicaid PCP incentive. This incentive encourages PCPs to proactively close care gaps for Medicaid patients in areas of preventative health, chronic care management and behavioral health. For 2020, a robust number of measures are included in the incentive, covering both Adult and Pediatric Medicaid members.
2. Gaps in Care corrections process through the Provider Portal: In May 2019, the gaps in care corrections collection process was launched to accept supplemental data electronically via the Provider Portal. This process allows for medical record documentation to be submitted to 'correct' inaccuracies in quality measures by making available encounters or lab values not readily available, data from exclusions such as mastectomies, and services rendered by a different payer. Since its launch, this targeted Quality Improvement process has led to an increase in accuracy for reporting quality measures.
3. Member Gaps in Care incentive: Independent Health will also provide member incentives for closing select gaps in 2020. In 2018, eight measures were incentivized, followed by twelve in 2019. The specific measures to be targeted in 2020 will be finalized in Q1.
4. PCP value-based payment programs: Independent Health will continue to expand the value-based payment arrangements, with individual provider groups and community IPA's. In 2019, Independent Health introduced a more robust version of 'Primary Value', a PCP based value-based payment arrangement, which includes twenty-seven quality measures. This program has resulted in an increase in preventative services including well visits, breast cancer screening, colorectal cancer screening rates, and chlamydia screening. Medication adherence to asthma medications, antidepressant and statin adherence rates also saw increases in 2019.
5. Community interventions: Independent Health also hosts targeted community health interventions to increase screenings and close care gaps. In 2020, mobile mammography units will continue to remove access to barriers for members who needed breast cancer screening services. In 2019, Independent Health also launched a colorectal cancer screening campaign, including a free FIT kit and member incentive to complete the colorectal cancer screening.
6. Health Home engagement: Since 2019, Independent Health has worked closely with the six lead health homes and downstream care management agencies to provide monthly gaps in care reports. Independent Health meets quarterly with each lead health home to review gaps in care closed. Additionally, the Health Home Optimization Project launched in 2019, is working to increase the number of eligible health home members who are enrolled in a health home.

- **2017 Recommendation:** As the MCO continues to struggle to improve measures related to asthma medication management and monitoring and follow-up for certain medications, including ADHD medication, the MCO should conduct a thorough root cause analysis to determine key drivers to poor performance on these measures. The MCO should then develop interventions designed to target those drivers. Some key drivers could include members not knowing they need to be monitored while on their medications, or members stopping medication regimens due to side effects or feeling better, among others. *[Repeat recommendation.]*

MCO Response: Independent Health agrees with this recommendation that it has been challenging to improve measures to medication management improving asthma medication and ADHD medication management. In 2019, a new corrective action plan was initiated to improve medication management for people with asthma with specific interventions, namely:

1. Timely identification of members with persistent asthma who are at risk for non-compliance to asthma medication on a monthly report
2. Member outreach by a respiratory therapist/case manager to assess ability to self-manage complex inhaler regimens and educate member on managing medications.
3. Linking members with a health home to improve access to providers and address barriers such as transportation.

These targeted interventions were designed to identify at risk non-compliant members quickly, provide them with appropriate resources and link them to providers to manage their chronic conditions and to support care coordination. Rates were monitored monthly to assess effectiveness of the interventions. It was noted that the rates improved from measurement year 2018 to measurement year 2019. Independent health will continue to manage members non adherent to asthma medications in 2020.

For ADHD medication management, Independent Health did a focused medical record review study of prescribing providers in late 2019 to better understand the evaluation, diagnosis and treatment of this condition. The findings of the study were reviewed with a regional behavioral health IPA to identify areas of opportunity for improvement. It was found that PCPs were frequently not documenting their diagnosis and evaluation criteria in accordance with clinical guidelines, and further, that key components of the clinical guideline treatment plan were not documented, including low levels of parent training, behavioral classroom interventions, or school treatment plans. In 2020, Independent Health will work with PCPs to ensure that pediatric patients are properly diagnosed and evaluated for ADHD, and once diagnosed, appropriately treated per the clinical guidelines. Once these foundational aspects of diagnosis, evaluation and treatment addressed, Independent Health will further explore ways in which to better address patient barriers to ADHD follow-up.

- **2017 Recommendation:** The MCO should continue its efforts to address issues identified in the operational and focused review surveys. First, the MCO should re-examine its processes for oversight in terms of review of utilization review documentation to ensure all documents have been updated as the MCO stated in its corrective action plan. Additionally, the MCO should ensure that access and availability issues have been remedied. *[Repeat recommendation.]*

  MCO Response: Independent Health agreed with the issues identified in the operational and focused review surveys. It has initiated several corrections to ensure that policies, procedures and state regulatory guidelines are met when preparing related documentation with correct information and the necessary language. To address corrections, Independent Health has:

  1. Updated letter templates and vendor notices,
  2. Documented clinical rationale requirements in SOPs, which have been shared with vendors
  3. Provided necessary retraining internally as well as with impacted vendors.

  Through its internal Quality Assurance and vendor oversight programs, Independent health continues to monitor utilization review documentation. The Provider Manual was revised in 2019 and will continue to be reviewed for accuracy and completeness in 2020. The Quality Assurance and vendor oversight programs will continue to ensure that utilization review documentation is complete and accurate in 2020.

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