

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Quality and Patient Safety

EXTERNAL QUALITY REVIEW
TECHNICAL REPORT
FOR
Univera Community Health, Inc.

Reporting Year 2013

Published July 2015

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Acronyms Used in This Report
(in alphabetical order)

<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>Q1:</i>	<i>First Quarter (Jan. – March)</i>
<i>FTE:</i>	<i>Full Time Equivalent</i>	<i>Q2:</i>	<i>Second Quarter (Apr. – June)</i>
<i>HCS:</i>	<i>Health Commerce System</i>	<i>Q3:</i>	<i>Third Quarter (July – Sept.)</i>
<i>HEDIS:</i>	<i>Health Effectiveness Data and Information Set</i>	<i>Q4:</i>	<i>Fourth Quarter (Oct. – Dec.)</i>
<i>HIE:</i>	<i>Health Information Exchange</i>	<i>QARR:</i>	<i>Quality Assurance Reporting Requirements</i>
<i>HIT:</i>	<i>Health Information Technology</i>	<i>R:</i>	<i>Rotated</i>
<i>HMO:</i>	<i>Health Maintenance Organization</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 2013 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 plan-reported and NYSDOH-calculated performance measures and review for plan 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 plans regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment and disenrollment 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 plans' Child Health Plus (CHP), Family Health Plus (FHP) and Commercial product lines. For some measures, including QARR 2014 (MY 2013), aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the plans' 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 plan 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 2013.

II. Corporate Profile

Univera Community Health, Inc. (UCH) is a not-for-profit prepaid health services plan (PHSP) that services Medicaid, Family Health Plus (FHP), and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the FHP and CHP product lines.

- Plan ID: 2190696
- DOH Area Office: WRO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: July 5, 1996
- Product Line(s): Medicaid (MCD), Family Health Plus (FHP), and Child Health Plus (CHP)
- Contact Information: 205 Park Club Lane
Buffalo, NY 14221
(800) 494-2215
- NCOA Accreditation as of 8/31/14: Did Not Apply
- Medicaid Dental Benefit: Provided

Participating Counties and Programs

Allegany	MCD	CHP	FHP	Cattaraugus	MCD	CHP	FHP	Chautauqua	MCD	CHP	FHP
Erie	MCD	CHP	FHP								

III. Enrollment and Provider Network

Enrollment

Figure 1 depicts total membership for the plan's Medicaid product line for calendar years 2011 to 2013, as well as the percent change from the previous year. Membership has fluctuated over this period, increasing by 11.8% from 2011 to 2012 and decreasing by 1.0% from 2012 to 2013. Figure 1a represents the membership for other product lines carried by the plan. Figure 1b trends Medicaid membership and membership in these other product lines.

Figure 1: Membership: Medicaid – 2011-2013

	2011	2012	2013
Number of Members	34,861	38,974	38,593
% Change From Previous Year		11.8%	-1.0%

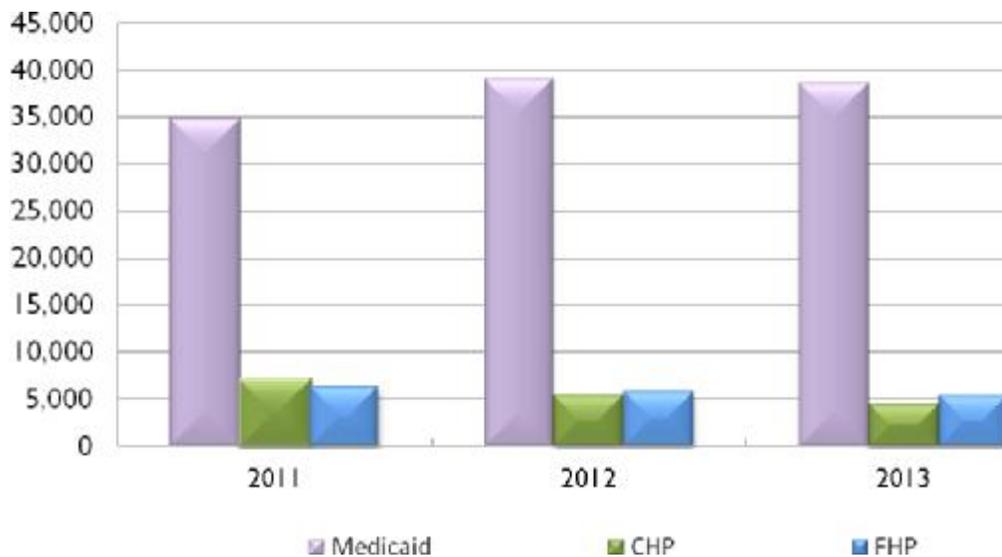
Data Source: MEDS II

Figure 1a: Membership: Other Product Lines – 2011-2013

	2011	2012	2013
FHP	6,363	5,763	5,385
CHP	6,989	5,355	4,475

Data Source: Managed Care Enrollment Report

Figure 1b: Enrollment Trends – All Product Lines



The percentage of members by each method of enrollment in the plan's Medicaid product line for 2011 through 2013 is presented in Figure 2. Whether a plan received a qualifying Medicaid auto-assignment quality algorithm score is also available for each of these years. These scores determine 75% of auto-assignee distribution.

Figure 2: Methods of Medicaid Enrollment – 2011-2013

Note: As of the date of publication, 2013 method of enrollment data were not available. Upon availability of enrollment data, the EQRO will update and reissue the 2013 Technical Report.

Provider Network

Figure 3 shows the percentages of various provider types in the plan's Medicaid product line for the fourth quarter of 2013 in comparison to the statewide rates. For this figure, plan percentages above statewide rates are indicated by ▲, while percentages below the statewide rates are indicated by ▼.

Figure 3: Providers by Specialties – Medicaid – 2013 (Q4)

Note: As of the date of publication, 2013 network provider data were not available. Upon availability of provider network data, the EQRO will update and reissue the 2013 Technical Report.

Figure 3a 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 Medicaid product line of Univera. Statewide data are also included. For this figure, 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.

Figure 3a: Ratio of Enrollees to Providers – Medicaid – 2013 (Q4)

Note: As of the date of publication, 2013 network provider data were not available. Upon availability of provider network data, the EQRO will update and reissue the 2013 Technical Report.

Figure 4 displays QARR Board Certification rates for 2011 through 2013 of providers in the plan's network in comparison to the statewide averages (SWAs). The Figure also indicates whether the plan's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average. The plan's Board Certification rates for the Medicaid/CHP product line were similar to the statewide average for all provider types.

Figure 4: QARR Board Certification Rates – 2011-2013

Provider Type	2011 ¹		2012 ¹		2013	
	Univera	SWA	Univera	SWA	Univera	SWA
Medicaid/CHP						
Family Medicine	79%	80%	77%	78%	77%	78%
Internal Medicine	70% ▼	81%	71% ▼	80%	73%	78%
Pediatricians	77%	82%	75%	81%	74%	80%
OB/GYN	69% ▼	77%	73%	74%	76%	78%
Geriatricians	66%	73%	69%	70%	72%	69%
Other Physician Specialists	79%	80%	77%	78%	79%	78%

¹ For RY 2011 and RY 2012, rates reflect the Medicaid product line only.

NYSDOH Primary Care and OB/GYN Access and Availability Survey – 2013

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.

Note: At the time of publication of this report, the 2013 Access and Availability Survey was in progress. The results of this survey will be published in the 2014 Technical Report.

IV. Utilization

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

Encounter Data

Figure 5 depicts selected Medicaid encounter data for 2011 through 2013. The plan's rates for these periods are also compared to the statewide averages. For this figure, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Figure 5: Medicaid/FHP Encounter Data – 2011-2013

Encounters (PMPY)						
	2011		2012		2013	
	Univera	SWA	Univera	SWA	Univera	SWA
PCPs and OB/GYNs	4.42	4.65	3.60 ▼	4.24	3.52 ▼	4.45
Specialty	2.41	2.07	2.21	2.04	2.29	1.90
Emergency Room	0.81	0.63	0.81	0.60	0.76	0.60
Inpatient Admissions	0.18 ▲	0.15	0.15	0.15	0.14	0.14
Dental – Medicaid	NP	0.96	1.08	1.03	1.23 ▲	1.00
Dental – FHP	1.27	1.12	1.28	1.12	1.31	1.04

Data Source: MEDS II

PMPY: Per Member Per Year

QARR Use of Services Measures

For this domain of measures, the QARR reports assess performance by indicating whether the plan's rates reached the 90th or 10th percentiles. Figure 6 lists the Use of Services rates for the selected plan product lines for 2011 through 2013. The Figure indicates whether the plan's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of all rates for that measure (indicated by ▼).

Figure 6: QARR Use of Services – 2011-2013

Measure	Medicaid/CHP/FHP			
	2011 ¹	2012 ¹	2013	SWA 2013
Outpatient Utilization (PTMY)				
Outpatient Visits	4,558	4,470	4,310	5,162
Outpatient ER Visits	758	792	704	567
Inpatient ALOS				
Medicine	3.6	2.9 ▼	3.5	4.1
Surgery	5.8	4.4	6.0	6.2
Maternity	2.8	2.7	2.7	2.9
Total (Medicine, Surgery & Maternity)	3.7	3.2 ▼	3.9	4.1
Inpatient Utilization (PTMY)				
Medicine Cases	42	40	39	42
Surgery Cases	19	24	23 ▲	14
Maternity Cases	48	44	36	38
Total Cases	96	96	87	85

PTMY: Per Thousand Member Years.

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

¹ For RY 2011 and RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

V. Quality Indicators

To measure the quality of care provided by the plans, 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 2014 audit findings, as well as results of quality improvement studies, enrollee surveys and plan Performance Improvement Projects (PIPs).

Validation of Performance Measures Reported by Plans and Performance Measures Calculated by the NYSDOH

Performance measures are reported and validated using several methodologies. Plans 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, plans report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. Plan-reported performance measures were validated as per HEDIS® 2014 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA).

For measurement year (MY) 2013, the methodology for reporting performance measure rates was modified. Previously, Medicaid and Child Health Plus were reported separately; however, for QARR 2014 (MY 2013), 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 2011 and MY 2012 are Medicaid only (unless otherwise specified), trend analysis has been applied over the time period 2011 through 2013, 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 plan's HEDIS® 2014 Compliance Audit™ are summarized in its Final Audit Report (FAR).

Summary of HEDIS® 2014 Information System Audit™

As part of the HEDIS® 2014 Compliance Audit™, auditors assessed the plan'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 plans throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new plans, 3) serving as a liaison between the plans 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 plan questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® 2014 Final Audit Report (FAR) prepared for UCH indicates that the plan had no significant problems in any area related to reporting. The plan demonstrated compliance with all areas of the Information Systems and all areas of measure determination required for successful HEDIS®/QARR reporting.

The plan used NCOA-certified software to produce HEDIS[®] measures. Supplemental databases used to capture additional data were validated and determined to be HEDIS[®]-compliant with specification by the auditors. No issues were identified with the transfer or mapping of the data elements for reporting.

The plan passed Medical Record Review for the four measures validated, as well as for Exclusions. The plan was able to report all measures for the Medicaid product line.

Figure 7 displays QARR performance rates for Measurement Years 2011, 2012 and 2013, as well as the statewide averages (SWAs). The figure indicates whether the plan's rate was statistically better than the SWA (indicated by ▲) or whether the plan's rate was statistically worse than the SWA (indicated by ▼).

Table Notes for Figure 7	
R:	Rotated measure
FY:	First-Year Measure, plan-specific rates not reported
NR:	Not reported
NP:	Dental benefit not provided
SS:	Sample size too small to report (less than 30 members) but included in the statewide average.

Figure 7: QARR Plan Performance Rates – 2011-2013

Measure	Medicaid/CHP/FHP			
	2011 ¹	2012 ¹	2013	2013 SWA
Follow-up Care for Children on ADHD Meds - Continue	68	67	58	65
Follow-up Care for Children on ADHD Meds - Initial	57	55	53	56
Adolescents - Alcohol and Other Drug Use	58 ▼	R	68	70
Adolescents - Depression	54	R	63	61
Adolescents - Sexual Activity	52 ▼	R	68	69
Adolescents - Tobacco Use	60 ▼	R	75	74
Adolescent Immunization - Combo	67	68	71	72
Adolescent Immunization - HPV		FY	17 ▼	27
Adult BMI Assessment	R	86 ▲	91 ▲	85
Flu Shot for Adults (Ages 18-64)			45	44
Advising Smokers to Quit	80	R	83	78
Follow-up After Hospitalization for Mental Illness - 30 Days	94 ▲	72 ▼	68 ▼	78
Follow-up After Hospitalization for Mental Illness - 7 Days	93 ▲	60	52 ▼	63
Antidepressant Medication Management - Continue	32	38	36	35
Antidepressant Medication Management - Acute Phase	52	55	52	50
Drug Therapy for Rheumatoid Arthritis	74	74	77	79
Appropriate Meds for People with Asthma (Ages 19-64)	84	84	83	80
Appropriate Meds for People with Asthma (Ages 5-18)	92	92 ▲	90	86
Asthma Medication Ratio (Ages 19-64)		FY	61	59
Asthma Medication Ratio (Ages 5-18)		FY	72	69
Use of Imaging Studies for Low Back Pain	78	71 ▼	71 ▼	77
Persistence of Beta-Blocker Treatment After a Heart Attack	SS	SS	SS	85
Avoidance of Antibiotics for Adults with Acute Bronchitis	22 ▼	18 ▼	19 ▼	26
Chlamydia Screening (Ages 16-24)	68 ▼	68 ▼	67 ▼	72
Colon Cancer Screening	43 ▼	R	44 ▼	59
Dental Visit (Ages 19-21)	38	42	44	44
Annual Dental Visits (Ages 2-18)	NP	NP	69 ▲	61
Diabetes BP Controlled (<140/90 mm Hg)	68	R	63 ▼	69
Diabetes HbA1c below 8%	57	R	51 ▼	57
Diabetes Eye Exam	60 ▼	R	62	63

Figure 7: QARR Plan Performance Rates – 2011-2013 (Continued)

Measure	Medicaid/CHP/FHP			
	2011 ¹	2012 ¹	2013	2013 SWA
Diabetes Nephropathy Monitor	87 ▲	R	82	83
Diabetes HbA1c Test	86 ▼	R	83 ▼	89
HIV - Engaged in Care	94 ▲	61 ▼	83	82
HIV - Syphilis Screening	62	50 ▼	55 ▼	71
HIV - Viral Load Monitoring	77 ▲	72	73	70
Childhood Immunization - Combo 3	72	R	76	73
Lead Testing	86	R	87	87
Breast Cancer Screening	55 ▼	54 ▼	57 ▼	72
Smoking Cessation Medications	62	R	57	56
Medical Management for People with Asthma 50% (Ages 19-64)	55 ▼	63	62	68
Medical Management for People with Asthma 50% (Ages 5-18)	44	44	44 ▼	53
Smoking Cessation Strategies	54	R	48	47
Monitor Patients on Persistent Medications - Anticonvulsant	58	64	62	67
Monitor Patients on Persistent Medications - Combined	84 ▼	87 ▼	86 ▼	91
Pharmacotherapy Management for COPD - Bronchodilator	70 ▼	86	94	88
Pharmacotherapy Management for COPD - Corticosteroid	64	71	79	75
Testing for Pharyngitis	80 ▼	79 ▼	83 ▼	87
Diabetes Monitoring for Schizophrenia		FY	76	77
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds		FY	76	82
Antipsychotic Meds for Schizophrenia		FY	52 ▼	63
Spirometry Testing for COPD	43	39 ▼	38 ▼	51
Treatment for Upper Respiratory Infection	89 ▼	88 ▼	89 ▼	92
Well-Child Visits - First 15 Months	77 ▲	74	77 ▲	69
Well-Child Visits - 3 to 6 Year Olds	78 ▼	77 ▼	79 ▼	83
Well-Care Visits for Adolescents	53 ▼	56 ▼	63	64
Children BMI	72	R	82 ▲	75
Children Counseling for Nutrition	83 ▲	R	79	77
Children Counseling for Physical Activity	65	R	73 ▲	68

¹For RY 2011 and 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. Figure 8 displays the Access to/Availability of Care measures for Measurement Years 2011 through 2013. The figure indicates whether the plan's rate was higher than 90% of all plans for that measure (indicated by ▲) or whether the plan's rate was lower than 90% of plans for that measure (indicated by ▼).

Figure 8: QARR Access to/Availability of Care Measures – 2011-2013

Measure	Medicaid/CHP/FHP			
	2011 ¹	2012 ¹	2013	SWA 2013
Children and Adolescents' Access to PCPs (CAP)				
12–24 months	98% ▲	98%	99% ▲	97%
25 months–6 years	93%	91% ▼	92% ▼	94%
7–11 years	93% ▼	93% ▼	96%	97%
12–19 years	91% ▼	90% ▼	94%	94%
Adults' Access to Preventive/Ambulatory Services (AAP)				
20–44 years	85% ▲	85% ▲	84% ▼	85%
45–64 years	88% ▼	89% ▼	88% ▼	91%
65+ years	90%	90%	86%	90%
Access to Other Services				
Timeliness of Prenatal Care	R	85%	R	R
Postpartum Care	R	62% ▼	R	R
Annual Dental Visit*	38% ▼	42% ▼	67% ▲	59%

R: Rotated measure

*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.

¹For RY 2011 and RY 2012, rates reflect Medicaid and Family Health Plus product lines only.

QARR Prenatal Care Measures Calculated by the NYSDOH

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the plans, 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 plans, risk adjustment is used to remove or reduce the effects of confounding factors that may influence a plan's rate. Figure 9 presents prenatal care rates calculated by the NYSDOH for QARR 2010 through 2012. In addition, the figure indicates if the plan's rate was significantly better than the average (indicated by ▲) or whether the plan's rate was significantly worse than the average (indicated by ▼).

Figure 9: QARR Prenatal Care Measures Calculated by the NYSDOH – 2010-2012

Measure	Medicaid/FHP					
	2010		2011		2012	
	Univera	ROS Average	Univera	ROS Average	Univera	ROS Average
	ROS					
Risk-Adjusted Low Birth Weight*	6%	8%	8%	7%	7%	7%
Prenatal Care in the First Trimester	73%	70%	74%	71%	73%	71%
Risk-Adjusted Primary Cesarean Delivery*	17%	16%	15%	15%	14%	15%
Vaginal Birth After Cesarean	12%	11%	10%	11%	10%	11%

*A low rate is desirable for this measure.

ROS: Rest of State

Consumer Satisfaction

In 2013, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. Figure 10 displays the question category, the plan's rates and statewide averages for Measurement Years 2010, 2011 and 2013. The figure also indicates whether the plan's rate was significantly better than the statewide average (SWA) (indicated by ▲) or whether the plan's rate was significantly worse than the SWA (indicated by ▼).

Figure 10: CAHPS® – 2010, 2011 and 2013

Measures	Medicaid					
	2010	SWA 2010	2011	SWA 2011	2013	SWA 2013
Flu Shots for Adults Ages 18-64 ¹					45	44
Advising Smokers to Quit	75	74	80	78	83	78
Getting Care Needed ²	78 ▲	74	76	75	82 ▲	78
Satisfaction with Provider Communication ²	86	86	88	87	88	89
Coordination of Care ²	80 ▲	74	70	68	77	78
Customer Service ²	88 ▲	80	88 ▲	81	83	82
Collaborative Decision Making ²	57	57	61	58	48	48
Rating of Healthcare	67	65	66	67	77 ▲	71
Rating of Health Plan – High Users	72	71	69	73	81	77
Getting Care Quickly ²	81 ▲	77	79	76	81	78
Rating of Counseling/Treatment	61	57	65	59	64	61
Overall Rating of Health Plan	73	69	73	71	80	76
Rating of Personal Doctor ²	71	74	74	73	76	78
Rating of Specialist	77 ▲	67	69	69	78	76
Getting Needed Counseling/Treatment	72	66	76	71	75	70
Recommend Plan to Family/Friends	91	90	93 ▲	91	95 ▲	92
Wellness Discussion	52	52	54	55	76 ▲	71

¹ Prior to 2013, this measure was reported for adults ages 50-64 years.

² These indicators are composite measures.

Quality Performance Matrix Analysis – 2013 Measurement Year (Effectiveness of Care Measures)

Figure 11 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. Fifty-eight measures were selected for the 2013 Measurement Year (MY) Quality Performance Matrix, which include combined measures for Medicaid and CHP product lines. The matrix diagrams the plan's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid Managed Care plans, 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 plan'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 2013, additional measures were included to provide plans with a broader overview of quality performance, and further assist plans in identifying and prioritizing quality improvement interventions.

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 2013 Matrix, this requirement was modified, requiring the plan 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.

Figure 11: Quality Performance Matrix – 2013 Measurement Year

Trend *	Percentile Ranking		
	0 to 49%	50 to 89%	90 to 100%
↑	C HIV-Engaged in Care	B Adolescents-Sexual Activity Adolescents-Tobacco Use Children BMI Children Counseling for Physical Activity Pharmacotherapy Mgmt for COPD-Corticosteroid	A Adult BMI Assessment Pharmacotherapy Mgmt for COPD-Bronchodilator Well-Child Visits-First 15 Months
No Change	D Adolescent Immunization-Combo Adolescent Immunization-HPV Adolescents-Alcohol and Other Drug Use Antipsychotic Meds for Schizophrenia Asthma Medication Ratio (Ages 5-18) Avoid Antibiotics for Adults with Acute Bronchitis Breast Cancer Screening Child-Testing for Pharyngitis Child-Treatment for Upper Respiratory Infection Chlamydia Screening (Ages 16-24) Colon Cancer Screening Diabetes BP Controlled (<140/90 mm Hg) Diabetes Eye Exam Diabetes HbA1c below 8% Diabetes HbA1c Test Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds Drug Therapy for Rheumatoid Arthritis FU After Hospitalization for Mental Illness-30 Days FU After Hospitalization for Mental Illness-7 Days FU for Child on ADHD Meds-Initial HIV-Syphilis Screening Medical Mgmt for People with Asthma 50% (Ages 19-64) Medical Mgmt for People with Asthma 50% (Ages 5-18) Monitor Pts on Persist Meds-Anticonvulsant Monitor Pts on Persist Meds-Combined Spirometry Testing for COPD Use of Imaging Studies for Low Back Pain Well-Child Visits-3 to 6 Year Olds	C Adolescents-Depression Advising Smokers to Quit Appropriate Meds for People with Asthma (Ages 5-18) Asthma Medication Ratio (Ages 19-64) Child Lead Testing Childhood Immunization-Combo 3 Children Counseling for Nutrition Dental Visit (Ages 19-21) Diabetes Monitoring for Schizophrenia Diabetes Nephropathy Monitor Flu Shot for Adults (Ages 18-64) HIV-Viral Load Monitoring Smoking Cessation Medications Smoking Cessation Strategies Well-Care Visits for Adolescents	B Antidepress Meds Mgmt-Continue Antidepress Meds Mgmt -Acute Phase Appropriate Meds for People with Asthma (Ages 19-64)
↓	F FU for Child on ADHD Meds-Continue	D	C

*Trending analysis used rates from 2012 when the measure was not collected in 2013.

Quality Incentive – PQI/Compliance/Satisfaction/Quality Points

The percentage of the potential financial incentive that a plan receives is based on quality of care, consumer satisfaction and compliance. Points earned are derived from an algorithm that considers QARR 2013 rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores and compliance information from 2012 and 2013. The total score, based out of 150 possible points, determines what percentage of the available premium increase the plan qualifies for. For 2013, there were four levels of incentive awards that could be achieved by plans based on the results. Figure 12 displays the points the plan earned from 2011 to 2013, as well as the percentage of the financial incentive that these points generated based on the previous measurement year’s data. Figure 12a displays the measures that were used to calculate the 2013 incentive, as well as the points Univera earned for each measure.

Figure 12: Quality Incentive – PQI/Compliance/Satisfaction/Quality Points – 2011-2013

Category	2011		2012		2013	
	Univera	SWA	Univera	SWA	Univera	SWA
Total Points (150 Possible Points)	58	72.9	39	78.4	75.2	80.8
PQI Points (20 Possible Points)	10	9.5	10	9.9	4.8	6.9
Compliance Points (-20 Possible Points)	-8	-5.9	-8	-5.3	-4	-5.4
Satisfaction Points (30 Possible Points)	20	15.8	20	15.9	20	15.9
Quality Points* (100 Possible Points)	36	53.1	17	57.9	54	63.4
Percentage of Financial Incentive Earned	0%		0%		25%	

* Quality Points presented here are normalized.

Figure 12a: Quality Incentive – PQI/Compliance/Satisfaction/Quality Measures and Points – 2013

Measure	Univera
PQI	4.8
Pediatric Asthma PQI (5 points)	2.5
Pediatric Composite PQI (5 points)	0.0
Adult Respiratory PQI (3 points)	2.3
Adult Composite PQI (7 points)	0.0
Compliance (-4 points each, except where noted)	-4.0
MMCOR	0.0
MEDS	0.0
Access/Availability (-2 points)	0.0
Provider Directory (-2 points)	0.0
Member Services	-4.0
QARR	0.0
Satisfaction (10 points each)	20.0
Rating of Health Plan (CAHPS®)	5.0
Getting Care Needed (CAHPS®)	10.0
Customer Service and Information (CAHPS®)	5.0
Quality (3 points each, except where noted)	30.2
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.0
Adolescent Preventive Care: Depression Screening	1.6
Adult BMI Assessment	3.1
Annual Dental Visit (Ages 2-18)	3.1
Antidepressant Medication Management-Effective Acute Phase Treatment	3.1
Appropriate Testing for Pharyngitis	0.0
Asthma Medication Ratio (Ages 5-64)	1.6
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	0.0
Breast Cancer Screening	0.0
Childhood Immunization (Combo 3)	1.6
Chlamydia Screening (Ages 16-24)	0.0
Cholesterol Management for Patients with a Cardiovascular Event: Cholesterol below (<100 mg/dL)	0.0
Comprehensive Care for People Living with HIV/AIDS: Viral Load Monitoring	1.6
Comprehensive Diabetes Care – Received All Tests (6 points)	0.0
Comprehensive Diabetes Control – HbA1C Control (<8.0%)	0.0
Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder	0.0
Disease-Modifying Anti-Rheumatic Drugs for Rheum. Arthritis	0.0
Flu Shots for Adults	1.6
Follow-Up After Hospitalization for Mental Illness Within 7 Days	0.0
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	0.0
Immunizations for Adolescents	0.0
Lead Testing for Children	2.3
Medical Assistance with Tobacco Cessation (CAHPS®)	1.6
Medical Management for People with Asthma 50% Days Covered (Ages 5-64)	0.0
Persistence of Beta-Blocker Treatment	0.0
Pharmacotherapy Management of COPD Exacerbation – Corticosteroid Use	2.3
Use of Imaging Studies for Low Back Pain	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0
Weight Assessment and Counseling for Children and Adolescents – BMI Percentile	2.3
Well-Care Visits for Adolescents	1.6
Well-Child Visits in the 3 rd , 4 th , 5 th and 6 th Year of Life	0.0
Well-Child & Preventive Care Visits in the First 15 Months of Life (5+ visits)	3.1
Total Points Earned	50.0

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

Performance Improvement Project

Each plan 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 plan 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, plans and providers determine what processes need to be improved and how they should be improved.

The NYS EQRO provided technical assistance to plans throughout the PIP process in the following forms:

1) review of the plan's Project Proposal prior to the start of the PIP; 2) quarterly teleconferences with the plan for progress updates and problem-solving; 3) feedback on methodology, data collection tools and implementation of interventions and 4) feedback on drafts of the plan's final report.

In addition, the NYS EQRO validated the plan'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 plan's improvement strategies, the likelihood that the reported improvement is "real" improvement and whether the plan 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.

Univera's 2013-2014 PIP topic is "*The impact of planned interventions with comorbid conditions of schizophrenia and diabetes in a pilot study with managed Medicaid enrollees*". In 2013, the plan implemented the following interventions:

- Established a Specialized Care Management (SCM) team that prioritized interventions through stratification of the severity of the enrollee for compliance with treatments, including medications and diabetic screening compliance.
- Collaborated with a community agency to include articles regarding diabetes in the agency newsletters.
- Distributed TIPS Cards, promoting metabolic screening and monitoring with the use of antipsychotic medications have been well-received in the provider community. Several mental health agencies are prepared to distribute these to their clinical staff.

Figure 13 presents a summary of Univera's 2013-2014 PIP.

Figure 13: Performance Improvement Project – 2013-2014

Results not shown as 2013 was the first phase of the plan's two-year PIP. Results will be included in the 2014 EQRO Technical Report.

Clinical Study

New York State Medicaid Managed Care and Child Health Plus Developmental Screening in Early Childhood – Quality Measure Pilot

The Children's Health Insurance Program Reauthorization Act (CHIPRA) core set of children's health care quality measures includes the measure *Developmental Screening in the First Three Years of Life*, which measures the percentage of children who have had a standardized developmental screening in the year prior to their 1st, 2nd and 3rd birthdays. In 2013, a study was undertaken on behalf of the New York State Department of Health (DOH) to identify issues relating to the measure construction and collection of relevant information and to determine the scope of early childhood developmental screening in New York State as defined by the measure.

Objectives of the study included:

- 1) Test administrative specifications for the CHIPRA developmental screening measure.
- 2) Identify possible issues in reporting the CHIPRA developmental screening measure using existing specifications.
- 3) Establish baseline performance for recommended developmental screening as defined by the CHIPRA measure.
- 4) Describe development surveillance/screening of children enrolled in New York State (NYS) Medicaid and Child Health Plus (CHP) to determine information not captured by the existing CHIPRA measure specifications.
- 5) Describe follow-up of identified developmental concerns among children enrolled in Medicaid and CHP to determine information not captured by the existing CHIPRA measure specifications.

Each Medicaid Managed Care Organization (MCO) received a medical record request in September 2013 and was asked to provide medical records for randomly selected members enrolled in their plan. Records were requested for two groups of children: one group of children for whom an administrative claim for developmental screening (CPT code 96110) had been submitted, and a second group of children without a claim for developmental screening but with at least one well-child visit during the measurement year. There were 453 records requested for each group (906 records in total). Although records were requested from each MCO, the medical record samples were not stratified by MCO, since the intent was to provide a program-level evaluation of developmental assessment. Data collection was nearing completion at the end of 2013, and data were to be analyzed in 2014.

VI. Deficiencies and Appeals

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

Compliance with NYS Structure and Operation Standards

To assess the compliance of a health plan 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 plan's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories in Figure 15. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the plan 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 plan after the monitoring review, and the plan 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 plans are required to resubmit. Ultimately, all plans 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 plan 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 Figure 14. Plans are also required to submit POCs in response to deficiencies identified in any of these reviews.

Figure 15 reflects the total number of citations for the most current operational survey of the plan, which ended in 2013, as well as from the focused reviews conducted in 2013. This figure reflects the findings from reviews of the plan 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.

Univera was in compliance with 10 of 14 categories. The categories in which Univera was not in compliance were Complaints and Grievances (1 citation), Organization and Management (1 citation), Service Delivery Network (1 citation) and Utilization Review (9 citations).

Figure 14: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability for routine and urgent visits; re-audits are performed when results are below 75%.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS (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 Info-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

Figure 15: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	1	
Credentialing		
Disclosure		
Family Planning		
HIV		
Management Information Systems		
Medicaid Contract		
Medical Records		
Member Services		
Organization and Management	1	
Prenatal Care		
Quality Assurance		
Service Delivery Network	1	
Utilization Review	9	
Total	12	0

VII. Strengths and Opportunities for Improvement¹

This section summarizes the accessibility, timeliness, and quality of services provided by Univera to Medicaid and Child Health Plus recipients based on data presented in the previous sections of this report. The plan'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 plan 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 plan received PQI, compliance, satisfaction, and quality points that qualified it for 25% of the available financial incentive. The plan demonstrates improvement in this area.
- The 2013 HEDIS® Final Audit Report revealed no significant problems, and the plan was able to report all required rates for QARR.
- The plan reported better than average rates for the following HEDIS®/QARR measures: *Adult BMI Assessment, Annual Dental Visits (Ages 2-18), Well-Child Visits – First 15 Months, Children BMI, and Counseling Children for Physical Activity.*
- The plan performed well in regard to certain areas of member satisfaction. The plan reported better than average performance for the following CAHPS® measures: *Getting Care Needed, Rating of Healthcare, Recommend Plan to Family/Friend, and Wellness Discussion.*
- The plan was fully compliant with the NYSDOH focused review requirements.

Opportunities for Improvement

- The plan continues to demonstrate an opportunity for improvement in regard to its overall HEDIS®/QARR performance, as it has reported below average rates for the following measures: *Adolescent Immunization – HPV, Follow-Up After Hospitalization for Mental Illness – 7 Days and – 30 Days, Use of Imaging Studies for Low Back Pain, Avoidance of Antibiotics for Adults with Acute Bronchitis, Chlamydia Screening, Colon Cancer Screening, Diabetes BP Controlled (<140/90 mm Hg), Diabetes HbA1c below 8%, Diabetes HbA1c Test, HIV – Syphilis Screening, Breast Cancer Screening, Medical Management for People with Asthma 50% (Ages 5-18), Monitor Patients on Persistent Medications – Combined, Testing for Pharyngitis, Antipsychotic Medications for Schizophrenia, Spirometry Testing for COPD, Treatment for Upper Respiratory Infection, and Well-Child Visits – 3 to 6 Years.* (Note: *Use of Imaging Studies for Low Back Pain, Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis, Chlamydia Screening, Breast Cancer Screening, Monitor Patients on Persistent Medications – Combined, Testing for Pharyngitis, Treatment for Upper Respiratory Infection and Well-Child Visits – 3 to 6 Years* were opportunities for improvement in the previous year's report.)
- Although the plan was fully compliant with the NYSDOH focused review requirements, the plan demonstrates an opportunity for improvement as it received 12 Article 44 citations in the following categories: Complaints and Grievances, Organization and Management, 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.)

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.

Recommendations

- The plan should continue its efforts to improve poorly performing HEDIS®/QARR measures. The plan should routinely assess the effectiveness of its improvement strategy and modify it as needed. *[Repeat recommendation.]*
- The plan should continue to address the problems noted in the Article 44 Review with specific attention to utilization review processes. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

- **2012 Recommendation:** To ensure members receive appropriate care and the plan receives a percentage of the available financial incentive, the plan should continue to work to improve poorly performing HEDIS®/QARR measures. The plan's response to the previous year's recommendation indicates that several interventions were executed but failed to yield significant improvement. The plan should conduct a thorough root-cause analysis for each measure and develop a comprehensive strategy that includes more precise interventions that target provider behavior, member behavior and the plan's care delivery system. *[Repeat recommendation.]*

Plan Response: The Health Plan (HP) continues to monitor and work to improve HEDIS®/QARR measures and evaluates the effectiveness of the initiatives.

- In 2013, the HP continues to benefit from the new HEDIS® vendor (GDIT), creating opportunities to obtain data for purposes of monitoring trends, root cause analysis participation and evaluation of measure outcomes.
- 4th quarter of 2013, the Safety Net Manager of Quality Programs position was created to provide dedicated focus and drive improvement interventions; also, repurposed 8 Provider Outreach staff and dedicated these resources to Quality Improvement Initiatives.
- Internal development of a data tool, Safety Net Monthly Dashboard, allowing the HP to monitor trending, respond proactively, as well as being able to identify red flags in early stages and respond timely. The Dashboard allows for year-to-year comparisons as well as monthly comparison. It has proven to be a very effective tool.
- Designated a working committee to pursue data integrity concerns that have been identified through root cause analysis for specific measures.

The HP continues to work on, as a priority, the measures in which we have reported below average rates for a consecutive year including:

Current Process: Adolescent Well-Care Visits

The HP distributes population mailings which include monthly new enrollee brochures and annual preventive newsletters and member guidebooks. The mailings include information on recommendations to staying healthy and preventive health screening schedules for all ages. In 2013, the HP mailed newsletters to approximately 182,000 households. In 2013, the plan developed preventive messaging to include on the monthly health statements mailed to members. June and July contained information encouraging annual well-child visits.

- While the HP distributes population mailings, which include monthly new enrollee brochures and member guidebooks, this intervention has proven to not be key in moving the Adolescent Well-Care compliance rate.

New Initiatives: Adolescent Well-Care Visits

A. Embedded Outreach staff in 14 high-volume practices across all regions. Some of the practices allow access to the EMR, allowing embedded staff to assist with scheduling appointments for adolescent well-child visits; assess billing practices for coding accuracy, and focus on preventive and wellness measures.

- This intervention requires time to establish trusted working rapport with the practices.

- Continuing to engage more practices to have embedded staff.
 - Have seen a 1.5% increase from 2013 RY to 2014 RY; will continue intervention.
- B. Launched a Pediatric Quality Incentive Program (PQIP) across all regions
- Encompasses 8 pediatric quality measures.
 - 31 groups in the pilot, approximately 122,000 children.
 - 19 groups are in discussions around participation in the pilot.
 - Providers receive quarterly gap reports and progress reports.
 - Pilot was launched August 2014; requires time for provider participation to develop.
 - Intervention will continue in 2015 and 2016 RYs.
- C. Gap reports were hand delivered by the Provider Outreach Team to providers that had adolescents in their practices and did not yet have a well-child visit in the RY.
- The Gap Report program was modified to only target providers that did not qualify for the MPIP or the PQIP (qualification criteria of having 500 Medicaid/CHP members or greater).
 - Gap reports were delivered by end of September 2014.
 - When gap reports are delivered, they are always accompanied by an education tool the HP developed, QIS sheets (Quality Information Sheets). The sheets provide an explanation of the quality measure, the recommended coding, as well as some tips relative to recommended documentation in the medical record.
 - Outcomes to be determined.
- D. Member Telephonic outreach by internal staff
- Dedicated resources for a concentrated period of time to engage in telephonic member outreach.
 - Internal staff made reminder phone calls to parents/guardians relative to adolescent well-child visits for a total of 4,482 phone calls.
 - 3-way calls with HP, member and physician were made whenever possible.
 - Claims run out indicate a 7% greater compliance rate than those who did not have any phone call made. Second round of call results are anticipated in January, 2015.
 - Telephonic outreach activity data supports positive outcomes and will continue next year.
- E. Follow through on internal data integrity concerns
- Measure requires PCP to be a rendering provider.
 - Concern internally, when a facility bills, of not capturing the rendering provider information in the right repository that then feeds our HEDIS® data collection tool.

Current Process: Annual Monitoring for Patients on Persistent Medications - Combined Rate

In 2013, approximately 5,000 letters mailed to Managed Medicaid members explaining that if they take an ACE/ARB medication, they needed to contact their MD to have a blood test, across all regions.

- The data does not support that this sole intervention was effective and the intervention has been modified.

New Initiatives: Annual Monitoring for Patients on Persistent Medications - Combined Rate

A. The HP obtains data of the members who are taking an ACE/ARB, diuretic or digoxin and anticonvulsants and have not yet had the appropriate blood test.

- During the 3rd and 4th quarter of the current RY, a letter was sent to the member explaining the need for the blood test and that someone (LTHC) will be contacting them within two weeks to set up an appointment to have the blood drawn in his/her home.
- The HP works with one of our home care agency subsidiaries, Lifetime Health Care (LTHC), to contact the physician and obtain the order for the blood work.
- The member is then contacted and an appointment for a home blood draw is made.

- There have been operational challenges in the implementation that delayed the launch until November 2014.
- Measure outcomes are to be determined.

Current Process: Appropriate Testing for Pharyngitis

In the 4th quarter of 2013, a root cause analysis was performed by looking at several claims that did not have the codes for the appropriate testing but that had a pharyngitis diagnosis. The HP requested to look at 60 medical records corresponding with a subset of the claims. Of those medical records, 20 records were found to have supporting documentation indicating the appropriate testing has been done, but not billed. Provider education was performed at that time.

Part of root cause analysis findings also indicated that a significant percentage of the time, the member received the pharyngitis diagnosis in either the ED or an urgent care center. We have expanded our efforts relative to this measure.

New Initiatives: Appropriate Testing for Pharyngitis

- A. The aforementioned PQIP includes this measure.
 - Providers receive quarterly progress reports indicating how often they were compliant with the measure with their patients.
 - Provider education is ongoing.
- B. In progress is the internal discussion relative to engaging Emergency Departments in providing them with education around the quality measures and their role in impacting improved quality performance.
 - Measure outcomes to be determined.
- C. As root cause analysis evidence supports, the HP will request the data for the non-compliant members for this measure on a monthly basis.
 - This will allow for volume controlled and targeted provider outreach to review the medical record in search of supporting documentation that the service was rendered.
 - Also allows for ongoing provider education.

New Initiatives: Avoidance of Antibiotic Therapy in Adults with Acute Bronchitis

- A. In progress is the internal discussion relative to engaging Emergency Departments in providing them with education around the quality measures and their role in impacting improved quality performance.
 - Measure outcomes to be determined.
- B. One of the results of the root cause analysis was the discovery that providers are billing the diagnosis code for acute bronchitis. A sample review of 52 medical records was requested and, due to resource and time constraints, the HP was unable to complete the reviews. However, based on similar chart reviews performed in other regions, anticipated 28% of them had coding education opportunities.
 - QIS (internally developed tool, Quality Information sheet, intended as a resource for the providers) distributed as provider education.
 - Anticipate some practices may require EMR updates.
 - Per monitoring of our monthly dashboard, the trend indicates these interventions are working and will continue.

Current Process: Breast Cancer Screening

In the summer of 2013, Provider Outreach staff distributed women's health gap reports to high-volume PCP providers. The reports included a list of members with a gap for a mammogram screening. Outcome reporting was evaluated in January 2014.

- Outcomes were favorable in that compliance of the membership of the groups that gap reports were delivered to demonstrated increases of up to 51% at the practice level.
- However, the lesson learned is that it was not enough to impact the measure due to the high denominator of membership for this measure and the HP did not engage enough provider practices.
- Gap report activity will continue targeting a larger provider audience.

New and Continued Initiatives: Breast Cancer Screening

- A. Gap reports hand delivered by the Provider Outreach team to providers.
- Delivered by end of September.
 - Outcomes to be determined.
 - Well-received by providers.
- B. The Monroe Plan launched a pilot program in a high membership volume county in which they participated with 2 large radiology practices within Monroe County in September of 2014. Monroe Plan secured appointments for an entire day.
- Three events have been held to date:
 - o 1st event in September was coordinated with Borg and Ide at Clinton Crossings on a Saturday. We called 200 members, scheduled 16 and had 12 complete the mammogram. (75% success rate).
 - o 2nd event in October was coordinated with Highland Imaging at Anthony Jordan Health Center on Holland Avenue. We called 217 members, scheduled 13 and had 9 members complete the mammogram. (69% success rate).
 - o 3rd event was in November with Highland Imaging at Anthony Jordan. We called 220 members, scheduled 15 and 10 members completed the mammogram. (67% success rate).
 - At all events members are scheduled by the same staff who are also onsite to greet members the day of the event and give the \$25 gift card, as well as a mammogram themed gift bag. (Normal incentive processing is 4-6 weeks by mail).
 - Cab transportation was contracted by the Monroe Plan with Medical Motors and provided to members for mammogram appointments. Members received a confirmation letter, as well as a reminder call.
 - On the day of the event, all members who complete their mammogram on that day are also entered in a drawing to receive a \$50 gift card. This \$50 gift card is delivered the following day to the winner.
 - One of the big drivers for the success of this program is the personal connection between the call to members and staff being onsite the day of the event.
 - Due to the high success rates, this intervention will potentially expand to the UCH counties in the next RY.

The HP continues to work on the measures in which we have reported below average rates:

New Initiatives: Appropriate Treatment for Upper Respiratory Infection

- A. The aforementioned incentive programs (PQIP) include this measure.
- Providers receive quarterly progress reports indicating how often they were compliant with the measure with their patients.
 - Provider education is ongoing.
- B. In progress is the internal discussion relative to engaging Emergency Departments in providing them with education around the quality measures and their role in impacting improved quality performance.
- Measure outcomes to be determined.

New Initiatives: Chlamydia Screening

- A. Chlamydia Screening is included in the PQIP for the appropriate age group.
- Providers receive quarterly gap reports and progress reports.
 - Measure outcomes to be determined.
- B. Gap reports delivered to providers not participating in the incentive program.
- Focus area of the CNY counties.
 - Delivered by end of September.
 - Measure outcomes to be determined.
 - QIS distributed as part of provider education, as well as ensuring the provider is aware that a urine sample can be obtained to satisfy this quality measure.

New Initiatives: Frequency of ongoing Prenatal Care, Postpartum Care

- A. Root cause analysis has indicated that the weakest part of this measure for the HP is with postpartum compliance.
- In the short term, the HP receives data relative to the appropriate population who have a claim for a live birth.
 - Provider Outreach and Case Management teams work together with Member Outreach encouraging and facilitating the scheduling of this appointment.
 - HP is in the process of redesigning the form used when provider offices are visited with the intent of performing prenatal record reviews to ensure we are capturing areas of low performance, as well as ensuring the quality goals are being addressed.
 - For the longer term, it is the HP's intent to continue exploring and expanding interventions to ensure this population is receiving the appropriate prenatal and postpartum care.

New Initiatives: Use of Imaging Studies for Low Back Pain

- A. Root cause analysis of this measure indicated that 65% of the claims for the members that did receive imaging for low back pain in less than a 6-week period following the low back pain diagnosis came from the Emergency Departments.
- QIS developed and distributed to providers.
- B. In progress is the internal discussion relative to engaging Emergency Departments in providing them with education around the quality measures and their role in impacting improved quality performance.
- Measure outcomes to be determined.

New Initiatives: Well-Child and Preventive Care Visits in 3rd, 4th, 5th and 6th Year of Life

- A. Embedded Outreach staff in 14 high-volume practices across all regions. Some of the practices allow access to the EMR, allowing embedded staff to assist with scheduling appointments for adolescent well-child visits, ensuring they are using the recommended coding and focusing on preventive and well measures.
- This intervention requires time to establish trusted working rapport with the practices.
 - Continuing to engage more practices to have embedded staff.
 - This intervention will continue, as the monthly monitoring indicates positive movement.
- B. PQIP was launched across all regions.
- Encompasses 8 pediatric quality measures.
 - 31 groups in the pilot, approximately 122,000 children.
 - 19 groups are in discussions around engaging in the pilot.
 - Providers receive quarterly gap reports and progress reports.
 - Pilot was launched August 2014; requires time to on-board.
 - Intervention will continue in 2015 and 2016 RYs.

- C. Gap reports were hand delivered to providers by the Provider Outreach Team that had 3, 4, 5 and 6-year-olds in their practices and did not yet have a well-child visit in the RY.
- The Gap Report program was modified to only target providers in counties that did not qualify for either the MPIP or the PQIP (qualifying criteria is 500 or greater Medicaid/CHP members).
 - Gap reports were delivered by end of September 2014.
 - When gap reports are delivered, they are always accompanied by an education tool the Outreach team developed, QIS sheets (Quality Information Sheets). The sheets provide an explanation of the quality measure, the recommended coding, as well as some tips relative to documentation in the medical record.
 - Outcomes to be determined.
- D. One of the results of the root cause analysis for this measure indicated that our weakest component of this measure is specifically with the 3-year-olds and the 6-year-olds
- Provider Outreach team participates in making reminder phone calls to the parent/guardian, focusing on the targeted age group of 3 and 6-year-olds and facilitating a 3-way call when appropriate. (80 calls per week per Outreach Team member).

New Initiatives: Appropriate Treatment for Upper Respiratory Infection

- A. The aforementioned incentive program includes this measure.
- Providers receive quarterly progress reports indicating how often they were compliant with the measure with their patients.
 - Provider education is ongoing.
- B. In progress is the internal discussion relative to engaging Emergency Departments in providing them with education around the quality measures and their role in impacting improved quality performance.
- Measure outcomes to be determined.

New Initiatives: Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase

- A. The HP receives pharmacy data that indicates the members who have filled new prescriptions for ADHD.
- The Provider Outreach team then works with that data and sends a letter to the relevant providers that indicates the member name, as well as the recommended follow-up appointment dates. HP tracks the physicians that letters are sent to.
 - The Provider Outreach team then sends the list of the members to our Case Management team to maximize opportunities to educate the member, as well as ensure follow-up appointments have been scheduled.
 - HP has seen improvement with scores in monitoring the monthly dashboard and this initiative will continue.
 - HP has recognized a potential data integrity concern in that the place of service information on the claim for the allowable psychiatric centers for services to be rendered is potentially being captured incorrectly. This root cause analysis is in progress.

New Initiatives: Cervical Cancer Screening

- A. Gap reports delivered to providers.
- Delivered by end of September.
 - Measure outcomes to be determined.
 - QIS sheets distributed with gap reports for purposes of provider education inclusive of medical record documentation recommendations.

- Monthly (administrative) monitoring of this measure indicates the HP is maintaining compliance but no strong upward trend.

New Initiatives: HIV/AIDS Comprehensive Care

- A. Distribution of gap reports to high-volume providers ensuring all HIPAA regulations are followed
 - Gap reports are specific as to which component of the comprehensive care is needed.
 - Distributed QIS sheets to providers. They have been well-received, as providers were unaware of the quality measure requiring the frequency and type of blood draws.
 - Lesson learned is that the HP needs to distribute gap reports for the first 6 months of the year, as well as for the second 6 months of the year.
- B. Follow through on internal data integrity concerns
 - Measure requires PCP to be a rendering provider.
 - Concern that internally when a facility bills, not capturing the rendering provider information in the right repository that then feeds our HEDIS® data collection tool.
 - This analysis is in progress.

New Initiatives: Use of Spirometry Testing in the Assessment and Diagnosis of COPD

- A. Receives data on a monthly basis of the members that have a COPD diagnosis but that lack evidence of a spirometry test being rendered.
 - HP works with subsidiary home care agency, Life Time Health Care (LTHC) as a resource to ensure the member is getting the appropriate testing.
 - LTHC provides follow-up with the ordering PCP.
 - Per the monitoring of our monthly dashboard, the trend indicates these interventions are working and will continue.

New Initiatives: Use of Appropriate Medications for People with Asthma

- A. HP receives data that helps us understand the members that have a diagnosis of asthma within the specified timeframes; however, there is no corresponding pharmacy claim for an appropriate asthma medication.
 - The Provider Outreach team and Case Management team work together to call the members to gain an understanding of why they are not on a controller medication and to help in scheduling appointments with a physician, if appropriate.
 - For the members that state they do not have asthma, an analysis of the claims is performed and a variety of responses can be made: referral to CM, advise member to contact doctor for an appointment, facilitate a 3-way call, when appropriate, to schedule MD appointment, and having conversations with the rendering providers to ensure an understanding of why the asthma diagnosis is on the claim.
 - Monthly monitoring of this measure indicates the HP is trending in the right direction and the intervention will continue.
- B. HP piloted a letter to the providers stating that the HP has a claim with an asthma diagnosis but no claim for an asthma medication and asking for clarification around either the diagnosis or the lack of controller medication.
 - Have not been very successful in getting responses/feedback from the provider.
 - HP will look at modifying the letter.
 - It is also the intent of the HP to expand efforts to the other asthma measures, as well.

New Initiative: Follow-Up After Hospitalization for Mental Illness 7-day Follow-Up

- A. The Monroe Plan has a pilot program titled the Bridge Program. A licensed medical Social Worker (LMSW) meets with the member in the hospital on the day of discharge from the inpatient psychiatric admission.

- LMSW also ensures that the member has a follow-up appointment scheduled and encourages keeping the scheduled visit.

New Initiatives: Lead Screening in Children

- A. The aforementioned PQIP includes this measure.
- Providers receive monthly progress reports indicating how often they were compliant with the measure with their patients.
- B. Root cause analysis of this measure indicated that our members were, indeed, having the lead testing done but that they were missing the required timeframe for having the test done by the age of 2.
- HP receives monthly data and it is prioritized by member's birth date.
 - Telephonic member outreach is performed, ensuring the reminder call to the member's parent/guardian is made well before the child turns 2.
 - Provider Outreach also sends a letter to the provider offices seeking their assistance in getting the members in prior to that second birthday. The letter indicates the member that is requiring the test.
 - Monthly (administrative) monitoring of this measure indicates the HP is trending in the right direction and this intervention will continue.

New Initiatives: Comprehensive Diabetes Care

- A. Root cause analysis indicated that the HP is the weakest in the Dilated Retinal Exam component of this measure. There was speculation that our retail eye centers (i.e., LensCrafters, Empire vision, etc.) were not billing the DRE exam correctly. However, some claim analysis indicates that they are billing the professional component correctly when this service is rendered at their place of service. [When the retail eye centers were queried, the consistent comment was that many of the actual diabetic patients do not state they are diabetic on their exam questionnaire].
- This shifted the focus from the Retail Eye Centers to Ophthalmology practices.
 - Reports identifying gaps in care with specific Medicaid membership were distributed to 35 high-volume ophthalmology practices.
 - Outcomes to be determined.
 - It is the HP's intent to continue exploring and expanding interventions to include the other reporting criteria elements of this measure.

Other Programs offered by the Health Plan to improve QARR measures include:

Disease Management Program

The Disease Management Program is a multi-disciplinary, continuum-based approach to proactively identify populations with chronic diseases. The program interventions support the practitioner-patient relationship and plan of care, while emphasizing prevention of complications using evidence-based practice guidelines. Consistent with best practices, education, self-management and healthy lifestyles are supported and promoted. Patients are assisted in managing their conditions by addressing related health issues, such as medication compliance, nutritional management, lifestyle issues, physical activity and co-morbid conditions. Through various educational interventions and individualized reporting both to practitioners and members, the program actively engages participants to improve the management of their chronic condition.

- The Disease Management Program supports the quality improvement efforts for diseases of diabetes, asthma and coronary heart disease by engaging a sub set of our eligible populations.

Case Management

Members with asthma, diabetes or CAD and stratified as Level 3 are referred into case management. This program services complex patients with multiple medical and/or mental health co-morbidities and is based on physician referral, self-referral, an individualized assessment or utilization history.

- In addition to the above 3 disease entities, COPD and HIV are also chronic conditions that are managed by supporting quality improvement initiatives.
- In 2013, there were a total of 532 cases managed for diabetes, 56 for COPD, 45 for CAD and 385 cases for asthma.

- **2012 Recommendation:** The plan should continue to work to address the problems noted in the focused surveys, with specific attention to the accuracy of its provider directories and HPN submissions, as well as provider adherence to appointment standards. [Repeat recommendation.]

Plan Response: The health plan continues to monitor directory accuracy and address issues identified in the HPN reviews related to directory accuracy. Below are initiatives underway within the health plan to address these issues.

New Initiative:

Quality Office Demographic Audits – Quality Office team performs a random, statistically valid audit of the provider record adds and updates to ensure accuracy of information. As a result of those audits and any accuracy issue trends discovered, the Provider File Management leadership creates action plans to address accuracy issues. Those action plans are tailored based on an individual or broader trend and underlying root cause.

Sutherland Outbound Calls - The HP hired a vendor, Sutherland Global Services, to perform outbound calls to providers inquiring about several pieces of key demographic information, ensuring accuracy of plan data and making updates if needed. These calls began in October, 2013 and are continuing into 2015. To date, several thousand offices have been called resulting in information updates where needed, including termination of providers no longer practicing at a location. Initially, offices of any specialty type were being called, but subsequent to the most recent HPN deficiency findings, calls have focused on primary care provider types, including PCPs, OB/GYNs and Pediatricians. Included in this process is an Excellus internal random quality audit of these calls to ensure the accuracy of updates.

Returned Mail – All returned mail related to provider address information is reviewed by the Provider File Management team. Information is reviewed against systems, and offices are called to validate the information in question with updates to all systems based on call outcomes. The Returned Mail process (unlike outbound calls referenced above) encompasses all provider types and includes participating and non-participating providers.

Data Compare Reports – A series of reports are run against our provider data across systems (using business rules) to find any inconsistencies or blank fields. Reports are prioritized based on critical fields (HPN requirements and deficiency reports would be a factor in prioritization). These reports are then assigned to staff to validate errors that exist and ensure all corrections are made. In addition, the information gleaned from these reports is used to evaluate the root cause of the errors and if current programs are in place to address root cause issues and if not, to implement process changes to address the root cause. Each month report trends are reviewed to determine progress and discuss root cause and resolution.

A new Desk Top Tool was created (“Are You Ready to Take The Call”) that began being shared with office staff October 15, 2014. This tool is discussed with offices to ensure they have the required knowledge to answer questions related to scheduling appointments, etc. In addition, the Provider Relations Representatives carry with them forms that outline website options so offices are familiar with reference information that can be found on this site.

IVR Messaging began November 2014. A series of provider educational messages was created of which Access and Availability is once such reminder. Messages play every time a provider office contacts the plan. This allows us the flexibility of rotating messages and targeting certain campaigns, as needed or that are being proposed.

Reinforcing Current Process:

The plan conducts provider office visits where discussion on Access and Availability standards is addressed, especially with new office managers. Meetings are also scheduled with provider offices should the plan identify an issue with the standards not being met. Should this happen and after plan re-education with an office, the plan then monitors offices through a "secret shopper" process to ensure compliance with the standards.

The plan's quarterly Provider Newsletter includes articles reminding providers of the Access & Availability standards. This communication is emailed to all providers and then posted to the web for reference.

The Provider Relations representatives review Access and Availability standards during the plan's Quarterly Provider Office seminars. The plan just completed over 25 'Fall Session' presentations, capturing over 1,000 attendees.

The Plan's Desk Top Tool on Access and Availability standards continues to be shared with provider office staff by Provider Relations representatives during office visits and any direct office contact as a result of Quality related visits.

On an annual basis, the plan conducts a telephonic "secret shopper" survey using scenarios that are consistent with the IPRO access and availability surveys. All providers that are determined non-complaint from the IPRO results are included in the plan's survey. Any provider that is determined non-compliant from this "secret shopper" call is put back into a subsequent annual survey. If it is determined that the provider remains non-compliant, then further intervention is implemented, taking steps to bring the provider into compliance. Interventions may include, but are not limited to, a provider notification letter or contact from the plan's Medical Director to discuss barriers to access. In addition, results are made available to the plan's Provider Relations department for follow-up with the office and a referral to Credentialing is made upon Medical Director review. This process continues annually.

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, 2013
- NCQA Accreditation website, <http://hprc.ncqa.org/index.asp>, Accessed August 31, 2013

B. Enrollment/Provider Network

1) Enrollment/Disenrollment

- NYSDOH OMC Membership Data, 2011-2013
- Enrollment Status by Aid Category and County as of December 2013
- Auto Assignment Data, 2011-2013
- Auto Assignment Quality Algorithm Scores, 2011-2013
- Enrollment Status Report, 2013

2) Provider Network

- Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, December 2013
- Total Number of FTEs by Managed Care Plans, December 31, 2013
- QARR Measurement Year, 2011-2013
- NYSDOH Primary Care and OB/GYN Access and Availability Survey, 2013

C. Utilization

1) Encounter Data

- MMC Encounter Data System, 2011-2013

2) QARR Use of Services

- QARR Measurement Year, 2011-2013

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 (2013 Measurement Year)
- QARR Measurement Year, 2011-2013

3) CAHPS® 2013 Data

- QARR Measurement Year, 2013

4) Quality/Satisfaction Points and Incentive

- Quality/Satisfaction Points and Incentive, 2011-2013

5) Performance Improvement Project

- 2013-2014 PIP Report

E. Deficiencies and Appeals

1) Summary of Deficiencies

- MMC Operational Deficiencies by Plan/Category, 2013
- Focus Deficiencies by Plan/Survey Type/Category, 2013