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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

METROPLUS HEALTH PLAN, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

MetroPlus Health Plan, Inc. (MetroPlus) is a regional, not-for-profit prepaid health services plan (PHSP) that serves Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

MetroPlus Web Page: https://www.metroplus.org/

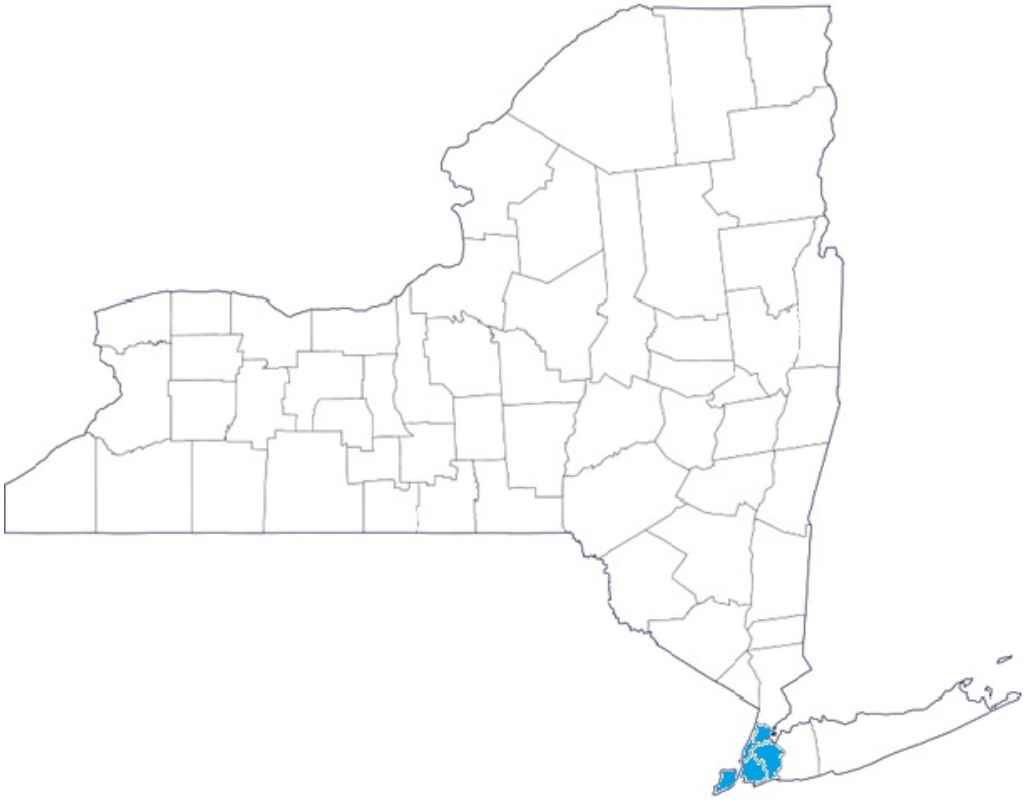
*Participating Regions and Products			
New York City:	MCD	CHP	HARP

* 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

Figure 1: MetroPlus Map of Participating Counties



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 2.7%. MetroPlus' membership represents 8.4% 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	382,190	377,045	366,732
% Change from Previous Year	-7.5%	-1.3%	-2.7%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	8.8%	8.6%	8.4%

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	14,573	16,593	18,075

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: MetroPlus Enrollment Trends—All Product Lines

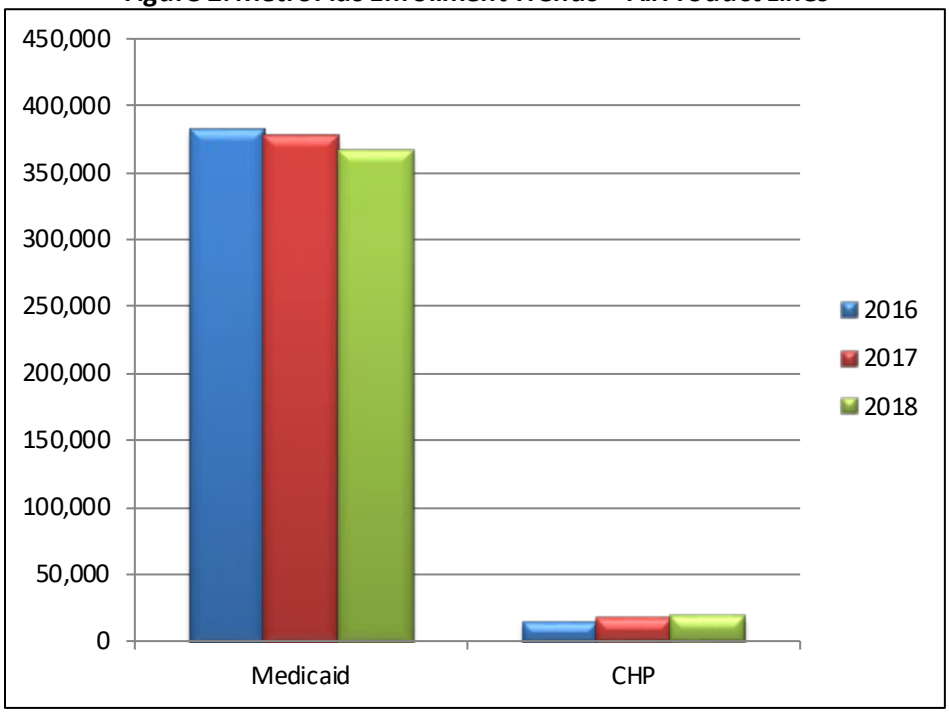


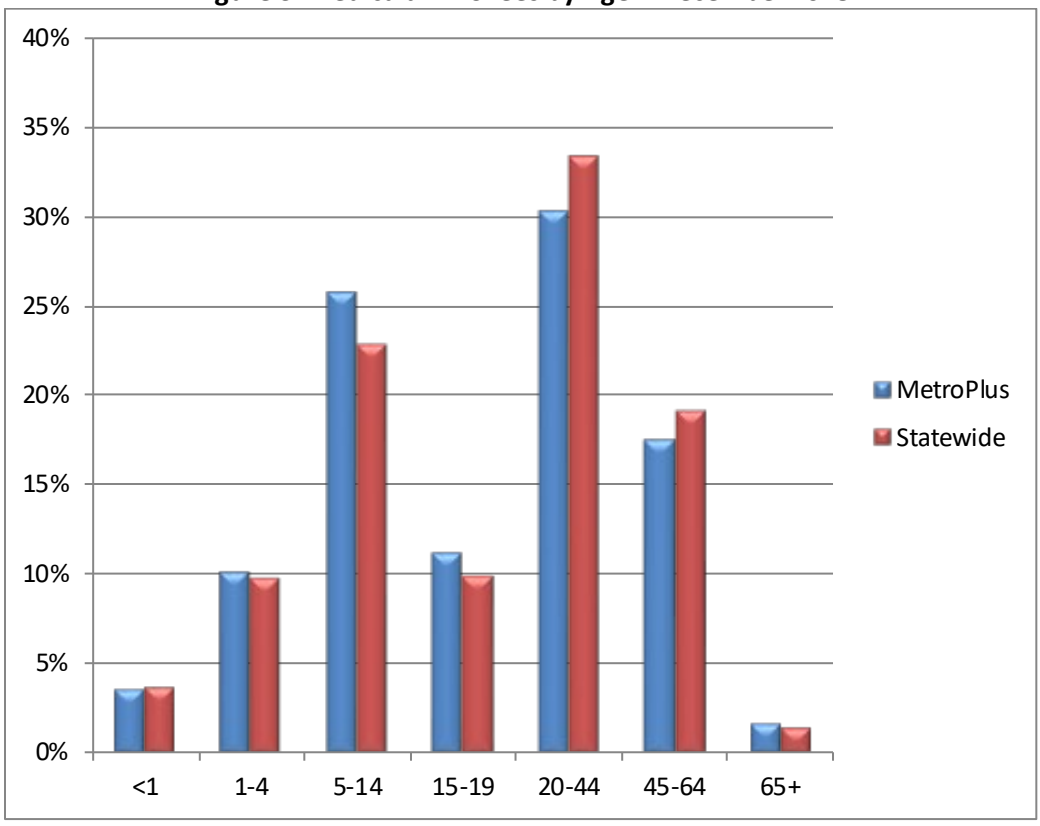
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. MetroPlus Health Plan's enrollment rates were above the statewide average for members aged 5-14 years old and 15-19 years old..

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	6,684	6,247	12,931	3.5%	3.6%
1-4	18,774	17,973	36,747	10.1%	9.7%
5-14	47,780	46,030	93,810	25.7% ▲	22.8%
15-19	20,860	19,923	40,783	11.2% ▲	9.9%
20-44	47,184	63,533	110,717	30.4% ▼	33.3%
45-64	31,093	32,696	63,789	17.5%	19.1%
65 and Over	2,146	3,705	5,851	1.6%	1.4%
Total	174,521	190,107	364,628		
Under 20	94,098	90,173	184,271	50.5%	46.1%
Females 15-64		116,152		31.9% ▼	34.7%

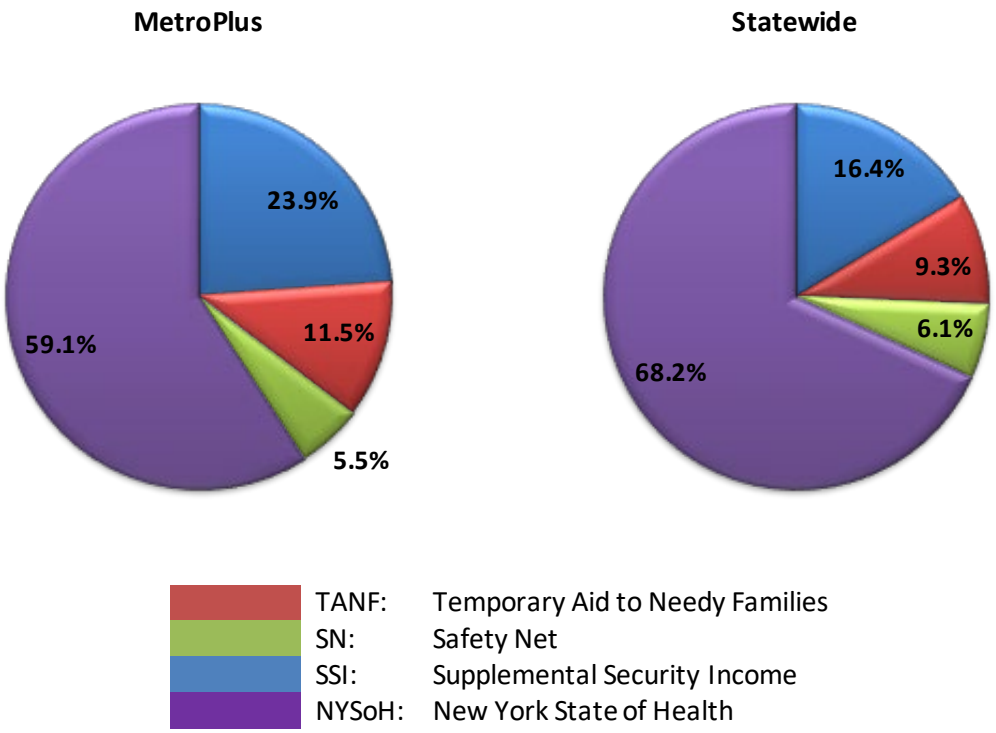
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

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 rates for all provider types improved from 2017. 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*[1].

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

Provider Type	2016		2017		2018	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus[1]	Statewide Average
			Medicaid/CHP			
Family Medicine	54% ▼	71%	68%	72%	69%	74%
Internal Medicine	67% ▼	75%	66% ▼	76%	72%	76%
Pediatricians	63% ▼	78%	67% ▼	79%	75%	80%
OB/GYN	55% ▼	75%	67% ▼	77%	81%	80%
Geriatricians	56%	63%	55%	63%	65%	63%
Other Physician Specialists	57% ▼	75%	52% ▼	76%	68%	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 ▼. The MCO had rates below the statewide average for 60% of the listed specialty types.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	3929	5.7% ▼	19.5%
Pediatrics	926	4.7%	3.8%
Family Practice	580	0.1% ▼	3.5%
Internal Medicine	1839	0.5% ▼	8.4%
Other PCPs	584	0.4% ▼	3.8%
OB/GYN Specialty[1]	758	4.0%	3.8%
Behavioral Health	5,363	28.0% ▲	17.2%
Other Specialties	7,058	36.8% ▼	46.0%
Non-PCP Nurse Practitioners	252	1.3% ▼	8.7%
Dentistry	1,812	9.5% ▲	4.9%
Total	19,172		

[1] *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/

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 had rates above the statewide median for 2 provider types and for FTEs.

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

	MetroPlus			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	93:1 ▲	2845	128:1 ▲	42:1	80986	42:1
Pediatrics (Under age 20)	199:1			70:1		
OB/GYN (Females age 15-64)	153:1 ▲			59:1		
Behavioral Health	68:1			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 ▼.

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

	2016			2017			2018		
	MetroPlus		Statewide	MetroPlus		Statewide	MetroPlus		Statewide
	Number	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**
Medicaid									
Providers with Open Panel	2985	98.5	85.0	3654	98.8	95.7	3867	98.6	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 MetroPlus 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
150	109	**72.7%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 167 providers (total number of providers who were compliant for participation (173), less total number of providers with closed panels (6)). The MCO performed above the threshold for Routine and Non-Urgent "sick" 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	13	13	100.0%
	Pediatrician	13	13	100.0%
	OB/GYN	9	9	100.0%
	Total Routine	**35[2]**	**35**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	13	13	100.0%
	Pediatrician	15	15	100.0%
	OB/GYN	11	11	100.0%
	Total Non-Urgent	**39**	**39**	**100.0%**
After-Hours Access	Internist/Family Practitioner	10	6	60.0%
	Pediatrician	12	10	83.3%
	OB/GYN	11	7	63.6%
	Total After-Hours	**33**	**23**	**69.7%**

[1] Timeliness was not considered when determining appointment availability rates.
[2] Final sample less excluded providers. One (1) Provider was excluded because the survey 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 has rates below the statewide average for 3 consecutive years for member encounters with specialists.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
PCPs and OB/GYNs	3.62	3.85	3.38	3.56	3.33	3.50
Specialty	1.57 ▼	2.45	1.54 ▼	2.30	1.55 ▼	2.33
Emergency Room	0.69	0.54	0.67	0.55	0.66	0.53
Inpatient Admissions	0.16	0.14	0.15	0.14	0.13	0.13
Dental	0.92	1.03	0.92	1.02	0.90	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 ▼.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	MetroPlus	SWA	MetroPlus	SWA	MetroPlus	SWA
	Medicaid					
Enrollee Health Screenings	7.5%	12.5%	11.2%	12.7%	8.4%	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 ▼). In 2018, the MCO's *Inpatient ALOS* rates were above the statewide average for all provider types.

Table 12: QARR Use of Services Rates

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	8,432 ▲	4,580	4,539	5,317
ER Visits	656	636	618	492
Inpatient ALOS				
Medicine	2.8 ▼	6.9 ▲	8.1 ▲	4.5
Surgery	6.8	7.7 ▲	9.6 ▲	7.0
Maternity	2.8	3.1 ▲	3.2 ▲	2.9
Total	3.2 ▼	5.7 ▲	6.6 ▲	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	106 ▲	43 ▲	42 ▲	30
Surgery Cases	13	9 ▼	9 ▼	12
Maternity Cases	47 ▲	41 ▲	38 ▲	32
Total Cases	152 ▲	81	77	66

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 MetroPlus indicated that the MCO had no significant issues in any areas related to reporting. MetroPlus demonstrated compliance all areas of Information Systems. MetroPlus demonstrated compliance with all areas of Measure Determination. 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.

MetroPlus 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. [2]

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.

[2] 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 ▼). The MCO had rates above the SWA for 93% of the measures related to prevention and screening.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	92 ▲	92 ▲	94 ▲	**89**
WCC—BMI Percentile	83 ▲	93 ▲	94 ▲	**86**
WCC—Counseling for Nutrition	80	90 ▲	93 ▲	**83**
WCC—Counseling for Physical Activity	69	78 ▲	85 ▲	**74**
Childhood Immunizations—Combo 3	86 ▲	87 ▲	93 ▲	**73**
Lead Screening in Children	95 ▲	95 ▲	94 ▲	**89**
Adolescent Immunizations—Combo 2[2]		64 ▲	61 ▲	**43**
Adolescents—Alcohol and Other Drug Use[3]	62	80 ▲	88 ▲	**70**
Adolescents—Depression[3]	70 ▲	82 ▲	84 ▲	**67**
Adolescents—Sexual Activity[3]	66	81 ▲	85 ▲	**67**
Adolescents—Tobacco Use[3]	70	85 ▲	91 ▲	**74**
Breast Cancer Screening	73 ▲	74 ▲	75 ▲	**71**
Colorectal Cancer Screening	65 ▲	67 ▲	67	**63**
Chlamydia Screening (Ages 16-24)	79 ▲	78 ▲	82 ▲	**76**

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 otherwise noted.

[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, 5 out of 20 measures had a reported rate above the SWA.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	81 ▼	88 ▼	81 ▲	**91**
Spirometry Testing for COPD	53	51	46 ▲	**56**
Use of Imaging Studies for Low Back Pain	80 ▲	79 ▲	79 ▲	**77**
Pharmacotherapy Management for COPD—Bronchodilators	88	90	87	**89**
Pharmacotherapy Management for COPD—Corticosteroids	72	73	72	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	71 ▲	70	70	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	53	57	57 ▼	**59**
Asthma Medication Ratio (Ages 19-64)	52 ▼	54 ▼	59	**60**
Asthma Medication Ratio (Ages 5-18)	58 ▼	61 ▼	62 ▼	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	82	79	78	**80**
CDC—HbA1c Testing	93	94 ▲	90	**92**
CDC—HbA1c Control (<8%)	51	59	57	**60**
CDC—Eye Exam Performed	62	66	69	**67**
CDC—Nephropathy Monitor	91	93	89	**92**
CDC—BP Controlled (<140/90 mm Hg)	62	70 ▲	72 ▲	**66**
Drug Therapy for Rheumatoid Arthritis	84	89 ▲	89 ▲	**83**
Monitor Patients on Persistent Medications—Total Rate	93 ▲	93 ▲	92	**92**
Appropriate Treatment for URI	95 ▲	96 ▲	95	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	33	35	36	**36**
HIV Viral Load Suppression[2,3]	77	76	78	**77**
Flu Shots for Adults (Ages 18-64)[4]	48 ▲	46		
Advising Smokers to Quit[4]	79	79		
Smoking Cessation Medications[4]	61	58		
Smoking Cessation Strategies[4]	61	55		

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

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

[1] All measures included in this table are HEDIS® measures, unless 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 rate was above the SWA for the *Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds* measure.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	50	53	53	**53**
Antidepressant Medication Management—Effective Continuation Phase	36	37	36	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	67 ▲	62	62	**59**
Follow-Up Care for Children on ADHD Medication—Continue	88 ▲	80 ▲	77	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	74 ▼	69 ▼	75	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	56 ▼	51 ▼	64	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	82	86 ▲	86 ▲	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	84	86	82	**80**
Antipsychotic Medications for Schizophrenia	61	59	61	**63**

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.[3]

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, the MCO had 1 out of 3 rates above the SWA.

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

Measure	2016	2016	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	67 ▲	70 ▲	81	**81**
Well-Child Visits—3 to 6 Year Olds	87 ▲	87 ▲	87 ▲	**86**
Adolescent Well-Care Visits	67 ▼	67 ▼	67 ▼	**68**

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

[3] 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 ▼). MetroPlus Health Plan had rates below the SWA for 70% of the measures in 2018...

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

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	94% ▼	94% ▼	93% ▼	**97**
25 Months-6 Years	94%	92% ▼	91% ▼	**94**
7-11 Years	97%	96% ▼	95% ▼	**97**
12-19 Years	94% ▼	93% ▼	93% ▼	**95**
Adults' Access to Preventive/Ambulatory Services				
20-44 Years	79% ▼	77% ▼	76% ▼	**81**
45-64 Years	90%	89% ▼	87% ▼	**89**
65+ Years	91%	91%	91%	**91**
Access to Other Services				
Timeliness of Prenatal Care	93% ▲	92% ▲	89	**88**
Postpartum Care	74%	71%	70	**70**
Annual Dental Visit[2]	60%	60%	59% ▼	**61**

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 15** presents prenatal care rates calculated by the NYSDOH for QARR 2015 through 2017 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼). The MCO's rate for *Prenatal Care in the First Trimester* was below the regional average for 3 consecutive years.

Table 15: QARR Prenatal Care Rates—2017-2019

Measure	2017		2018		2019	
	MetroPlus	Regional Average	MetroPlus	Regional Average	MetroPlus	Regional Average
			NYC			
Risk-Adjusted Low Birth Weight[1]	7%	6%	7%	6%	-	-
Prenatal Care in the First Trimester	65% ▼	75%	67% ▼	76%	67% ▼	75%
Risk-Adjusted Primary Cesarean Delivery[1]	14%	14%	14%	14%	-	-
Vaginal Birth After Cesarean	14% ▼	18%	14% ▼	18%	-	-

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

NYC: New York City

[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 had rates below the SWA for 2 out of 12 measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
			Medicaid			
Getting Care Needed[1]	79	**83**	78 ▼	**85**	78	**84**
Getting Care Quickly[1]	78 ▼	**87**	80 ▼	**88**	86	**88**
Customer Service[1]	77	**82**	83	**86**	83	**86**
Coordination of Care[1]	69	**74**	72	**74**	82	**75**
Collaborative Decision Making[1]	50	**53**	71	**74**	73	**76**
Rating of Personal Doctor[1]	89	**89**	90	**89**	92	**90**
Rating of Specialist	80	**81**	80	**83**	68 ▼	**84**
Rating of Healthcare	83	**85**	84	**86**	86	**87**
Satisfaction with Provider Communication[1]	92	**93**	90 ▼	**93**	90 ▼	**93**
Rating of Counseling/Treatment	68	**64**	75	**68**	58	**69**
Rating of Health Plan—High Users	86	**84**	85	**85**	89	**84**
Overall Rating of Health Plan	83	**83**	84	**85**	88	**85**

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

Performance Improvement Project

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

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

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

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

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

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

Member-Focused Interventions:

- Member outreach to newly pregnant members included member portal postings, mailings, and text messages with education about preterm birth, depression, tobacco use, contraception and community resources.
- Member rewards program which awards points redeemable for prizes when prenatal and postpartum visits are completed.
- Mailing and telephonic outreach were conducted to members who recently delivered regarding importance of postpartum care.

Provider-Focused Interventions:

- Providers received education regarding Medicaid Prenatal Standards and ACOG Guidelines for 17P, conducting depression screening and coding, availability of Beacon Health Options as a behavioral health referral resource, tobacco use assessment and resources, and contraception counseling.
- Onsite visits were made to three targeted NYC Health and Hospitals facilities for education and barrier discussion.

MCO-Focused Interventions:

Use of MetroPlus Integrated CM and claims reports to identify pregnant members with prior history of spontaneous preterm birth**.**

Table 18 presents a summary of MetroPlus' 2017-2018 PIP. The MCO demonstrated an improvement for 8 out of 12 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Received at least one 17P injection	13%	25%	20%	Demonstrated improvement
Depression Screening	**	88%	75%	Demonstrated improvement
Tobacco Screening	**	91%	75%	Demonstrated improvement
Tobacco Screening Follow-Up	**	100%	75%	Demonstrated improvement
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	6%	4%	N/A[1]	Performance declined
Age 15-20 years; within 60 days	26%	22%	30%	Performance declined
Age 21-44 years; within 3 days	3%	4%	N/A[1]	Demonstrated improvement
Age 21-44 years; within 60 days	22%	22%	35%	Performance level was maintained
Received a long acting reversible method of contraception (LARC)				

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Age 15-20 years; within 3 days	0%	1%	N/A[1]	Demonstrated improvement
Age 15-20 years; within 60 days	4%	6%	7%	Demonstrated improvement
Age 21-44 years; within 3 days	0%	0%	N/A[1]	Performance level was maintained
Age 21-44 years; within 60 days	4%	5%	7%	Demonstrated improvement

*Interim rates not reported for PPC.

**Chart review for depression and tobacco use was not conducted in 2016 for the selected facilities.

[1] Members who receive contraception within 3 days or while inpatient will be difficult to identify due to bundle payment methodology

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.

MetroPlus 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:

- MetroPlus has characterized, identified and analyzed the MCO's Medicaid population according to at-risk characteristics. The MetroPlus Enhanced Plan is a HARP product that has 12,583 members. MetroPlus Partnership in Care HIV SNP is a product for Medicaid members who are living with HIV/AIDS and their eligible children. Homeless individuals who qualify can also choose a SNP even if they do not have HIV. For both the HIV SNP and HARP population, there is a subset of adult members with Serious Mental Illness (SMI) who are at risk of becoming disengaged from care and therefore, need intensive, collaborative, and person-centered approaches to treatment and recovery. To support this at-risk population of HIV SNP and HARP members, MetroPlus utilized the Follow-up after Hospitalization for Mental Illness (FUH) denominator to identify members for outreached to ensure transition to follow-up care. The findings indicated that the MCO had low rates of follow-up visit post-hospitalization for mental illness. As a result a PIP was created to address the barriers facing this population, improve care transitions, and decrease hospital readmissions.
- Regarding the HEDIS/QARR measure, follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), MetroPlus identified that Black or African-American members were the most prevalent racial group in the measure denominator at 45%. For these members, both the FUA 7-day and 30-day follow-up rates (18.7% and 25.7% respectively) were significantly lower than other racial groups. To address this health outcome disparity, Peer Support Specialists were utilized to establish a relationship with the member prior to the member's hospital discharge. Field based and onsite case managers from Beacon Health Options also attempt to reach the members before they are discharged to provide education on the importance of follow-up care, available services, social supports, and community resources which are also address cultural barriers as part of their discharge plan.
  In 2018, a quality care gap was identified for colorectal cancer screening (COL) between the Medicaid and HARP populations. The COL rate for Medicaid was 58.3%, but for HARP the COL rate was much lower at 44.4%. FIT kits were distributed to 150 HARP members. These members were outreached via letter and live phone calls by MCO staff and by a partner provider. Providers were educated through the provider portal and the Pay for Performance program which incentivizes providers to increase colorectal cancer screenings. The MCO also partnered with the American Cancer Society to co-present a webinar regarding the different alternatives available for colorectal cancer screening which may be more appropriate for special populations.

- In 2018, the MCO analyzed the Adolescent Well-Child (AWC) visit measure in the Medicaid population and identified that adolescent members living in the Bronx, Brooklyn, and Manhattan all had a lower rate of completing their well-child visit as compared to Queens which had a significantly higher rate. To address this geographic disparity based on members' location of residence, a series of MetroTeen Health Fairs were held during 2018-2019 across the three low performing boroughs at the following facilities: East New York, Woodhull Hospital, Lincoln Hospital and Metropolitan Hospital. Targeted outreach to teenage members who live in the zip codes surrounding the facilities was conducted via live phone calls. Members were invited to the MetroTeen events and were offered an annual physical examination or were assisted to make future appointments. The MetroTeen events were well-received with a total of 954 members in attendance at six different events.
- MetroPlus developed and implemented interventions that aimed to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for members identified with at-risk characteristics. Based on 2018 data analysis, a performance improvement project was implemented for 2019 – 2020 to address care transitions after emergency department and inpatient admissions for mental illness and designed to reduce a variety of barriers confronting the HIV SNP and HARP populations. Education by field-based case managers and onsite case managers from the behavioral health vendor was provided to members prior to being discharged from the hospital. Case Managers referred members to their Health Home (if enrolled) or coordinate enrollment if the member is agreeable into a Health Home. Health Homes provide additional assistance with scheduling follow-up appointments, troubleshoot issues with pharmacy to increase medication adherence, and connect members to community-based resources to address social determinants of health that may impact the members' ability to follow-up with aftercare.

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)[4]
- 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%

[4] 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.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Secure access through member/provider portals.
  - Utilizes encrypted emails for quality management operations reporting.
  - Utilize secure FTP sites and/or direct uploads to secure websites.

- Use of telecommunications technologies:
  - Utilize IVR system for communication member eligibility for providers and clients, as well as claims status.
  - Use of a telehealth vendor to offer telehealth visits.
  - Care managers coordinate members care via telephonic outreach.

- Use of Electronic Health Records (EHR):
  - The MCO conducts site-approved, HIPAA compliant onsite review of medical records in provider EHRs.

- Use of clinical risk group (CRG) or similar software:
  - The MCO assigns members into risk categories through a variety of methods, including risk algorithms in the care management software, DCMS, and through referrals from a variety of sources, including but not limited to UM and the Restricted Recipient Program (RRP).
  - DCMS has a logic that flags members with certain claims, authorizations and utilization.

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

- Electronic communication with providers:
  - Utilizes secure messaging, secure transfer and secure collaboration tools.
  - Utilize secure FTP sites.
  - Use of secure fax when sharing medical record requests.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Associated with the NY Care Information Gateway (NYCIG) RHIO.

- Participation in a medical home pilot or program:
  - The MCO is not currently involved in any medical home pilots or programs.

- Future plans to implement HIT:
    - The MCO is currently working with a large provider systems' build-out of their Health Information Exchange (HIE) as they transition to an EPIC platform. This will assist with patient registration data (technically referred to as "ADT" messages) to get almost real-time notifications of members receiving care in various settings.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

For the focused reviews, MetroPlus was in compliance with 13 of the 14 categories. The category in which MetroPlus was not in compliance was Organization and Management (1 citation). MetroPlus was in compliance in all of the operational review 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	1	Behavioral Health Claims	1
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	0	0		
Utilization Review	0	0		
Total	**0**	**1**		

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, MetroPlus Health Plan had 69% of external appeals upheld.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	52	60	73
Overturned in Part	9	7	7
Upheld	141	196	177
Medicaid Total	**202**	**263**	**257**
		CHP	
Overturned	1	1	0
Overturned in Part	0	0	0
Upheld	0	0	3
CHP Total	**1**	**1**	**3**

VIII. Strengths and Opportunities for Improvement[5]

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 HEDIS®/QARR Board Certification rates, the MCO demonstrated an improvement for all provider types in 2018.
- The provider types in the MCO's Medicaid product line with rates above the statewide average in 2018 are Behavioral Health and Dentistry specialties.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed above the threshold for Routing (100%) and Non-Urgent "sick" (100%) call types.
- The MCO demonstrated a strong performance for the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO has reported rates above the statewide average for at least three consecutive reporting years for the following measures: Adult BMI Assessment, *Weight Assessment and Counseling for Children for Adolescents—BMI Percentile, Childhood Immunization Status—Combination 3, Lead Screening in Children, Adolescent Preventive Care—Depression, Breast Cancer Screening and Chlamydia Screening in Women (Ages 16-24).* Additional measures for which the MCO reported rates above the statewide average for 2018 include: *Weight Assessment and Counseling for Children and Adolescents—Counseling for Nutrition, Weight Assessment and Counseling for Children and Adolescents—Counseling for Physical Activity, Immunizations for Adolescents—Combination 2, Adolescent Preventive Care—Alcohol and Other Drug Use, Adolescent Preventive Care—Sexual Activity and Adolescent Preventive Care—Tobacco Use.*
- In the domain of Effectiveness of Care: Acute and Chronic Care, the MCO has reported rates above the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Use of Imaging Studies for Low Back Pain* measure. Additionally, the MCO's rates were above the statewide average in

[5] 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.

2018 for *Testing for Children with Pharyngitis, Spirometry Testing for COPD*, *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg),* and *Drug Therapy for Rheumatoid Arthritis*.

- In the HEDIS®/QARR Behavioral Health domain, the MCO's rates were reported above the statewide average in 2018 for the *Diabetes Screening for People with Schizophrenia and Bipolar Disorder using Antipsychotic Medications* measure.
- In regard to HEDIS®/QARR Access/Timeliness Indicators, the MCO has reported rates above the statewide average for at least three consecutive reporting years for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

Opportunities for Improvement

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

Opportunities for Improvement:

- In regards to the percentages of providers in the MCO's Medicaid network, the MCO had rates below the statewide average for the following provider types: Primary Care Providers, Family Practice, Internal Medicine, Other PCPs, Other Specialties and Non-PCP Nurse Practitioners.
- The MCO demonstrates an opportunity for improvement with the ratio of enrollees to Medicaid providers. The MCO had rates above the statewide average for Primary Care Providers, OB/GYNs and Full Time Equivalents. A higher percentile indicates fewer providers per enrollee.
- The MCO demonstrates an opportunity for improvement in regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO's appointment rate was below the 75% threshold for the After-Hours Access call type.
- In regard to the HEDIS®/QARR Quality Indicators, the MCO has reported rates below the statewide average for at least three consecutive reporting years for the *Asthma Medication Ratio (Ages 5-18)* measure. The MCO also has reported rates below the statewide average in 2018 for the *Medication Management for People with Asthma 50% (Ages 5-18). (Note: Asthma Medication Ratio was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regard to HEDIS®/QARR Access/Timeliness Indicators. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Adolescent Well-Care Visits, Children and Adolescents' Access to Primary Care Practitioners—12-24 Months* and *12-19 Years,* and *Adults' Access to Preventive/Ambulatory Health Services—20-44 Years*. Additionally, the MCO reported rates below the statewide average for *Children and Adolescents' Access to Primary Care Practitioners—25 Months-6 Years* and *7-11 Years*, *Adults' Access to Preventive/Ambulatory Health Services—45-64 Years* and *Annual Dental Visit* in 2018. *(Note: Adolescent Well-Care Visits, Children and Adolescents' Access to Primary Care Practitioners, and Adults' Access to Preventive/Ambulatory Health Services were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regards to the QARR Prenatal Care measure, *Prenatal Care in the First Trimester.* In 2017, the MCO's rate (67%) was below the statewide average.
- The MCO demonstrates an opportunity for improvement in regard to member satisfaction. The MCO has reported rates below the statewide average for *Rating of Specialist* and *Satisfaction with Provider Communication*. *(Note: member satisfaction was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO should continue its efforts to improve the HEDIS®/QARR measures related to asthma care. The MCO should consider utilizing Pharmacists to assist with educating members regarding when and how to use recuse inhalers and long-acting inhalers. The MCO should evaluate the effectiveness of its current initiatives, including the use of community health workers, text message reminders and provider and member incentives.
- The MCO should work to improve members' access to care, as the MCO's rates for several HEDIS®/QARR Access to Care measures are continuously performing below the statewide averages. The MCO identified barriers such as, provider appointment times conflicting with parents' work schedules, adequate childcare so that the adult can make annual well visits, member education regarding the importance of annual check ups and provider motivation to encourage members to make appointments. The MCO developed provider incentives and member education to target these measures. The MCO should also consider implementing member incentives and offer educational materials to providers on the MCO's HEDIS®/QARR performance goals. The MCO should continuously evaluate the current interventions to determine if rates are improving. *[Repeat recommendation.]*
- The MCO should evaluate its provider network to determine its impact on members accessing care. In 2018, the MCO's ratio of enrollees to Medicaid providers indicates that the MCO has fewer providers per enrollee. With the MCO's Medicaid membership consisting of mostly members aged 15-19 years and 20-44 years, the MCO should consider making additional efforts to contract with Primary Care Providers. With the MCO's appointment rate below the 75% threshold for Primary Care and OB/GYN providers during 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. Additionally, the MCO should investigate if the low performance on HEDIS®/QARR measures is related to the low performance for CAHPS® measures related to care received from specialists and provider communication with members.

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 the HEDIS®/QARR measures performing below the statewide average. The MCO should evaluate the effectiveness of its current initiatives, including its MetroTeen events, the ACT and Home-Based Therapy programs for follow-up after hospitalizations, and the education campaign for asthma care. The MCO should track attendance at community events, as well as the number of care gaps closed after members receive interventions. The MCO should also continue to identify barriers to care for members and providers and create innovative ways to ensure members are receiving the care they need. *[Repeat recommendation.]*

  MCO Response: For Reporting Year 2017, the following HEDIS®/QARR measures performed below the statewide average (SWA): Testing for Children with Pharyngitis (CWP), Asthma Medication Ratio (AMR) - Ages 5-18/Ages 19-64, Follow-Up After Hospitalization for Mental Illness (FUH) - 7/30 Days, and Adolescent Well-Care Visit (AWC). These measures also performed under the statewide average in Reporting Year 2016. These measures are tracked and reported through monthly Dashboards and quarterly updates on the Quality Management Work Plan. As these measures continue to be under the SWA, the rates are also reported to

the quarterly Quality Management Committee which reports up to the Quality Assurance Committee of the Board of Directors.

CWP: Reporting Year 2017 rate for CWP was 88%, and the SWA was 91%. Current interventions include engagement with Emergency Department staff as data analysis revealed that members appeared to have been started on antibiotics without a rapid strep test done during an ED visit. Facilities are taking steps to educate their ED providers on appropriate testing for pharyngitis. Some facilities have initiated quality improvement projects to focus on antibiotic stewardship in pharyngitis. Educational letters were sent to community providers regarding their performance and offering an opportunity to provide documentation of a rapid strep test completed during the patient encounter.

HEDIS specifications have changed for this measure with an expansion of the population to include all members ages three and up. Provider education will be conducted to raise awareness of the specifications which now include the adult population and the need to code for the testing on claims and encounters submitted to the Plan. Education will be accomplished through provider presentations and onsite visits.

AMR: Reporting Year 2017 rate for AMR (Ages 5-18) was 61%, and the SWA was 64%. For AMR (19-64), the Reporting Year 2017 rate was 54%, and the SWA was 57%. Analysis revealed that members often fill multiple rescue inhalers so that they can keep the rescue medication in different locations in case of emergencies, especially for children who split their time between multiple caregivers and the school they attend.

The MCO has been collaborating with a large provider organization which has contracted with Community Based Organizations with Community Health Workers to conduct education, care coordination, and home assessments for members with asthma. The MCO continues to send text messages to members with asthma regarding medication adherence and conducts personalized outreach calls to members. The MCO distributes gaps in care reports to participating providers and has partnered with facilities in high risk areas such as the Bronx and Harlem to promote medication adherence. Clinical practice guidelines are posted on the provider portal as well as discussed during provider education site visits. AMR is a measure that is included in the Provider Pay for Performance program. Asthma medication management is also part of the member rewards program where member earn points which are redeemable for prizes for adhering to their medication regimens.

FUH: Reporting Year 2017 rate for FUH (7 Days) was 51%, and the SWA was 62%. FUH (30 Days) rate was 69%, and the SWA was 78%. FUH rates continue to perform below the SWA.

Members are assessed for Assertive Community Treatment (ACT) services on a routine basis and referrals are made based upon program openings. Limited capacity for ACT treatment remains a barrier. In response the Plan has initiated a Field Based Case Management (FBCM) Program of Social Workers and Peers that meet with members in community settings. Along with our Behavioral Health Vendor the Plan began the FBCM program in 2018. The team is given data on members who are Inpatient with a Behavioral Health diagnosis and follow them through the admission and discharge to the community. The goal of these interventions is to connect members to care, reduce readmissions and improve Plan performance in the aftercare follow up HEDIS/QARR measures.

The Plan along with its Behavioral Health vendor have contracted with individual providers in the community as well as agencies to conduct Home-Based Therapy (HBT) services. HBT continues to be an underutilized service. The Plan has provided education to hospital discharge staff and provided face to face support to increase utilization. The Plan implemented discussion of HBT services during the discharge planning process

for member with barriers to attending aftercare. In addition, Field Based Case managers seeing members on the inpatient unit offer HBT services for members with barriers. Lastly, Aftercare Coordinators who are assisting members with addressing barriers to attending their appointment offer HBT services to members. The expected outcome for the actions taken is an increase in members utilizing HBT services and their 7-day FUH aftercare compliance. HBT service utilization is measured and reported monthly.

A significant barrier in improving the FUH measure is the time lag in receiving useful data; the MCO learns of a discharge with either no time or very little time to intervene with members. A new data source from a large participating provider has been identified that provides the MCO with more timely discharge information so that outreach to members can occur before the seven days and/or thirty days lapse. Monthly performance reports continue to be sent to large provider groups. The MCO's BH team institutes facility visits with the goal of bringing together mental health and substance use inpatient (IP)/outpatient (OP) staff to improve the aftercare measures.

AWC: Reporting Year 2017 rate for AWC is 67%, and the SWA was 68%. MetroTeen events were successful in bringing attention to the importance of preventive health visits for adolescents, connecting with local facilities and community-based organizations (CBOs), providing health education on topics relevant to the adolescent population (i.e. safe sex, harm reduction, nutrition, etc.), and closing gaps in care. The events will be expanded to more facilities to increase the number of adolescent members who access care. During the MetroTeen events, members are also able to enroll into the MetroPlus Rewards Program, and book future appointments. The MCO continues to partner with NYC H+H, Youth Health, NYC DOH, and CBOs to service our adolescent members in the communities where they live.

Additional interventions include collaborating with participating providers to hold regular teen clinic hours during the evenings when adolescents can come in for care after school. The MCO is working closely with a participating providers School Based Health Center (SBHC) to identify adolescent members that are missing annual physicals and/or immunizations and strategize how to capture services rendered at SBHCs which are not submitted via claims. Event attendance is tracked as well as the number of members screened and reported quarterly to the Quality Management Committee and Quality Assurance Committee of the Board.

2017 Recommendation: The MCO should work to improve members' access to care, as the MCO's rates for several HEDIS®/QARR Access to Care measures are continuously performing below the statewide averages. The MCO should conduct thorough, age-specific barrier analyses to identify factors that prevent members from seeking or receiving care and should develop an intervention strategy designed to target each age group's specific needs. Additionally, the MCO should investigate if the performance on these measures is related to the low performance for CAHPS® measures related to getting care. *[Repeat recommendation.]*

MCO Response: For Reporting Year 2017, Children and Adolescents' Access to PCPs (CAP) for all age ranges performed below the statewide average. For Adults' Access to Preventive/Ambulatory Services (AAP) for 20-44 Years and 45-64 Years performed below the statewide average. Barrier analysis and corresponding interventions to improve access to care are detailed below.

Based on member feedback, not being able to afford taking off from work is a significant barrier to taking their children in for an annual well-child visit. For the adolescent age range, many teenagers are not willing to go for their annual well-visit, and their caregivers do not prioritize the annual well-visit. Many caregivers only take their children to the doctor for sick visits, not understanding the importance of a preventive well-visit.

For adults, not being able to take off from work to attend annual well-visits is a common barrier. Not having childcare to take care of young children so that the adult caregiver can go in for a well-visit has also been cited as an obstacle to seeking care. Not understanding the importance of preventive health and only seeing doctors for sick visits is another reason why adult members age 20-64 are not going for their annual physical exams.

Additional barriers that face the entire membership regardless of age include lack of real-time feedback from membership gauging the member experience in relation to access and availability; members are uneducated on how to navigate the provider network; providers/clinics do not efficiently manage their scheduling to meet the needs of members; providers lack the incentive to give proper attention to member satisfaction.

A large participating network has hired a significant number of primary care providers and also has improved its call center scheduling system and workflow to open up more appointments to increase access, decrease wait times, and increase continuity of care so that members can see the same primary care provider.

Ongoing member satisfaction CAHPS proxy survey has been implemented and is conducted to assess member experience with accessing care and capture feedback. The MCO delivers provider and facility member satisfaction report cards to highlight strengths and areas of opportunity for improvement and track satisfaction trends and promote member loyalty. Membership is educated on how to obtain immediate medical attention when needed through MetroPlus' Urgent Care Network. Education is conducted via newsletter, website, and text messages. Additionally, membership is educated via newsletter and website on how Customer Service can assist with locating nearby physicians with after-hour services as well as scheduling appointments.
MetroPlus also implemented a provider incentive to give further attention to member satisfaction, specifically Getting Care Quickly. To better motivate providers to shift their priorities to improving access to care, MetroPlus added an access measure to its Pay for Performance (P4P) program. Members with a provider visit in 2019 trigger a member survey; members were asked 2 questions regarding access to care. Baseline data was collected and shared with eligible providers, along with subsequent quarterly reporting of newly surveyed members, to motivate providers to actively monitor and improve in this measure. A bonus payment is awarded to practices that meet/exceed defined benchmarks. MetroPlus expects to see improvement as providers dedicate resources to improving access to care to ensure bonus payments through the P4P program. Reports are tracked, trended and shared with providers quarterly.

CAP and AAP rates are tracked and monitored on the QM Work Plan. Access to Care measures are reported to the Quality Management Committee which reports up to the Quality Assurance Committee of the Board.

- **2017 Recommendation:** The MCO should continue to take necessary steps to address the issues identified in the operational and focused surveys. First, the MCO should re-evaluate the corrective actions taken to address issues with Utilization Review and Complaints and Grievances documents, as well as the policies and procedures related to each, as the MCO received citations for this issue the previous year. Second, the MCO should evaluate and amend its policies and procedures related to execution of contracts and contract amendments to ensure all contracts are approved before implementation. Last, the MCO should work to improve the information within its provider directories to ensure that data are as up to date as possible and that all information on providers is included. *[Repeat recommendation.]*

  MCO Response: Contracting: Beginning, January 2018, MetroPlus' Network Relations Department started conducting quarterly verification audits to ensure that participating provider demographic information is

accurate. The Director of Network Relations is charged with supervising and ensuring that these audits are conducted in a consistent and timely manner.

Provider Manual: In accordance with the MMC/FHP Contract, Section 14.4(b), Section 3.4 the Provider Manual was updated to include the toll-free number for filing oral complaints. The section was also updated with language which directs the provider to Section 7.16.8 for fair hearing information.

Utilization Management

- MetroPlus Health Plan conducted UM Staff re-education and routinely assess staff needs for training.
- Updated its Timeframes and Notice Requirements policy and procedure.
- Updated the Provider Manual
- Provided staff training regarding the requirement to clearly document telephonic outreach attempts of provider notification of adverse determinations and confirm with the provider that enrollee will be notified.
- The Commercial/CHP IAD letters were updated to remove incorrect information.
- The FAD letters were updated to ensure the member is informed of this information.

The Plan has implemented quarterly UM audits to ensure accuracy and timeliness of the UM process.

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