

**NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF QUALITY AND PATIENT SAFETY**

**EXTERNAL QUALITY REVIEW
TECHNICAL REPORT FOR:
TOTAL CARE, A TODAY'S OPTIONS OF NEW YORK HEALTH PLAN**

Reporting Year 2014

Published August 2016

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Acronyms Used in This Report

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

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs 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.

The technical reports are individualized reports on the Managed Care Organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2014 External Quality Review (EQR) to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR 438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR 438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified vendor and technical assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment data, provider network information, encounter data summaries, and PQI/compliance/satisfaction/quality points and incentive.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, and Deficiencies and Appeals. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP), Family Health Plus (FHP), and Commercial product lines. For some measures, including QARR 2015 (MY 2014), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section VII 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 has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. 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. 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 report is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2014.

II. MCO Corporate Profile

Total Care, a Today's Options of New York Health Plan, is a regional, for-profit prepaid health services plan (PHSP) that services Medicaid (MCD) and Child Health Plus (CHP) populations. Today's Options of New York Inc. purchased SCHC Total Care, Inc. on December 1, 2013. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

- Plan ID: 2161013
- DOH Area Office: SAO
- Corporate Status: PHSP
- Tax Status: For-profit
- Medicaid Managed Care Start Date: October 16, 2013
- Product Lines: Medicaid and Child Health Plus
- Contact Information: 5232 Witz Drive
N. Syracuse, NY 13212
(315) 634-5555
(315) 425-5502 (Fax)
- NCQA Accreditation Status as of 08/31/14: Did not apply
- Medicaid Dental Benefit Status: Provided

Participating Counties and Products

Cortland:	MCD	CHP	Onondaga:	MCD	CHP	Oswego:	CHP
Tompkins:	MCD						

III. Enrollment and Provider Network

ENROLLMENT

Table 1 displays enrollment for the MCO’s Medicaid product line for 2012, 2013, and 2014, as well as the percent change from the previous year. Enrollment has increased from 2013 to 2014 by a rate of 23.5%. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 1** trends enrollment for all product lines.

Table 1: Enrollment: Medicaid – 2012-2014

	2012	2013	2014
Number of Members	30,584	31,029	38,332
% Change From Previous Year		1.5%	23.5%

Data Source: MEDS II

Table 2: Enrollment: Other Product Lines – 2012-2014

	2012	2013	2014
FHP¹	2,404	2,429	-
CHP	2,519	2,149	1,591

¹ In RY 2014, the MCO discontinued its Family Health Plus product line.

Figure 1: Enrollment Trends – All Product Lines

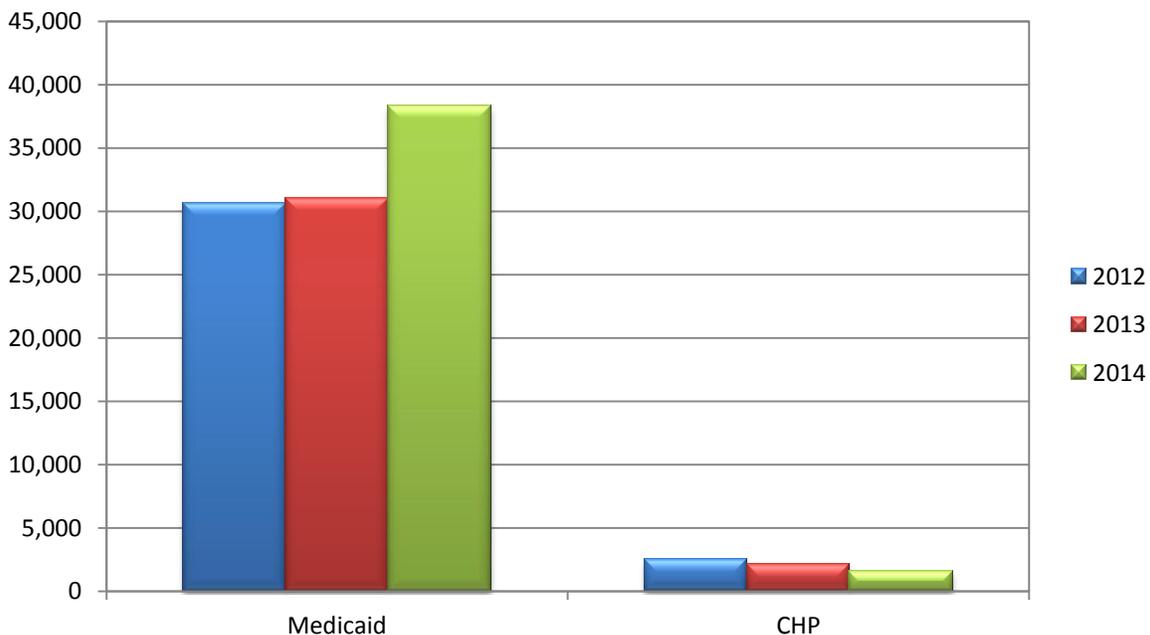
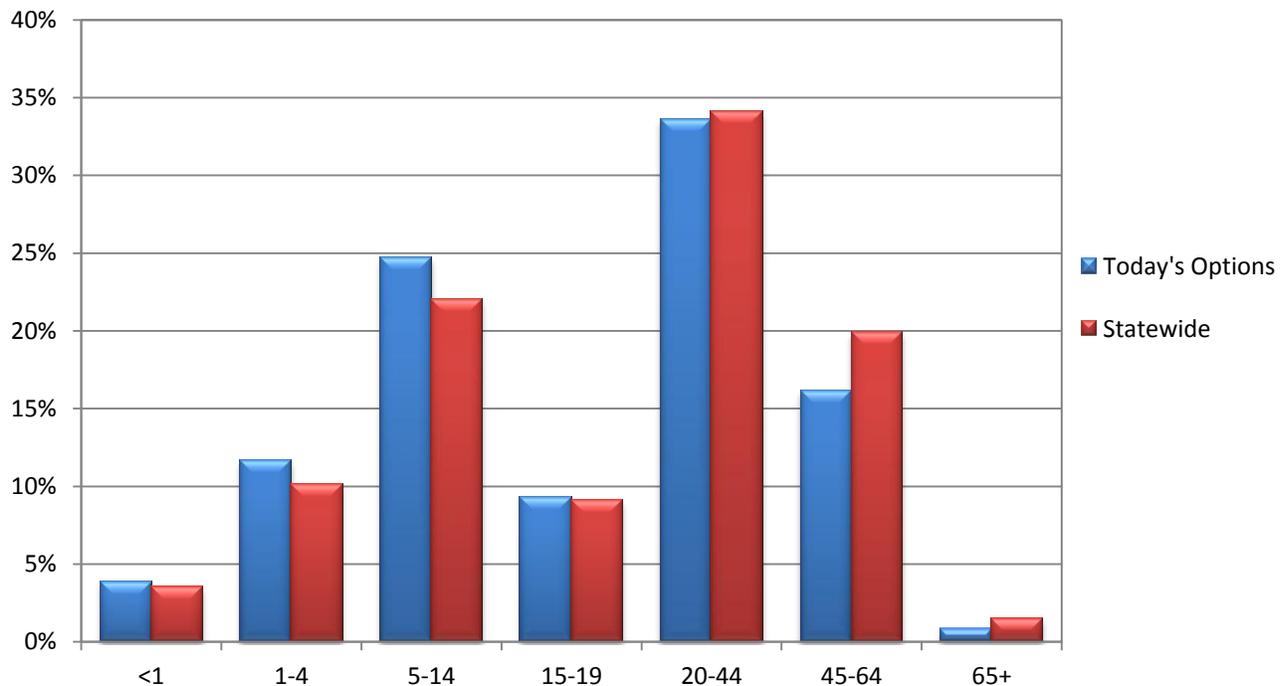


Table 3 and **Figure 2** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2014, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 3: Medicaid Membership Age and Gender Distribution – December 2014

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	764	681	1,445	3.8%	3.5%
1-4	2,240	2,224	4,464	11.6%	10.1%
5-14	4,875	4,590	9,465	24.7% ▲	22.0%
15-19	1,751	1,829	3,580	9.3%	9.1%
20-44	4,641	8,255	12,896	33.6%	34.1%
45-64	2,813	3,352	6,165	16.1% ▼	19.9%
65 and Over	159	158	317	0.8%	1.5%
Total	17,243	21,089	38,332		
Under 20	9,630	9,324	18,954	49.4% ▲	44.6%
Females 15-64		13,436		35.1%	36.1%

Figure 2: Medicaid Enrollees by Age – December 2014



PROVIDER NETWORK

Table 4 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2014 in comparison to the statewide percentages. For this table, MCO percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Table 4: Medicaid Providers by Specialty – 2014 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	403	11.8% ▼	19.8%
Pediatrics	94	2.7% ▼	4.5%
Family Practice	179	5.2% ▼	3.9%
Internal Medicine	82	2.4% ▼	8.9%
Other PCPs	48	1.4% ▼	2.5%
OB/GYN Specialty¹	127	3.7%	4.1%
Behavioral Health	101	2.9% ▼	19.6%
Other Specialties	1,660	48.5%	43.6%
Non-PCP Nurse Practitioners	269	7.9%	5.7%
Dentistry	128	3.7%	6.2%
Unknowns	736	21.5% ▲	0.9%
Total	3,424		

Data Source: HCS

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

Table 5 displays the ratio of enrollees to providers for the MCO’s Medicaid product line. 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 5: Ratio of Enrollees to Medicaid Providers – 2014 (4th Quarter)

	Today’s Options	Statewide
	Ratio of Enrollees to Providers	Median Ratio of Enrollees to Providers ¹
Primary Care Providers	95:1 ▲	47:1
Pediatricians (Under Age 20)	202:1 ▲	95:1
OB/GYN (Females Age 15-64)	106:1 ▲	42:1
Behavioral Health	380:1 ▲	56:1

Data Source: Derived Medicaid ratios calculated from MEDS II enrollment data and HCS provider data.

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

Table 6 displays HEDIS®/QARR *Board Certification* rates for 2012 through 2014 of providers in the MCO’s network in comparison to the statewide averages. The table also indicates whether the MCO’s rate was above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 6: HEDIS®/QARR Board Certification Rates – 2012-2014

Provider Type	2012 ¹		2013		2014	
	Today’s Options	Statewide Average	Today’s Options	Statewide Average	Today’s Options	Statewide Average
	Medicaid/CHP					
Family Medicine	89% ▲	78%	89% ▲	78%	93% ▲	77%
Internal Medicine	87%	80%	87%	78%	84%	77%
Pediatricians	88%	81%	88%	80%	89%	80%
OB/GYN	82%	74%	82%	78%	73%	75%
Geriatricians	SS	70%	SS	69%	SS	64%
Other Physician Specialists	84% ▲	78%	89% ▲	78%	87% ▲	76%

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

¹ For RY 2012, rates reflect the Medicaid product line only.

PRIMARY CARE AND OB/GYN ACCESS AND AVAILABILITY SURVEY – 2014

On behalf of the NYSDOH’s Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid/Family Health Plus 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.

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee’s request, while non-urgent “sick” office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a “live voice” representing the named provider is reached or if the named provider’s beeper number is reached.

A random sample of 240 provider sites was selected from each region in which the MCO operated and provided primary care as a Medicaid and/or Family Health Plus benefit. Of these 240 provider sites, 120 were surveyed for routine appointments, 80 were surveyed for non-urgent “sick” appointments, and 40 were surveyed for after hours access. For MCOs with less than the 240 available provider sites, all providers were selected.

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

Table 7 displays the seven regions in New York State, as well as the MCOs operating in each region that offered primary care and obstetrics/gynecological benefits to its Medicaid members at the time of the survey.

Table 7: Provider Network: Access and Availability Survey – Region Details – 2014

Region Name	Counties	MCOs Operating in Region
Region 1: Buffalo	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming	Excellus Health Plan, Inc.; Fidelis Care New York; HealthNow New York, Inc.; Independent Health Association, Inc.; MVP Health Plan, Inc.; and Univera Community Health, Inc.
Region 2: Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, and Yates	Excellus Health Plan, Inc.; Fidelis Care New York; and MVP Health Plan, Inc.
Region 3: Syracuse	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, and Tompkins	Capital District Physicians’ Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; SCHC Total Care, Inc.; and UnitedHealthcare Community Plan
Region 4: Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington	Capital District Physicians’ Health Plan, Inc.; Excellus Health Plan, Inc.; Fidelis Care New York; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 5: New Rochelle	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Health Insurance Plan of Greater New York; Hudson Health Plan, Inc.; MVP Health Plan, Inc.; UnitedHealthcare Community Plan; and WellCare of New York, Inc.
Region 6: New York City	Bronx, Kings, New York, Queens, and Richmond	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Amida Care, Inc.; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; MetroPlus Health Plan, Inc.; MetroPlus Health Plan, Inc. Special Needs Plan; UnitedHealthcare Community Plan; VNS Choice SelectHealth; and WellCare of New York, Inc.
Region 7: Long Island	Nassau and Suffolk	Affinity Health Plan, Inc.; AMERIGROUP New York, LLC; Fidelis Care New York; Healthfirst PHSP, Inc.; Health Insurance Plan of Greater New York; and UnitedHealthcare Community Plan

Table 8 displays the MCO’s Primary Care and OB/GYN Access and Availability results for 2014. The MCO met the 75% threshold for routine and after hours calls in Region 3.

Table 8: Provider Network: Access and Availability Survey Results – 2014

Region	Call Type	Today’s Options	Region Average
Region 3	Routine	77.2%	61.8%
	Non-Urgent “Sick”	74.4%	57.4%
	After Hours Access	89.5%	72.2%

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 9 displays selected Medicaid encounter data for 2012 through 2014. The MCO's rates for these periods are also compared to the statewide averages. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Table 9: Medicaid Encounter Data – 2012-2014

	Encounters (PMPY)					
	2012		2013		2014	
	Today's Options	Statewide Average	Today's Options	Statewide Average	Today's Options	Statewide Average
PCPs and OB/GYNs	4.54	4.24	4.38	4.45	4.21	4.36
Specialty	2.29	2.04	2.23	1.90	2.39	1.94
Emergency Room	0.76	0.60	0.73	0.60	1.08	2.11
Inpatient Admissions	0.15	0.15	0.15	0.14	0.18 ▲	0.15
Dental – Medicaid	0.80	1.03	0.89	1.00	0.95	1.03
Dental – FHP	1.18	1.12	1.13	1.04	1.02	1.02

Data Source: MEDS II

PMPY: Per Member Per Year

QARR USE OF SERVICES MEASURES

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentiles. **Table 10** lists the Use of Services rates for the selected product lines for 2012 through 2014. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

Table 10: QARR Use of Services – 2012-2014

Measure	Medicaid/CHP			2014 Statewide Average
	2012 ¹	2013	2014	
Outpatient Utilization (PTMY)				
Visits	4,089 ▼	3,953 ▼	4,853	5,366
ER Visits	602	582	783	555
Inpatient ALOS				
Medicine	4.0	4.2	4.6	4.3
Surgery	7.4 ▲	8.1 ▲	7.0	6.4
Maternity	3.1 ▲	3.2 ▲	3.0 ▲	2.8
Total	4.1	4.4	4.5	4.2
Inpatient Utilization (PTMY)				
Medicine Cases	53	48	50 ▲	40
Surgery Cases	14	13	15	13
Maternity Cases	50	43	43	36
Total Cases	103	92	94 ▲	79

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

V. Quality Indicators

To measure the quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including HEDIS®/QARR 2015 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

VALIDATION OF PERFORMANCE MEASURES

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2015 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA).

For measurement year (MY) 2014, the methodology for reporting performance measure rates was modified. Previously, Medicaid and Child Health Plus were reported separately; however, for QARR 2015 (MY 2014), rates for these populations were combined, following HEDIS® methodology (summing numerators and denominators from each population). Although the data presented in this report for MY 2012 are Medicaid only (unless otherwise specified), trend analysis has been applied over the time period 2012 through 2014, as the effect of combining the CHP and Medicaid populations was determined to be negligible through an analysis of historical QARR data.

The results of each MCO's HEDIS® 2015 Compliance Audit™ are summarized in its Final Audit Report (FAR).

SUMMARY OF HEDIS® 2015 INFORMATION SYSTEM AUDIT™

As part of the HEDIS® 2015 Compliance Audit™, auditors assessed the MCO's compliance with NCQA standards in the six designated information system categories, as follows:

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

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

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

The NYS EQRO provided technical assistance to MCOs throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new MCOs, 3) serving as a liaison between the MCOs and NCQA to clarify questions regarding measure specifications, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® 2015 Final Audit Report (FAR) prepared for Today's Options indicated that the MCO had no significant issues in any area related to reporting. The MCO demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS®/QARR reporting.

Today's Options used NCQA-certified software to produce HEDIS® measures. Supplemental databases were used to capture additional data. All databases were validated and determined to be HEDIS®-compliant by the auditors.

The MCO passed Medical Record Review for the three measures validated, as well as exclusions. The MCO was able to report all measures for the Medicaid product line.

Table 11 displays QARR performance rates for Measurement Years 2012, 2013, and 2014, as well as the statewide averages (SWAs). The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table Notes for Table 11

R: Rotated measure.

NR: Not reported.

NP: Dental benefit not provided.

FY: First-Year Measure, MCO-specific rates not reported.

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

Table 11: QARR MCO Performance Rates – 2012-2014

Measure	Medicaid/CHP			
	2012 ¹	2013	2014	2014 SWA
Follow-up Care for Children on ADHD Meds – Continue	55	76	74	67
Follow-up Care for Children on ADHD Meds – Initial	55	59	53	58
Adolescents – Alcohol and Other Drug Use	R	67	R	R
Adolescents – Depression	R	73 ▲	R	R
Adolescents – Sexual Activity	R	67	R	R
Adolescents – Tobacco Use	R	73	R	R
Adolescent Immunization – Combo	72	76 ▲	R	R
Adolescent Immunization – HPV	FY	35 ▲	37 ▲	28
Adult BMI Assessment	83 ▲	88	R	R
Flu Shots for Adults (Ages 18-64)		44	R	R
Advising Smokers to Quit	R	72	R	R
Follow-up After Hospitalization for Mental Illness – 30 Days	63 ▼	67 ▼	64 ▼	78
Follow-up After Hospitalization for Mental Illness – 7 Days	48 ▼	48 ▼	46 ▼	63
Antidepressant Medication Management – Continue	37	31	29 ▼	35
Antidepressant Medication Management – Acute Phase	51	44 ▼	43 ▼	50
Drug Therapy for Rheumatoid Arthritis	72	67	65 ▼	81
Appropriate Meds for People with Asthma (Ages 19-64)	83	80	78	78
Appropriate Meds for People with Asthma (Ages 5-18)	92 ▲	91	91 ▲	85
Asthma Medication Ratio (Ages 19-64)	FY	57	55	53
Asthma Medication Ratio (Ages 5-18)	FY	76	60	61
Use of Imaging Studies for Low Back Pain	72 ▼	71 ▼	73	77
Persistence of Beta-Blocker Treatment After a Heart Attack	SS	SS	SS	86
Avoidance of Antibiotics for Adults with Acute Bronchitis	34 ▲	24	21 ▼	28
Chlamydia Screening (Ages 16-24)	70	71	70	72
Colon Cancer Screening	R	47 ▼	R	R
Dental Visit (Ages 19-21)	33	40	36 ▼	43
Annual Dental Visits (Ages 2-18)	NP	55 ▼	54 ▼	60
Diabetes BP Controlled (<140/90 mm Hg)	R	75 ▲	R	R
Diabetes HbA1c below 8%	R	53	R	R
Diabetes Eye Exam	R	66	R	R

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

Table 11: QARR MCO Performance Rates – 2012-2014 (continued)

Measure	Medicaid/CHP			
	2012 ¹	2013	2014	2014 SWA
Diabetes Nephropathy Monitor	R	78 ▼	R	R
Diabetes HbA1c Test	R	88	R	R
HIV – Engaged in Care	94	47 ▼	89	81
HIV – Syphilis Screening	73	59	73	73
HIV – Viral Load Monitoring	85	75	65	71
Childhood Immunization – Combo 3	R	78 ▲	R	R
Lead Testing	R	85	R	R
Breast Cancer Screening	71 ▲	74	72	71
Smoking Cessation Medications	R	46 ▼	R	R
Medical Management for People with Asthma 50% (Ages 19-64)	59	59	59	66
Medical Management for People with Asthma 50% (Ages 5-18)	53	61	42 ▼	50
Smoking Cessation Strategies	R	38	R	R
Monitor Patients on Persistent Medications – Combined	90	89	89 ▼	92
Pharmacotherapy Management for COPD – Bronchodilator	80	82	86	88
Pharmacotherapy Management for COPD – Corticosteroid	66	65	73	75
Testing for Pharyngitis	71 ▼	69 ▼	74 ▼	88
Diabetes Monitoring for Schizophrenia	FY	58 ▼	67	78
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	FY	80	83	82
Antipsychotic Meds for Schizophrenia	FY	51 ▼	49 ▼	61
Spirometry Testing for COPD	44	44	34 ▼	53
Treatment for Upper Respiratory Infection	87 ▼	90	91 ▼	93
Well-Child Visits – First 15 Months	70	69	57 ▼	66
Well-Child Visits – 3 to 6 Year Olds	82	83	78 ▼	84
Well-Care Visits for Adolescents	59	64	57 ▼	65
Children BMI	R	87 ▲	R	R
Children Counseling for Nutrition	R	80	R	R
Children Counseling for Physical Activity	R	74 ▲	R	R

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

QARR ACCESS TO/AVAILABILITY OF CARE MEASURES

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care, and dental services for selected product lines. **Table 12** displays the Access to/Availability of Care measures for Measurement Years 2012 through 2014. 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 MCOs for that measure (indicated by ▼).

Table 12: QARR Access to/Availability of Care Measures – 2012-2014

Measure	Medicaid/CHP			
	2012 ¹	2013	2014	2014 SWA
Children and Adolescents' Access to PCPs (CAP)				
12 – 24 Months	99% ▲	98%	98%	97%
25 Months – 6 Years	93%	93% ▼	90% ▼	94%
7 – 11 Years	93% ▼	94% ▼	94% ▼	97%
12 – 19 Years	92%	94%	93% ▼	94%
Adults' Access to Preventive/Ambulatory Services (AAP)				
20 – 44 Years	87% ▲	87% ▲	85%	84%
45 – 64 Years	91%	91%	90%	91%
65+ Years	93%	92%	92%	90%
Access to Other Services				
Timeliness of Prenatal Care	87%	R	88%	88%
Postpartum Care	73%	R	72%	69%
Annual Dental Visit²	33% ▼	54% ▼	53% ▼	58%

R: Rotated measure

¹ For RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

² For the Annual Dental Visit measure, the Medicaid/FHP age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-CALCULATED QARR PRENATAL CARE MEASURES

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, as well as 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. **Table 13** presents prenatal care rates calculated by the NYSDOH for QARR 2011 through 2013. In addition, the table indicates if the MCO's rate was significantly better than the average (indicated by ▲) or whether the MCO's rate was significantly worse than the average (indicated by ▼).

Table 13: QARR Prenatal Care Measures – 2011-2013

Measure	2011		2012		2013	
	Today's Options	ROS Average	Today's Options	ROS Average	Today's Options	ROS Average
	ROS					
Risk-Adjusted Low Birth Weight ¹	7%	7%	8%	7%	5%	7%
Prenatal Care in the First Trimester	67%	71%	62%	71%	63% ▼	72%
Risk-Adjusted Primary Cesarean Delivery ¹	14%	15%	12%	15%	13%	15%
Vaginal Birth After Cesarean	12%	11%	19%	11%	15%	12%

¹ A low rate is desirable for this measure.

ROS: Rest of State

MEMBER SATISFACTION

In 2014, the CAHPS® survey for child Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Surveys were administered to parents/caretakers of Medicaid enrollees aged 0-17 years. **Table 14** displays the question category, the MCO's rates, and the statewide averages for Measurement Year 2014. The table also indicates whether the MCO's rate was significantly better than the statewide average (SWA) (indicated by ▲) or whether the MCO's rate was significantly worse than the SWA (indicated by ▼).

Table 14: Child CAHPS® – 2012 and 2014

	Medicaid			
	2012		2014	
	Today's Options	Statewide Average	Today's Options	Statewide Average
Coordination of Care ¹	73	74	76	74
Getting Care Needed ¹	75	78	85	83
Satisfaction with Provider Communication ¹	93	93	91	93
Customer Service ¹	80	85	77	82
Collaborative Decision Making ¹	89	87	55	53
Getting Information	74 ▼	82	90	89
Rating of Healthcare	77 ▼	83	80 ▼	85
Rating of Personal Doctor ¹	87	88	90	88
Getting Care Quickly ¹	86	86	86	87
Rating of Counseling	65	63	63	64
Overall Rating of Health Plan	73 ▼	82	72 ▼	83
Rating of PCP	88	89	87	89
Rating of Specialist	81	78	80	81
Access to Specialized Services ¹	72	71	76	76

¹ These indicators are composite measures.

QUALITY PERFORMANCE MATRIX ANALYSIS – 2014 MEASUREMENT YEAR

Table 15 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. Twenty-eight measures were selected for the 2014 Measurement Year (MY) Quality Performance Matrix, which include combined measures for 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 Managed Care Organizations through a percentile ranking.

For the MY 2012 Quality Performance Matrix, the NYSDOH made modifications in order to focus on those measures in need of the most improvement statewide. For previous measurement years, the cell category (A-F) was determined by the year-over-year trend of the measure (vertical axis) and by any significant difference from the statewide average (horizontal axis). For the 2012 MY, the matrix was reformatted to maintain the year-over-year evaluation on the vertical axis, but to evaluate the MCO's performance based on a percentile ranking on the horizontal axis. The new percentile ranking was partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. The 2012 matrix included only those measures for which the 2011 Medicaid statewide average was less than a predetermined benchmark; however, for MY 2014, additional measures were included to provide MCOs with a broader overview of quality performance, and further assist MCOs in identifying and prioritizing quality improvement.

With the issuance of the 2008 MY Matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY Matrix, MCOs were required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO had more than three measures reported in the F category, the MCO was required to submit root cause analyses and plans of action on all measures reported in the F category. For the MY 2014 Matrix, this requirement was modified, requiring the MCO to submit a maximum of three root cause analyses and plans of action, regardless of the number of measures reported in the F category. Beginning with MY 2008, if an 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 15: Quality Performance Matrix – 2014 Measurement Year

Trend *	Percentile Ranking		
	0 to 49%	50 to 89%	90 to 100%
<p>↑</p> <p>No Change</p> <p>↓</p>	<p>C</p> <p>Diabetes Monitoring for Schizophrenia Pharmacotherapy Mgmt for COPD-Corticosteroid</p>	<p>B</p> <p>HIV-Engaged in Care</p>	<p>A</p>
	<p>D</p> <p>Annual Dental Visits (Ages 2-18) Antidepressant Medication Management-Acute Phase Antipsychotic Meds for Schizophrenia Appropriate Testing for Pharyngitis Asthma Medication Ratio (Ages 19-64) Asthma Medication Ratio (Ages 5-18) Avoid Antibiotics for Adults with Acute Bronchitis Cervical Cancer Screening Chlamydia Screening (Ages 16-24) Controlling High Blood Pressure Drug Therapy for Rheumatoid Arthritis FU After Hospital for Mental Illness-7 Days FU for Child on ADHD Meds-Initial Medical Mgmt for People with Asthma 50% (Ages 19-64) Medical Mgmt for People with Asthma 50% (Ages 5-18) Spirometry Testing for COPD Use of Imaging Studies for Low Back Pain Well-Care Visits for Adolescents</p>	<p>C</p> <p>Breast Cancer Screening Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds Frequency of Ongoing Prenatal Care Postpartum Care</p>	<p>B</p>
	<p>F</p> <p>Well-Child Visits-3 to 6 Year Olds Well-Child Visits-First 15 Months (5+visits)</p>	<p>D</p>	<p>C</p>

NYSDOH QUALITY INCENTIVE

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. Points earned are derived from an algorithm that considers QARR 2015 (MY 2014) rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores, and compliance information from MY 2012 and MY 2013. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCO qualifies for. For 2014, there were four levels of incentive awards that could be achieved by MCOs based on the results. **Table 16** displays the points the MCO earned from 2012 to 2014, as well as the percentage of the financial incentive that these points generated based on the previous measurement year's data. **Table 17** displays the measures that were used to calculate the 2014 incentive, as well as the points the MCO earned for each measure.

Table 16: Quality Incentive – Points Earned – 2012-2014

	2012		2013		2014	
	Today's Options	Statewide Average	Today's Options	Statewide Average	Today's Options	Statewide Average
Total Points (150 Possible Points)	66	78.4	69.8	80.8	29.5	73.8
PQI Points (20 Possible Points)	13	9.9	3.8	6.9	5	6.9
Compliance Points (-20 Possible Points)	-8	-5.3	-4	-5.4	-6	-4
Satisfaction Points (30 Possible Points)	10	15.9	10	15.9	10	16.3
Quality Points¹ (100 Possible Points)	51	57.9	60	63.4	20.5	54.5
Percentage of Financial Incentive Earned	25%		25%		0%	

¹Quality Points presented here are normalized.

Table 17: Quality Incentive – Measures and Points Earned – 2014

Measure	MCO Points
PQI	5.0
Adult Prevention Composite PQI (10 points)	0.0
Pediatric Composite PDI (10 points)	5.0
Compliance (-4 points, except where noted)	-6.0
MEDS	0.0
MMCOR	0.0
QARR	0.0
Provider Directory (-2 points)	-2.0
Member Services	-4.0
Satisfaction (10 points each)	10.0
Rating of Health Plan (CAHPS®)	0.0
Getting Care Needed (CAHPS®)	5.0
Customer Service and Information (CAHPS®)	5.0
Quality (3.84 points each, except where noted)	12.48
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.0
Antidepressant Medication Management—Effective Acute Phase Treatment	0.0
Appropriate Testing for Pharyngitis	0.0
Asthma Medication Ratio (Ages 5-18) (1.92 points)	0.0
Asthma Medication Ratio (Ages 19-64) (1.92 points)	0.0
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	0.0
Breast Cancer Screening	2.88
Cervical Cancer Screening	0.0
Chlamydia Screening (Ages 16-24)	0.0
Comprehensive Care for People Living with HIV/AIDS—Engaged in Care	3.84
Controlling High Blood Pressure	0.0
Diabetes Monitoring for People with Diabetes and Schizophrenia	0.0
Diabetes Screen for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	1.92
Disease-Modifying Anti-Rheumatic Drugs for Rheumatoid Arthritis	0.0
Follow-Up After Hospitalization for Mental Illness Within 7 Days	0.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	0.0
Medication Management for People with Asthma 50% Days Covered (Ages 5-18) (1.92 points)	0.0
Medication Management for People with Asthma 50% Days Covered (Ages 19-64) (1.92 points)	0.0
Persistence of Beta-Blocker Treatment After a Heart Attack ¹	—
Pharmacotherapy Management of COPD Exacerbation—Corticosteroid	0.0
Use of Imaging Studies for Low Back Pain	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0
Annual Dental Visit (Ages 2-18)	0.0
Frequency of Ongoing Prenatal Care	1.92
Postpartum Care	1.92
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	0.0
Well-Child & Preventive Care Visits in 3 rd , 4 th , 5 th , & 6 th Year of Life	0.0
Well-Care Visits for Adolescents	0.0
Total Normalized Quality Points²	20.5
Total Points Earned	29.5

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

¹ Sample size too small (less than 30 members).

² Quality Points were normalized before being added to the total points earned. The points each MCO earned for each quality measure were aggregated and converted to normalized quality points. Quality points were normalized in order to control for a difference in base points, as not every MCO could earn points for each measure due to small sample sizes (less than 30 members).

PERFORMANCE IMPROVEMENT PROJECT

Each MCO is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating MCO- and provider-based improvements in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, MCOs and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to 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) 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 validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

Total Care’s 2013-2014 PIP topic is *“Improving Performance in Chronic Disease Prevention and Management—Diabetes Control”*. Throughout the conduct of the PIP, the MCO implemented the following interventions:

- Distributed provider tool, which promotes diabetes self management education.
- Collaborated with community agencies to determine availability of resources, such as diabetes education and support sites.
- Produced special diabetes newsletter containing tips, recipes, and expected testing to increase awareness of the disease. Performed a telephone follow-up survey of member receiving the newsletter to determine if content was informative and useful.
- Conducted Member Services follow-up calls with members who were in need of required testing.
- Implemented the Quality Nurse Consultant (QNC) program. The QNC conducted onsite visits with high-volume providers to educate them on the measures and provide gap in care reports.

Table 18 presents a summary of Total Care’s 2013-2014 PIP.

Table 18: Performance Improvement Project – 2013-2014

Indicators	Results
HbA1c Testing	Performance declined.
Lipid Profile Testing	Performance declined.
Dilated Eye Exam	Performance declined.
Nephropathy Testing	Performance level maintained.
Poor A1c control	Demonstrated improvement.
Lipids Controlled	Performance declined.
Blood Pressure Controlled (<140/80)	Demonstrated improvement.
Blood Pressure Controlled (<140/90)	Performance declined.

VI. Deficiencies and Appeals

COMPLIANCE WITH NYS STRUCTURE AND OPERATION STANDARDS

This section of the report examines deficiencies identified by the NYSDOH in operational and focus 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 in **Table 20**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO is not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers, adverse determination utilization review files, complaints and grievances files, meeting minutes, and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys." The NYSDOH retains the option to deem compliance with standards for credentialing/recredentialing, 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 MCO 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 structure and operation standards. The focused review types are summarized in **Table 19**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 20 reflects the total number of citations for the most current operational survey of the MCO, which ended in 2014, as well as from the focused reviews conducted in 2014. 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 have multiple citations.

Today's Options was in compliance with 7 of 14 categories. The categories in which Today's Options was not in compliance were Complaints and Grievances (1 citation), Credentialing (1 citation), Medicaid Contract (2 citations), Organization and Management (2 citations), Quality Assurance (7 citations), Service Delivery Network (3 citations), and Utilization Review (14 citations).

Table 19: 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 (Medicaid Encounter Data Set)	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.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information – Web	Review of MCO’s web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listing of primary, specialty, and ancillary providers for 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 (Quality Assurance Reporting Requirements)	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.

AO: Area Office

HCS: Health Commerce System

SOD: Statement of Deficiency

Table 20: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	1	
Credentialing	1	
Disclosure		
Family Planning		
HIV		
Management Information Systems		
Medicaid Contract		2
<i>Member Services Phone Calls</i>		2
Medical Records		
Member Services		
Organization and Management	2	
Prenatal Care		
Quality Assurance	7	
Service Delivery Network	3	
Utilization Review	14	
Total	28	2

VII. Strengths and Opportunities for Improvement¹

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

Strengths

- The 2015 HEDIS® Final Audit Report revealed no significant issues and the MCO was able to report all required QARR rates.
- In regard to the Primary Care Access and Availability Survey, the MCO met the 75% compliance rate for routine appointments and after hours access in Region 3.
- The MCO reported above average rates for the HEDIS®/QARR measures *Adolescent Immunizations—HPV* and *Use of Appropriate Medications for People with Asthma (Ages 5-18)*.

Opportunities for Improvement

- The MCO did not earn PQI, compliance, satisfaction, and quality points to qualify for a percentage of the available financial incentive.
- The MCO demonstrates an opportunity for improvement in regard to access to primary care. The MCO did not meet the 75% compliance rate for non-urgent “sick” appointments. Additionally, the MCO's rates were below the 10th percentile for the HEDIS®/QARR *Children and Adolescents' Access to PCPs* measure for the age groups 25 months-6 years, 7-11 years, and 12-19 years. The MCO's rates were below average for the HEDIS®/QARR measures *Well-Child Visits—First 15 Months of Life*, *Well-Child Visits—3 to 6 Year Olds*, and *Well-Care Visits for Adolescents*, as well.
- The MCO continues to demonstrate an opportunity in regard to its overall HEDIS®/QARR performance. The MCO has reported below average rates for at least three consecutive reporting periods for the following HEDIS®/QARR measures: *Follow-Up After Hospitalization for Mental Illness—30 Days*, *Follow-Up After Hospitalization for Mental Illness—7 Days*, and *Appropriate Testing for Pharyngitis*. The MCO's rates were also below average for the following HEDIS®/QARR measures: *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Antidepressant Medication Management—Effective Initiation Phase Treatment*, *Drug Therapy for Rheumatoid Arthritis*, *Avoidance of Antibiotics for Adults with Acute Bronchitis*, *Dental Visit (Ages 19-21)*, *Annual Dental Visits (Ages 2-18)*, *Medication Management for People with Asthma 50% of Days Covered (Ages 5-18)*, *Annual Monitoring for Patients on Persistent Medications—Combined Rate*, *Adherence to Antipsychotic Medications for People with Schizophrenia*, *Spirometry Testing for COPD*, and *Appropriate Treatment for Upper Respiratory Infection*. (Note: *Follow-Up After Hospitalization for Mental Illness*, *Annual Dental Visits (Ages 2-18)*, *Appropriate Testing for Pharyngitis*, and *Adherence to Antipsychotics for People with Schizophrenia* were opportunities for improvement in the previous year's report.)

¹ This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to “Strengths” and “Opportunities for Improvement” rather than “Strengths” and “Weaknesses” as indicated in federal regulations.

- The MCO reported below average rates for two child CAHPS® measures, *Rating of Healthcare* and *Overall Rating of Health Plan*.
- In regard to compliance with NYS structure and operation standards, the MCO continues to demonstrate an opportunity for improvement. The MCO received 30 citations, including 28 operational citations and 2 focused review citations related to Complaints and Grievances, Credentialing, Medicaid Contract, Organization and Management, Quality Assurance, Service Delivery Network, and Utilization Review. (Note: compliance with NYS structure and operation standards was an opportunity for improvement in the previous year's report.)

Recommendations

- To ensure members receive appropriate care, and that the MCO receives a percentage of the available financial incentive, the MCO should continue to work to improve poorly performing HEDIS®/QARR and CAHPS® measures. Additionally, the MCO should evaluate the effectiveness of the interventions described in the MCO's response to the previous year's recommendations, and update them based on a thorough root cause analysis. [*Repeat recommendation.*]
- The MCO should work with its provider network to ensure members have adequate access to primary care and to meet the 75% compliance threshold for the Primary Care Access and Availability Survey.
- The MCO should continue to work to address the issues noted in the Article 44 and focused review surveys. [*Repeat recommendation.*]

Response to Previous Year's Recommendations

- **2013 Recommendation:** The plan should continue to work to improve poorly performing HEDIS®/QARR rates, and routinely assess the effectiveness of initiatives previously implemented and modify them as needed. [*Repeat recommendation.*]

MCO Response: Total Care, A Today's Options of New York Health Plan (TC/TONY), continues interventions targeting members, providers, and its communities to improve our overall quality outcomes.

Member Interventions:

Current Interventions:

Telephonic outreach and mailings are conducted throughout each year. TC/TONY contacts members for specific quality measures in an attempt to further educate and improve measures. If members are receptive, staff conducts a 3-day call to assist in scheduling an appointment. The Health Plan targets the following measures:

- Cervical cancer screening
- Breast cancer screening
- Chlamydia screening in women
- Comprehensive Diabetes Care (including diabetics with schizophrenia)
- Use of Appropriate Medications for People with Asthma
- Use of Spirometry Testing in Assessment and Diagnosis of COPD
- Annual Monitoring for Patients on Persistent Medications
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- HIV Comprehensive Care
- Prenatal and Postpartum Care
- Well Child Visits (3 to 6 years) and Adolescent Visits
- Follow up Care for Children Prescribed ADHD medications

- Follow up after Hospitalization for Mental Illness
- Annual Dental Visits

Members also receive education via the TC/TONY website and the member newsletter.

2014 Interventions

TC/TONY provided a Member Incentive program in 2014. Members had an opportunity to earn \$25/measure and were notified of available incentives through telephonic outreach, general, and targeted mailings. The following measures had associated incentives:

- Breast cancer screening
- Postpartum care
- Well Child (3 to 6 years) and Adolescent visits
- Annual Monitoring for Patients on Persistent Medications
- Comprehensive Diabetes Care (A1C, LDL, eye exam, and nephropathy)
- Comprehensive HIV Testing (viral load)
- Use of Spirometry Testing in Assessment and Diagnosis of COPD

An in-depth analysis was conducted to determine the impact the incentive had on the above measures. It was determined that there was no significant impact on the rates and the member incentive was discontinued in 2015.

In an effort to continue to improve women's health, TC/TONY collaborated with our largest provider group and embedded staff at the group's facility to assist in member outreach and scheduling of appointments for mammography. In 2015, we expanded the outreach to include cervical cancer screening at the time of a mammogram to minimize a woman's need to return for an additional visit.

TC/TONY also targeted general health and wellness. The TC/TONY embedded staff contacted members in need of dental preventive services, well child visits, and postpartum visits to assist with scheduling appointments. Members also received Health Prevention magnets which include timeframes for well child visits.

In an effort to improve 7 Day and 30 Day follow up after hospitalization for mental illness, TC/TONY utilized ongoing mental health admission and clinical updates to identify members who require assistance with their follow up appointments. A designated nurse verifies the member discharge instructions from the discharge planner and then contacts the member to offer assistance. This initiative continued throughout 2015 and continues in 2016/

In the fall of 2014, TC/TONY developed current HEDIS/QARR reporting which proactively identifies members in need of health preventive services. TC/TONY performs ongoing analysis to assess the impact of member and provider interventions.

2015 Interventions

Member education was expanded through an initiative with the TC/TONY Case Managers. Case Managers utilized gap in care reports to enroll diabetic members into the Diabetes Disease Management Program. Targeted outreach was conducted to educate members on the Comprehensive Diabetes Care measures. All gaps in care were reviewed and assistance in scheduling diabetic eye exams was provided. Diabetic patients with a co-diagnosis of schizophrenia were also assisted through targeted outreach calls for education and assistance with scheduling labs. This initiative continues through 2016.

TC/TONY expanded the above targeted measures to include *Medical Assistance with Smoking and Tobacco Use Cessation*. The interventions included:

- Targeted outreach calls to new members who indicate they smoke on the new enrollee survey.
- Auto enrollment into the New York State (NYS) Quitline, for members who agree.
- Follow up calls for members to assess smoking status and obtain feedback.
- Member smoking cessation survey with analysis, education in member newsletter, website, and general mailings for health plan benefits.
- Quarterly gap in care reports, and medical and pharmacy claims review to analyze and respond appropriately.
- Case Management for pregnant members and referral of members to the NYS Quitline.

To enhance current behavioral health interventions, TC/TONY partnered with a Behavioral Health vendor to provide expertise in management of these services. This vendor began care management activities in February 2016.

Provider Interventions:

Current Interventions:

Provider interventions continue to include newsletter articles, targeted and general mailings, and direct outreach and education efforts by TC/TONY staff members. Gap in care reports and member rosters are supplied. To improve the plan's responsiveness, possibilities for further data dissemination are being examined in light of continued expression of interest by providers, as well as by office and practice managers. The Health Plan targets the following measures:

- Follow-Up after Hospitalization for Mental Illness—7 Days and —30 Days
- HIV—Engaged in Care and Testing
- Testing for Pharyngitis
- Annual Dental Visits (Ages 2-18)
- Comprehensive Diabetes Care
- Smoking Cessation—Medications and Strategies
- Diabetes Monitoring for Schizophrenia
- Antipsychotic Medication for Schizophrenia
- DMARDs
- Lead Screening

2014 Interventions

TC/TONY offered a Provider Incentive Program in 2014. An in-depth analysis was conducted to determine the impact the incentive had on the above measure. It was determined that there was no significant impact on the rates. The Health Plan is currently pursuing a different provider rewards strategy to better impact the HEDIS/QARR rates.

TC/TONY hired a Quality Nurse Consultant (QNC) in 2014 to conduct face to face appointments with our larger provider groups to educate them about the incentive program and the recommended health and wellness screenings. The QNC visited the offices regularly to report on updates to the quality measures and to provide gap in care reports. TC/TONY is exploring other opportunities to better assist a wider range of practices.

To better enhance the care provided to our HIV members, providers were notified monthly of which comprehensive HIV services a member was missing; this intervention continues through 2016.

2015 Interventions

In 2015, TC/TONY began working with our pharmacy vendor to develop a weekly list of members with a new pharmacy fill for ADHD medications. Telephonic outreach is conducted to providers to ensure follow up appointments were scheduled for the initiation and continuation phases of ADHD care. This intervention continues into 2016.

TC/TONY identified a decrease in the measures for *Appropriate Testing for Children with Pharyngitis, Lead Screening in Children, Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis, and Use of Spirometry Testing in the Assessment and Diagnosis of COPD*. To address the decline, outreach calls were made to providers based on gap in care reports. Education on appropriate treatment guidelines was given to providers. Provider groups were also encouraged to engage in timely billing practices. These measures will continue to be addressed in 2016.

In 2015, TC/TONY conducted multiple interventions to address *Medical Assistance with Smoking and Tobacco Use Cessation*. The provider newsletter educated on the health plan benefits for smoking cessation counseling, formulary medications, and coordination with New York State Quitline. Additional education included a mailing of Agency for Healthcare Research and Quality (AHRQ) recommendations as well as plan benefits, and applicable ICD 10 codes. Interactive educational meetings were held with the largest OB provider group in efforts to increase smoking cessation screenings within the pregnant member population. The health plan continues to generate quarterly gap in care reports, claims, and obtain monthly pharmacy data to analyze and adjust interventions as needed.

TC/TONY redesigned the Case Management (CM) and Disease Management (DM) Programs in 2015. Members and providers were educated on the changes and providers were encouraged to refer members, as indicated. The Asthma and Diabetes Disease Management Programs were implemented with an emphasis on management of their condition and medication compliance.

To better identify and engage at-risk members into the Disease management program, the CM/DM staff utilize multiple sources to identify members. These include daily ER/Inpatient reports from several of our large hospital systems, coordination with the quality department including gap in care reports, internal referrals from the UM department and Member Services, members indicating they have a condition on the monthly New Enrollee Survey, and providers.

- **2013 Recommendation:** As the plan's internal process for monitoring member satisfaction yielded a very low response rate, the plan should consider alternative monitoring methods. Also, the plan should use the results of the most current NYSDOH-sponsored CAHPS® as a starting point to identify areas of concern, to conduct measure-level root cause analysis, and to develop targeted interventions. [*Repeat recommendation.*]

MCO Response:

Measure -	2013 Survey Responses	2013 SWA	2011	2013	Expect 2015 results Spring 2016
Improve Member Experience					
*CAHPS - Rating Customer Service	445	82%	71%	76%	TBD
*CAHPS - Rating of the Health Plan	445	76%	65%	67%	TBD
Goal - Increase CAHPS Customer Service rate					79%
Outreach					
Task	New or Continuing	Frequency/ Due Date	Comments/Barriers	Comments	
Establish distinct phone ques for members, providers, UM, Provider Relations and Switchboard	N	5/1/2015	Complete	Allows for more accurate queueing of calls, and quicker response time. Overall improvement of ASA by 2 seconds, and reduction of Abandon calls by over 25%.	
Implement dedicated staff for member calls	N	12/31/2015	In process/ongoing	Prompting in aforementioned telecom system allowed for call types (i.e. member, provider) to be sent to respective SME area's for response.	
Staff training focusing on member & benefits	N	April 2015	Ongoing	Specialty trainings set up ad hoc, highlight training conducted biweekly at Call Center staff meetings.	
Implement Survey Style Audit	N	2/1/2015	Monthly	50 calls per/month placed anonymously into Call Center mirroring DOH Survey Calls, to ensure any gaps are addressed immediately. Accuracy at start in 2015 was 54%, at Y/E 2015, Average Accuracy =96%	
Monitoring					
Monitoring Mechanism	Monitoring Frequency	Monitoring Start Date	Comments	Outcome	
Internal Call Monitoring	Monthly	3/1/2015	10 calls per rep/month	Currently trending 95% accuracy, improvement of over 21% in 12 months.	

TC/TONY has targeted four (4) major areas in the outreach and member contact segment to improve our CAHPS survey, as well as globally improve our overall customer service experience, whether by provider, member, or prospective member. These items are deconstructing and reconstructing our telephone lines to have distinct prompting and routing by call type, and customer type. This allows for specialized servicing by subject matter experts (SMEs), which in turn results in more appropriate, accurate, and customer-focused responses. We have also built in regular bi-weekly refresher training to all customer service representatives to ensure most up to date knowledge is disbursed equitably and expediently, and lastly, we have implemented a monthly survey style audit that mirrors the Department of Health phone survey. We initially started this survey reflecting an accuracy rate of 54% in February 2015; by the end of the year, we had an accuracy rate of 96%.

TC/TONY has also implemented regular phone monitoring with performance standard expectations for all call center staff. We monitor 10 calls per representative per month, combination of recorded and live calls. We started this in March 2015 with an average accuracy of 74%, and as of February 2016, trend an accuracy score of 95%. This is a 21% improvement in 12 months. This provides evidentiary proof that the

outreach protocol put into place reflected notable and sustained improvement. Our expectation is that we will see improvement in the CAHPS survey, expected results to be received by TC/TONY in spring 2016.

- **2013 Recommendation:** The plan should continue to address the problems noted in the focused review surveys, with specific attention to access and availability. [*Repeat recommendation.*]

MCO Response: TC/TONY has made it a priority to update our provider information and maintain the most current provider panel status for our members. Our Provider Relations Representatives work with our in-network Primary Care Providers on a monthly basis to obtain this information. TC/TONY encourage our providers to utilize the “Provider Office Data Sheet”, located on our website, to keep the plan informed of practice changes. The provider may submit the form to the plan via e-mail, fax, or mail.

In addition to communicating with our network providers on practice information, our Provider Relations Representatives consistently engage our providers on NYS Access & Availability (A&A) standards; these standards are listed in the Provider Manual, which is located on the TC/TONY website, and are reviewed during the Representatives monthly office visits, and are also highlighted in the provider newsletter. In an effort to make these standards more accessible to our providers, in 2016 they will be posted on our website as a Provider Resource. TC/TONY monitors A&A through our annual survey; if a provider is non-compliant they are addressed with a corrective action plan and monitored thereafter. TC/TONY also requires providers who are non-compliant with the NYS administered A&A survey to adhere to a corrective action plan with additional monitoring by the plan. Results of the plans annual survey are shared with the provider community via the provider newsletter.

In 2015, TC/TONY initiated a monthly outreach intervention for our members who indicate they had no PCP or had not seen their PCP in over a year on the new enrollee survey. Our Outreach Coordinator attempts telephonic contact with each member and guides them through the process of selecting a PCP and setting up an appointment, if needed. If the member is agreeable, TC/TONY will set up a 3-way calling with the provider office to facilitate the appointment. This intervention is continuing in 2016.

VIII. Appendix

REFERENCES

A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
 - Managed Care Plan Directory, Accessed August 31, 2015
 - NCQA Accreditation website, <http://hprc.ncqa.org>, Accessed August 31, 2015

B. Enrollment/Provider Network

1. Enrollment

- NYSDOH OMC Membership Data, 2012-2014
- Enrollment by Age and Gender Report as of December 2014
- Enrollment Status Report, December 2014

2. Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, December 2014
- QARR Measurement Year, 2012-2014
- NYSDOH Primary Care Access and Availability Survey, 2014

C. Utilization

1. Encounter Data

- MMC Encounter Data System, 2012-2014

2. QARR Use of Services

- QARR Measurement Year, 2012-2014

D. Quality Indicators

1. Summary of HEDIS® Information Systems Audit™ Findings

- 2014 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors

2. QARR Data

- Performance Category Analysis, Quality Performance Matrix (2014 Measurement Year)
- QARR Measurement Year, 2012-2014

3. CAHPS® 2014 Data

- QARR Measurement Year, 2014

4. Quality/Satisfaction Points and Incentive

- Quality/Satisfaction Points and Incentive, 2012-2014

5. Performance Improvement Project

- 2013-2014 PIP Report

E. Deficiencies and Appeals

1. Summary of Deficiencies

- MMC Operational Deficiencies by Plan/Category, 2014
- Focus Deficiencies by Plan/Survey Type/Category, 2014