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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

MOLINA HEALTHCARE OF NEW YORK, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

Table of Contents

List of Tables

List of Figures

Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

Molina Healthcare of New York, Inc. (Molina) is a regional, for-profit prepaid health services plan (PHSP) that serves Medicaid (MCD), Health and Recovery Plan (HARP), Child Health Plus (CHP), and Medicare populations. Molina Healthcare purchased Today's Options of New York on August 1, 2017. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

Molina Web Page: www.molinahealthcare.com

*Participating Regions and Products			
Central[1]:	MCD	CHP	HARP

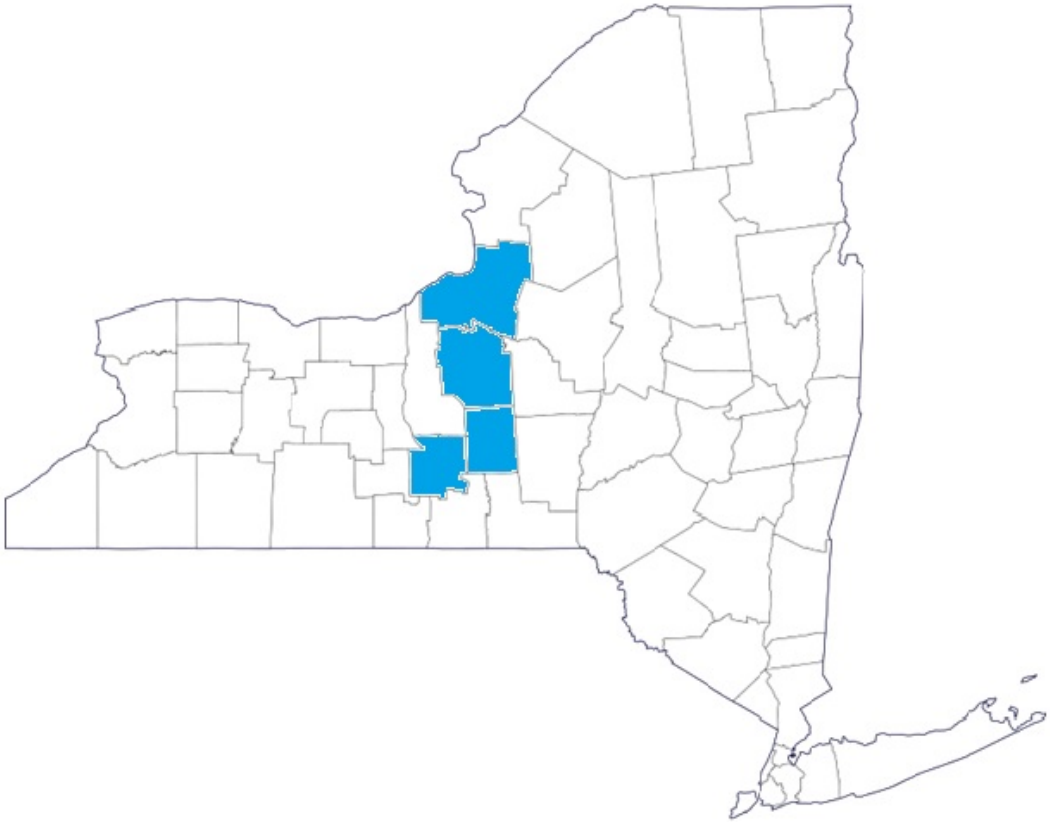
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

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

[1] Molina participates in CHP, HARP and MCD in Cortland, Onondaga, Oswego and Tompkins counties only.

Figure 1: Molina Map of Participating Counties



III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has decreased from 2017 to 2018 by a rate of 6.9%. Molina's membership represents 0.6% 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—2016-2018

	2016	2017	2018
Number of Members	32,832	30,062	27,977
% Change from Previous Year	-13.2%	-8.4%	-6.9%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	0.7%	0.7%	0.6%

Data Source: NYS OHIP Medicaid DataMart

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

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

	2016	2017	2018
CHP	1,328	1,104	837

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: Molina Enrollment Trends—All Product Lines

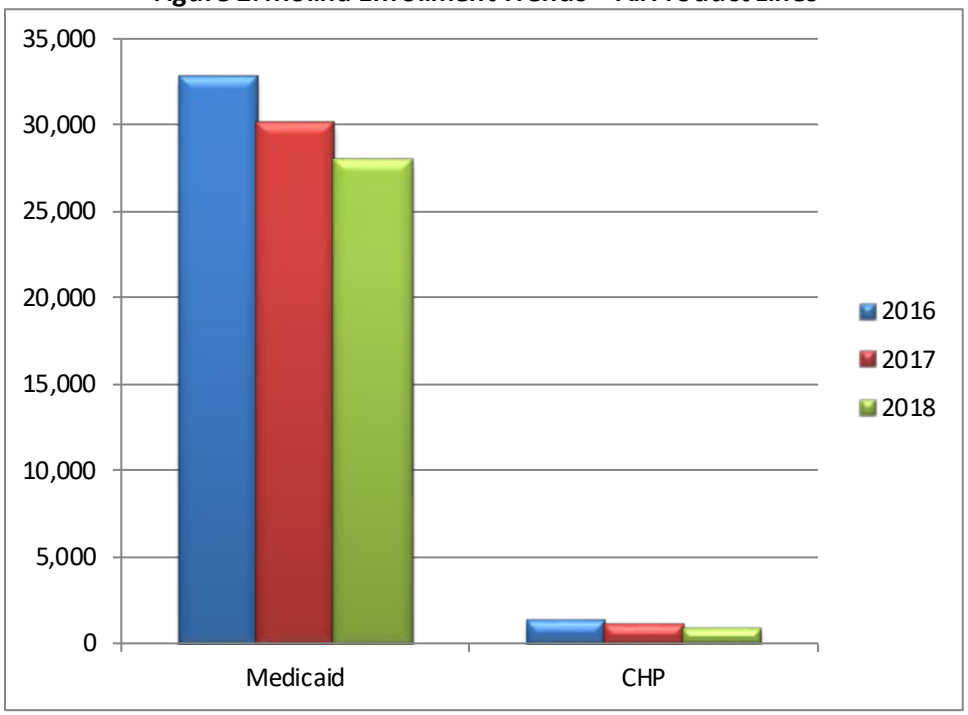


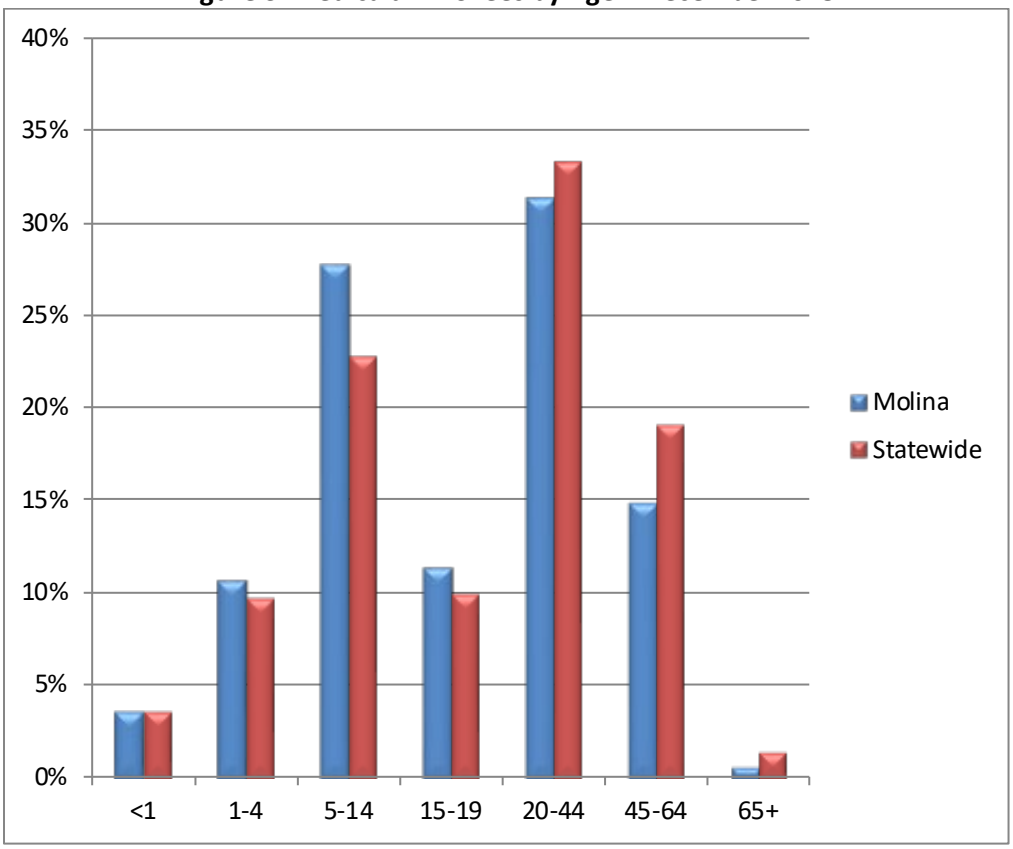
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. The MCO's Medicaid membership's largest age group is 20-44 year olds.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	529	496	1,025	3.7%	3.6%
1-4	1,513	1,467	2,980	10.7%	9.7%
5-14	4,005	3,710	7,715	27.6%	22.8%
15-19	1,634	1,546	3,180	11.4%	9.9%
20-44	3,165	5,550	8,715	31.2%	33.3%
45-64	1,929	2,223	4,152	14.9%	19.1%
65 and Over	79	95	174	0.6%	1.4%
Total	12,854	15,087	27,941		
Under 20	7,681	7,219	14,900	53.3%	46.1%
Females 15-64		9,319		33.4%	34.7%

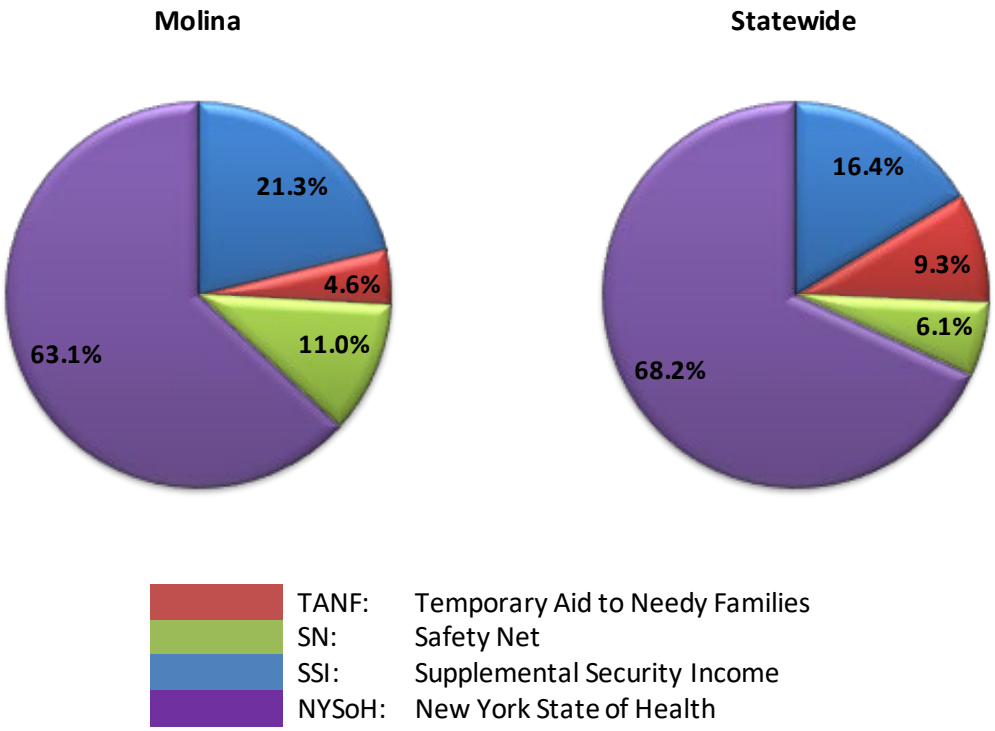
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. The MCO's rates were above the statewide average for 50% of the provider types. For detailed information regarding board certification of providers, please see the *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[2].

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

Provider Type	2016		2017		2018	
	Molina	Statewide Average	Molina	Statewide Average	Molina	Statewide Average
	Medicaid/CHP					
Family Medicine	92% ▲	71%	89% ▲	72%	91% ▲	74%
Internal Medicine	83%	75%	92% ▲	76%	84% ▲	76%
Pediatricians	88%	78%	89% ▲	79%	81%	80%
OB/GYN	77%	75%	86%	77%	90%	80%
Geriatricians	*SS*	63%	*SS*	63%	*SS*	63%
Other Physician Specialists	88% ▲	75%	41% ▼	76%	84% ▲	77%

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

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. The MCO had rates below the statewide average for 40% of the specialty types.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	193	10.7% ▼	19.5%
Pediatrics	23	1.3% ▼	3.8%
Family Practice	75	4.2%	3.5%
Internal Medicine	35	1.9% ▼	8.4%
Other PCPs	60	3.3%	3.8%
OB/GYN Specialty[1]	58	3.2%	3.8%
Behavioral Health	142	7.9% ▼	17.2%
Other Specialties	824	45.8%	46.0%
Non-PCP Nurse Practitioners	306	17.0% ▲	8.7%
Dentistry	277	15.4% ▲	4.9%
Total	1,800		

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

	Molina			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	145:1 ▲	256	109:1 ▲	42:1	80986	42:1
Pediatrics (Under age 20)	648:1 ▲			70:1		
OB/GYN (Females age 15-64)	161:1 ▲			59:1		
Behavioral Health	197:1 ▲			73:1		

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

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

The number of Medicaid PCPs with an "Open Panel" is presented in **Table 7** for the fourth quarters of 2016 through 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼. The MCO had 100% of providers with an open panel in 2017 and 2018.

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

	2016			2017			2018		
	Molina		Statewide	Molina		Statewide	Molina		Statewide
	Number	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**
Medicaid									
Providers with Open Panel	325	97.0	85.0	257	100.0	95.7	188	100.0	90.8

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

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

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

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
50	39	**78.0%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 34 providers (total number of providers who were compliant for participation (39), less total number of providers with closed panels (5)). The MCO performed above the threshold for Routine and After-Hours Access call types.

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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	3	3	100.0%
	Pediatrician	6	5	83.3%
	OB/GYN	3	3	100.0%
	Total Routine	**12**	**11**	**91.7%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	2	66.7%
	Pediatrician	5	3	60.0%
	OB/GYN	3	3	100.0%
	Total Non-Urgent	**11**	**8**	**72.7%**
After-Hours Access	Internist/Family Practitioner	3	1	33.3%
	Pediatrician	5	5	100.0%
	OB/GYN	3	3	100.0%
	Total After-Hours	**11**	**9**	**81.8%**

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

IV. Utilization

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

Encounter Data

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

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	Molina	Statewide Average	Molina	Statewide Average	Molina	Statewide Average
PCPs and OB/GYNs	4.26	3.85	3.82	3.56	3.62	3.50
Specialty	2.51	2.45	2.05	2.30	1.77 ▼	2.33
Emergency Room	0.74 ▲	0.54	0.66	0.55	0.59	0.53
Inpatient Admissions	0.17	0.14	0.14	0.14	0.12	0.13
Dental	1.02	1.03	1.02	1.02	0.95	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a)(ii) of the Medicaid Managed Care and Family Health Plus Model Contract, MCOs must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone, or by mail, and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 11** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2016 through 2018, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. The MCO has had rates above the statewide average for 3 consecutive years.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	Molina	SWA	Molina	SWA	Molina	SWA
	Medicaid					
Enrollee Health Screenings	22.6% ▲	12.5%	26.7% ▲	12.7%	23.4% ▲	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). The MCO has a rate above the statewide average for 1 out 10 measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	4,605	4,980	4,528	5,317
ER Visits	713	661	625 ▲	492
Inpatient ALOS				
Medicine	4.2	3.7 ▼	3.7	4.5
Surgery	7.4 ▲	6.2	7.4	7.0
Maternity	2.9	2.9	2.7	2.9
Total	4.4	4.0	4.2	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	44 ▲	39	31	30
Surgery Cases	17	18	17	12
Maternity Cases	36	37	36	32
Total Cases	86 ▲	83 ▲	74	66

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

V. Performance Indicators

To measure the quality, accessibility, and timeliness of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of performance indicators. This section is a summary of findings from those reports, including HEDIS®/QARR 2019 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

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

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

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

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[3]

Quality Indicators

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

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

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

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	93 ▲	82 ▼	93 ▲	**89**
WCC—BMI Percentile	91 ▲	73 ▼	91 ▲	**86**
WCC—Counseling for Nutrition	85 ▲	68 ▼	86 ▲	**83**
WCC—Counseling for Physical Activity	85 ▲	65 ▼	83 ▲	**74**
Childhood Immunizations—Combo 3	83 ▲	80 ▲	75	**73**
Lead Screening in Children	86	87	88	**89**
Adolescent Immunizations—Combo 2[2]		47 ▲	44	**43**
Adolescents—Alcohol and Other Drug Use[3]	68	54 ▼	75	**70**
Adolescents—Depression[3]	78 ▲	62	75 ▲	**67**
Adolescents—Sexual Activity[3]	68	53 ▼	68	**67**
Adolescents—Tobacco Use[3]	82 ▲	65	82 ▲	**74**
Breast Cancer Screening	68	70	69	**71**
Colorectal Cancer Screening	50 ▼	54 ▼	52 ▼	**63**
Chlamydia Screening (Ages 16-24)	70 ▼	72	75	**76**

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

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

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

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

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates below the SWA for 3 out of 20 measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	78 ▼	82 ▼	86 ▼	**91**
Spirometry Testing for COPD	45	38 ▼	38 ▼	**56**
Use of Imaging Studies for Low Back Pain	67 ▼	73	74	**77**
Pharmacotherapy Management for COPD—Bronchodilators	80	91	83	**89**
Pharmacotherapy Management for COPD—Corticosteroids	70	82	82	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	62	61	63	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	44 ▼	50	55	**59**
Asthma Medication Ratio (Ages 19-64)	61	58	58	**60**
Asthma Medication Ratio (Ages 5-18)	63	61	70	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	*SS*	*SS*	*SS*	**80**
CDC—HbA1c Testing	91	90	94	**92**
CDC—HbA1c Control (<8%)	34 ▼	36 ▼	59	**60**
CDC—Eye Exam Performed	66	64	64	**67**
CDC—Nephropathy Monitor	92	89 ▼	90	**92**
CDC—BP Controlled (<140/90 mm Hg)	58 ▼	57 ▼	67	**66**
Drug Therapy for Rheumatoid Arthritis	85	80	78	**83**
Monitor Patients on Persistent Medications—Total Rate	91	90 ▼	90 ▼	**92**
Appropriate Treatment for URI	95	96	96	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	20 ▼	30	32	**36**
HIV Viral Load Suppression[2,3]	84	80	86	**77**
Flu Shots for Adults (Ages 18-64)[4]	46 ▲	45		
Advising Smokers to Quit[4]	82	77		
Smoking Cessation Medications[4]	66	63		
Smoking Cessation Strategies[4]	46	54		

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

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

NV: Not valid. The MCO reported in valid data for the reporting year.

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

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

[2] NYS-specific measure.

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

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates above the SWA for 2 out of 9 measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	45 ▼	45 ▼	41 ▼	**53**
Antidepressant Medication Management—Effective Continuation Phase	31 ▼	33	28 ▼	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	67	61	97 ▲	**59**
Follow-Up Care for Children on ADHD Medication—Continue	82	77	85 ▲	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	63 ▼	61 ▼	76	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	46 ▼	43 ▼	68	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	81	79	78	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	*SS*	*SS*	*SS*	**80**
Antipsychotic Medications for Schizophrenia	61	52	44 ▼	**63**

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
ADHD: Attention-Deficit/Hyperactivity Disorder
[1] All measures included in this table are HEDIS® measures.

Access/Timeliness Indicators

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

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).In 2018, the MCO had rates below the SWA for 2 out of 3 measures.

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

	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	65	62 ▼	79	**81**
Well-Child Visits—3 to 6 Year Olds	78 ▼	79 ▼	80 ▼	**86**
Adolescent Well-Care Visits	61 ▼	62 ▼	60 ▼	**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.

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). The MCO had rates below the SWA for 40% of the measures in 2018.

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

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
	Children and Adolescents' Access to PCPs (CAP)			
12-24 Months	97%	97%	99 ▲	**97**
25 Months-6 Years	91% ▼	93% ▼	92 ▼	**94**
7-11 Years	94% ▼	96%	96	**97**
12-19 Years	92% ▼	96%	95	**95**
	Adults' Access to Preventive/Ambulatory Services (AAP)			
20-44 Years	85% ▲	85% ▲	82	**81**
45-64 Years	90%	91%	89	**89**
65+ Years	90%	90%	91	**91**
	Access to Other Services			
Timeliness of Prenatal Care	83% ▼	78% ▼	82 ▼	**88**
Postpartum Care	71%	56% ▼	62 ▼	**70**
Annual Dental Visit[2]	56% ▼	53% ▼	50 ▼	**61**

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

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

NYSDOH-Calculated Prenatal Care Measures

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

Table 15: QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	Molina	Regional Average	Molina	Regional Average	Molina	Regional Average
			ROS			
Risk-Adjusted Low Birth Weight[1]	6%	7%	6%	7%	-	-
Prenatal Care in the First Trimester	64% ▼	74%	66% ▼	74%	66% ▼	74%
Risk-Adjusted Primary Cesarean Delivery[1]	13%	14%	13%	13%	-	-
Vaginal Birth After Cesarean	23%	14%	23%	14%	-	-

Note: Some of the 2017 rates were not available at the time of the report.
ROS: Rest of State
[1] A low rate is desirable for this measure.

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2013, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). In 2018, the MCO had rates below the statewide average for 1 out of 12 measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	Molina	Statewide Average	Molina	Statewide Average	Molina	Statewide Average
			Medicaid			
Getting Care Needed[1]	85	**83**	77 ▼	**85**	81	**84**
Getting Care Quickly[1]	86	**87**	86	**88**	83 ▼	**88**
Customer Service[1]	77	**82**	83	**86**	83	**86**
Coordination of Care[1]	76	**74**	77	**74**	78	**75**
Collaborative Decision Making[1]	55	**53**	81 ▲	**74**	73	**76**
Rating of Personal Doctor[1]	87	**89**	89	**89**	89	**90**
Rating of Specialist	80	**81**	80	**83**	86	**84**
Rating of Healthcare	80	**85**	83	**86**	85	**87**
Satisfaction with Provider Communication[1]	91	**93**	91	**93**	91	**93**
Rating of Counseling/Treatment	63	**64**	72	**68**	55	**69**
Rating of Health Plan—High Users	75	**84**	81	**85**	75	**84**
Overall Rating of Health Plan	72	**83**	79 ▼	**85**	82	**85**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

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

Performance Improvement Project

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

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

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

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

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

Molina's 2017-2018 PIP topic was *"Improvement of Perinatal Care and Birth Outcomes"*. During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- Pregnant members identified as receiving 17P injections will be referred to high-risk pregnancy case management. Case Management will provide telephonic outreach to all pregnant members identified via Health Risk Assessments, provider referrals, mental health co-management referrals, quality referrals for gaps in care, member self-referrals, 17P claims, and early pregnancy notification forms.
- Executed community baby showers to promote perinatal health and available services.

Provider-Focused Interventions:

- Engaged in meetings with the Syracuse Community Health Center and St. Joseph Hospital Healthcare to discuss the PIP and established a partnership to deliver higher quality of care and impact pregnancy and birth outcomes. Also educated additional provider groups within the MCO's network.
- Embedded staff will educate high-volume OB provider groups on data findings, behavioral health screening recommendations, referral processes for Case Management, and ACOG recommendations for LARC.
- Embedded staff will educate providers on the early pregnancy notification form, after development and implementation, which will be completed within 7 days of a positive pregnancy test or first prenatal visit. Staff will review and discuss 17P eligibility and referrals.

MCO-Focused Interventions:

- Pregnancy CM provided telephonic outreach to all pregnant members identified by the new member Health Risk Assessment, provider referrals, mental health co-management referrals, quality referrals for gaps in care, member self-referrals, 17P claims, and early pregnancy notification forms. Services provided by CM included: assessment including smoking and depression screening, 17P education, perinatal education, outreach for engagement, birth control education, assistance with transportation and/or home visits for weekly injections if needed, community resources, reminder calls for appointments, enrollment in NYS Quitline, if appropriate, and referral to mental health services, if appropriate.
- Continue promoting recommended tobacco assessment screenings, NYS Quitline referrals, and smoking cessation benefits.

Table 18 presents a summary of Molina's 2017-2018 PIP. The MCO demonstrated an improvement for 11 out of 16 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	83%	82%	**90%**	Performance declined
Postpartum Care	71%	62%	**73%**	Performance declined
Received at least one 17P injection	2%	4%	**3%**	Demonstrated improvement
Depression Screening	52%	87%	**75%**	Demonstrated improvement
Tobacco Screening during 1st trimester*	40%	73%	**90%**	Demonstrated improvement
Tobacco Screening during 2nd trimester*	66%	83%	**90%**	Demonstrated improvement
Tobacco Screening during 3rd trimester*	62%	96%	**90%**	Demonstrated improvement
Tobacco Screening Follow-Up				Plan did not measure or report results
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	0%	17%	**3%**	Demonstrated improvement
Age 15-20 years; within 60 days	2%	28%	**5%**	Demonstrated improvement
Age 21-44 years; within 3 days	0%	24%	**3%**	Demonstrated improvement
Age 21-44 years; within 60 days	3%	7%	**5%**	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	2%	19%	**5%**	Demonstrated improvement
Age 15-20 years; within 60 days	5%	23%	**10%**	Demonstrated improvement
Age 21-44 years; within 3 days	6%	6%	**8.5%**	Performance level was maintained
Age 21-44 years; within 60 days	10%	9%	**15%**	Performance declined

***** Tobacco screening was assessed separately for three trimesters.

Health Disparities

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

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

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

- MHNY has developed internal reporting to identify members with at-risk characteristics; including those who are gapped for preventative measures such as breast cancer screening, and comprehensive diabetes care. Key findings include: a) members generally unaware of the benefits of preventative care, b) assumption of financial obligation for receiving services, c) socioeconomic barriers such as transportation, and d) cultural barriers play a role in a members' desire to engage within the healthcare ecosystem.
- MHNY utilizes its internal data to identify areas with the largest gaps-in-care by zip code. A key finding is the existence of a significant gap in members who have not completed appropriate diabetic screenings in zip code 13208. To address this issue, MHNY has developed partnerships with local community-based organizations, to increase awareness of the importance of medical care, and to address any knowledge barriers regarding utilization of benefits. Also, MHNY has executed five community mobile clinics, to address the gap attributed to diabetes care. Finally, MHNY has a program titled Care Connections, where nurse practitioners provide in-home assessments for members; closing barriers such as transportation, and apprehension to engagement with primary care physicians.
- Using the population in the 13208 zip code, a gap in quality of care is the lower rate of comprehensive diabetes care, breast cancer screening, colorectal cancer screening, and annual dental visits among children in this area, compared to other member populations. Two major key findings are related to language barriers, and cultural competency. MHNY utilized connections with local community-based organizations to connect to the members. Many follow-up actions have been completed to date, including education sessions, and the implementation of the mobile clinics.
- Determinants impacting outcomes are: 1) access to transportation, 2) socio-cultural concerns, 3) availability of services, 4) limited cultural competency, 5) limited trust of healthcare system, and 6) language barriers. Follow-up actions that have already occurred include: 1) connecting with local CBO's, 2) increased engagement with targeted population, 3) development of health education materials (pending), and 4) connecting members in need to appropriate social services.
- As of December 19th, 2019, MHNY has held nine mobile health events; targeting the zip codes with the highest needs. Nearly 70 members have received services for diabetes, postpartum care, breast cancer screening, and adult comprehensive examinations.

VI. Health Information Technology

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

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

- Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
- Use of telecommunications technologies
- Use of Electronic Health Records (EHR)
- Use of electronic internal registries
- Use of clinical risk group (CRG) or similar software
- Secure electronic transfer of member data between the MCO, its vendors, and network providers
- Electronic communication with providers
- Electronic communication with members
- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)[4]
- Participation in State, Federal, or privately funded HIT initiatives
- Participation in a medical home pilot or program
- Future plans to implement HIT

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

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

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

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

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

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

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Utilizes secure email for providers and members.
  - Utilize secure FTP sites.
  - Use of a secure provider portal.

- Use of telecommunications technologies:
  - Utilizes a telehealth program

- Use of Electronic Health Records (EHR):
  - The MCO captures information from provider electronic health records-with an objective of capturing coding for targeted measures.

- Use of clinical risk group (CRG) or similar software:
  - MHNY utilizes 3M, a third-party vendor that provides the MCO with pertinent Clinical Risk Group (CRG) member data, which includes a member risk scoring model.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Use of a secure transfer via the Internet.
  - Utilize secure FTP sites.

- Electronic communication with providers:
  - Utilize secure FTP sites.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - The MCO is not associated with a RHIO.

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

- Future plans to implement HIT:
  - The MCO plans to collaborate with the HIE in early 2020, with the objective of improving data sharing between network providers and MHNY.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers, adverse determination utilization review files, complaints and grievances files, meeting minutes, and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys". The NYSODH 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 response with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and MCOs are required to resubmit. Ultimately, all MCOs with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the MCOs to ensure that all deficiencies or issues from the operational survey have been remedied.

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

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

For the operational review, Molina was in compliance with 12 of the 14 categories. The categories in which Molina was not compliant were, Organization and Management (1 citation), and Service Delivery Network (1 citation). Molina was in compliance for all of the focused review types in 2018.

Table 20: Focused Review Types

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

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

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	0
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	1	0
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	1	0
Utilization Review	0	0
Total	**2**	**0**

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, MHNY had 75% of external appeals overturned.

Table 22: External Appeals—2016-2018

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

VIII. Strengths and Opportunities for Improvement[5]

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

Strengths

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

Strengths:

- The MCO has reported a rate above the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *Family Medicine*. Additionally, the MCO's rates were above the statewide average for 2018 for *Internal Medicine* and *Other Physician Specialists.*
- In regards to provider types in the MCO's Medicaid product line, the MCO had rates above the statewide average for *Non-PCP Nurse Practitioners* and *Dentistry*.
- The MCO had 100% of Medicaid PCPs with an "Open panel" for 2 consecutive years.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO had rates above the 75% threshold for Routine (91.7%) and After-Hours Access (81.8%) call types.
- The MCO had rates above the statewide average for 3 consecutive years for health screenings conducted for new enrollees.
- In the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO reported rates above the statewide average in 2018 for *Adult BMI Assessment, Weight Assessment and Counseling for Children and Adolescents (BMI Percentile, Counseling for Nutrition and Physical Activity), Adolescents Preventative Care (Depression and Tobacco Use), and Colorectal Cancer Screening*.
- In 2018, the MCO had rates above the statewide average for HEDIS®/QARR *Follow-Up Care for Children on ADHD Medication-Initiation* and *Follow-Up Care for Children on ADHD Medication-Continue,*
- The MCO has reported a rate above the statewide average in 2018 for the 12-24 Months age group of the HEDIS®/QARR *Children and Adolescents' Access to PCPs measure*.

Opportunities for Improvement

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

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

Opportunities for Improvement:

- Regarding Medicaid providers by specialty, the MCO had rates below the statewide average for Primary Care Providers, Pediatrics, Internal Medicine and Behavioral Health specialists.
- In regards to the ratio of enrollees to Medicaid providers, the MCO had rates above the statewide average for all specialty types.
- The MCO's appointment rate for Non-urgent "sick" calls was below the 75% threshold in the 2018 Primary Care and OB/GYN Access and Availability Survey...
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Colorectal Cancer Screenings*. *(Note: Colorectal Cancer Screening was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain. The MCO has reported a rate below the statewide average for at least three consecutive reporting years for the Testing for Children with Pharyngitis measure. Additionally, the MCO's rates for Spirometry Testing for COPD and Monitor Patients on Persistent Medications – Total Rate were reported below the statewide average for 2018. *(Note:* Monitor Patients on Persistent Medications – Total Rate *was an opportunity for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Behavioral Health domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Antidepressant Medication Management—Effective Acute Phase Treatment.* Additionally, the MCO had rates below the statewide average in 2018 for *Antidepressant Medication Management – Effective Continuation Phase* and *Antipsychotic Medications for Schizophrenia. (Note: Antidepressant Medication Management—Effective Acute Phase Treatment* was an opportunity *for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regards to access and timeliness indicators. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Children and Adolescents' Access to Primary Care Practitioners—25 Months-6 Years; Timeliness of Prenatal Care;* and *Annual Dental Visit (Ages 2-20)*. Additionally, the MCO's rate for *Postpartum Care* was reported below the statewide average for 2018. *(Note: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Children and Adolescents' Access to Primary Care Practitioners—25 Months-6 Years; Timeliness of Prenatal Care; and Annual Dental Visit (Ages 2-20) were opportunities for improvement in the previous year's report.)*
- In regard to QARR Prenatal Care rates, the MCO had reported rates below the statewide average for 3 consecutive years for *Prenatal Care in the First Trimester*.
- In regard to member satisfaction, the MCO demonstrates an opportunity for improvement, as the MCO's rates for the CAHPS® *Getting Care Quickly* measure was reported below the statewide average for 2018. *(Note: member satisfaction was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO should evaluate its provider network to determine its impact on members accessing care. In 2018, the MCO's ratio of enrollees to Medicaid providers indicates that the MCO has fewer providers per enrollee. Also, with the MCO's Medicaid population consisting of a large number of members aged 5-14 years and 20-44 years, the MCO should consider increasing the number of Primary Care Providers (PCPs). There should be a focus on increasing the number of Pediatricians and Internal Medicine PCPs. With the MCO's poor performance in appointment rates for Primary Care and OB/GYN providers during Non-Urgent calls, the MCO should develop a process to identify providers who did not meet the requirements. The MCO should offer education on the access and availability standards to the identified providers. Ongoing reminders to providers can be given through existing provider communications such as; quarterly provider newsletters and monthly meetings.
- The MCO should continue to create and implement initiatives to address the HEDIS®/QARR measures that continue to perform below the statewide average, such as colorectal cancer screenings, testing and monitoring of patients with acute and chronic diseases and medication management for depression. The MCO should consider barriers to care such as, available appointment hours conflicting with member work hours, transportation issues, and cultural beliefs regarding mental health treatments. The MCO should routinely evaluate its current interventions to determine if rates are improving and to identify additional barriers to care. *[Repeat recommendation.]*
- As the MCO continues to struggle to improve certain measures related to access to care, the MCO should conduct targeted root cause analyses for each measure and develop initiatives designed to address the true root cause(s) of poor performance. Additionally, the MCO should investigate if the low performance on access to care measures is related to the low performance for the Child CAHPS® measure *Getting Care Quickly. [Repeat recommendation.]*

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** The MCO should continue to create and implement initiatives to address the HEDIS®/QARR measures that continue to perform below the statewide average. The MCO should conduct a thorough root cause analysis for each individual measure to determine what factors are driving the performance of that measure. The MCO should consider using more active strategies, such as its pop-up clinics, rather than passive strategies, such as raising awareness of measure specifications. [Repeat recommendation.]

  MCO Response: To date, Molina Healthcare (MHNY) has implemented numerous proactive strategies with the intent to improve the outcomes attributed to HEDIS/QARR measures that previously fell below statewide average. From September 2018 through December 2019, MHNY has held 11 mobile clinics in underserved areas within our geographical footprint. The objective has three components: a) to address zip codes with the largest number of members with gaps in care, and b) address sociocultural barriers by partnering with community-based organizations to build goodwill in the areas we serve, and c) promote connectivity to their primary care providers. These efforts have contributed to the turnaround of a multitude of HEDIS/QARR measures, primarily Comprehensive Diabetes Care-Three Tests (HbA1c<8, Nephropathy, and Eye Exams), and Adult Comprehensive Examinations-to reengage members that have not utilized primary care within an 18-month window.

An additional factor toward improving HEDIS/QARR outcomes lies in our consistent engagement with our Value-Based Provider groups. Facilitating monthly meetings, with quality scorecard information, and member-level detail enables both parties to engage in strategic planning, designed to improve our collective outcomes. Having consistent dialogue has improved the tracking and closure of QARR/HEDIS measures we have not fared well with in the past; one example being Well-Child Visits in the First 15 Months of Life (5+)-which we have surpassed the 50th percentile benchmark for the first time in three years. We are within a couple percentage points from reaching the 75th percentile-based on the previous QARR benchmark (2018 ratings).

Finally, a root-cause analysis was completed, to address measures identified in the performance matrix as below-standard. Two areas identified for improvement include: a) limited engagement w/providers, and b) data integration. Each point has been addressed through the adage of a project plan-designed to track our quality activities and allow for re-direction if required. Similar to measurement year 2018, the quality measures for 2019 have mostly improved indicating our current processes are moving MHNY in the right direction.

- **2017 Recommendation:** As the MCO continues to struggle to improve certain measures related to access to care, the MCO should conduct targeted root cause analyses for each measure and develop initiatives designed to address the true root cause(s) of poor performance. Additionally, since many HEDIS®/QARR measures for which the MCO performed below the average are related to preventive care for adolescents, and the MCO performed below average for well-care visits, the MCO could consider implementation of interventions designed to improve both these areas. [Repeat recommendation.]

  MCO Response: MHNY implemented a targeted intervention strategy for 2018 and 2019-focused on identifying providers who have the largest volume of children and adolescent members. As noted above, MHNY's quality team established monthly meetings with our provider groups, to ensure awareness of members with gaps-in-care, and collaboratively intervene with our inactive members. Using our member-provider-community-data approach, MHNY began with a member outreach strategy-which included: a) mailers, b) telephonic outreach, and c) the development of a member incentive program for Adolescent Well Care Visits. This method of engagement played a role in the improvement of the Immunization for Adolescents-Combo 2 measure, of which MHNY has surpassed the 50th percentile, per the most recent QARR benchmarks. Our providers have been key to moving the members into higher engagement. We also have shared information on our member incentive program-improving the rate of engagement with our member population. Also, sharing targeted member-level detailed information gave providers guidance on which items to specifically address (combo 2 measure)-ensuring appropriate activity and reporting.

- **2017 Recommendation:** The MCO should conduct root cause analyses for the CAHPS® measures reported below the statewide average to determine reasons why members are reporting low rates of satisfaction with the MCO overall. The MCO should take steps to improve members' satisfaction with the plan by implementing initiatives designed to address factors effecting satisfaction.

  MCO Response: MHNY established a CAHPS task force to address the deficient measures noted in the report. The key areas of improvement were; a) improve customer service, b) improve provider engagement-including furthering understanding of patient engagement barriers, and c) addressing provider/member relational issues. To date, items a & b are being addressed as part of a continuous improvement strategy, while item c remains a work in progress. There is no specific timeline on this initiative; the objective is to integrate the internal and external engagement into our daily practices. The

expected outcome of this initiative would include; a) improved member engagement-first call resolution, b) improved provider relationships-resulting in better outcomes for our members, and c) determining who/where the negative member/provider interactions our occurring, and work toward improving this area.

- **2017 Recommendation:** The MCO should work to address the issues identified in the operational and focused review surveys. First, the MCO should evaluate its policies and procedures related to Complaints and Grievances and Utilization Review, as well as review all documentation in these areas, to ensure the appropriate information and language is included in all documentation. The MCO should also work to improve the accuracy of the data included in its provider directories to ensure members have appropriate access to providers.

  MCO Response: MHNY has taken the appropriate steps to address any deficiencies within our policies and procedures, and external-facing documentation. MHNY recently completed an Article 44 review, which prompted an additional review of our policies which proved to be a success based on the survey results. MHNY's policies are reviewed on an annual basis to ensure accuracy. MHNY now offers an online (real time) directory to its members, this allows for a more accurate directory.

IX. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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