

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

**EXTERNAL QUALITY REVIEW
ALL PLAN SUMMARY TECHNICAL REPORT FOR:
NEW YORK STATE
HIV SPECIAL NEEDS MEDICAID MANAGED CARE ORGANIZATIONS**

Reporting Year 2018

FINAL REPORT

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Acronyms Used in This Report

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

Purpose of This Report

The Centers for Medicare and Medicaid Services (CMS) require that states oversee Medicaid managed care organizations (MCOs) to ensure they are meeting the requirements set forth in the federal regulations that govern MCOs serving Medicaid recipients. State agencies must contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by MCOs. The EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that MCOs furnish to Medicaid recipients. CMS defines “quality” in Federal Regulation 42 CFR §438.320 as *“the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional knowledge, and through interventions for performance improvement.”*

Components of Care: Quality, Access and Timeliness

Island Peer Review Organization (IPRO), New York State’s (NYS) Medicaid EQRO, used 2018 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

- **Quality** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through healthcare services provided, which are consistent with current professional knowledge.
- **Access** is the timely use of personal health services to achieve the best possible health outcomes¹.
- **Timeliness** is the extent to which care and services, are provided within the periods required by the NYS Medicaid Managed Care Contract, federal regulations, and as recommended by professional organizations and other evidence-based guidelines. Timely interventions improve the quality of care and services provided as well as enrollee and practitioner satisfaction. Timeliness refers to the period during which an enrollee obtains needed care. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of healthcare services.

In order to comply with federal regulations, the New York State Department of Health (NYSDOH) contracts with IPRO to conduct the annual 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.

History of the New York State Medicaid Managed Care Program

The NYS Medicaid managed care program began in 1997, when NYS received approval from CMS to implement a mandatory Medicaid managed care program through a Section 1115 Waiver. Section 1115 waivers allow for “demonstration projects” to be implemented in states in order to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. The NYS 1115 Waiver project began with several goals, including:

¹ Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993. <https://www.ncbi.nlm.nih.gov/books/NBK235882/>

- Increasing access to health care for the Medicaid population;
- Improving the quality of health care services delivered; and
- Expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

In 2011, the Governor of NYS established the Medicaid Redesign Team (MRT) with the goal of finding ways to lower Medicaid spending in NYS while maintaining a high quality of care. The MRT provided recommendations that were enacted, and the team continues to work toward its goals.

Scope of This Report

This report serves as an aggregate of the detailed information included in the MCO-specific technical reports. In accordance with federal regulations, these reports summarize the results of the 2017 EQR to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified survey vendor and other member surveys, such as the MLTC, HARP and DSME surveys. Technical assistance provided by the NYSEQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: MCO corporate profiles, enrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction, and deficiencies and citations summaries.

Structure of This Report

This report is organized into the following domains: MCO Corporate Profiles, Enrollment and Provider Network, Utilization, Performance Indicators, and Structure and Operation Standards. For some measures, including QARR 2019 (MY 2018, aggregate rates are used, which represent the combined population of the Medicaid and CHP 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 the individual, MCO-specific technical reports provides an assessment of the MCOs' strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCOs have opportunities for improvement, recommendations for improving the quality of the MCOs' health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCOs effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCOs were given the opportunity to describe current or proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCOs did not feel were within their ability to improve. The responses by the MCOs are appended to this section of the individual, MCO-specific reports.

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. This report includes data from Reporting Year 2018.

II. MCO Corporate Profiles

Table 1 displays an overview of each MCO’s Corporate Profile. The table includes the dates the MCOs began their Medicaid managed care programs, the product lines each MCO carries, and the NCQA Accreditation rating each MCO received, where available. The National Committee for Quality Assurance (NCQA) surveys health plans on various systems and processes, and evaluates key dimensions of care and services provided by the MCOs. The NCQA awards health plans a rating based on the survey results. The table below provides definitions of each rating the NCQA awards to health plans.

NCQA Accreditation Survey Key:	
Excellent	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS® results are in the highest range of national performance.
Commendable	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
Accredited	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
Provisional	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
Denied	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

Table 1: MCO Corporate Profiles

MCO	Medicaid Managed Care Start Date	Product Line(s)	NCQA Accreditation Rating ¹ (as of 3/16/2020)
Amida Care	04/15/03	Medicaid SNP	Did not apply
MetroPlus SNP	02/14/03	Medicaid SNP	Did not apply
VNS Choice	12/23/11	Medicaid SNP	Did not apply

¹Please refer to the NCQA Accreditation Survey Key on the previous page for definitions of the Accreditation ratings. For more detail on the MCOs’ Accreditation ratings, please see <https://reportcards.ncqa.org/#/health-plans/list>.

III. Enrollment and Provider Network

Enrollment

Table 2 displays total enrollment for the MCOs’ Medicaid SNP product line for Calendar Years 2016, 2017, and 2018, as well as the percent change between 2017 and 2018. Amida Care had an increase in enrollment while MetroPlus SNP and VNS Choice had decreases in enrollment in 2018.

Table 2: Medicaid SNP Enrollment—2016-2018

MCO	2016	2017	2018	% Change from 2017-2018
Amida Care	6,171	6,266	6,636	5.9
MetroPlus SNP	4,471	4,156	4,107	-1.2
VNS Choice	3,542	3,364	3,210	-4.6
Statewide Total	14,184	13,786	13,953	1.2

Data Source: NYS OHIP Medicaid DataMart

Table 3 gives a breakdown of the MCOs’ enrollment by age and gender as of December 31, 2018 for the Medicaid product line. 63% of the SNP Medicaid membership is 45+ years old.

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

Plan Name	Male			Female			Total
	< 20 Years	20-44 Years	45+ Years	< 20 Years	20-44 Years	45+ Years	
Amida Care	89	1,845	2,458	83	705	1,427	6,607
MetroPlus SNP	193	763	1,522	170	464	973	4,085
VNS Choice	49	493	1,534	54	210	869	3,209
Statewide Total	331	3,101	5,514	307	1,379	3,269	13,901

Data Source: NYS OHIP Medicaid DataMart

Provider Network

This section of the report examines the MCOs’ provider networks through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey.

Network Adequacy Standards

In accordance with Federal Regulation 42 CFR §438.68, states that contract with MCOs are required to develop and enforce network adequacy standards, which include time and distance standards for various provider types within a provider network. These network adequacy standards must be developed with consideration of the anticipated number of Medicaid enrollees, the potential level of utilization of services, and the characteristics and health care needs of the population served. In order to comply with these requirements, NYS has developed access requirements for providers in an MCO’s network within its contracts with the MCOs. In the State’s Medicaid Managed Care (MMC) Model Contract, Section 15 defines access requirements for appointment availability standards, appointment wait times, and travel time and distance.

Section 15.1 of the Contract states *“The Contractor shall establish and implement mechanisms to ensure Participating Providers comply with timely access requirements, monitor regularly to determine compliance, and*

take corrective action if there is a failure to comply.” In order to determine compliance with access standards, the NYSDOH utilizes several different methodologies.

Appointment Availability/Timeliness Standards

Appointment availability standards are outlined in Section 15.2 of the MMC Model Contract for various types of services, including, but not limited to, routine visits, urgent and emergency services, specialty care, and behavioral health. In order to monitor MCOs for compliance with appointment availability standards, the EQRO conducts the Primary Care and OB/GYN Access and Availability Survey, which is detailed in a subsequent section of this report. MCOs with rates of compliant providers below an established threshold must develop corrective action plans to address non-compliance.

The Model Contract also establishes standards for appointment wait times. Section 15.4 states “Enrollees with appointments shall not routinely be made to wait longer than one hour.”

Travel Time and Distance Standards

In regard to travel time standards, the Contract defines time and distance standards for various provider types in Section 15.5. For primary care providers, Section 15.5(b)(i) of the Contract states “Travel time/distance to primary care sites shall not exceed thirty (30) minutes from the Enrollee’s residence in metropolitan areas or thirty (30) minutes/thirty (30) miles from the Enrollee’s residence in non-metropolitan areas.” However, the Contract also states that the time/distance may exceed the established standard if the member chooses a provider outside that standard. Section 15.5(b)(ii) states “Enrollees may, at their discretion, select participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCPs themselves.”

For all other services, Section 15.5(c) states “Travel time/distance to specialty care, hospitals, mental health, lab, and x-ray providers shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee’s residence.” This section continues by stating that travel time/distance to these providers in rural areas “...may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee’s residence if based on the community standard for accessing care or if by Enrollee choice.”

Table 4 shows the sum of various provider types in each MCO for the fourth quarter of 2018. Other Specialties is 46% of the statewide total for Medicaid providers. The providers with the most number of specialists within the Medicaid network are Other Specialists, with 46% of the statewide total. The providers with the least number of specialists within the Medicaid network are OB/GYN specialists, with 4% of the statewide total.

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

Plan Name	Primary Care Providers	OB/GYN Specialty ¹	Behavioral Health	Other Specialties	Non-PCP Nurse Practitioners	Dentistry	Total
Amida Care	2,297	847	4,950	8,036	570	1,608	18,308
MetroPlus SNP	1,095	758	5,362	6,922	255	1,812	16,204
VNS Choice	4,917	903	4,581	10,936	1,243	906	23,486
Statewide Total²	25,277	4,949	22,209	59,508	11,241	6,285	129,469

Data Source: NYS Provider Network Data System (PNDS)

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

² Statewide Total: Totals include unique providers for all Mainstream and HIV SNP Medicaid Plans.

Table 5 displays the ratio of enrollees to providers, as well as the ratio of enrollees to Full Time Equivalents (FTEs). 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. In 2018, there were no MCOs with a rate below the statewide median.

Table 5: Ratio of Enrollees to Medicaid Providers—2018 (4th Quarter)

Plan Name	Ratio of Enrollees to Providers				Ratio of Enrollees to FTEs
	Primary Care Provider	Pediatrics (Under age 20)	OB/GYN (Females age 15-64)	Behavioral Health	
Amida Care	3:1	<1:1	3:1	1:1	3:1
MetroPlus SNP	4:1	<1:1	2:1	1:1	5:1
VNS Choice	1:1	<1:1	1:1	1:1	3:1
Statewide Median ¹	1:1	<1:1	1:1	1:1	1:1

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

¹ The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers. <: Indicates the ratio rounded to the nearest whole number would be represented as zero, as the absolute value is between 0 and 0.5.

The number of Medicaid PCPs with an “Open Panel” is presented in **Table 6** for the fourth quarter of 2018. Panels are considered “open” if a provider has fewer than 1,500 Medicaid members. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼. 1 out of 3 MCOs had a rate below the statewide average for Medicaid PCPs with an Open Panel.

Table 6: Medicaid PCPs with an Open Panel—2018 (4th Quarter)

Plan Name	Number of PCPs with an Open Panel	% of Providers
Amida Care	0	0.0 ▼
MetroPlus SNP	1,069	97.6
VNS Choice	4,879	99.6
Statewide Average	5,948	71.9

Board Certification

Board certification ensures physicians meet rigorous criteria. In order to maintain an “active” board certification, providers must have evidence of professional standing, commitment to lifelong learning and self-assessment, cognitive expertise, and evaluation of practice performance. The American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) member boards require participation in a program of ongoing maintenance of certification².

The quality of the providers participating in an organization’s network has a significant effect on the overall quality of care delivered to members. As a result, purchasers and consumers want information that helps them assess the quality of an organization’s physicians, though HEDIS® *Board Certification* does not directly measure the quality of every provider in an organization. The changing scope of medical information, increased public concern for the need to recredential physicians, and evidence that knowledge and skills of practicing physicians declines over time motivated specialty boards to limit the duration of certificates³. To date, all ABMS member boards have agreed to issue time-limited certificates that necessitate subsequent re-certification, usually at intervals of 10 years or less.

Board certification shows what percentage of the organization’s physicians have sought and obtained board certification. While there are valid reasons why physicians may not have done this, and board certification alone is not a guarantee of quality, certification provides a benchmark established by standardized, specialty-specific competency testing. HEDIS®/QARR *Board Certification* rates represent the percentage of physicians in the MCOs’ provider networks that are board-certified in their specialty.

Table 7 displays HEDIS®/QARR *Board Certification* rates of providers in the MCOs’ networks for 2018, as well as the statewide averages. The table also indicates whether the MCOs’ rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. VNS Choice performed well, with 50% of provider types having rates above the statewide average.

Table 7: HEDIS®/QARR Board Certification Rates—2018

MCO	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Amida Care ¹	78	79	76	85	72	82
MetroPlus SNP ¹	80	77	81	75	66	68
VNS Choice	77	83 ▲	83 ▲	85	64	84 ▲
Statewide Average	78	80	77	84	68	78

¹Level of significance was unaudited.

² American Board of Medical Specialties (ABMS). *The Meaning of Board Certification*. <http://www.abms.org>.

³ Brennan, T.A., R.I. Horwitz, F.D. Duffy, C.K. Cassel, L.D. Goode, R.S. Lipner. 2004. “The Role of Physician Specialty Board Certification Status in the Quality Movement.” *JAMA* 292 (9): 1038-43.

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 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 week basis. The Contractor must instruct Enrollees on what to do to obtain services after business hours and on weekends.*” Section 15.3(b) of the Contract also states 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.

The validation of provider participation and the assessment of appointment availability are conducted during the same survey call to provider offices. The assessment of after-hours access includes a telephone call to provider offices during nonbusiness hours (7PM-7AM, 7 days a week) to determine that an after-hours protocol has been established by the provider.

MCO performance below the 75% threshold results in a NYSDOH-issued statement of deficiency and a requirement for the MCO to submit a plan of correction (POC). POCs must be approved by the NYSDOH prior to implementation. Following an allowable time period for MCOs to execute their POCs, a resurvey of the failed providers is conducted.

Table 8 shows the MCOs’ results of the 2018 Provider Access and Availability Survey. 100% of MCOs performed above the 75% threshold for routine and non-urgent call types. After-Hours access and availability is an area for improvement for all MCOs.

Table 8: Access and Availability Survey Results—2018

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate ¹
Amida Care				
Routine	HIV PCP	5	4	80.0%
	Pediatrician/HIV PCP	4	4	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	11	10	90.9%
Non-Urgent “Sick”	HIV PCP	2	2	100.0%
	Pediatrician/HIV PCP	3	3	100.0%
	OB/GYN	4	4	100.0%
	Total Non-Urgent	9	9	100.0%
After-Hours Access	HIV PCP	5	3	60.0%
	Pediatrician/HIV PCP	4	2	50.0%
	OB/GYN	0	0	No Rate
	Total After Hours	9	5	55.6%
MetroPlus SNP				
Routine	HIV PCP	5	5	100.0%
	Pediatrician/HIV PCP	5	5	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	12	12	100.0%
Non-Urgent “Sick”	HIV PCP	5	4	80.0%
	Pediatrician/HIV PCP	5	5	100.0%
	OB/GYN	4	4	100.0%
	Total Non-Urgent	14	13	92.9%
After-Hours Access	HIV PCP	4	2	50.0%
	Pediatrician/HIV PCP	4	3	75.0%
	OB/GYN	2	2	100.0%
	Total After Hours	10	7	70.0%
VNS Choice				
Routine	HIV PCP	4	4	100.0%
	Pediatrician/HIV PCP	1	1	100.0%
	OB/GYN	3	3	100.0%
	Total Routine	8	8	100.0%
Non-Urgent “Sick”	HIV PCP	4	3	75.0%
	Pediatrician/HIV PCP	3	3	100.0%
	OB/GYN	1	1	100.0%
	Total Non-Urgent	8	7	87.5%
After-Hours Access	HIV PCP	3	2	66.7%
	Pediatrician/HIV PCP	0	0	No Rate
	OB/GYN	2	1	50.0%
	Total After Hours	5	3	60.0%

¹Timeliness was not considered when determining appointment availability rates.

IV. Utilization

This section of the report explores utilization of the MCOs' services by examining QARR Use of Services rates.

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCOs' rates reached the 90th or 10th percentile. **Table 9** lists the Use of Services rates for 2018. The table displays whether the MCOs' rates were higher than 90% of all rates for that measure (indicated by ▲) or whether the MCOs' rates were lower than 90% of all rates for that measure (indicated by ▼). All 3 MCOs had sample sizes too small to report for the following measures: *Inpatient Utilization (Maternity)* and *Inpatient ALOS (Maternity)*. Amida Care had rates above the statewide average for 50% of the measures in the QARR Use of Services domain.

Table 9: QARR Use of Services Rates—2018

MCO	Outpatient Utilization (PTMY)		Inpatient Utilization (PTMY)			Inpatient ALOS		
	Visits	ER Visits	Medicine	Surgery	Maternity	Medicine	Surgery	Maternity
Amida Care	11,708 ▲	1,207 ▲	299 ▲	60 ▲	SS	4.6 ▼	9.7 ▼	SS
MetroPlus SNP	7,912 ▼	1,043	249	35 ▼	SS	9.6 ▲	18.0 ▲	SS
VNS Choice	9,958	837 ▼	162 ▼	NV	SS	6.3	NV	SS
Statewide Average	10,191	1,073	253	51	4	6.3	12.0	3.3

NV: Plan submitted invalid data.

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

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 findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

Validation of Performance Measures

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data to the NYSDOH for several measures. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2019 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2019 Compliance Audit™ are summarized in its Final Audit Report (FAR).

Summary of HEDIS® 2019 Information System Audit™

As part of the HEDIS® 2019 Compliance Audit™, auditors assessed the MCOs' compliance with NCQA standards in the six designated information system categories, as follows:

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

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

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

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

Note: MCO summaries of the HEDIS® 2019 Final Audit Reports are available within the individual, MCO-specific technical reports.

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 (Effectiveness of Care, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (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 MCOs’ HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.

Quality Indicators

This section of the report explores the quality of health care services provided by the MCOs. Performance in the domains of Effectiveness of Care, Acute and Chronic Care, and Behavioral Health is examined.

Effectiveness of Care

This domain includes measures of preventive care and screenings, acute and chronic care and behavioral health care for several health conditions which allows for the evaluation of the MCO’s performance.

The following table describes the measures included in the Effectiveness of Care: Prevention and Screening domain. These measures include BMI assessments for adults and children, immunizations for children and adolescents and certain cancer screenings.

Prevention and Screening Measures ¹		
Measure Type	Measure Name	Measure Description
HEDIS®	Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
HEDIS®	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity.
HEDIS®	Childhood Immunization Status—Combination 3 (CIS)	The percentage of children 2 years of age who had four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, and four PCV vaccines by their second birthday.
HEDIS®	Immunizations for Adolescents—Combination 2 (IMA)	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one Tdap vaccine, and have completed the HPV vaccine series by their 13 th birthday.
HEDIS®	Lead Screening in Children (LSC)	The percentage of children 2 years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday.

Prevention and Screening Measures ¹		
Measure Type	Measure Name	Measure Description
HEDIS®	Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
HEDIS®	Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.
HEDIS®	Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

¹Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® and CAHPS® measures.

Table 10a displays HEDIS®/QARR performance rates for Measurement Year 2018 for the prevention and screening measures, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). MetroPlus SNP performed well with 75% of measures having a rate above the SWA. Amida Care reported having rates below the SWA for 75% of the measures.

Table 10a: HEDIS®/QARR MCO Performance Rates 2018—Effectiveness of Care: Prevention and Screening¹

Measure	Amida Care	MetroPlus SNP	VNS Choice	2018 SWA
Adult BMI Assessment	74 ▼	94 ▲	89 ▲	83
Breast Cancer Screening	64 ▼	78 ▲	66	69
Colorectal Cancer Screening	58 ▼	72 ▲	66	64
Chlamydia Screening (Ages 16-24)	SS	80	SS	80

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

BMI: Body Mass Index; COPD: Chronic Obstructive Pulmonary Disease

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

The following table describes the measures included in the Effectiveness of Care: Acute and Chronic Care domain. Measures included evaluate the quality of care provided to MCO members who have acute and chronic medical conditions. These include respiratory, cardiovascular, and musculoskeletal diseases, as well as diabetes and HIV.

Acute and Chronic Care Performance Indicators ¹		
Measure Type	Measure Name	Measure Description
HEDIS®	Appropriate Testing for Children with Pharyngitis (CWP)	The percentage of children 3-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
HEDIS®	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.
HEDIS®	Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement period and who were dispensed appropriate medications.

Acute and Chronic Care Performance Indicators¹

HEDIS®	Medication Management for People with Asthma (MMA)	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medication, and remained on an asthma controller medication for at least 50% of their treatment period.
HEDIS®	Asthma Medication Ratio (AMR)	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
HEDIS®	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.
HEDIS®	Comprehensive Diabetes Care (CDC)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c testing, HbA1c control (<8.0%); eye exam (retinal) performed; medical attention for nephropathy; and BP control (<140/90 mm Hg).
HEDIS®	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	The percentage of members 18 years of age and older who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug (DMARD).
HEDIS®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain that did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
HEDIS®	Annual Monitoring for Patients on Persistent Medications—Total Rate (MPM)	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
NYS-specific ²	HIV Viral Load Suppression	The percentage of Medicaid enrollees confirmed HIV-positive who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

COPD: Chronic Obstructive Pulmonary Disease; ED: Emergency Department; AMI: Acute Myocardial Infarction; BP: Blood Pressure

¹ Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

² The measure description in the Quality Assurance Reporting Requirements (QARR) Technical Specifications Manual was used for this measure.

Table 10b displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). All MCOs had sample sizes too small to report for the *Use of Imaging Studies for Low Back Pain* and *Persistence of Beta-Blocker Treatment After a Heart Attack*. VNS Choice had a reported rate above the SWA for the *HIV Viral Load Suppression* measure.

Table 10b: HEDIS®/QARR MCO Performance Rates 2018—Effectiveness of Care: Acute and Chronic Care¹

Measure	Amida Care	MetroPlus SNP	VNS Choice	2018 SWA
Spirometry Testing for COPD	29	24	29	28
Use of Imaging Studies for Low Back Pain	SS	SS	SS	-
Pharmacotherapy Management for COPD— Bronchodilators	93	94	96	94
Pharmacotherapy Management for COPD— Corticosteroids	70	66	69	69
Medication Management for People with Asthma 50% (Ages 19-64)	84	81	85	83
Asthma Medication Ratio (Ages 19-64)	38 ▲	30	29	34
Persistence of Beta-Blocker Treatment After a Heart Attack	SS	SS	SS	88
CDC—HbA1c Testing	94	95	96	95
CDC—HbA1c Control (<8.0%)	63	66	55 ▼	62
CDC—Eye Exam Performed	55	62	55	57
CDC—Nephropathy Monitor	95	93	93	94
CDC—BP Controlled (<140/90 mm Hg)	43 ▼	77 ▲	62	58
Monitor Patients on Persistent Medications— Total Rate	98	98	99	98
HIV Viral Load Suppression ²	78 ▼	82	85 ▲	81

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

COPD: Chronic Obstructive Pulmonary Disease; CDC: Comprehensive Diabetes Care; BP: Blood Pressure

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

² NYS-specific measure.

The following table describes the measures included in the Effectiveness of Care: Behavioral Health domain. This section examines the quality of care MCOs provide 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.

Behavioral Health Performance Indicators ¹		
Measure Type	Measure Name	Measure Description
HEDIS®	Antidepressant Medication Management (AMM)	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (Effective Acute Phase Treatment) and for at least 180 days (Effective Continuation Phase Treatment).
HEDIS®	Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge and within 7 days after discharge.
HEDIS®	Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications (SSD)	The percentage of members 18-64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
HEDIS®	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	The percentage of members 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
HEDIS®	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	The percentage of members 19-64 years of age during the measurement year with schizophrenia who were diagnosed and remained on an antipsychotic medication for at least 80% of their treatment period.

¹ Measure descriptions in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 10c displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs), for the Medicaid and CHP populations. The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼). 1 out of 3 MCOs had rates below the SWA for behavioral health measures. 2 MCOs had sample sizes too small to report for the *Diabetes Monitoring for People with Diabetes and Schizophrenia* measure.

Table 10c: HEDIS®/QARR MCO Performance Rates 2018—Behavioral Health¹

Measure	Amida Care	MetroPlus SNP	VNS Choice	2018 SWA
Antidepressant Medication Management— Effective Acute Phase Treatment	56	59	59	57
Antidepressant Medication Management— Effective Continuation Phase Treatment	43	42	52	45
Follow-Up After Hospitalization for Mental Illness—30 Days	73	74	48 ▼	69
Follow-Up After Hospitalization for Mental Illness—7 Days	66	68	40 ▼	63
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	98	99	99	99
Diabetes Monitoring for People with Diabetes and Schizophrenia	84	SS	SS	86
Antipsychotic Medications for Schizophrenia	53	52	72 ▲	57

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

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

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. The table below provides descriptions of the measure included in this domain.

Access to Care Performance Indicators ¹		
Measure Type	Measure Name	Measure Description
HEDIS®	Adults’ Access to Ambulatory/ Preventive Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

¹ The measure description in the HEDIS® 2019 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measure.

Table 11 displays HEDIS®/QARR performance rates for Measurement Year 2018 for the Access to Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs’ rates were higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCOs’ rates were lower than 90% of all MCOs for that measure (indicated by ▼). Amida Care had rates below the SWA for all age groups in the *Adults’ Access to Preventative/Ambulatory Services* measure. VNS Choice performed well with 2 out of 3 measures having a rate above the SWA.

Table 11: HEDIS®/QARR MCO Performance Rates 2018—Access to Care¹

MCO	Adults’ Access to Preventive/Ambulatory Services		
	20-44 Years	45-64 Years	65+ Years
Amida Care	93 ▼	97 ▼	90 ▼
MetroPlus SNP	93	98	99
VNS Choice	97 ▲	99 ▲	100
Statewide Average	94	98	96

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

Performance Improvement Projects

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 access to and quality of care, and 3) evaluation of the effectiveness of interventions based on the performance measures.

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

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of 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 MCOs' 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. The common-themed PIP chosen for Reporting Years 2018-2019 was Inpatient Care Transitions. Each MCO designed and conducted a project involving appropriate measurement tools, including the following measures:

- Follow-Up after Hospitalization for Mental Illness (FUH) within 7 days.
- Follow-Up after Hospitalization for Mental Illness (FUH) within 30 days.
- Continuity of Care from Inpatient Detox to Lower Level of Care (COD).
- Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care (COR).

The NYS EQRO provided technical assistance to the MCOs throughout the PIP process in the following forms: 1) review of the MCOs' Project Proposals prior to the start of the PIP; 2) quarterly teleconferences with the MCOs for progress updates and problem-solving; 3) providing feedback on methodology, data collection tools, and implementation of interventions; 4) feedback on drafts of the MCOs' final reports; and 5) all plan webinars to share lessons learned.

In addition, the NYS EQRO validated the MCOs' PIPs 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 MCOs' improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCOs are likely to be able to sustain the 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 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.

Note: MCO summaries on the conduct of the PIPs are available within the individual, MCO-specific technical reports.

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 to improve the quality of care for MCO members with at-risk characteristics.

In 2018, 100% of SNPs reported on activities regarding health disparities. 100% of MCOs reported they analyzed their Medicaid population by at-risk characteristics to identify the differences in health outcomes. 100% of these MCOs provided key findings and the corresponding interventions that were created to reduce or eliminate differences in health outcomes for members identified with at-risk characteristics.

MCO summaries on activities performed related to health disparities are available within the individual technical reports.

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 healthcare.

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:

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

Table 12 displays the statewide results of the HIT survey. Of the three 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, all of MCOs reported future plans to implement HIT.

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

Table 12: MCO Use of Health Information Technology—2018 Survey of NYS MCOs

Plan Name	Electronic Health Records (EHR)	Electronic Communication with Providers	Electronic Transfer of Member Data	Electronic Transfer of PHI to Patients and/or Providers	Use of CRG or Similar Software	Use of Telecommunications Software	Has Future Plans to Implement HIT
Amida Care	✓	✓	✓	✓	✓	✓	✓
MetroPlus SNP	✓	✓	✓	✓	✓	✓	✓
VNS Choice	✓	✓	✓	✓	✓	✓	✓

PHI: Protected Health Information

CRG: Clinical Risk Group

MCO summaries of HIT-related activities are available within the individual technical reports.

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 MCOs' 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 MCOs' compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in the individual MCO-specific technical reports. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCOs were not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policies 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 MCOs after the monitoring review, and the MCOs are 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 structure and operation standards. The focused review types are summarized in **Table 13**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 14 reflects the total number of citations received by each MCO for the most current operational survey, where applicable, as well as from the focused reviews conducted in 2018. There were no operational survey deficiencies issued to any of the SNP MCOs in 2018. Amida Care received 2 focused review citations in 2018.

Table 13: 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 14: Summary of Citations—2018

MCO	Operational Citations	Focused Review Citations	Total Citations
Amida Care	0	2	2
MetroPlus SNP	0	0	0
VNS Choice	0	0	0
Statewide Total	0	2	2

Note: MCO summaries of deficiencies and citations received are available within the individual, MCO-specific technical reports.

External Appeals

Table 15 displays external appeals for 2018 for the Medicaid product lines. This table reflects absolute numbers and is not weighted by MCO enrollment. There were no external appeals partially overturned in 2018. 14 out of 19 total external appeals were upheld.

Table 15: Medicaid External Appeals—2018

Plan Name	Overtured	Overtured in Part	Upheld	Total
Amida Care	1	0	1	2
MetroPlus SNP	0	0	0	0
VNS Choice	4	0	13	17
Statewide Total	5	0	14	19

VIII. Strengths and Opportunities for Improvement⁵

This section summarizes the accessibility, timeliness, and quality of services provided by the MCOs to Medicaid and Child Health Plus recipients based on data presented in the various sections of the individual, MCO-specific technical reports. This section identifies the MCOs' strengths and weaknesses, and makes 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. 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. 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 Model Contract, federal and State regulations, or it performs substantially below both NYSDOHs' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS performance measure rate below the national average.

IPRO references both current and past performance, trends, benchmarks, and comparisons, along with specific NYSDOH goals and targets to make these determinations. Based on this evaluation, IPRO presents NYSDOH with a high-level commentary on the direction of each MCO's quality improvement programs and offers recommendations on facilitating positive change and further improving the care and services provided to enrollees of NY Medicaid Managed Care.

Note: Complete and detailed reports on strengths, opportunities for improvement, and recommendations made by the EQRO are available within the individual, MCO-specific technical reports.

Components of Care: Quality, Access and Timeliness

IPRO used 2018 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

- **Quality** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through healthcare services provided, which are consistent with current professional knowledge.
- **Access** is the timely use of personal health services to achieve the best possible health outcomes.¹
- **Timeliness** is the extent to which care and services are provided within the periods required by the NYS Medicaid Managed Care Model Contract, federal regulations, and as recommended by professional organizations and other evidence-based guidelines. Timely interventions improve the quality of care and services provided as well as enrollee and practitioner satisfaction. Timeliness refers to the period during which an enrollee obtains needed care. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of healthcare services.

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

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

- *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