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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

MVP HEALTH PLAN, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

MVP Health Plan, Inc. (MVP) is a regional, not-for-profit health maintenance organization (HMO) serving the Medicaid (MCD), Child Health Plus (CHP), Health and Recovery Plan (HARP), Commercial (COM), and Medicare populations. MVP merged with Rochester Area HMO/Preferred Care (Preferred Care) on May 1, 2009. Prior to May 1, 2009, both plans held separate certificates of authority and maintained separate operations. On October 31, 2013, the Department approved the acquisition of Hudson Health Plan, Inc. by MVP. On January 1, 2016, the Medicaid and Child Health Plus populations of Hudson Health Plan, Inc. migrated to MVP. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP and Commercial product lines.

MVP Web Page: https://www.mvphealthcare.com

Participating Regions and Products[1]			
Central[2]:	MCD	CHP	COM
Hudson Valley[3]:	MCD	CHP	COM
Northeast[4]:	MCD	CHP	COM
Western[5]:	MCD	CHP	COM

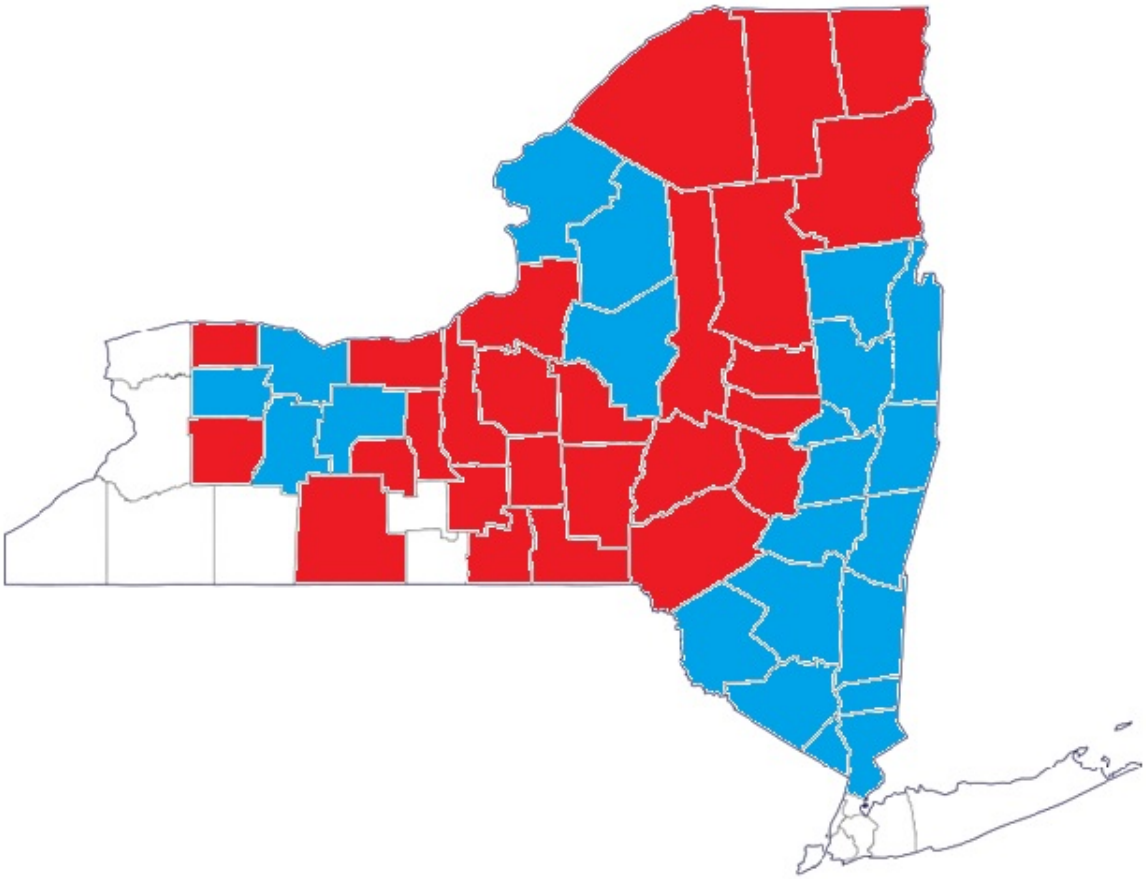
Note: Please contact the plan directly to confirm the plan participation counties.

Region Definitions

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

[1] Note that the HARP product line is available in all counties that serve the Medicaid population.
[2] MVP offers COM only in Broome, Cayuga, Chenango, Cortland, Herkimer, Madison, Onondaga, Oswego, St. Lawrence, Tioga, and Tomkins counties.
[3] MVP offers CHP and COM in Duchess County.
[4] Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Montgomery Otsego, Schoharie, offers only COM product.
[5] MVP offers MCD, CHP and COM in Genesee, Livingston, Monroe and Ontario counties. In Orleans, Seneca, Steuben, Wayne, Wyoming and Yates only COM is offered.

Figure 1: MVP Map of Participating Counties



Note: Counties shaded in blue serve the Medicaid and/or CHP populations, while counties shaded in red serve the Commercial population only. The Commercial product line is available in all participating counties, and the HARP product line is available in counties serving Medicaid members.

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 increased from 2017 to 2018 by a rate of 0.9%. MVP's membership represents 3.8% 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	164,132	163,552	165,007
% Change from Previous Year	392.5%	-0.4%	0.9%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	3.8%	3.7%	3.8%

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	13,928	16,413	19,311
Commercial	74,006	63,617	64,103

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: MVP Enrollment Trends—All Product Lines

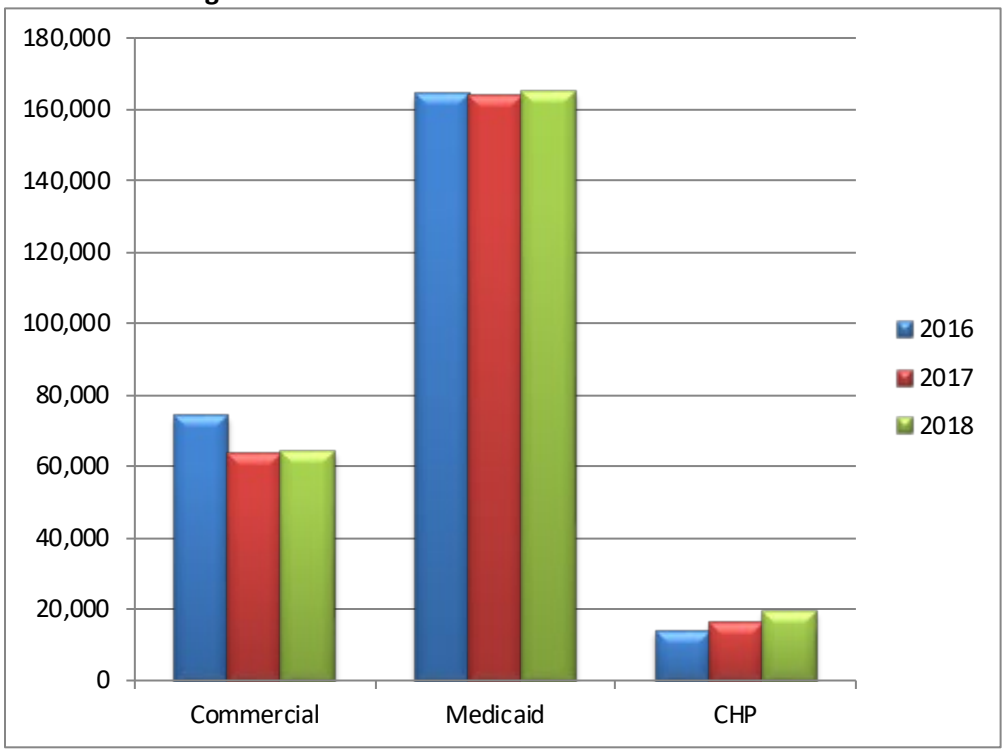


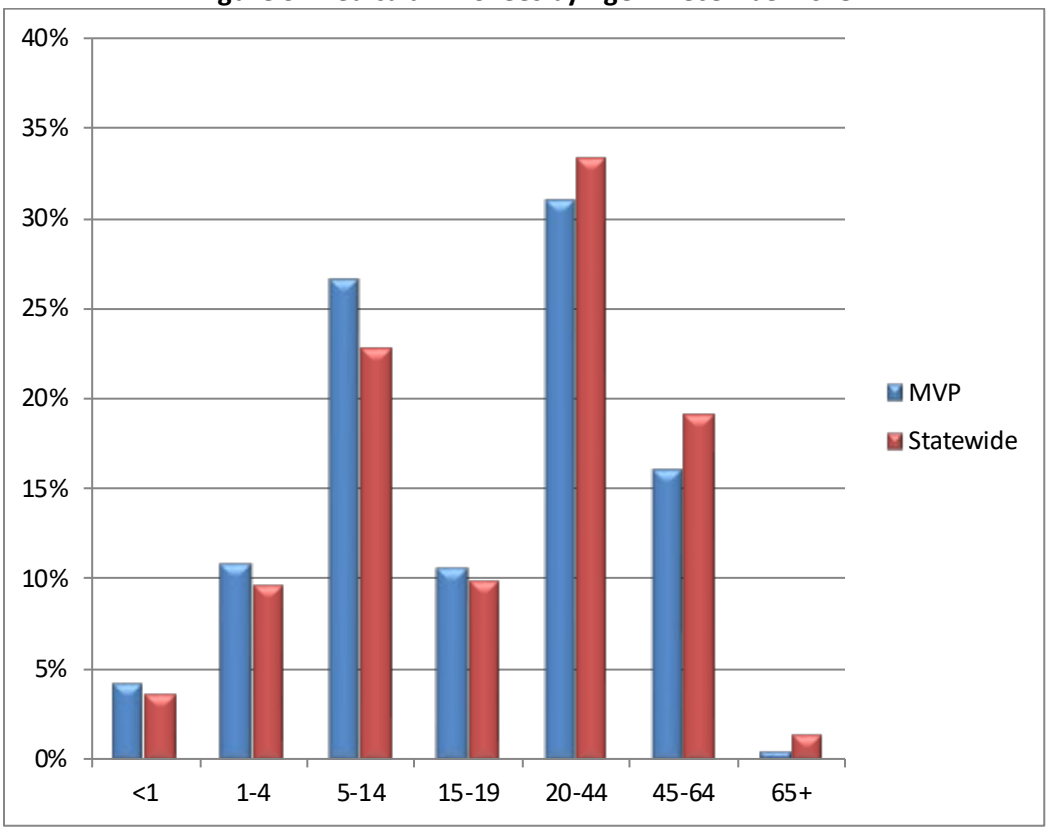
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. The MCO had rates above the statewide average for 4 out of 8 age groups.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	3,523	3,461	6,984	4.2% ▲	3.6%
1-4	9,186	8,759	17,945	10.9%	9.7%
5-14	22,552	21,334	43,886	26.6% ▲	22.8%
15-19	8,852	8,663	17,515	10.6% ▲	9.9%
20-44	18,904	32,260	51,164	31.0% ▼	33.3%
45-64	11,485	15,076	26,561	16.1% ▼	19.1%
65 and Over	282	562	844	0.5% ▼	1.4%
Total	74,784	90,115			
Under 20	44,113	42,217	86,330	52.4% ▲	46.1%
Females 15-64		55,999		34.0%	34.7%

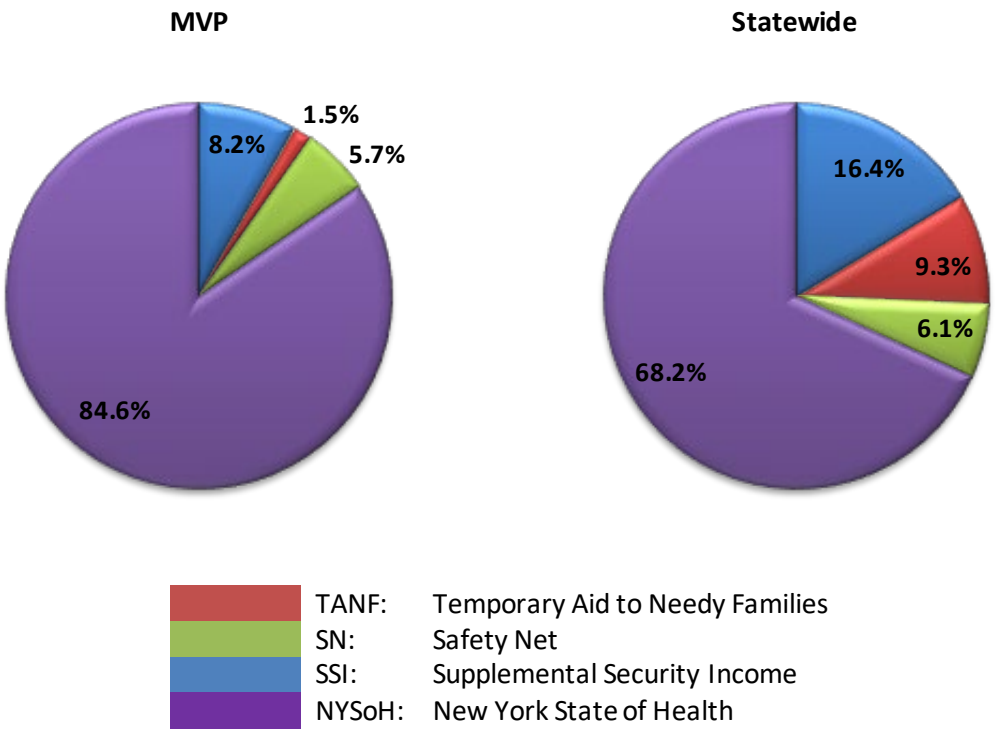
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. The MCO's Medicaid product line rates improved for 3 out of 6 measures. For detailed information regarding board certification of providers, please see *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[6].

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

Provider Type	2016		2017		2018	
	MVP	Statewide Average	MVP	Statewide Average	MVP[1]	Statewide Average
Medicaid/CHP						
Family Medicine	81% ▲	71%	81% ▲	72%	81%	74%
Internal Medicine	75%	75%	75%	76%	75%	76%
Pediatricians	78%	78%	78%	79%	80%	80%
OB/GYN	78%	75%	80%	77%	82%	80%
Geriatricians	69%	63%	70%	63%	70%	63%
Other Physician Specialists	79% ▲	75%	80% ▲	76%	82%	77%
Commercial						
Family Medicine	80% ▲	74%	81% ▲	77%	80%	72%
Internal Medicine	73%	73%	74% ▼	77%	74%	73%
Pediatricians	78%	77%	81%	79%	82%	75%
OB/GYN	77%	78%	82%	79%	81%	78%
Geriatricians	66%	63%	69%	69%	67%	66%
Other Physician Specialists	78%	78%	79%	79%	79%	77%

[1]Level of significance was unaudited.

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

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. The MCO had 1 out of 10 provider types with a rate above the statewide average.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	4,379	17.0%	19.5%
Pediatrics	1,242	4.8%	3.8%
Family Practice	1,437	5.6% ▲	3.5%
Internal Medicine	1,627	6.3%	8.4%
Other PCPs	73	0.3% ▼	3.8%
OB/GYN Specialty[1]	953	3.7%	3.8%
Behavioral Health	5,237	20.3%	17.2%
Other Specialties	11,651	45.2%	46.0%
Non-PCP Nurse Practitioners	2,423	9.4%	8.7%
Dentistry	1,110	4.3%	4.9%
Total	25,753		

Data Source: NYS Provider Network Data System (PNDS).

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

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

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

Specialty Type	MVP			Statewide		
	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	38:1	4,531	36:1	42:1	80,986	42:1
Pediatrics (Under age 20):	70:1			70:1		
OB/GYN (Females age 15-64)	59:1			59:1		
Behavioral Health	31:1			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's rate of Medicaid PCPs with an Open Panel remained the same from 2017.

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

	2016			2017			2018		
	MVP		Statewide	MVP		Statewide	MVP		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	3,560	97.7	85.0	2,424	86.1	95.7	3,663	86.1	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 MVP 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
100	71	**71.0%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 65 providers [total number of providers who were compliant for participation (71), less total number of providers with closed panels (6).] The MCO performed above the threshold for all call types.

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

Region	Call Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	8	6	75.0%
	Pediatrician	11	9	81.8%
	OB/GYN	5	5	100.0%
	Total Routine	**24**	**20**	**83.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	4	3	75.0%
	Pediatrician	10	7	70.0%
	OB/GYN	10	9	90.0%
	Total Non-Urgent	**24**	**19**	**79.2%**
After-Hours Access	Internist/Family Practitioner	2	2	100.0%
	Pediatrician	9	8	88.9%
	OB/GYN	6	5	83.3%
	Total After-Hours	**17**	**15**	**88.2%**

[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 had rates above the statewide average for 1 out of 5 measures.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	MVP	Statewide Average	MVP	Statewide Average	MVP	Statewide Average
PCPs and OB/GYNs	3.55	3.85	1.20 ▼	3.56	3.58	3.50
Specialty	2.65	2.45	1.02 ▼	2.30	2.86 ▲	2.33
Emergency Room	0.62	0.54	0.60	0.55	0.6	0.53
Inpatient Admissions	0.17	0.14	0.16	0.14	0.15	0.13
Dental	1.21	1.03	1.12	1.02	1.11	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

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

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	MVP	SWA	MVP	SWA	MVP	SWA
	Medicaid					
Enrollee Health Screenings	13.2%	12.5%	6.5%	12.7%	17.1%	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). In 2018, the MCO had rates below the statewide average for 2 out of 10 measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)								
Visits	5,187	4,972	4,984	5,317	4,999	5,067 ▲	5,079 ▲	4,209
ER Visits	657	587	567	492	241	221	230	204
Inpatient ALOS								
Medicine	3.8	3.9	3.7	4.5	3.5	3.7	3.5	3.5
Surgery	4.7 ▼	4.9 ▼	5.6 ▼	7.0	3.9 ▼	3.5 ▼	4.2	4.4
Maternity	2.8	2.8	2.8	2.9	2.7	2.6	2.6	2.6
Total	3.6 ▼	3.7 ▼	3.7 ▼	4.4	3.5	3.5	3.6	3.6
Medicine Cases	37	30	28	30	27 ▲	26 ▲	24	17
Surgery Cases	14	13	13	12	22 ▲	22 ▲	16	15
Maternity Cases	37	39 ▲	37 ▲	32	10 ▼	8 ▼	13	12
Total Cases	76	70	67	66	57 ▲	55 ▲	44	42

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

V. Performance Indicators

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

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

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

The MCO 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 to 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.[7]

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.

[7] 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's Medicaid product line had rates above the SWA for 2 out of 14 measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	90 ▲	84	93 ▲	**89**	91 ▲	88	84 ▼	**89**
WCC—BMI Percentile	86 ▲	87 ▲	88	**86**	84 ▲	89 ▲	87	**90**
WCC—Counseling for Nutrition	82	84	82	**83**	85 ▲	84	82 ▼	**87**
WCC—Counseling for Physical Activity	74 ▲	74	74	**74**	77 ▲	79	77	**80**
Childhood Immunizations—Combo 3	80 ▲	77	82 ▲	**73**	89 ▲	85	86	**84**
Lead Screening in Children	87	91	88	**89**	88 ▲	86	88	**88**
Adolescent Immunizations—Combo 2[2]		42	44	**43**		27	26 ▼	**31**
Adolescents—Alcohol and Other Drug Use[3]	70	65	67	**70**	72	75	71 ▼	**78**
Adolescents—Depression[3]	63	60	65	**67**	51 ▼	57 ▼	66	**70**
Adolescents—Sexual Activity[3]	66	59	63	**67**	67	68	68	**74**
Adolescents—Tobacco Use[3]	77	72	78	**74**	80 ▲	79	79	**82**
Breast Cancer Screening	70	68 ▼	66 ▼	**71**	74 ▲	75 ▼	74 ▼	**77**
Colorectal Cancer Screening	54	54 ▼	58 ▼	**63**	73 ▲	73	68	**71**
Chlamydia Screening (Ages 16-24)	74	72 ▼	72 ▼	**76**	59	57	60	**60**

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

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

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

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

[3] NYS-specific measure.

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

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	89	93 ▲	91	**91**	92	93	91	**93**
Spirometry Testing for COPD	41 ▼	40 ▼	47 ▼	**56**	35 ▼	38 ▼	43	**45**
Use of Imaging Studies for Low Back Pain	65 ▼	71 ▼	71 ▼	**77**	65 ▼	72 ▼	73 ▼	**80**
Pharmacotherapy Management for COPD—Bronchodilators	84	86	86	**89**	69	81	69 ▼	**80**
Pharmacotherapy Management for COPD—Corticosteroids	69	80	75	**76**	60	70	70	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	62 ▼	62 ▼	68	**71**	73	78	78	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	51	52 ▼	55 ▼	**59**	64	71	62	**63**
Asthma Medication Ratio (Ages 19-64)	60 ▲	61	64	**60**	78	84	83	**81**
Asthma Medication Ratio (Ages 5-18)	70 ▲	70 ▲	72 ▲	**68**	86	85	83	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	80	80	75	**80**	88	94	85	**83**
CDC—HbA1c Testing	91	89	95	**92**	90	90	91	**92**
CDC—HbA1c Control (<8%)	59	58	55	**60**	63	65	60	**61**
CDC—Eye Exam Performed	53 ▼	56 ▼	65	**67**	59	66	62	**63**
CDC—Nephropathy Monitor	90	91	92	**92**	90	91	89	**89**
CDC—BP Controlled (<140/90 mm Hg)	75 ▲	66	71 ▲	**66**	74 ▲	71	70	**69**
Drug Therapy for Rheumatoid Arthritis	77	80	78	**83**	87	88	79 ▼	**84**
Monitor Patients on Persistent Medications—Total Rate	90 ▼	90 ▼	90 ▼	**92**	83 ▼	84	84	**84**
Appropriate Treatment for URI	95	95	96 ▲	**95**	91	93	95	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	28	29 ▼	32	**36**	25	28	38	**34**

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
HIV Viral Load Suppression[2,3]	84 ▲	85 ▲	85 ▲	**77**				
Flu Shots for Adults (Ages 18-64)[4]	38	39			52	59	55	**56**
Advising Smokers to Quit[4]	81	82			89 ▲	88	83	**81**
Smoking Cessation Medications[4]	60	60			66	69	61	**62**
Smoking Cessation Strategies[4]	53	48			51	53	51	**55**

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

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

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

[2] NYS-specific measure.

[3] The *HIV Viral Load Suppression* measure was introduced in Reporting Year 2017.

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO's Medicaid product line had rates below the SWA for 33% of the measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	50	51	50	**53**	64	61 ▼	68	**68**
Antidepressant Medication Management—Effective Continuation Phase	36	37	35	**37**	50	46 ▼	51	**53**
Follow-Up Care for Children on ADHD Medication—Initiation	54 ▼	51 ▼	51 ▼	**59**	40	38	44	**45**
Follow-Up Care for Children on ADHD Medication—Continue	68	56 ▼	61	**66**	43	*SS*	57	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	77	79	69 ▼	**74**	80	75	69	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	61	62	56 ▼	**63**	63	54	51	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	81	82	83	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	77	79	78	**80**				
Antipsychotic Medications for Schizophrenia	62	66	62	**63**				

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

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

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[8].

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). The MCO's Medicaid product line had rates above the SWA for 1 out 3 measures.

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

Measure	2016	2017	2018	2018 Statewide Average
Medicaid/CHP				
Well-Child Visits—First 15 Months	63	69	86 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	85	84 ▼	85 ▼	**86**
Adolescent Well-Care Visits	68	67 ▼	67 ▼	**68**
Commercial				
Well-Child Visits—First 15 Months	92 ▲	92 ▲	95	**94**
Well-Child Visits—3 to 6 Year Olds	89 ▲	91 ▲	91 ▲	**88**
Adolescent Well-Care Visits	68 ▲	69 ▲	70 ▲	**67**

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

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

Access to Care

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

Table14b 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 ▼). In 2018, the MCO's Medicaid product line had rates above the SWA for 50% of the measures.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Children and Adolescents' Access to PCPs (CAP)								
12-24 Months	98% ▲	98% ▲	98 ▲	**97**	100%	100%	99	**98**
25 Months-6 Years	95% ▲	95% ▲	95 ▲	**94**	97% ▲	98% ▲	98 ▲	**95**
7-11 Years	97%	98% ▲	97	**97**	99% ▲	99% ▲	98 ▲	**97**
12-19 Years	95%	97% ▲	96 ▲	**95**	97% ▲	98% ▲	98 ▲	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	85% ▲	83% ▲	84 ▲	**81**	94%	94%	95 ▲	**94**
45-64 Years	90%	89%	89	**89**	97% ▲	97% ▲	97 ▲	**96**
65+ Years	86% ▼	89%	91	**91**	98% ▲	98% ▲	98 ▲	**97**
Access to Other Services								
Timeliness of Prenatal Care	93% ▲	83% ▼	85	**88**	95% ▲	92%	93	**92**
Postpartum Care	74%	69%	67	**70**	83% ▲	87% ▲	82	**83**
Annual Dental Visit[2]	68% ▲	66% ▲	67 ▲	**61**				

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

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Birth Statistics 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 2017 through 2019. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2017-2019

Measure	2015		2016		2017	
	MVP	ROS Average	MVP	ROS Average	MVP	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	8%	7%	6%	7%	-	-
Prenatal Care in the First Trimester	74%	74%	79%	74%	79%	**74%**
Risk-Adjusted Primary Cesarean Delivery[1]	16%	14%	13%	13%	-	-
Vaginal Birth After Cesarean	11%	14%	11%	14%	-	-
Commercial						
Risk-Adjusted Low Birth Weight[1]	4%	4%	5%	4%	-	-
Prenatal Care in the First Trimester	89%	88%	89%	88%	89%	**88%**
Risk-Adjusted Primary Cesarean Delivery[1]	19%	19%	19%	18%	-	-
Vaginal Birth After Cesarean	7%	11%	7%	11%	-	-

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

ROS: Rest of State

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

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). The MCO's Medicaid product line had 1 out 12 measures above the statewide average.

Table 16: CAHPS®—2014, 2016, 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	MVP	SWA	MVP	SWA	MVP	SWA	MVP	SWA	MVP	SWA	MVP	SWA
Flu Shots for Adults Ages 18-64							54	**52**	52	**52**	55	**56**
Advising Smokers to Quit							86	**84**	89 ▲	**80**	83	**81**
Getting Care Needed[1]	86	**83**	88	**85**	87	**84**	92 ▲	**88**	91	**88**	87	**89**
Getting Care Quickly[1]	93 ▲	**87**	90	**88**	89	**88**	90	**88**	90 ▲	**87**	86	**87**
Customer Service[1]	79	**82**	89	**86**	86	**86**	86	**88**	92	**89**	90	**91**
Coordination of Care[1]	82 ▲	**74**	79	**74**	70	**75**	82	**84**	86	**83**	83	**87**
Collaborative Decision Making[1]	57	**53**	70	**74**	75	**76**	82	**80**	80	**80**	79	**80**
Rating of Personal Doctor[1]	89	**89**	88	**90**	93	**90**	86	**84**	86	**86**	83	**86**
Rating of Specialist	84	**81**	89	**83**	87	**84**	83	**83**	82	**84**	86	**84**
Rating of Healthcare	90	**85**	88	**86**	90	**87**	81	**78**	86 ▲	**80**	80	**81**
Satisfaction with Provider Communication[1]	94	**93**	93	**93**	92	**93**	94	**96**	96	**96**	93 ▼	**96**
Wellness Discussion							78	**77**	74	**76**	78	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	59	**64**	81 ▲	**68**	66	**69**						
Rating of Health Plan—High Users	84	**84**	91 ▲	**85**	87	**84**	67	**68**	74	**68**	73	**72**
Overall Rating of Health Plan	84	**83**	88 ▲	**85**	89 ▲	**85**	69	**67**	68	**66**	73	**71**
Recommend Plan to Family/Friends												

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

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking 0 to 49%	50% to 89%	90 to 100%
	**C** **Monitoring Diabetes - Eye Exams**	**B**	**A**
No Change	**D** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Antidepressant Medication Management-Effective Acute Phase Treatment Antidepressant Medication Management-Effective Continuation Phase Treatment Breast Cancer Screening Cervical Cancer Screening Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Colon Cancer Screening Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD - Total Managing Diabetes Outcomes - Poor HbA1C Control 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 Statin Therapy for Patients with Cardiovascular Disease - Adherent Weight Assessment for Children and Adolescents - BMI Percentile	**C** Adolescent Immunization (Combo2) Annual Dental Visits (Ages 2-18) Childhood Immunization Status (Combo 3) Controlling High Blood Pressure 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 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) Viral Load Suppression	**B** Asthma Medication Ratio (Ages 5-64)

	Weight Assessment for Children and Adolescents - Counseling for Nutrition Weight Assessment for Children and Adolescents - Counseling for Physical Activity Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Postpartum Care Timeliness of Prenatal Care		
	**F**	**D**	**C**

Performance Improvement Project

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

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

The 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 populations 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; 4) feedback on drafts of the MCO's final report and 5) all plan webinars to share lessons learned.

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.

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

Member-Focused Interventions:

- Welcome calls made to all new and renewing members by the customer care department included scripting to identify members with a self-reported history of preterm birth. Using the roster of pregnant members, customer care staff outreached pregnant members and conducted a Maternity Assessment. With the member's permission, each member self-reporting a history of preterm birth was referred to the MVP Little Footprints (LFP) case management program.
- All members referred to the LFP program were provided an assessment for tobacco use, and a depression screening using a validated tool. All women enrolled in the program were coached on use/compliance with Makena (when appropriate) and educated on optimal birth spacing.
- The Medicaid member newsletter was used to educate members on the importance of smoking cessation during pregnancy, depression and pregnancy, Makena, and optimal birth spacing.

Provider-Focused Interventions:

- Clinical staff used samples from HEDIS to conduct provider medical record reviews on high volume obstetrics practices to ensure that the New York Medicaid Prenatal Care Standards of comprehensive risk assessment and care coordination were met. An assessment of the results of this review was conducted and practices in need of education were outreached.
- Faxes and the provider newsletter were used to provide education on appropriate use of Makena and optimal birth spacing.

MCO-Focused Interventions:

- Reassess the MVP Welcome Call script pregnancy questions and include a question that will specifically identify members with a history of spontaneous pre-term birth.
- Reassess the MVP Prenatal Assessment script to include a question specifically identifying members with a history of pre-term birth. Members who are identified as at risk for adverse birth outcomes during this assessment are auto-referred to the LFP program.
- The MCO will conduct provider medical record reviews to ensure providers are meeting the New York Medicaid Prenatal Care Standards of comprehensive risk assessment and care coordination. Provider education will be conducted if standards are not met.

Table 18 presents a summary of MVP's 2017-2018 PIP. The MCO demonstrated improvement for 7 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	93%	85%		Performance declined
Postpartum Care	74%	67%		Performance declined
Received at least one 17P injection				Plan did not measure or report results
Depression Screening*	83%	97%	91%	Demonstrated improvement
Tobacco Screening*	83%	93%	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	2%	5%	3%	Demonstrated improvement
Age 15-20 years; within 60 days	44%	39%	49%	Performance declined
Age 21-44 years; within 3 days	8%	12%	9%	Demonstrated improvement
Age 21-44 years; within 60 days	41%	42%	45%	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	0.4%	4%	.44%	Demonstrated improvement
Age 15-20 years; within 60 days	14%	14%	15%	Performance level was maintained
Age 21-44 years; within 3 days	0.3%	2%	.33%	Demonstrated improvement
Age 21-44 years; within 60 days	12%	12%	14%	Performance level was maintained

*Among members enrolled in the Little Footprints Program.

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.

MVP 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:

- In 2018, MVP did not characterize, identify or analyzed its Medicaid population according to at-risk characteristics. MVP identifies gaps in care, monitors outcomes and rates by geographic regions only. MVP did not provide examples of identified gaps in care or the follow-up actions as a result of these findings.

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)[9]
- 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%

[9] 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
Use of Electronic Health Records (EHR)	92%
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.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Member Portal.
  - Use of secure email and secure chat.

- Use of telecommunications technologies:
  - Use of toll free numbers for members and providers to obtain information.
  - Case management is conducted telephonically.
  - Use of a 24 hour nurse line.
  - Use of a 24 hour crisis lines.
  - Use of outbound campaigns to outreach to members.

- Use of Electronic Health Records (EHR):
  - The MCO does currently use EHRs.

- Use of clinical risk group (CRG) or similar software:
  - The MCO utilizes a CRG or similar software.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Via SFTP, SFTP w/PGP, and FTP w/PGP and fax.
  - Use of secure chat and secure email.
  - Use of constituent portals.

- Electronic communication with providers:
  - Via SFTP, SFTP w/PGP, and FTP w/PGP and fax.
  - Utilizes a provider portal.
  - Use of fax, telephone, secure chat and secure email.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Participation with Health Information Exchange of New York (HIXNY).

- Participation in a medical home pilot or program:
  - The MCO participates in a medical home pilot and/or program but does not support them on their HIT needs.

- Future plans to implement HIT:
    - The MCO is looking to implement an Interoperability Platform to be able to process inbound and outbound HL7 and HL7 FHIR transactions. The MCO is also investigating the expansion of EHR acquisition with 2 additional RHIOs.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

For the operational review, MVP was in compliance with 11 of the 14 categories. The categories in which MVP was not compliant were Complaints and Grievances (1 citation), Organization and Management (5 citations), and Utilization Review (2 citations). For the focused review, MVP was in compliance with 13 of the 14 categories. The category in which MVP was not compliant was Organization and Management – Behavioral Health Claims (2 citations).

Table 20: Focused Review Types

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

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

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Tool	
Complaints and Grievances	1	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	5	2	Behavioral Health Claims	2
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	0	0		
Utilization Review	2	0		
Total	**8**	**2**		

External Appeals

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

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	13	23	20
Overturned in Part	1	1	1
Upheld	27	39	56
Medicaid Total	**41**	**63**	**77**
		CHP	
Overturned	0	1	0
Overturned in Part	0	0	0
Upheld	1	2	1
CHP Total	**1**	**3**	**1**

VIII. Strengths and Opportunities for Improvement[10]

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

Strengths

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

Strengths:

- In 2018, the MCO's HEDIS®/QARR *Board Certification* rates were above the statewide average for Family Medicine and Other Physician Specialists.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed above the 75% threshold for all Routine, Non-Urgent "sick" and After-Hours Access call types.
- In 2018, the MCO's rates of new enrollees receiving a health screening improved from 2017.
- In the HEDIS®/QARR Effectiveness of Care; Prevention and Screening domain, the MCO had rates above the statewide average for *Adult BMI Assessment* and *Childhood Immunizations – Combo 3.*
- In the HEDIS®/QARR Effectiveness of Care; Acute and Chronic Care domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for the *Asthma Medication Ratio (Ages 5-18)* and *HIV Viral Load Suppression* measures.. Additional measures for which the MCO reported rates above the statewide average for 2018 include *Comprehensive Diabetes Care – Blood Pressure Controlled (<140/90 mm Hg)* and *Appropriate Treatment for URI*.
- The MCO performed well in regard to the access and timeliness indicators. In 2018 the MCO had a reported rate above the statewide average for the *Well-Child Visits-First 15 Months* measure. The MCO has also reported rates above the statewide average for at least three consecutive years for the *Children and Adolescents Access to PCPs: 12-24 Months* and *25 Months-6 Years, Adults Access to Preventative/Ambulatory Services: 20-44 Years,* and *Access to Other Services: Annual Dental Visit* measures. Additionally, the MCO had a reported rate above the statewide average in 2018 for the *Children and Adolescents' Access to PCPs: 12-19 Years* measure.
- The MCO performed well on the 2018 CAHPS® member satisfaction survey. The MCO's rate for *Overall Rating of Health Plan was above the statewide average in 2018.*

[10] 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.

Opportunities for Improvement

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

Opportunities for Improvement:

- In the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO demonstrates opportunities for improvement. The MCO reported rates below the statewide average for the following measures: *Breast Cancer Screening, Colorectal Screening and Chlamydia Screening in Women (Ages 16-24). (Note: Breast Cancer Screening, Colorectal Screening and Chlamydia Screening in Women (Ages 16-24) were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain. The MCO has reported a rate below the statewide average for at least three consecutive reporting years for *Spirometry Testing for COPD, Use of Imaging Studies for Low Back Pain* and *Annual Monitoring for Patients on Persistent Medications—Total Rate*. Additionally, the MCO's rate for *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18),* was reported below the statewide average for 2018. *(Note: Medication Management for People with Asthma 50% of Days Covered (Ages 5-18) and Annual Monitoring for Patients on Persistent Medications—Total Rate was opportunities for improvement in the previous year's report.)*
- In the HEDIS®/QARR Behavioral Health domain, the MCO has reported a rate below the statewide average for at least three consecutive reporting years for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure. The MCO also had rates below the statewide average 2018 for *Follow-Up After Hospitalization for Mental Illness – (30 Days and 7 Days). (Note: Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase was an opportunity for improvement in the previous year's report.)*
- In regard to the HEDIS®/QARR Access/Timeliness Indicators, the MCO reported rates below the statewide average for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life and Adolescent Well-Care Visits*.
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 2 citations from the focused review surveys related to Behavioral Health Claims and 8 citations from the operational survey related to Complaints and Grievances, Organization and Management and Utilization Review. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO continues to struggle with certain prevention and screening measures. With the rate for breast cancer screenings and chlamydia screenings in women consistently below the statewide average, the MCO should continuously evaluate current interventions to determine how effective these interventions are at targeting women's health needs. In addition to women's health needs, the MCO should continue to conduct measure-specific barrier analysis to determine factors preventing members from seeking or receiving preventative screenings, such as cultural barriers that prevent members from seeking care, member education on when screenings are recommended, or lack of available appointment times.
- The MCO should continue to work to improve those HEDIS®/QARR measures that continuously perform below the statewide average. The MCO should routinely evaluate the current interventions such as, the

provider and member incentives to determine its effectiveness. The MCO should consider including additional member outreach through community events, use of Community Health Workers to engage members in the home and utilizing Pharmacists to educate members on medication management for chronic diseases.

- As the MCO performed well in the HEDIS®/QARR Access to Care domain but reported below average rates for the well-child visit measures for 3-6 year olds and adolescents, the MCO should investigate the factors that influence these measures. The MCO should consider analyzing provider documentation to verify if well-care visits are completed but incorrectly coded on claims.
- The MCO should continue its efforts to address the issues identified in the operational and focused review surveys. Specifically, the MCO should focus on determination letters, provider credentialing process and oversight of delegated functions *[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 take steps to ensure that the issues identified in the HEDIS® Final Audit Report have been addressed.

  MCO Response: For Reporting Year 2017, MVP received Biased Rates for FUA and FUM due to software errors within Cotiviti's (previously GDIT) HEDIS® Engine Software on how the count of ED visits resulting in an inpatient stay were calculated.

  To ensure this software issue was addressed for the following Reporting Year, MVP conducted a monthly comparison that compared MVP's rates for the current month against the prior year's (Jan. 2018 to Jan. 2017) rates as well as month to month comparisons. If any differences were identified, MVP works with Cotiviti to understand the root of the discrepancy and find a resolution. MVP also held weekly calls with Cotiviti's Database Analyst to ensure this issue was corrected. For Reporting Year 2018, MVP successfully submitted the FUA and FUM measures without any issues.

- **2017 Recommendation:** As the MCO did not meet the 75% compliance threshold for most call types included in the Primary Care and OB/GYN Access and Availability Survey, the MCO should ensure all providers in its network are aware of the accessibility standards, are providing appointments within contractual timeframes, and have adequate after-hours access protocols in place.

  MCO Response: MVP created laminated access and availability standards references and hand-delivered them to all MVP PCP practices. The references outlined the standards for all payers. MCP provided education to the provider offices regarding access and availability. MVP followed up with "secret shopper" calls for those provider offices that failed the DOH External Quality Review audit. Those that failed a second attempt received a letter stating their failure and what they need to do to improve implying consequences, yet to be determined, for continued failure. This outreach continues today.

- **2017 Recommendation:** The MCO should continue its strategy for quality improvement in regard to HEDIS®/QARR measures. Additionally, as the MCO reported rates below average for several consecutive reporting years for some measures related to follow-up and monitoring for members on certain

medications, the MCO should conduct a population-specific barrier analysis to determine factors preventing members from receiving or seeking this type of service and initiate interventions to assist members in receiving appropriate follow-up and monitoring. *[Repeat recommendation.]*

MCO Response: MVP continues to engage in a series of activities to address deficiencies in HEDIS®/QARR performance: MVP continues to revise all provider gaps0in-care reports to easily identify their care gaps for HEDIS®/QARR measures, including any variance from 90th and 75th percentile. Also, we have added which measures have been completed as well, providing one all-inclusive report that providers can use. Reports are produced monthly in excel and PDF format. MVP has also continued to maintain the new quality dashboard which was introduced in RY2017 and allows monthly review and reporting of all quality measures. This dashboard compares monthly rates year over year it also provides year over year trend and milestones to reach the next percentile. MVP also created two new positions, Leader, Quality Intervention and Leader, Provider Quality Interventions. These two positions are responsible for overseeing all member and provider quality initiatives. Reviewing monthly data and monitoring results and updating the incentive program as needed. As well as conducting monthly meeting with key providers to ensure that interventions are working as intended and identify any issues as they arise.

Member Incentive Program—MVP members continue to receive monetary incentives in the form of gift cards for seeking relevant preventive and/or treatment based care for specific quality measures. Mailings inform members of the incentive program and encourage those who have not achieved compliance. Non-compliant members are contacted by mail and/or telephone to inform them of the importance of the services and to assist in addressing barriers to compliance. Data is collected on the response to the incentives to determine which are effective for future adjustments.

Provider Incentive Program—MVP providers continued to receive monetary incentives for delivering preventive or treatment-based care to at-risk members. MVP also continues to provide aggregate level provider specific reporting for select quality measures and met with providers to assist them with understanding and responding to their specific areas of opportunity. The Provider Incentive program is linked to the member incentives to improve compliance. All of the aforementioned incentive activities were continuous, fully implemented and mature interventions for RY 2018. Most continued into or were enhanced for RY 2019. Expected outcomes for these interventions are generally to maintain or improve the performance of MVP quality measures and support increased member satisfaction with the plan.

MVP performed annual program evaluations for the incentive and gaps-in-care interventions to monitor ongoing effectiveness. Evaluations focused on statistical analysis to correlate interventions with potential changes to measure performance. Interventions may be discontinued or changed as a result of these ongoing evaluations.

- **2017 Recommendation:** The MCO should continue its efforts to address the issues identified in the focused review surveys. Specifically, the MCO should take steps to ensure that all contract renewal requests are forwarded to the NYSDOH in a timely manner and continue efforts to improve the accuracy of the information in the provider directories. *[Repeat recommendation.]*

  MCO Response: The two issues identified above are unrelated.

  1. The issue was identified on a focused audit performed by the DOH and was stated "MVP Health Plan, Inc. has failed to submit an application for renewal of the Beacon Health Options, Inc. management agreement at least 90 days prior to the expiration date (December 31, 2017). The application was received by DOH on December 14, 2017."

MVP's remediation plan for this issue includes semi-weekly meetings in which the MVP Delegated Vendor Group and the Legal Department review vendor amendments and filings. Additionally, Legal and the Delegated Vendor Group maintain a contract tracking spreadsheet and the Delegated Vendor Group conducts an annual audit of all delegate vendor agreements to ensure timely amendments and filings.

2. In 2018, we completed a consolidation of two Cactus systems which reduced data inaccuracies which appear in the provider directory.

   In June 2018, MVP updated the Provider Change of Information form on the MVP public website for providers (contracted and non-contracted to use to ensure their data in our systems is accurate). MVP shared the tool to update our directories in all 2018 provider newsletters sent to providers.

   In May 2019, MVP introduced an on-line form to supplement the printed form that is used by providers to update demographic information. MVP announced the availability of the on-line form using the May/June issue of the provider newsletter and followed up in each issue of the provider newsletter through the most recent issue.

   MVP continues to send quarterly faxes to providers to remind providers to update their demographic information.

IX. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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