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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

UNITEDHEALTHCARE COMMUNITY PLAN

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. MCO Corporate Profile

UnitedHealthcare of New York, Inc. (UHC) is a regional, for-profit health maintenance organization (HMO) serving Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP) populations. UnitedHC acquired AmeriChoice of New York, Inc. on January 1, 2008 and utilized the DBA AmeriChoice by United-Healthcare (AmeriChoice) up until January 1, 2011. The HMO is now called UnitedHealthcare Community Plan (UHCCP). UHCCP serves Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and select information for the CHP product line.

UHC Web Page: https://www.uhc.com/

*Participating Regions and Products			
Central[1]:	MCD	CHP	HARP
Hudson Valley[2]:	MCD	CHP	HARP
Long Island:	MCD	CHP	HARP
Northeast[3]:	MCD	CHP	HARP
New York City:	MCD	CHP	HARP
Western[4]:	MCD	CHP	HARP

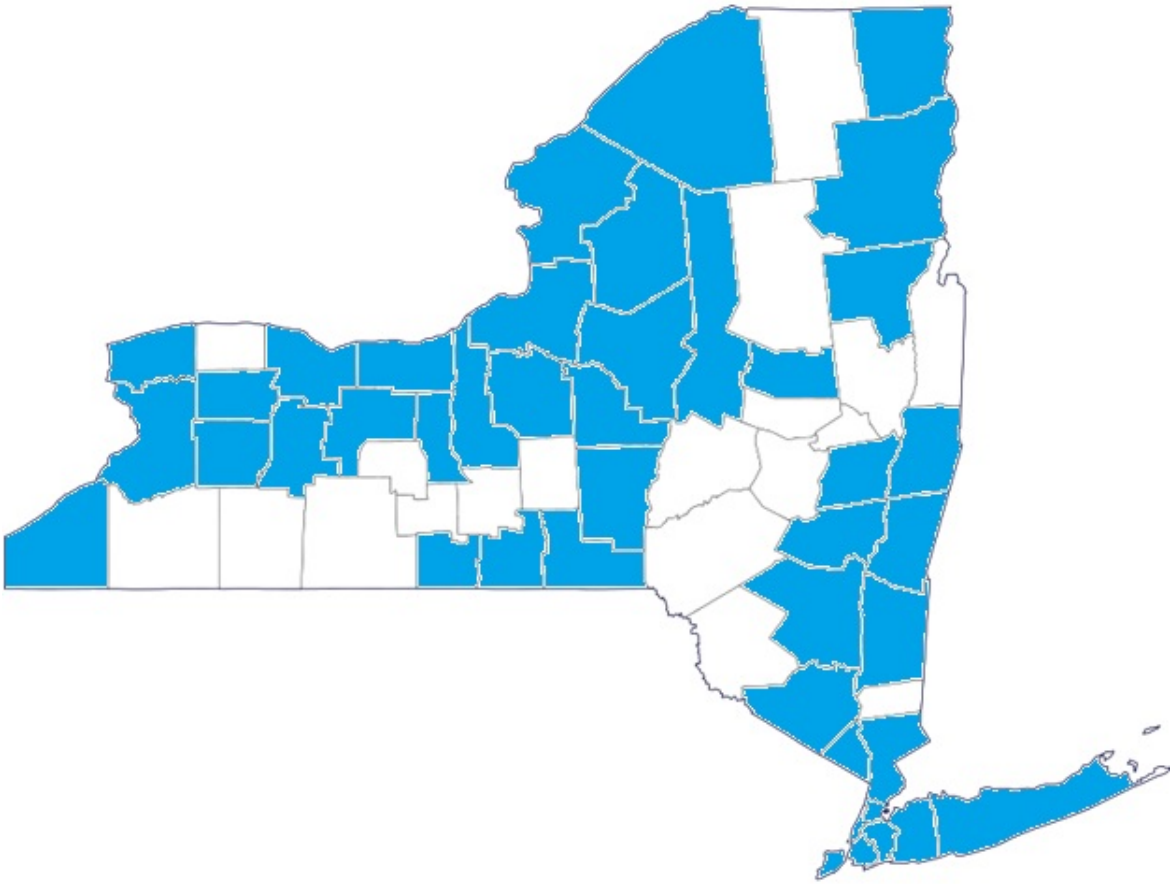
* Please contact the plan directly to confirm the plan participation counties.

Region Definitions

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

[1] UHC does not participate in Cortland and Tomkins counties.
[2] UHC offers MCD, CHP and HARP products in Orange, Rockland and Ulster counties. UHC offers MCD and HARP products in Duchess County.
[3] UHC offers MCD, CHP and HARP products in Albany, Clinton, Columbia, Essex, Fulton, Rensselaer and Warren counties. MCD and HARP products offered in Franklin, Greene and Schenectady counties.
[4] UHC offers MCD, CHP and HARP products in Chautauqua, Chemung, Genesee, Monroe, Niagara, Ontario, Seneca, and Wayne counties. UHC offers HARP and MCD products in Erie, Livingston, Orleans, Wyoming, and Yates counties.

Figure 1: UHCCP Map of Participating Counties



Note: The CHP population is not served in all counties of operation. Refer to the list on the previous page for counties in which the CHP product line is offered.

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 0.3%. UHCCP's membership represents 10.9% 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	458,021	475,607	474,100
% Change from Previous Year	-3.8%	3.8%	0.3%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	10.5%	10.8%	10.9%

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	41,344	47,484	52,355

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: UHCCP Enrollment Trends—All Product Lines

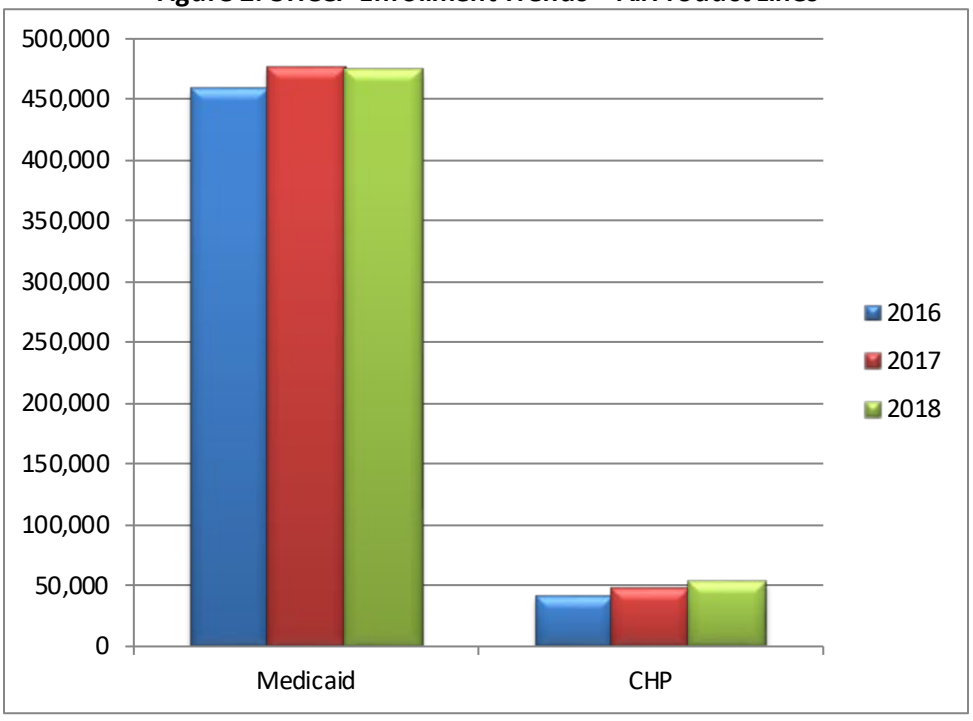


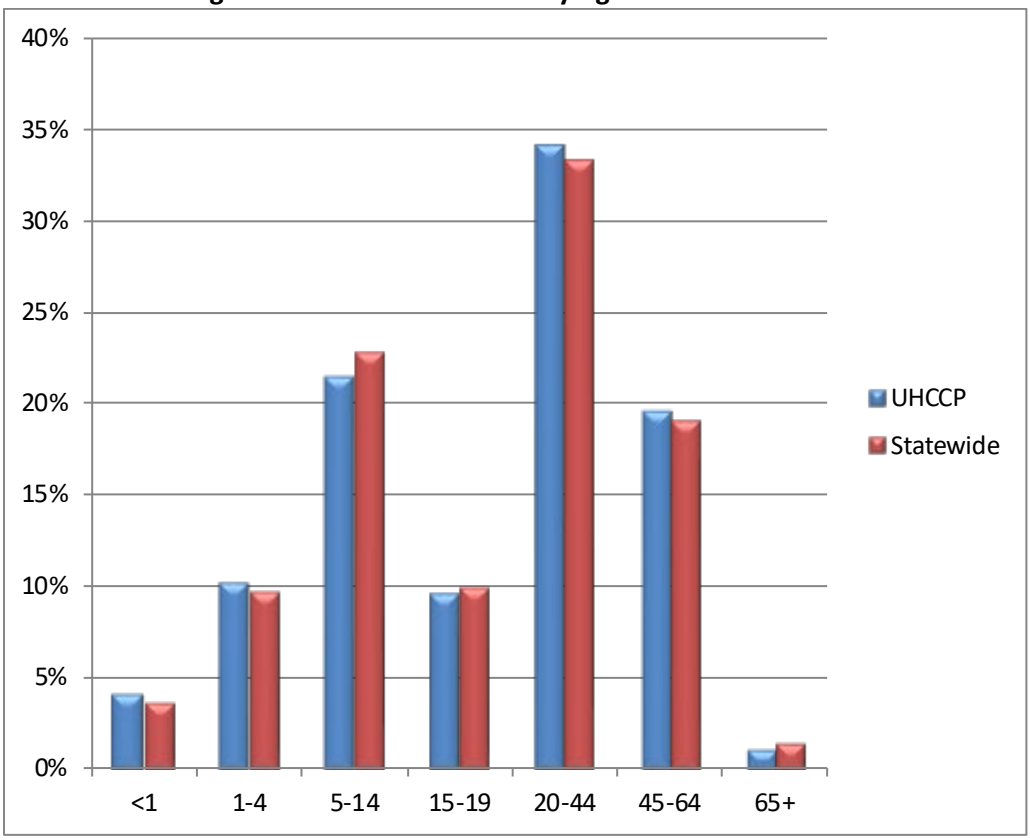
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. The MCO's largest membership age group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

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	9,998	9,531	19,529	4.1%	3.6%
1-4	24,649	23,411	48,060	10.2%	9.7%
5-14	52,107	49,509	101,616	21.5%	22.8%
15-19	22,968	22,474	45,442	9.6%	9.9%
20-44	74,096	86,919	161,015	34.0%	33.3%
45-64	43,532	48,839	92,371	19.5%	19.1%
65 and Over	2,017	3,255	5,272	1.1%	1.4%
Total	229,367	243,938	473,305		
Under 20	109,722	104,925	214,647	45.4%	46.1%
Females 15-64		158,232		33.4%	34.7%

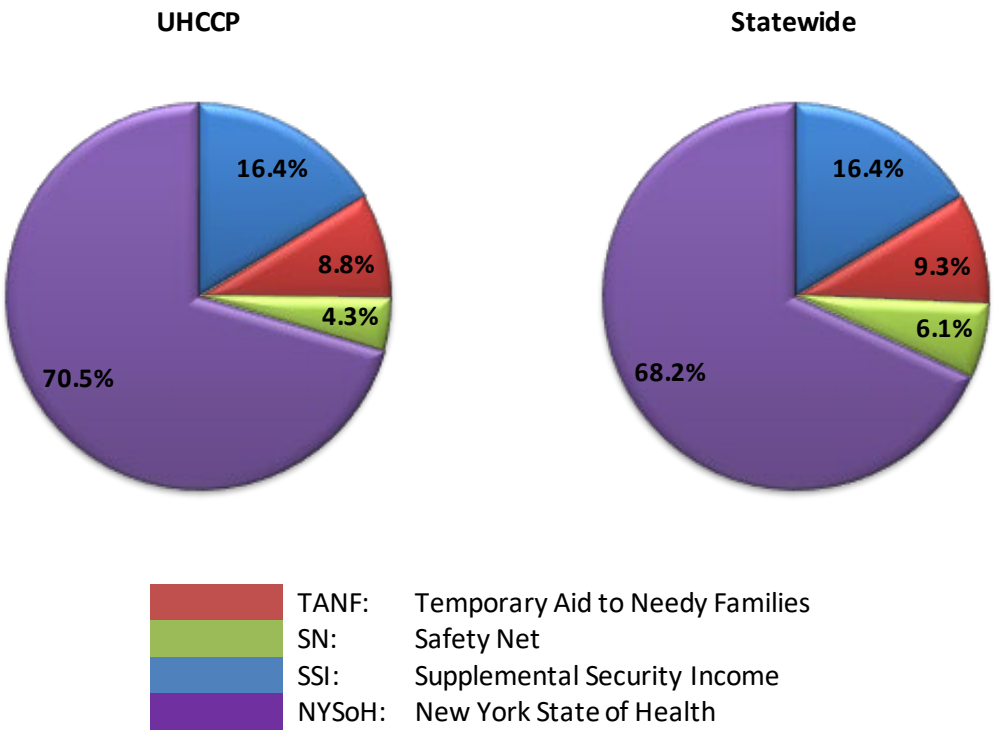
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. The MCO had rates above the statewide average for 2 out of 6 measures. For detailed information regarding board certification of providers, please see the *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[5].

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

Provider Type	2016		2017		2018	
	UHCCP	Statewide Average	UHCCP	Statewide Average	UHCCP	Statewide Average
			Medicaid/CHP			
Family Medicine	66% ▼	71%	69% ▼	72%	73%	74%
Internal Medicine	75%	75%	77% ▲	76%	77%	76%
Pediatricians	79%	78%	80%	79%	80%	80%
OB/GYN	83% ▲	75%	85% ▲	77%	85% ▲	80%
Geriatricians	63%	63%	62%	63%	61%	63%
Other Physician Specialists	80% ▲	75%	80% ▲	76%	80% ▲	77%

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. The MCO had rates above the statewide average for 2 out of 10 specialty types.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	11,286	19.3%	19.5%
Pediatrics	3,057	5.2% ▲	3.8%
Family Practice	2,862	4.9%	3.5%
Internal Medicine	5,237	8.9%	8.4%
Other PCPs	130	0.2% ▼	3.8%
OB/GYN Specialty[1]	2,914	5.0% ▲	3.8%
Behavioral Health	6,230	10.6%	17.2%
Other Specialties	28,881	49.3%	46.0%
Non-PCP Nurse Practitioners	6,225	10.6%	8.7%
Dentistry	3,015	5.1%	4.9%
Total	58,551		

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

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

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

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

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

Specialty Type	UHCCP			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	42:1	20,765	23:1	42:1	80,986	42:1
Pediatrics (Under age 20)	70:1			70:1		
OB/GYN (Females age 15-64)	54:1			59:1		
Behavioral Health	76:1			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 rates of Providers with an Open Panel decreased from 2016 to 2018.

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

	2016			2017			2018		
	UHCCP		Statewide	UHCCP		Statewide	UHCCP		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	9,036	82.7	85.0	9,177	99.3	95.7	8,896	80.6	90.8

Data Source: NYS Provider Network Data System (PNDS)

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

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

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

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

For call type categories in which compliance is below the 75% threshold, MCOs will receive a Statement of Deficiency (SOD) issued by the NYSDOH and will be required to develop a Plan of Correction (POC). 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 UHCCP provider participation rate. The total number of providers surveyed (or sample size) is based on MCO Medicaid enrollment size and provider network size. The total number of compliant providers is the number of providers that will be included in the Appointment Availability and After-Hours Access-Survey.

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
150	98	**65.3%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 87 providers (total number of providers who were compliant for participation (98), less total number of providers with closed panels (11)). The MCO performed above the threshold for all call types.

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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	7	6	85.7%
	Pediatrician	10	10	100.0%
	OB/GYN	13	12	92.3%
	Total Routine	**30**	**28**	**93.3%**
Non-Urgent "Sick"	Internist/Family Practitioner	8	7	87.5%
	Pediatrician	12	8	66.7%
	OB/GYN	5	4	80.0%
	Total Non-Urgent	**25**	**19**	**76.0%**
After-Hours Access	Internist/Family Practitioner	9	7	77.8%
	Pediatrician	11	9	81.8%
	OB/GYN	12	10	83.3%
	Total After-Hours	**32**	**26**	**81.3%**

[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 ▼. In 2018, the MCO had rates below the statewide average for 2 out of 5 measures.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	UHCCP	Statewide Average	UHCCP	Statewide Average	UHCCP	Statewide Average
PCPs and OB/GYNs	3.88	3.85	3.83	3.56	3.79	3.50
Specialty	2.05	2.45	2.07	2.30	1.95 ▼	2.33
Emergency Room	0.32 ▼	0.54	0.36 ▼	0.55	0.37 ▼	0.53
Inpatient Admissions	0.09	0.14	0.13	0.14	0.11	0.13
Dental	1.07	1.03	1.03	1.02	1.09	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 had rates above the statewide average for 3 consecutive years.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	UHCCP	SWA	UHCCP	SWA	UHCCP	SWA
	Medicaid					
Enrollee Health Screenings	32.7% ▲	12.5%	26.7% ▲	12.7%	25.5% ▲	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 above the statewide average for 2 out of 10 measures.

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

	Medicaid/CHP			
Measure	2016	2017	2018	2018 Statewide Average
Outpatient Utilization (PTMY)				
Visits	5,591	5,616 ▲	5,647 ▲	5,317
ER Visits	388 ▼	369 ▼	348 ▼	492
Inpatient ALOS				
Medicine	4.8 ▲	4.4	4.8 ▲	4.5
Surgery	6.4	6.7	6.8	7.0
Maternity	2.7	3.0	2.7	2.9
Total	4.2	4.2	4.2	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	21 ▼	23 ▼	18 ▼	30
Surgery Cases	10 ▼	12	9	12
Maternity Cases	34	36	35	32
Total Cases	56 ▼	60 ▼	52 ▼	66

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

V. Performance Indicators

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

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

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

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

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[6]

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.

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates below the SWA for 93% of the measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	75 ▼	78 ▼	82	**89**
WCC—BMI Percentile	69 ▼	78 ▼	78 ▼	**86**
WCC—Counseling for Nutrition	69 ▼	80	72 ▼	**83**
WCC—Counseling for Physical Activity	58 ▼	74	64 ▼	**74**
Childhood Immunizations—Combo 3	70 ▼	63 ▼	56 ▼	**73**
Lead Screening in Children	80 ▼	83 ▼	81 ▼	**89**
Adolescent Immunizations—Combo 2[2]		18 ▼	19 ▼	**43**
Adolescents—Alcohol and Other Drug Use[3]	NV	61	55 ▼	**70**
Adolescents—Depression[3]	NV	55	50 ▼	**67**
Adolescents—Sexual Activity[3]	NV	59	52 ▼	**67**
Adolescents—Tobacco Use[3]	NV	65	58 ▼	**74**
Breast Cancer Screening	66 ▼	65 ▼	65 ▼	**71**
Colorectal Cancer Screening	50 ▼	53 ▼	56 ▼	**63**
Chlamydia Screening (Ages 16-24)	68 ▼	68 ▼	70 ▼	**76**

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

NV: Not valid. The MCO reported invalid data for the measure.

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 had rates above the SWA for 15% of the measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	87 ▼	95 ▲	92 ▲	**91**
Spirometry Testing for COPD	55	56	51 ▲	**56**
Use of Imaging Studies for Low Back Pain	74 ▼	78	77	**77**
Pharmacotherapy Management for COPD—Bronchodilators	82	86	85 ▼	**89**
Pharmacotherapy Management for COPD—Corticosteroids	69	76	74	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	65	70	69	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	53	56	58	**59**
Asthma Medication Ratio (Ages 19-64)	56	59	56 ▼	**60**
Asthma Medication Ratio (Ages 5-18)	68 ▲	72 ▲	73 ▲	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	87	82	77	**80**
CDC—HbA1c Testing	90	90	89 ▼	**92**
CDC—HbA1c Control (<8%)	52	59	55	**60**
CDC—Eye Exam Performed	NV	59 ▼	62	**67**
CDC—Nephropathy Monitor	91	91	92	**92**
CDC—BP Controlled (<140/90 mm Hg)	NV	60	61	**66**
Drug Therapy for Rheumatoid Arthritis	78	79	79	**83**
Monitor Patients on Persistent Medications—Total Rate	91 ▼	92	91 ▼	**92**
Appropriate Treatment for URI	91 ▼	92 ▼	92 ▼	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	25 ▼	26 ▼	28 ▼	**36**
HIV Viral Load Suppression[2,3]	73	75	77	**77**
Flu Shots for Adults (Ages 18-64)[4]	33 ▼	35 ▼		
Advising Smokers to Quit[4]	76	69		
Smoking Cessation Medications[4]	64	48		
Smoking Cessation Strategies[4]	50	43		

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 otherwise noted.

[2] NYS-specific measure.

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

[4] CAHPS® measure.

Behavioral Health

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

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

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	52	54	54	**53**
Antidepressant Medication Management—Effective Continuation Phase	38 ▲	39	39	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	59	58	56	**59**
Follow-Up Care for Children on ADHD Medication—Continue	69	66	61	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	79	75 ▼	63 ▼	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	67	63	52 ▼	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	81	81	81	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	76	80	85	**80**
Antipsychotic Medications for Schizophrenia	64	64	66	**63**

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care plan 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.[7]

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

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

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	58 ▼	59 ▼	65 ▼	**81**
Well-Child Visits—3 to 6 Year Olds	83 ▼	83 ▼	86	**86**
Adolescent Well-Care Visits	66 ▼	65 ▼	65 ▼	**68**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). In 2018, the MCO had rates above the SWA for 30% of the measures.

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

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
	Children and Adolescents' Access to PCPs (CAP)			
12-24 Months	97% ▲	97% ▲	97	**97**
25 Months-6 Years	95% ▲	94%	95 ▲	**94**
7-11 Years	98% ▲	97%	97	**97**
12-19 Years	96% ▲	96% ▲	95	**95**
	Adults' Access to Preventive/Ambulatory Services (AAP)			
20-44 Years	83%	81% ▼	82 ▲	**81**
45-64 Years	89% ▼	88% ▼	88 ▼	**89**
65+ Years	86% ▼	90%	91	**91**
	Access to Other Services			
Timeliness of Prenatal Care	83% ▼	76% ▼	85	**88**
Postpartum Care	69%	71%	68	**70**
Annual Dental Visit[2]	58% ▼	60%	62 ▲	**61**

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

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

NYSDOH-Calculated Prenatal Care Measures

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

Table 15: QARR Prenatal Care Rates—2015-2017

Measure	2015		2016		2017	
	UHCCP	Regional Average	UHCCP	Regional Average	UHCCP	Regional Average
NYC						
Risk-Adjusted Low Birth Weight[1]	6%	6%	6%	6%	-	-
Prenatal Care in the First Trimester	81% ▲	75%	81% ▲	76%	81% ▲	75%
Risk-Adjusted Primary Cesarean Delivery[1]	13%	14%	13% ▲	14%	-	-
Vaginal Birth After Cesarean	39% ▲	18%	39% ▲	18%	-	-
ROS						
Risk-Adjusted Low Birth Weight[1]	7%	7%	8%	7%	-	-
Prenatal Care in the First Trimester	77%	74%	76%	74%	77%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	15%	14%	15%	13%	-	-
Vaginal Birth After Cesarean	10%	14%	10%	14%	-	-

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

NYC: New York City; 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 ▼). In 2018, the MCO had rates above the statewide average for 4 out of 12 measures.

Table 16: CAHPS®—2014, 2016, 2018

Measure	2014		2016		2018	
	UHCCP	Statewide Average	UHCCP	Statewide Average	UHCCP	Statewide Average
				Medicaid		
Getting Care Needed[1]	79	**83**	85	**85**	82	**84**
Getting Care Quickly[1]	91 ▲	**87**	94 ▲	**88**	92 ▲	**88**
Customer Service[1]	81	**82**	89	**86**	89	**86**
Coordination of Care[1]	75	**74**	71	**74**	77	**75**
Collaborative Decision Making[1]	49	**53**	73	**74**	79	**76**
Rating of Personal Doctor[1]	93 ▲	**89**	91	**89**	94 ▲	**90**
Rating of Specialist	81	**81**	80	**83**	90 ▲	**84**
Rating of Healthcare	86	**85**	87	**86**	90	**87**
Satisfaction with Provider Communication[1]	95 ▲	**93**	95	**93**	96 ▲	**93**
Rating of Counseling/Treatment	68	**64**	65	**68**	79	**69**
Rating of Health Plan—High Users	78	**84**	82	**85**	85	**84**
Overall Rating of Health Plan	80	**83**	81	**85**	85	**85**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
	**C** Timeliness of Prenatal Care	**B**	**A**
No Change	**D** Adolescent Immunization (Combo2) Breast Cancer Screening Cervical Cancer Screening Childhood Immunization Status (Combo3) Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Colon Cancer Screening Controlling High Blood Pressure Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds 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 Managing Diabetes Outcomes - Poor HbA1C Control Medication Management for People with Asthma 50% Days Covered (Ages 5-64) Metabolic Monitoring for Children and Adolescents on Antipsychotics Monitoring Diabetes - Eye Exams Statin Therapy for Patients with Cardiovascular Disease - Adherent Weight Assessment for Children and Adolescents - BMI Percentile Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits) Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Postpartum Care Viral Load Suppression	**C** Annual Dental Visits (Ages 2-18) Antidepressant Medication Management-Effective Continuation Phase Treatment Asthma Medication Ratio (Ages 5-64) Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement of AOD - Total Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD - Total Medication Management for People with Asthma 75% Days Covered (Ages 5-64) Use of Spirometry Testing in the Assessment and Diagnosis of COPD Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	**B** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Antidepressant Medication Management-Effective Acute Phase Treatment

	**F** Weight Assessment for Children and Adolescents - Counseling for Nutrition Weight Assessment for Children and Adolescents - Counseling for Physical Activity	**D**	**C**

Performance Improvement Project

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

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

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

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

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

UHCCP's 2018-2019 PIP topic was *"Maternal Child Health: Focused Interventions Aimed at Improving Birth Outcomes"*. During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- Member education was provided to those identified through the plan's pregnancy case management program and via educational articles in the member newsletter.

Provider-Focused Interventions:

- Identification of large OB/GYN offices with significant membership to provide education, a variety of resources, and interventions on all focus areas aimed at improving provider knowledge and improved health outcomes for members.
- CPCs will disseminate provider guidelines, coding, and other resources for promoting the use of 17P/ Makena for the prevention of pre-term birth, depression screening, promoting the use of LARC and other forms of moderately effective contraceptives, and smoking cessation including referral to Health Coaches, with the intention of improving health outcomes for members.

MCO-Focused Interventions:

- The Health Education Specialist will research and develop member educational materials, with review by the Chief Medical Officer, on 17P. The materials will be used to for member education with the intention of improving the members' knowledge of the benefits of 17P and why to accept the treatment.
- The Health Education Specialist will research and develop provider educational materials on 17P/Makena, leveraging NYSDOH and other resources, to be reviewed by the Chief Medical Officer with the intention of influencing permanent change on providers offering 17P when appropriate.

Table 18 presents a summary of UHCCP's 2017-2018 PIP. The MCO demonstrated an improvement for 4 out of 12 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Received at least one 17P injection	30%	76%	40%	Demonstrated improvement
Depression Screening	42%	35%	55%	Performance declined
Tobacco Screening	80%	55%	85%	Performance declined
Tobacco Screening Follow-Up	100%	22%	100%	Performance declined
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	21%	21%	25%	Performance level was maintained
Age 15-20 years; within 60 days	19%	17%	20%	Performance declined
Age 21-44 years; within 3 days	32%	33%	35%	Demonstrated improvement
Age 21-44 years; within 60 days	33%	37%	35%	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	1%	1%	2%	Performance level was maintained
Age 15-20 years; within 60 days	2%	2%	2%	Performance level was maintained
Age 21-44 years; within 3 days	3%	5%	6%	Demonstrated improvement
Age 21-44 years; within 60 days	10%	10%	14%	Performance level was maintained

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.

UHCCP 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:

- UHCCP utilizes a complex case management model, Whole Person Care, to identify members with at-risk characteristics such as overutilization of services, multiple chronic illnesses, or concurrent medical/behavioral/substance use disorder conditions. Members identified with at risk characteristicsare stratified for case management by clinicians or for care management by non-clinicians.
- UHCCP identified Long Island has the highest ratio of CHP/Medicaid members in the Plan. A large majority of CHP members on Long Island are Hispanic, many with undocumented parents from Central and South America. The rates of well care for Hispanic children age 3-6 and age 12-21 are lower than rates for children in other ethnic groups. UHCCP partnered with a CBO in Suffolk County to hold well child screening events with incentives and with pediatric providers in Suffolk County. The plan provided brochures and Spanish-speaking outreach coordinators to attend Marketing events to provide education about the importance of well visits.
- UHCCP found that rates of Breast Cancer Screening in the Ultra-Orthodox Jewish population in Brooklyn were significantly lower than any other ethnic group in Brooklyn or in the State. In order to improve rates of Breast Cancer Screening in this group the Plan sponsored and executed a "Women's Day of Health" with a local faith based Community Based Organization. The Plan offered incentives and giveaways for members who bring in evidence of a recent mammography and offered on-site mammograms.
- The MCO identified the rates of preventative care was significantly lower for Black/African Americans living in Brooklyn that the rates of other groups. The MCO worked with an FQHC in Central Brooklyn to hold events for adolescent well care and breast cancer screenings and to provide incentives to members who attended. The incentives were monetary in the form of a gift card and also movie tickets to a local independent theater. The MCO also offered well visits and mobile mammography screenings at the UHC Storefront office in Brooklyn.
- UHCCP implemented interventions that aimed to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members identified with at-risk characteristics. Members who have substance use disorder and who leave detox Against Medical Advice (AMA) have extremely high rates of readmission and overdose. UHCCP partnered with a detox facility that had a high

rate of patients leaving AMA. Embedded community health workers in the facility work closely with members to immediately address their needs and to prevent leaving AMA.

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)[8]
- 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%

[8] 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 telecommunications technologies	100%
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.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Secure access through a web-based portal.
  - Use of UHCCP Health4Me app.
  - Use of encrypted email.
  - Utilize secure web-based file transfer applications.

- Use of telecommunications technologies:
  - Use of telehealth services.
  - Providers utilize the UHC website for administrative information (authorizations, claim assistance, roster review).

- Use of Electronic Health Records (EHR):
  - Utilizes Athena to collect data on quality metrics.

- Use of clinical risk group (CRG) or similar software:
  - Use predictive software to identify members at risk for re-hospitalization, members who are over utilizers of services, and members with multiple chronic diseases.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Use of ECG Quick Connect.
  - Utilize secure FTP sites.
  - Use of secure email.

- Electronic communication with providers:
  - Secure access through a web-based portal.
  - Utilize secure FTP sites.
  - Use of ECG Quick Connect.
  - Use of secure email.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Associated with Healthix (HIE).

- Participation in a medical home pilot or program:
    - UHCCP was involved in a pilot program on improving Controlling High Blood Pressure rates an ACO with whom we have a value based contract as part of DSRIP. At the time the measure was 100% chart review with no administrative component. The ACO collected medical record data from all of its providers and was able to provide the plan with values of systolic and diastolic blood pressure values which the plan would take in to convert to compliant or non-compliant data based on HEDIS specifications. Lessons were learned on how to navigate the complexities of aggregating data from multiple EMRs, and converting it into Standard administrative data.

- Future plans to implement HIT:
    - The MCO would like to be connected to additional EHRs for HEDIS quality improvement purposes.

VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

In regards to the operational review; UHCCP was in compliance with 13 of the 14 categories. The category in which UHCCP was not in compliance was Service Delivery Network (1 citation). In regards to the focused review; UHCCP was in compliance with 12 out of 14 categories. The categories in which UHCCP was not in compliance was Organization and Management – Contracts (1 citation) and Service Delivery Network - Contracts (1 citation).

Table 20: Focused Review Types

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

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

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Type	
Complaints and Grievances	0	0		
Credentialing	0	0		
Disclosure	0	0		
Family Planning	0	0		
HIV	0	0		
Management Information Systems	0	0		
Medicaid Contract	0	0		
Medical Records	0	0		
Member Services	0	0		
Organization and Management	0	1	Contracts	1
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	1	1	Contracts	1
Utilization Review	0	0		
Total	**1**	**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. In 2018, the MCO had 34% of external appeals overturned.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	390	274	275
Overturned in Part	58	52	27
Upheld	533	464	510
Medicaid Total	**981**	**790**	**812**
		CHP	
Overturned	4	10	11
Overturned in Part	0	0	0
Upheld	1	8	15
CHP Total	**5**	**18**	**26**

VIII. Strengths and Opportunities for Improvement[9]

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

Strengths

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

Strengths:

- The MCO has reported rates above the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *OB/GYN* and *Other Physician Specialists*.
- Regarding the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed above the 75% threshold for Routine, Non-Urgent "sick", and After-Hours Access call types.
- In regards to new enrollees receiving health screenings, the MCO has had rates above the statewide average for 3 consecutive years.
- 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 *Asthma Medication Ratio (Ages 5-18)*. The MCO also had rates above the statewide average in 2018 for the *Testing for Children with Pharyngitis* and *Spirometry Testing for COPD* measures.
- In the HEDIS®/QARR Access to Care domain, the MCO has reported rates above the statewide average for *Children and Adolescents' Access to Primary Care Practitioners*: *25 Months-6 Years, Adults' Access to Preventative/Ambulatory Services:20-44 Years* and *Annual Dental Visit* measures.
- In regards to the QARR Prenatal Care domain, the MCO had rates above the statewide average for 3 consecutive years from 2015 through 2017.
- The MCO performed well in regards to member satisfaction. In 2018, the MCO's Child CAHPS® rates were above the statewide average for the following measures: *Getting Care Needed, Rating of Personal Doctor, Rating of Specialist and Satisfaction with Provider Communication.*
- The MCO performed well regarding the 2018 Focused Review Survey. The MCO was in compliance with all 14 categories.

[9] 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:

- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Weight Assessment and Counseling for Children and Adolescents—BMI Percentile, Childhood Immunization Status—Combination 3, Lead Screening in Children, Breast Cancer Screening, Colorectal Cancer Screening and Chlamydia Screening in Women (Ages 16-24).* Additionally, rates for Weight Assessment and Counseling for Children and Adolescents: Counseling for Nutrition and Physical Activity, *Immunizations for Adolescents—Combination 2, Adolescent Preventative Care measures: Alcohol and Other Drug Use, Depression, Sexual Activity and Tobacco Use* were reported below the statewide average for 2018. *(Note: Weight Assessment and Counseling for Children and Adolescents—BMI Percentile, Childhood Immunization Status—Combination 3, Lead Screening in Children, Breast Cancer Screening, Colorectal Cancer Screening, and Chlamydia Screening in Women (Ages 16-24) were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Appropriate Treatment for Children with Upper Respiratory Infection* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* while the MCO's rate for *Pharmacotherapy Management for COPD-Bronchodilators, Asthma Medication Ratio (Ages 19-64), Comprehensive Diabetes Care-HbA1c Testing* and *Annual Monitoring of Patients on Persistent Medications – Total Rate* was reported below the statewide average for 2018. *(Note: Appropriate Treatment for Children with Upper Respiratory Infection and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis were opportunities for improvement in the previous year's report.)*
- The MCO reported a rate below the statewide average for the HEDIS®/QARR Behavioral Health measures *Follow-Up After Hospitalization for Mental Illness: 30 Days and 7 Days.*
- The MCO continues to demonstrate opportunities for improvement in regard to HEDIS®/QARR Access/Timeliness measures. The MCO has reported rates below the statewide average for at least three consecutive reporting years for *Well-Child Visits in the First 15 Months of Life—6+ Visits;* and *Adolescent Well-Care Visits*; as well as the *45-64 Years* age group of the *Adults' Access to Preventive/Ambulatory Health Services* measure. *(Note: Well-Child Visits in the First 15 Months of Life—6+ Visits; Adolescent Well-Care Visits and Adults' Access to Preventive/Ambulatory Health Services—45-64 Years were opportunities for improvement in the previous year's report.)*

Recommendations:

- The MCO continues to have poor performance for the HEDIS®/QARR prevention and screening measures. The MCO should conduct a root cause analysis to determine the factors preventing members from seeking or receiving these services. The MCO outreached to only providers to identify barriers regarding these measures. The MCO should consider barriers to members accessing care such as cultural barriers, member education on when screenings are recommended, lack of cultural competency training for providers or office hours that conflict with work schedules. The MCO should also consider implementing more member focused initiatives such as member incentives, community events and collaboration with a community

based organization (CBO) that works within the communities that have poor performance for prevention and screening measures. *[Repeat recommendation.]*

- The MCO continues to perform below the statewide averages for measures in the HEDIS®/QARR Acute and Chronic Care domain. The MCO should consider developing case management programs that educate members on medication management for COPD, Asthma, and Upper Respiratory Infections. The MCO should also consider offering to members an evidence based self-management program for chronic conditions.

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** The MCO should continue to work to improve the HEDIS®/QARR measures consistently performing below average. As many of these measures are related to preventive care and screenings, the MCO should conduct a thorough barrier analysis specific to each measure in order to determine key factors preventing members from seeking or receiving these services. The MCO should also continue to keep an open dialogue with the Community-Based Organizations in the Hasidic communities served by the MCO in order to continue to find ways to engage this population in care. [Repeat recommendation.]

  MCO Response: UnitedHealthcare Community Plan (UHCCP or the Plan) has put a lot of effort into determining the cause of below average scores in all areas, especially for preventive care. We specifically solicited the opinions of providers across the State to gauge their thoughts on why rates are low. The response from many providers on why members are not seeking regular routine care with their PCP is that the "open" nature of our network allows members to be seen by any provider, regardless of PCP assignment. Many providers only reported seeing about 20% of their assigned members. On further analysis it was shown that members were seeking care from multiple different providers for sick care, but not establishing the relationship with their PCP for routine care. This was especially prevalent in Kings County in the Hasidic communities. We found that a common occurrence was for a PCP practice credentialed with UHCCP would remain open until midnight and advertise that they accept walk-in "urgent care". They often had a number of "pop-up" offices around the community. Members of the community would utilize these practices instead of seeing their PCP. Not only does this cause a decrease in preventive care, but also members did not benefit from the counseling and continuity of care that a PCP provides. In order to reduce the prevalence of this, UHCCP instituted a PCP "lock-in" which meant that members had to see to PCP that is on their card or the provider would not be paid. We allow members to change their PCP whenever they want to (up to 3 times in a year) but they must see their assigned PCP. We also did a call campaign to members who were not seeing their PCP to inform them of the new process and to try to get them appointments and engaged with their PCP.
  In addition, the Plan took steps to reduce the prevalence of urgent care centers in our service areas along with call campaigns advising members to seek care from their PCPs, most of who have extended hours in the evenings and weekends. The Plan monitored claims to assure that this would not cause in increase in ED rates and it did not.

The Plan changed its methodology for provider incentives in 2019. The Community Plan Primary Care Provider Incentive (CP-PCPi) offers bonus dollars to PCPs for meeting measure thresholds based on the State quality incentive benchmarks. Almost all of the State quality measures are included in the program. The Plan provides monthly scorecards with member-level detail to all participating providers

- **2017 Recommendation:** The MCO should evaluate its current initiatives targeting improving HEDIS®/QARR measures related to access to primary and preventive care for children and adults. Further, as the MCO also struggles with many quality measures related to preventive care, the MCO should investigate whether there is a correlation across measures and develop a comprehensive strategy aimed at improving preventive care overall.

  MCO Response: The Plan has ramped up Value Based Contracting across the State. The contracts have varying methodologies for shared savings but they all have quality measures as a "gate" to those savings. The quality targets are primarily preventive care measures and the goals are based on State quality incentive thresholds. We partner with ACOs, IPAs and individual providers on value based contracting in order to cover large numbers of members under each contract. All providers with a VBC have a Clinical Transformation Consultant assigned who takes the lead in helping the provider address their quality gate measures and also their opportunity for shared savings.

  The Plan has expanded on the Primary Core Account Management (PCAM) model. This is a service model that has a dedicated multi-functional team assigned to high volume providers. The team consists of at minimum, a Provider Advocate, Clinical Practice Consultant and a Marketing or Community Outreach Manager. The Plan internal Member Outreach team utilizing an autodialer reaches out to the members assigned to PCAM providers to advise them of preventive care needs and attempts to make primary care appointments. In addition, member incentives are offered for well child visits (w15, W34, AWC), dental visits (ADV), and cancer screenings (BCS, CCS, COL). The team for each provider coordinates with the practice to determine what additional support the Plan can provide and how the Plan can align with their quality strategy.

  In Q4 of 2019, the Plan embarked on a call campaign for members who are not attached to PCAM providers but whose providers were included in the CP-PCPi program. Marketing and Community Outreach teams were deployed into practices with whom they had a close working relationship to make calls from the practice site. For practices without that close Marketing relationship, the teams utilized a database to track the calls. The measures of focus for the teams were well child, dental, cancer screenings and diabetes management, for a total of about 40k members. The each rate for the representatives working on the practices was about 40% which is much higher and average reach rate of 20-25%.

- **2017 Recommendation:** The MCO should continue to work to address the issues identified in the focused review surveys. As all the citations the MCO received were related to provider data accuracy and access and availability, the MCO should continue to identify barriers to data accuracy in the provider directories, evaluate the effects of inaccurate data on member access to care, and develop innovative ways to improve the accuracy of the information in the provider directories. [Repeat recommendation.]

  MCO Response: The Provider Verification Office (PVO) continues to conduct proactive outreach to the network provider community to verify demographic information and participation status. The goal of the PVO is to call all UHC providers annually and to confirm demographics and participation. The team members can, if necessary turn off provider assignments and directory flags and forward providers who

are not accepting UHC to the appropriate team to remove them from the network. Because this same information is a component of the Access and Availability surveys, removing erroneous information will lead to improvement. The Plan continues to utilize HealthDetail as a vendor to QA the work of the PVO and to be a second line of oversight to provider data corrections. Internal workgroups meet on a regular basis to review the work of the PVO and HealthDetail.

The Plan has expanded its roster management program to add more providers who have a dedicated roster manager who will track the provider assignments, addresses, and whether or not they are accepting new members. All groups are encouraged to participate in the quarterly attestation process through which providers can verify their own rosters and attest to them quarterly online on the My Practice Profile platform.

The internal Access and Availability studies conducted quarterly by the Plan also help with finding any potential data errors so they can be quickly fixed. If a provider fails because of a "demographic deficiency" the information is sent to the PVO for remediation. Once that is complete, if appropriate the provider is resurveyed to assure that they pass the true study. Any providers who fail any of the components receive a letter detailing the reason for failure. The Manager who oversees the process has added her email and telephone number to the letter and she receives a surprising number of calls and emails to discuss the issues. We believe this personal approach encourages providers to be proactive in communicating with the Plan because they have a person to call, not just a call center.

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