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 2017

FINAL REPORT

Published April 2019

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

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

History of the New York State Medicaid Managed Care Program

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

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

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

Scope of This Report

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

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

Structure of This Report

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

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

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. Where trending is desirable, data for prior years may also be included. This report includes data for Reporting Year 2017.

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

II. MCO Corporate Profile

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.

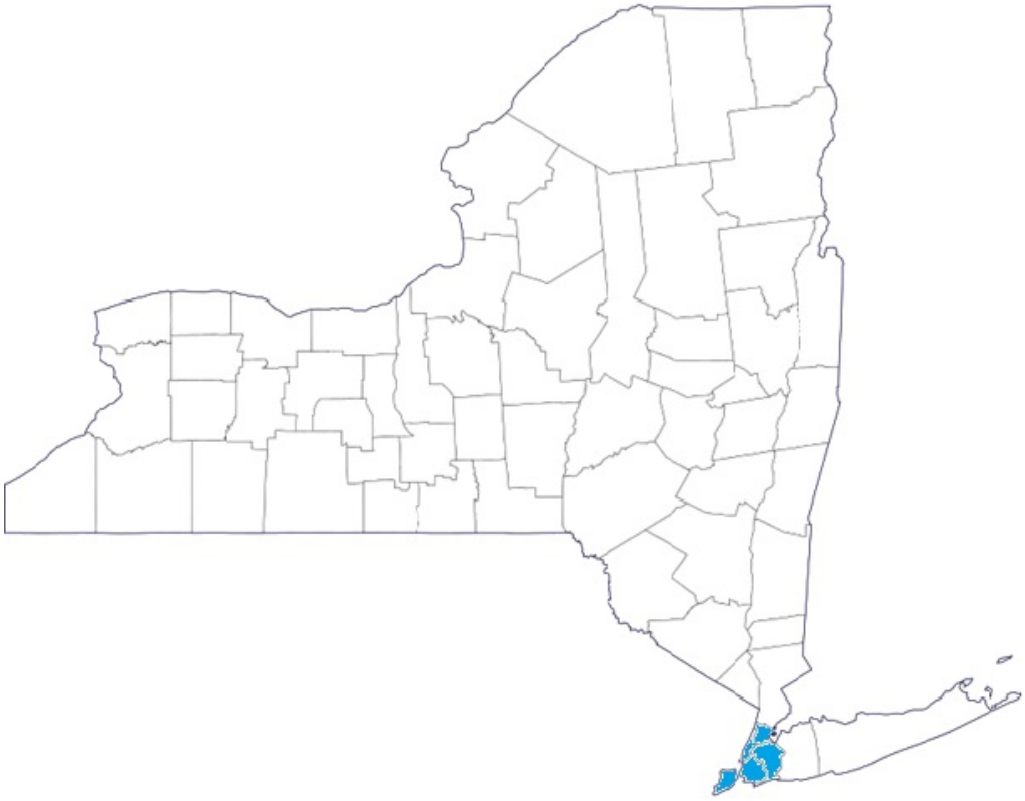
- Plan ID: 1130185
- DOH Area Office: MARO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: June 15, 1985
- Product Line(s): Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP)
- Contact Information: 160 Water Street, 3rd Floor
  New York, NY 10038
- NCQA Accreditation Rating[2] (as of 10/15/18): Unknown
- Medicaid Dental Benefit Status: Mandatory

Participating Counties and Products

Bronx:	MCD	CHP	HARP	**Kings:**	MCD	CHP	HARP	**New York:**	MCD	CHP	HARP
Queens:	MCD	CHP	HARP	**Richmond:**	MCD	CHP	HARP				

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

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 2015, 2016, and 2017, as well as the percent change from the previous year. Enrollment has decreased from 2016 to 2017 by a rate of 1.3%. MetroPlus' membership represents 8.6% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2015-2017

	2015	2016	2017
Number of Members	413,262	382,190	377,045
% Change from Previous Year		-7.5%	-1.3%
Statewide Total[1]	4,593,911	4,349,457	4,378,153
% of Total Medicaid Enrollment	9.0%	8.8%	8.6%

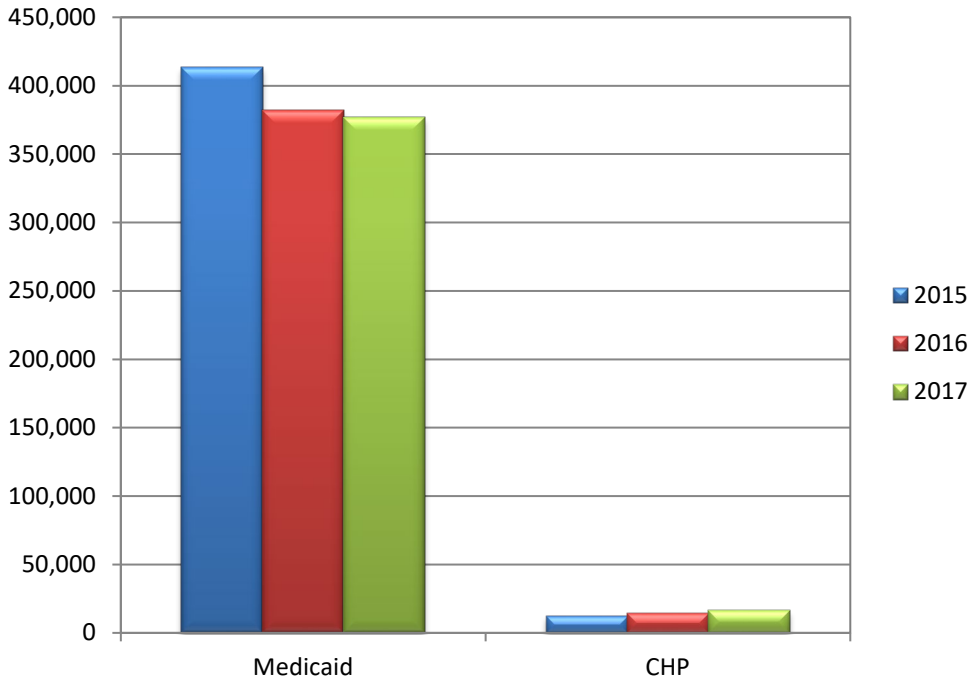
Data Source: MEDS II

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

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

	2015	2016	2017
CHP	12,389	14,573	16,593

Figure 2: MetroPlus Enrollment Trends—All Product Lines



Provider Network

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

Network Adequacy Standards

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

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

Appointment Availability/Timeliness Standards

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

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

Travel Time and Distance Standards

In regard to travel time standards, the Contract defines time and distance standards for various provider types in Section 15.5. For primary care providers, Section 15.5(b)(i) of the Contract states *"Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Enrollee's residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee's residence in non-metropolitan areas."* However, the Contract also states that the time/distance may exceed the established standard if the member chooses a provider outside that standard. Section 15(b)(ii) states *"Enrollees may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCPs themselves."*

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

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

Board Certification

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

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

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

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

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

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

Provider Type	2015		2016		2017	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
			Medicaid/CHP			
Family Medicine	55% ▼	77%	54% ▼	71%	68%	72%
Internal Medicine	66% ▼	76%	67% ▼	75%	66% ▼	76%
Pediatricians	63% ▼	79%	63% ▼	78%	67% ▼	79%
OB/GYN	46% ▼	76%	55% ▼	75%	67% ▼	77%
Geriatricians	48%	63%	56%	63%	55%	63%
Other Physician Specialists	55% ▼	76%	57% ▼	75%	52% ▼	76%

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

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

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

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

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

IV. Utilization

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

Encounter Data

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

Table 4: Medicaid Encounter Data—2015-2017

	Encounters (PMPY)					
	2015		2016		2017	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
PCPs and OB/GYNs	3.64	4.12	3.62	3.85	3.38	3.56
Specialty	1.62	1.92	1.57 ▼	2.45	1.54 ▼	2.30
Emergency Room	0.72 ▲	0.54	0.69	0.54	0.67	0.55
Inpatient Admissions	0.16	0.14	0.16	0.14	0.15	0.14
Dental	0.94	0.99	0.92	1.03	0.92	1.02

Data Source: MEDS II
PMPY: Per Member Per Year

QARR Use of Services Measures

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

Table 5: QARR Use of Services Rates

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	4,966	8,432 ▲	4,580	5,302
ER Visits	651	656	636	512
Inpatient ALOS				
Medicine	NV	2.8 ▼	6.9 ▲	4.4
Surgery	NV	6.8	7.7 ▲	6.2
Maternity	NV	2.8	3.1 ▲	2.9
Total	NV	3.2 ▼	5.7 ▲	4.3
Inpatient Utilization (PTMY)				
Medicine Cases	NV	106 ▲	43 ▲	32
Surgery Cases	NV	13	9 ▼	14
Maternity Cases	NV	47 ▲	41 ▲	33
Total Cases	NV	152 ▲	81	71

PTMY: Per Thousand Member Years
ER: Emergency Room
ALOS: Average Length of Stay. These rates are measured in days.
NV: Not valid. The MCO reported invalid data for the Reporting Year.

V. Performance Indicators

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

Validation of Performance Measures

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

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

Summary of HEDIS® 2018 Information System Audit™

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

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

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

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

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

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

all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well as for exclusions.

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

HEDIS®/QARR Performance Measures

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

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

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

Quality Indicators

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

Effectiveness of Care

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

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

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

COPD: Chronic Obstructive Pulmonary Disease

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

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

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

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

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

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Adult BMI Assessment	86 ▼	92 ▲	92 ▲	**86**
WCC—BMI Percentile	82 ▲	83 ▲	93 ▲	**84**
WCC—Counseling for Nutrition	87 ▲	80	90 ▲	**83**
WCC—Counseling for Physical Activity	78 ▲	69	78 ▲	**73**
Childhood Immunizations—Combo 3	84 ▲	86 ▲	87 ▲	**75**
Lead Screening in Children	95 ▲	95 ▲	95 ▲	**88**
Adolescent Immunizations—Combo 2[2]			64 ▲	**41**
Adolescents—Alcohol and Other Drug Use[3]	70	62	80 ▲	**67**
Adolescents—Depression[3]	71 ▲	70 ▲	82 ▲	**61**
Adolescents—Sexual Activity[3]	70	66	81 ▲	**65**
Adolescents—Tobacco Use[3]	77	70	85 ▲	**71**
Breast Cancer Screening	73 ▲	73 ▲	74 ▲	**71**
Colorectal Cancer Screening	56 ▼	65 ▲	67 ▲	**62**
Chlamydia Screening (Ages 16-24)	79 ▲	79 ▲	78 ▲	**74**
Testing for Children with Pharyngitis	85 ▼	81 ▼	88 ▼	**91**
Spirometry Testing for COPD	53	53	51	**55**
Use of Imaging Studies for Low Back Pain	82 ▲	80 ▲	79 ▲	**77**
Flu Shots for Adults (Ages 18-64)[4]	48 ▲	48 ▲	46	**42**
Advising Smokers to Quit[4]	79	79	79	**80**
Smoking Cessation Medications[4]	61	61	58	**59**
Smoking Cessation Strategies[4]	61	61	55	**51**

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

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

[4] CAHPS® measure.

Acute and Chronic Care

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

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

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

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

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

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

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

	Medicaid/CHP			
Measure	**2015**	**2016**	**2017**	**2017 SWA**
Pharmacotherapy Management for COPD—Bronchodilators	89	88	90	**88**
Pharmacotherapy Management for COPD—Corticosteroids	70 ▼	72	73	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	75 ▲	71 ▲	70	**69**
Medication Management for People with Asthma 50% (Ages 5-18)	60 ▲	53	57	**57**
Asthma Medication Ratio (Ages 19-64)	47 ▼	52 ▼	54 ▼	**57**
Asthma Medication Ratio (Ages 5-18)	55 ▼	58 ▼	61 ▼	**64**
Persistence of Beta-Blocker Treatment After a Heart Attack	*SS*	82	79	**85**
CDC—HbA1c Testing	93 ▲	93	94 ▲	**91**
CDC—HbA1c Control (<8%)	60	51	59	**59**
CDC—Eye Exam Performed	59	62	66	**67**
CDC—Nephropathy Monitor	92	91	93	**93**
CDC—BP Controlled (<140/90 mm Hg)	67	62	70 ▲	**61**
Drug Therapy for Rheumatoid Arthritis	81	84	89 ▲	**83**
Monitor Patients on Persistent Medications—Total Rate	93 ▲	93 ▲	93 ▲	**92**
Appropriate Treatment for URI	95 ▲	95 ▲	96 ▲	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	32	33	35	**34**
HIV Viral Load Suppression[2,3]		77	76	**77**

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

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

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

[2] NYS-specific measure.

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

Behavioral Health

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

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

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

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

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

Measure	Medicaid/CHP			
	2015	2016	2017	2017 SWA
Antidepressant Medication Management—Effective Acute Phase	59 ▲	50	53	**52**
Antidepressant Medication Management—Effective Continuation Phase	43 ▲	36	37	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	61	67 ▲	62	**58**
Follow-Up Care for Children on ADHD Medication—Continue	72	88 ▲	80 ▲	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	63 ▼	74 ▼	69 ▼	**78**
Follow-Up After Hospitalization for Mental Illness—7 Days	48 ▼	56 ▼	51 ▼	**62**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	84 ▲	82	86 ▲	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	84	84	86	**81**
Antipsychotic Medications for Schizophrenia	60	61	59	**62**

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.

Utilization

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

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

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

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

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

Measure	2015	2015	2017	2017 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	67 ▲	67 ▲	70 ▲	**68**
Well-Child Visits—3 to 6 Year Olds	86 ▲	87 ▲	87 ▲	**85**
Adolescent Well-Care Visits	64 ▼	67 ▼	67 ▼	**68**

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

Access to Care

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

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

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

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

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

Measure	Medicaid/CHP			
	2015	2016	2017	2017 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	92% ▼	94% ▼	94% ▼	**96%**
25 Months-6 Years	92% ▼	94%	92% ▼	**94%**
7-11 Years	96% ▼	97%	96% ▼	**97%**
12-19 Years	92% ▼	94% ▼	93% ▼	**95%**
Adults' Access to Preventive/Ambulatory Services				
20-44 Years	80% ▼	79% ▼	77% ▼	**82%**
45-64 Years	90%	90%	89% ▼	**90%**
65+ Years	91%	91%	91%	**91%**
Access to Other Services				
Timeliness of Prenatal Care	89%	93% ▲	92% ▲	**88%**
Postpartum Care	75% ▲	74%	71%	**71%**
Annual Dental Visit[2]	58% ▼	60%	60%	**60%**

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

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

NYSDOH-Calculated Prenatal Care Measures

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

Table 8: QARR Prenatal Care Rates—2014-2016

Measure	2014		2015		2016	
	MetroPlus	Regional Average	MetroPlus	Regional Average	MetroPlus	Regional Average
			NYC			
Risk-Adjusted Low Birth Weight[1]	6%	6%	7%	6%	7%	6%
Prenatal Care in the First Trimester	63% ▼	75%	65% ▼	75%	67% ▼	76%
Risk-Adjusted Primary Cesarean Delivery[1]	13%	15%	14%	14%	14%	14%
Vaginal Birth After Cesarean	17%	18%	14% ▼	18%	14% ▼	18%

NYC: New York City

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

Member Satisfaction

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

Table 9: CAHPS®—2013, 2015, 2017

Measure	2013		2015		2017	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
			Medicaid			
Flu Shots for Adults Ages 18-64	49	**44**	48 ▲	**40**	46	**42**
Advising Smokers to Quit	75	**78**	79	**80**	79	**80**
Getting Care Needed[1]	72 ▼	**78**	67 ▼	**79**	71 ▼	**79**
Getting Care Quickly[1]	71 ▼	**78**	68 ▼	**80**	71 ▼	**78**
Customer Service[1]	78	**82**	80	**84**	88	**86**
Coordination of Care[1]	72	**78**	78	**80**	80	**81**
Collaborative Decision Making[1]	48	**48**	77	**79**	74 ▼	**80**
Rating of Personal Doctor[1]	72 ▼	**78**	74 ▼	**80**	78	**81**
Rating of Specialist	73	**76**	76	**80**	77	**80**
Rating of Healthcare	65 ▼	**71**	70 ▼	**75**	74	**77**
Satisfaction with Provider Communication[1]	87	**89**	87 ▼	**91**	90	**91**
Wellness Discussion	71	**71**	67	**68**	72	**72**
Getting Needed Counseling/Treatment	73	**70**	71	**74**	72	**69**
Rating of Counseling/Treatment	58	**61**	69	**64**	52	**60**
Rating of Health Plan—High Users	78	**77**	74	**77**	84	**80**
Overall Rating of Health Plan	77	**76**	73	**76**	79	**76**
Recommend Plan to Family/Friends	93	**92**	92	**93**	93	**92**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2017

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

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

Table 10: Quality Performance Matrix—Measurement Year 2017

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Weight Assessment for Children and Adolescents—Counseling for Physical Activity	**A** Controlling High Blood Pressure Weight Assessment for Children and Adolescents—BMI Percentile Weight Assessment for Children and Adolescents—Counseling for Nutrition
No Change	**D** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Follow-Up After Emergency Department Visit for Mental Illness—7 Days Follow-Up After Hospitalization for Mental Illness—7 Days Engagement of Alcohol and Other Drug Dependence Treatment—Total Rate HIV Viral Load Suppression	**C** Annual Dental Visits (Ages 2-18) Antidepressant Medication Management—Effective Acute Phase Treatment Antidepressant Medication Management—Effective Continuation Phase Treatment Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase Initiation of Alcohol and Other Drug Dependence Treatment—Total Rate Managing Diabetes Outcomes—HbA1c Control (<8.0%) Medication Management for People with Asthma 50% of Days Covered (Ages 5-64) Medication Management for People with Asthma 75% of Days Covered (Ages 5-64) Metabolic Monitoring for Children and Adolescents on Antipsychotics Use of Spirometry Testing in the Assessment and Diagnosis of COPD Well-Child Visits in the First 15 Months of Life (5+ Visits) Postpartum Care	**B** Adolescent Immunizations (Combo 2) Breast Cancer Screening Cervical Cancer Screening Childhood Immunization Status (Combo 3) Colon Cancer Screening Diabetes Screen for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Meds Statin Therapy for Patients with Cardiovascular Disease—Adherence Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life Timeliness of Prenatal Care
↓	**F** Advising Smokers to Quit Discussing Smoking Cessation Medications	**D** Flu Shots for Adults (Ages 18-64)	**C** Discussing Smoking Cessation Strategies Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase

NYSDOH Quality Incentive

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

Table 11: Quality Incentive Points Earned—2015-2017

	2015		2016		2017	
	MetroPlus	Statewide Average	MetroPlus	Statewide Average	MetroPlus	Statewide Average
Total Points *(150 Possible Points)*	104.0	75.2	112.5	92.5	117.0	87.9
PQI Points *(20 Possible Points)*	0.0	6.9	0.0	7.3	5.0	7.3
Compliance Points *(-20 Possible Points)*	-6.0	-3.6	-2.0	-2.3	-4.0	-7.2
Satisfaction Points *(30 Possible Points)*	10.0	20.0	10.0	15.7	10.0	15.7
Bonus Points *(6 Possible Points)*			6.0	6.0	6.0	6.0
Quality Points[1] *(100 Possible Points)*	100.0	56.0	98.5	66.4	100.0	66.1
Financial Incentive Award Designation[2]	Tier 1		Tier 2		Tier 2	

[1] Quality points presented here are normalized.

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

Table 12: Quality Incentive Measures and Points Earned—2017

Measure	MCO Points
PQI (10 points each)	**5.0**
Adult Prevention Quality Overall Composite (PQI 90)	5.0
Pediatric Quality Overall Composite (PDI 90)	0.0
Compliance (-4 points each, except where noted)	**-4.0**
MMCOR	0.0
MEDS	0.0
QARR	0.0
Access/Availability *(-2 points)*	-2.0
Provider Directory *(-2 points)*	-2.0
Member Services	0.0
Satisfaction (10 points each)	**10.0**
Rating of Health Plan	5.0
Getting Care Needed	0.0
Customer Service	5.0
Bonus Points (6 points)	**6.0**
Telehealth Plan	6.0
Quality (3.33 points each)	**74.093**
Annual Dental Visit (Ages 2-18)	1.665
Antidepressant Medication Management	2.498
Breast Cancer Screening	3.33
Cervical Cancer Screening	1.664
Chlamydia Screening	2.498
Childhood Immunization Status—Combination 3	3.33
Colorectal Cancer Screening	3.33
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	2.498
Comprehensive Diabetes Care—Received All Tests	3.33
Controlling High Blood Pressure	3.33
Flu Shots for Adults	2.498
Immunizations for Adolescents—Combination 2	3.33
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	3.33
Medical Assistance with Tobacco Cessation (Composite Rate)	1.665
Medication Management for People with Asthma (Ages 5-64)	2.498
Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%	3.33
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1.665
Weight Assessment and Counseling for Children and Adolescents	3.33
Well-Child Visits in the First 15 Months of Life—Five or More Visits	1.665
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	2.498
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.00
Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications	3.33
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	3.33
Follow-Up After Emergency Department Visit for Mental Illness—7 Days	3.33
Follow-Up After Hospitalization for Mental Illness—7 Days	3.33
Follow-Up for Children Prescribed ADHD Medication	1.665
Metabolic Monitoring for Children and Adolescents on Antipsychotics	1.665
Timeliness of Prenatal Care	2.498
Postpartum Care	1.665
HIV Viral Load Suppression	0.00
Total Normalized Quality Points[1]	**100.0**
Total Points Earned	**117.0**

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

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

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

Performance Improvement Project

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

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

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

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

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

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

Member-Focused Interventions:

- MetroPlus Quality Management Department (MP QM) will educate members about the importance of prenatal care. Educational materials addressing preterm birth, maternal depression, smoking cessation, and LARC will be provided via mailings and postings on the member portal.
- Finity (incentive vendor) will mail educational materials to members about the following prenatal rewards: first prenatal care visit (250 points), ongoing prenatal care visits (50 points per visit, with a maximum of 700 points for all visits), and postpartum visit (250 points).
- Integrated Case Management will mail a letter out to members identified as high risk for preterm birth informing them of their risk level and providing education. Integrated Case Management will also conduct assessments for risk of preterm birth, depression, and tobacco use and work with members to facilitate needed services, including coordination of care with contracted OB home care providers to administer 17P and follow-up for positive screens for depression and/or smoking.
- Educate pregnant members of the adverse effects of smoking during pregnancy and the availability of resources for smoking cessation, such as the NYS Quitline, via mailings and the member portal.
- MP QM will educate members about contraception options, including LARC, and the benefits of birth spacing via the member portal, mailings, and/or text messaging.

Provider-Focused Interventions:

- Medicaid Prenatal Standards and ACOG Guidelines regarding 17P will be posted on the provider portal. MP QM will educate providers on ACOG Guidelines, which indicate treatment initiation at 16 weeks.
- Letters will be sent to all OB/GYN providers about the PIP, educating them on the importance of using the PHQ-9 depression assessment, information on depression screening outcomes claims codes, and the availability of Beacon (behavioral health vendor); information on tobacco use assessment, proper coding and documentation; and resources for smoking cessation, including the NYS Quitline. Information on the PHQ-9 tool and its importance will be posted to the provider portal.
- Selected NYC Health + Hospitals facilities will receive targeted education via email, phone calls, and/or site visits.
- Providers will be informed via the provider portal and through email of the provider referral campaign for smoking cessation (http://talktoyourpatients.ny.gov/).

MCO-Focused Interventions:

- Early identification of pregnant members with a history of preterm birth and members at high risk for preterm birth through Integrated Case Management and claims reports.
- Partner with Beacon for case management of members screened positively for depression.
- Partner with the NYS Quitline to offer cessation services for members who want to quit.

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

Table 13: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
17P Use	13%		20%	
Percentage of Preterm Births	5%		2%	
Screening for Depression	1%		10%	
Positive Depression Screens	0%		0%	
Negative Depression Screens	1%		5%	
Members who Smoke	<1%		0%	
Most or Moderately Effective Contraception within 3 days of delivery(Ages 15-20)	N/A[1]		9%	
Most or Moderately Effective Contraception within 3 days of delivery(Ages 21-44)	N/A[1]		5%	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 15-20)	26%		30%	
Most or Moderately Effective Contraception within 60 days of delivery(Ages 21-44)	22%		25%	
LARC within 3 days of delivery(Ages 15-20)	N/A[1]		1%	
LARC within 3 days of delivery(Ages 21-44)	N/A[1]		1%	
LARC within 60 days of delivery(Ages 15-20)	4%		7%	
LARC within 60 days of delivery(Ages 21-44)	4%		7%	

LARC: Long-Acting Reversible Contraception; N/A: Not available

[1] Members who receive contraception within 3 days or while inpatient are difficult to identify due to the bundle payment methodology utilized. Baseline rates will be reported if and when available.

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

VI. Structure and Operation Standards[6]

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

MetroPlus was in compliance with 9 of the 14 categories. The categories in which MetroPlus was not in compliance were Complaints and Grievances (3 citations), Disclosure (4 citations), Organization and Management (6 citations), Service Delivery Network (3 citations), and Utilization Review (6 citations).

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

Table 14: Focused Review Types

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

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

Table 15: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	3	0
Credentialing	0	0
Disclosure	0	4
Provider Directory Information		*2*
Provider Participation—Directory		*2*
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	6
Access and Availability		*2*
Contracts		*2*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	1	2
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Utilization Review	6	0
Total	**10**	**12**

VII. Strengths and Opportunities for Improvement[7]

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

Strengths:

- The MCO demonstrated a strong performance for the HEDIS®/QARR Effectiveness of Care domain. The MCO has reported rates above the statewide average for at least three consecutive reporting years for the following measures: *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, Chlamydia Screening in Women (Ages 16-24),* and *Use of Imaging Studies for Low Back Pain*. Additional measures for which the MCO reported rates above the statewide average for 2017 include: *Adult BMI Assessment, 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, Adolescent Preventive Care—Tobacco Use,* and *Colorectal Cancer Screening*.
- In the domain of Acute and Chronic Care, the MCO has reported rates above the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Annual Monitoring for Patients on Persistent Medications—Total Rate* and *Appropriate Treatment for Children with Upper Respiratory Infection* measures. Additionally, the MCO's rates were above the statewide average for 2017 for *Comprehensive Diabetes Care—HbA1c Testing, Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg),* and *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*.
- In the domain of Behavioral Health, the MCO's rates were reported above the statewide average for 2017 for two HEDIS®/QARR measures, *Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase* and *Diabetes Screening for People with Schizophrenia and Bipolar Disorder using Antipsychotic Medications*.
- 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 First 15 Months of Life—6+ Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, while the MCO's rate for *Timeliness of Prenatal Care* was above the statewide average for 2017.

Opportunities for Improvement:

- The MCO has reported rates below the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for the following provider types: *Internal Medicine,*

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

Pediatricians, OB/GYN, and *Other Physician Specialists*. *(Note: board certification was an opportunity for improvement in the previous year's report.)*

- 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 following measures: *Appropriate Testing for Children with Pharyngitis, Asthma Medication Ratio (Ages 19-64), Asthma Medication Ratio (Ages 5-18), Follow-Up After Hospitalization for Mental Illness—30 Days,* and *Follow-Up After Hospitalization for Mental Illness—7 Days. (Note: Appropriate Testing for Children with Pharyngitis, Asthma Medication Ratio, and Follow-Up After Hospitalization for Mental Illness were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates opportunities 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* and *Adults' Access to Preventive/Ambulatory Health Services—45-64 Years* for 2017. *(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 regard to member satisfaction. The MCO has reported rates below the statewide average for at least three consecutive survey cycles for *Getting Care Needed* and *Getting Care Quickly.* Additionally, the MCO reported a rate below the statewide average for *Collaborative Decision Making* for 2017. *(Note: member satisfaction was an opportunity for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 22 citations from the operational and focused review surveys related to Complaints and Grievances, Disclosure, Organization and Management, Service Delivery Network, and Utilization Review. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- 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.]*
- 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.]*
- 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.]*

Response to Previous Year's Recommendations:
Note: The responses below are taken directly from the MCO and are not edited for content.

- **2016 Recommendation:** The MCO should work to correct the issues identified in the HEDIS® Final Audit Report by ensuring there are policies and procedures in place for medical record reviews and for the capture of supplemental data, and those policies are adhered to.

  MCO Response: MetroPlus terminated the contract with the vendor that failed to pass supplemental audit. A third level review for over-readers, which includes sampling of no less than 10% per measure per over-reader was added to the medical record review process in 2017. As a result, the 2017 Final Audit Report indicates that there were no issues with over-reader results.

- **2016 Recommendation:** Although the MCO met the 75% compliance threshold on the Primary Care and OB/GYN Access and Availability Survey for routine and non-urgent "sick" calls, the MCO failed to reach the threshold for after-hours access. To ensure members have appropriate after-hours access, the MCO should take steps to ensure that all providers in its network have appropriate after-hours procedures in place.

  MCO Response: MetroPlus continues to contract with additional primary care providers (Internal Medicine, Family Practice, Geriatric, and Pediatric providers) that are willing to adjust their operational timeframes to accommodate our members seeking after-hours care. MetroPlus also contracted with over 50 Urgent Care Providers with over 120 service locations across the five (5) boroughs to ensure access and availability for our members. Additionally, Health + Hospitals, our parent organization is in the process of expanding primary care services across the New York City service area which in turn will increase the Plan's primary care provider network and enhance access to care.

  MetroPlus' goals are:
  - To increase access to primary care through continued growth in network expansion.
  - Reduce unnecessary emergency room utilization through newly contracted urgent care centers.
  - Continue to strategically credential and load all incoming Health + Hospitals primary care providers through a fast track process.

  The plan reviews the outcomes of the network's enhancements on a quarterly basis. This information is presented at the Quality Management Committee for review and determination of course of action.

- **2016 Recommendation:** The MCO should continue to work to improve HEDIS®/QARR performance for measures that are consistently performing below average. The MCO continues to demonstrate poor performance on measures related to follow-up care for members after being hospitalized for mental illness, as well as asthma-related measures and adolescent well and preventive care measures. MetroPlus should conduct a thorough root cause analysis for each measure to determine key drivers to poor performance and focus its intervention strategies at addressing those identified factors. *[Repeat recommendation.]*

MCO Response: MetroPlus continues to work on strategies to improve QARR measures that perform below the statewide average. For Reporting Year 2016, the measures that fell below the statewide average were Annual Dental Visit (19-21), Adolescent Well-Care Visits, Testing for Pharyngitis, Follow-Up After Hospitalization for Mental Illness (7/30 Days), and Asthma Medication Ratio (Ages 5-18/Ages 19-64). In fact, these measures have consistently performed poorly over the past three reporting years. More thorough root cause analysis needs to be conducted to determine the reasons why these measures have not been improving. However, Quality Improvement Specialists, In-Field Coordinators, Clinical Reviewers, and HEDIS® Analysts have been hired and assigned to work on these measures as a priority since the beginning of 2017 to present (December 2018). The following are interventions that have been put into place to improve quality rates to raise them above the statewide average. We are beginning to see success in some areas as noted below.

Annual Dental Visit (19-21)

Intervention: Quarterly meetings occur with HealthPlex, the dental vendor, to discuss ongoing quality improvement initiatives which include outreach calls to members who have not seen a dentist, mailings to members who are having access issues to refer them to dentists with availability, invites to community events which include dental screenings by HealthPlex dental technicians, primary care physician (PCP) incentive to encourage PCPs to refer and remind their patients to go for their yearly dental visit. In addition, the MetroPlus Quality Improvement team has scheduled over 40 community events in 2018 to provide greater access to dental care in convenient locations. Members are invited to dental screening events through live personalized calls and via text messaging. Provider education regarding HEDIS®/QARR compliant coding is distributed at onsite visits and on the MetroPlus website. Members are incentivized through the Member Rewards program where they earn points for an annual dental visit which can be redeemed for prizes.

Interventions (Data): Monthly data reconciliation reports are shared with HealthPlex, members with dental gaps are shared with providers through regular panel and gap in care reports. HEDIS®/QARR rates are tracked through monthly dashboards. Interventions are monitored through a Quality Improvement Activity Tool and the Quality Management Workplan. Data gaps have been addressed through supplemental data collection via reviews in PSYCKES, and provider EMR systems since 2017.

Progress: For the past two years, MetroPlus has met the 50th percentile for this measure. We continue to increase our efforts to continually improve.

Adolescent Well-Care Visits

Interventions: MetroTeen events is a new collaborative initiative created to engage the adolescent population to increase accessibility and awareness of preventive healthcare. Partnerships between NYC Health + Hospitals, Youth Health, NYC Department of Health, and community-based organizations have formed to organize community events where teens are able to get their annual well-visit as well as get health education on topics such as safe sex; counseling on substance, tobacco, and alcohol use; and mental health information. These events have been very successful with high turnout and much publicity. Other interventions include provider education on HEDIS®/QARR compliant coding and documentation through postings on the MetroPlus website and at onsite visits or conference calls. Adolescent Well-Care has been an incentivized measure in the Provider Pay for Performance Program. Members are educated regarding the importance of an annual wellness visit through text messages. Members are also notified of the MetroPlus Rewards Program where they can earn points for a completed adolescent well-care visit and redeem prizes.

Interventions (Data): Gap in Care reports and Provider Report Cards are regularly distributed. Data gaps have been addressed through supplemental data collection via reviews in provider EMR systems since 2017. Increased collaboration with high volume vendors to collect encounters and standard files based on monthly gap reports to ensure services are captured. Monthly dashboards are used to track HEDIS®/QARR rates. Quality Improvement Activity Tools and the Quality Management Workplan monitor interventions and outcomes.

Progress: The rate remains below the statewide average; however, we are starting to see increase. MetroPlus continues to build and monitor outcomes of interventions to improve this measure.

Testing for Pharyngitis

Interventions: As part of a diagnosis-based audit intervention conducted by Clinical Reviewers, proof of strep testing was requested from providers diagnosing members with pharyngitis throughout 2017 as means to close gaps. In 2018, MetroPlus began conducting targeted outreach to low-performing providers which includes a panel report indicating members who are missing appropriate testing for pharyngitis and a letter requesting providers to do a review as to the reasons why these members have no administrative data for pharyngitis testing. Some providers offered feedback that this was a useful report so they could better understand the barriers in their own practice. Provider education regarding clinical practice guidelines and the HEDIS®/QARR measure specifications has been offered during onsite visits and through provider portal postings and newsletters. Testing for Pharyngitis was included in the 2017 Provider Pay for Performance Program.

Interventions (Data): Gap in Care reports are distributed so that providers can provide documentation of testing such as a throat culture or strep test if available. HEDIS®/QARR rates are monitored through monthly dashboards. Quality Improvement Activity Tools and the Quality Management Workplan are used to track interventions and outcomes.

Progress: Because of increased data collection throughout 2017, the rate increased above the 50th percentile for reporting year 2018. MetroPlus continues to build and monitor outcomes of interventions to improve this measure.

Follow-Up After Hospitalization for Mental Illness (7/30 Days)

Interventions: Beacon's (behavioral health vendor), Utilization Management (UM) clinicians continue to work on comprehensive discharge planning with hospital UM staff beginning with the preauthorization whenever possible. Upon discharge Beacon case managers are responsible for following up with members to facilitate compliance and support with follow-up appointments.

In addition, case managers have been hired by MetroPlus to be onsite at NYC Health + Hospitals facilities to better coordinate, manage, and track the care of members who have been hospitalized with a mental health diagnosis. The focus is to ensure that there is an appropriate discharge plan in place and that there is follow-up after the member leaves the facility. This transitional period is critical in improving not only the measure rate but the health maintenance and well-being of the member so that they can remain safe and stabilized in the community and not be cycling in and out of the hospital. A workflow was created to standardize the process that the new case managers will follow at the facilities and subsequent meetings with members in the community. Case management reports will be utilized to monitor and capture relevant documentation required for supplemental data submission for HEDIS®/QARR.

Daily alerts about inpatient members are sent to Health Homes for staff to follow up with members and attempt to coordinate care as members move through the often-complicated healthcare system. Beacon is also making efforts to improve utilization and prior authorization processes through education of their network. Beacon promotes mental health services such as Assertive Community Treatment (ACT) and Home-Based Therapy Treatment. MetroPlus is in the process of contracting with a TeleHealth vendor which may be able to offer timely follow-up services for members recently discharged.

Interventions (Data): Beacon and MetroPlus conduct regular reconciliation of claims and supplemental data. Chart review and supplemental look-ups through various data sources such as PSYCKES, QuadraMed, EPIC, and other EMR systems are done by Clinical Reviewers, In-Field Coordinators, and Quality Improvement Specialists. Setting up access to Regional Health Information Organization (RHIO) data such as daily discharge alerts is in process. HEDIS®/QARR rates are shared with high volume facilities monthly and during onsite visits and with the Chief of Psychiatry for NYC Health + Hospitals on a quarterly basis. Monthly dashboards and interventions planned in the Quality Improvement Activity Tool and the Quality Management Workplan are monitored through discussions at weekly Health Status Improvement Workgroup, monthly Behavioral Health Taskforce, and quarterly presentations by Beacon.

Progress: The rates remain below the statewide average. MetroPlus continues to build and monitor interventions to improve this measure.

Asthma Medication Ratio (Ages 5-18/Ages 19-64)

Interventions: Lack of information and understanding of information by members are significant barriers to the Asthma Medication Ratio (AMR) measure. To address these barriers, outreach calls offer asthma education, medication reminders, and explain the importance of visits to primary care physicians, asthma action plans, and medication adherence. Members are targeted based on a status of "uncontrolled" asthma based on claims information indicating more than two emergency department admissions during the measurement year, more than one hospital admission for asthma during the measurement year, and AMR gaps in filling controller medications. In addition to outreach calls, members also receive education through mail and text messaging which also promote the Member Rewards program, awarding points to members for filling their controller medications which can be redeemed for prizes. An asthma tip sheet was created for the member portal which includes inhaler user guide, asthma action plan, asthma checklist, and asthma wallet card. Asthma programs are being identified throughout NYC Health + Hospitals as well as the rest of the MetroPlus network. Collaboration with DSRIP and other asthma-focused organizations are being formed to share best practices and resources. Clinical practice guidelines are regularly reviewed and posted to the provider portal. Prescribing provider trends as per pharmacy claims are analyzed to identify ratio of controller and rescue medications, and to encourage 90-day scripts. Asthma Medication Ratio is included in the Pay for Performance Program.

Interventions (Data): HEDIS®/QARR rates are tracked through monthly dashboards. Outcomes, barriers, and interventions are monitored through Quality Improvement Activity tools and the Quality Management Workplan.

Progress: The rates remain below the statewide average. MetroPlus continues to build and monitor interventions to improve this measure.

- **2016 Recommendation:** MetroPlus should continue to work to address the issues identified in the operational and focused review surveys. The MCO should take steps to ensure that all vendors' Utilization Review documents and notifications contain the correct information and all required language and that

any contracts are not enacted until required protocols are completed. Additionally, the MCO should continue to investigate new methods of increasing the accuracy of the information included in the provider directories. *[Repeat recommendation.]*

MCO Response: To ensure that all vendors' Utilization Review documents and notifications contain the correct information and all required language, the Utilization Management Department along with Vendor Delegation Oversight will conduct ad hoc audits of delegates' notices. The UM department will recommend and oversee corrective actions to satisfy regulatory and Plan requirements and will follow all corrective actions through to resolution. In addition, all vendor delegates will submit notice templates for review and approval by the Regulatory Affairs Department prior to implementation. The vendors will also be required to submit an implementation timeline that meets State deadlines. Non-compliance with corrective actions will be escalated to MetroPlus' Senior Leadership and the delegates' executive management. To ensure ongoing compliance, MetroPlus formed the Medical Management Audit Team in Q4 2016. This team is responsible for quarterly audits of all UM delegates, review of all new or revised delegate notices, and ad hoc or spot audits when non-compliance is suspected. The Medical Management Audit Team reports their findings to the Delegation Oversight Committee.

VIII. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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