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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

VISITING NURSE SERVICE OF NEW YORK (VNSNY) CHOICE SELECTHEALTH SPECIAL NEEDS PLAN

Reporting Year 2017

FINAL REPORT

Published April 2019

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Acronyms Used in This Report

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

I. About This Report

Purpose of This Report

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."*

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:

- 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 high quality of care. The MRT provided recommendations that were enacted, and the team continues to work toward its goals.

Scope of This Report

In accordance with federal regulations, the technical report summarizes 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 technical assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the

following: MCO corporate profiles, enrollment data, provider network information, encounter data summaries, PQI/compliance/satisfaction/quality points and incentive, and deficiencies and citations summaries[1].

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. When available and appropriate, the MCOs' data are compared to the Special Needs Plan (SNP) benchmark rate, which is the combined rate of all HIV SNPs. 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 benchmark rate.

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

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. Where trending is desirable, data for prior years may also be included. This report includes data for Reporting Year 2017.

[1] External Appeals data are reported in the Full EQR Technical Report prepared every third year.

II. MCO Corporate Profile

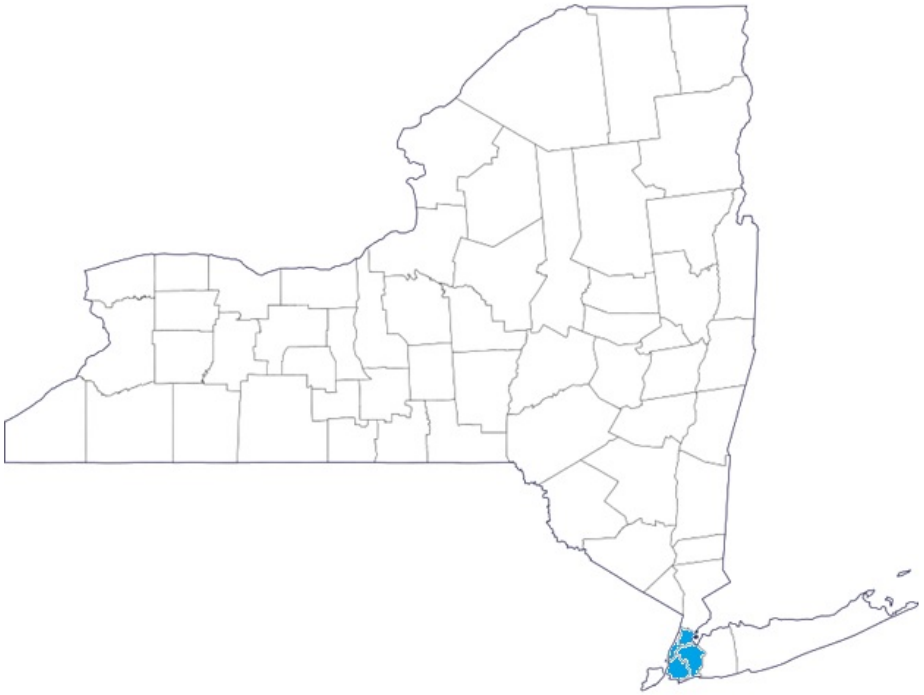
VNS Choice SNP (VNS Choice) is a regional, not-for-profit HIV special needs plan (SNP) that serves the Medicaid (MCD) population. The following report presents plan-specific information for the Medicaid line of business.

- Plan ID: S99B010
- DOH Area Office: MARO
- Corporate Status: Active
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: December 23, 2011
- Product Line(s): Medicaid Special Needs Plan (MCD SNP)
- Contact Information: 1250 Broadway, 11th Floor
  New York, NY 10001
  (212) 609-5631
- NCQA Accreditation Rating[2] (as of 10/15/18): Unknown
- Medicaid Dental Benefit Status: Mandatory

Participating Counties and Products:

Bronx:	MCD SNP	**Kings:**	MCD SNP	**New York:**	MCD SNP
Queens:	MCD SNP				

Figure 1: VNS Choice Map of Participating Counties



[2] For further information on the NCQA Accreditation rating, please refer to www.ncqa.org.

III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2015, 2016, and 2017, as well as the percent change from the previous year. Enrollment had decreased from 2016 to 2017 by a rate of 5.0%.

Table 1: Medicaid Enrollment—2015-2017

	2015	2016	2017
Number of Members	3,931	3,542	3,364
% Change from Previous Year		-9.9%	-5.0%

Provider Network

This section of the report examines the MCO's provider network through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey[3]. This section also includes an overview of network adequacy standards.

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 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 that 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 Medicaid Managed Care 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."*

[3] Additional data on provider networks, including panel data, enrollee-to-provider ratios, and number of providers by specialty, are reported in the Full EQR Technical Report prepared every third year.

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."*

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 certification[4].

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 decays over time motivated specialty boards to limit the duration of certificates[5]. 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 baseline established by standardized, specialty-specific competency testing. HEDIS®/QARR *Board Certification* rates represent the percentage of physicians in the MCO's provider network that are board-certified in their specialty. **Table 2** displays HEDIS®/QARR *Board Certification* rates of providers in the MCO's network for 2015 through 2017, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average.

[4] American Board of Medical Specialties (ABMS). *The Meaning of Board Certification*. http://www.abms.org.

[5] 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.

Table 2: HEDIS®/QARR Board Certification Rates—2015-2017

Provider Type	2015		2016		2017	
	VNS Choice	Statewide Average	VNS Choice	Statewide Average	VNS Choice	Statewide Average
Medicaid						
Family Medicine	37% ▼	52%	12% ▼	53%	15% ▼	55%
Internal Medicine	63%	65%	0% ▼	51%	23% ▼	58%
Pediatricians	40% ▼	53%	0% ▼	47%	11% ▼	52%
OB/GYN	17% ▼	44%	0% ▼	46%	*SS*	78%
Geriatricians	49%	54%	*SS*	36%	36% ▼	65%
Other Physician Specialists	47% ▼	54%	0% ▼	35%	20% ▼	44%

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

Primary Care and OB/GYN Access and Availability Survey—2017

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

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

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

Note: The Primary Care and OB/GYN Access and Availability Survey was not conducted for Reporting Year 2017. The results of the next survey will be published in a future report.

IV. Utilization

This section of the report explores utilization of the MCO's 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 MCO's rates reached the 90th or 10th percentile. **Table 3** lists the Use of Services rates for 2015 through 2017. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

Table 3: QARR Use of Services Rates—2015-2017

	Medicaid			
Measure	**2015**	**2016**	**2017**	**2017 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	10,708	10,431 ▼	10,622	10,544
ER Visits	872 ▼	811 ▼	920 ▼	1,104
Inpatient ALOS				
Medicine	5.7	5.4 ▲	4.7 ▼	5.8
Surgery	9.6	8.9 ▼	6.3 ▼	7.6
Maternity	*SS*	*SS*	*SS*	4.3
Total	6.5	6.2	5.6	6.1
Inpatient Utilization (PTMY)				
Medicine Cases	243	190 ▼	65 ▼	217
Surgery Cases	60	60 ▲	75 ▲	52
Maternity Cases	*SS*	*SS*	*SS*	4
Total Cases	306	253 ▼	209 ▼	291

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 2018 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® 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2018 Compliance Audit™ are summarized in its Final Audit Report (FAR).

Summary of HEDIS® 2018 Information System Audit™

As part of the HEDIS® 2018 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.

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

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

HEDIS®/QARR Performance Measures

For Reporting Year (RY) 2017, performance measures were organized into the following domains:

- Effectiveness of Care
- Acute and Chronic Care
- Behavioral Health
- 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 MCO's 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 MCO. Performance in the domains of Effectiveness of Care, Acute and Chronic Care, and Behavioral Health is examined.

Effectiveness of Care

This domain of measures includes various indicators which are used to measure preventive care and screenings for several health issues. These indicators are used to evaluate how well the MCO provided these services for their enrollees. The following table describes the measures included in the Effectiveness of Care domain.

Effectiveness of Care Performance 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®	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.
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®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
CAHPS®	Flu Vaccinations for Adults Ages 18-64 (FVA)	The percentage of members 18-64 years of age who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS® 5.0H survey was completed.
CAHPS®	Advising Smokers and Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.

Effectiveness of Care Performance Measures[1]		
Measure Type	**Measure Name**	**Measure Description**
CAHPS®	Discussing Cessation Medications	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
CAHPS®	Discussing Cessation Strategies	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods and strategies during the measurement year.

COPD: Chronic Obstructive Pulmonary Disease

[1] Measure descriptions in the HEDIS® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® and CAHPS® measures.

Table 4a displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Effectiveness of Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 4a: HEDIS®/QARR MCO Performance Rates 2015-2017—Effectiveness of Care[1]

Measure	2015	2016	2017	2017 SWA
Adult BMI Assessment	NV	76	67 ▼	**77**
Breast Cancer Screening	66	66	66	**68**
Colorectal Cancer Screening	62	63	63	**61**
Chlamydia Screening (Ages 16-24)	*SS*	*SS*	*SS*	**77**
Spirometry Testing for COPD	28	25	21	**26**
Use of Imaging Studies for Low Back Pain	61	*SS*	*SS*	**—**
Flu Shots for Adults (Ages 18-64)	76	76	77	**74**
Advising Smokers to Quit[2]	89	89	95	**92**
Smoking Cessation Medications[2]	80	80	80	**81**
Smoking Cessation Strategies[2]	71	71	75	**75**

NV: Not valid. The MCO submitted invalid data.

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.

[2] CAHPS® measure.

Acute and Chronic Care

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

Acute and Chronic Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
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.
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®	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® 2018 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 4b displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 4b: HEDIS®/QARR MCO Performance Rates 2015-2017—Acute and Chronic Care[1]

Measure	2015	2016	2017	2017 SWA
Pharmacotherapy Management for COPD—Bronchodilators	95	91	92	**94**
Pharmacotherapy Management for COPD—Corticosteroids	78	67	73 ▲	**60**
Medication Management for People with Asthma 50% (Ages 19-64)	82	85	82	**82**
Asthma Medication Ratio (Ages 19-64)	29 ▼	28 ▼	29 ▼	**37**
Persistence of Beta-Blocker Treatment After a Heart Attack	*SS*	*SS*	*SS*	**—**
CDC—HbA1c Testing	94	93	94	**95**
CDC—HbA1c Control (<8.0%)	NV	22 ▼	13 ▼	**50**
CDC—Eye Exam Performed	42 ▲	NV	49	**50**
CDC—Nephropathy Monitor	93 ▼	90 ▼	91	**93**
CDC—BP Controlled (<140/90 mm Hg)	NV	57	19 ▼	**48**
Monitor Patients on Persistent Medications—Total Rate	98 ▼	98	99	**99**
HIV Viral Load Suppression[2,3]		81 ▲	83 ▲	**79**

NV: Not valid. The MCO submitted invalid data.

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.

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

Behavioral Health

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

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® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measures.

Table 4c displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table 4c: HEDIS®/QARR MCO Performance Rates 2015-2017—Behavioral Health[1]

Measure	2015	2016	2017	2017 SWA
Antidepressant Medication Management—Effective Acute Phase Treatment	53	62	70	**62**
Antidepressant Medication Management—Effective Continuation Phase Treatment	36	44	54	**45**
Follow-Up After Hospitalization for Mental Illness—30 Days	64	73	72	**63**
Follow-Up After Hospitalization for Mental Illness—7 Days	57	37	42	**39**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	97 ▼	96 ▼	96	**98**
Diabetes Monitoring for People with Diabetes and Schizophrenia	*SS*	76	*SS*	**89**
Antipsychotic Medications for Schizophrenia	65	68 ▲	61	**58**

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® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measure.

Table 5 displays HEDIS®/QARR performance rates for Measurement Years 2015, 2016, and 2017 for the Access to Care domain, as well as the statewide averages (SWAs) for 2017. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼).

Table 5: HEDIS®/QARR MCO Performance Rates 2015-2017—Access to Care[1]

Measure	Medicaid			
	2015	2016	2017	2017 SWA
	Adults' Access to Preventive/Ambulatory Services (AAP)			
20-44 Years	96%	96%	96%	**96%**
45-64 Years	98% ▲	98%	99%	**98%**
65+ Years	98%	97%	100%	**99%**

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

Member Satisfaction

In 2017, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 6** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2013, 2015, and 2017. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼).

Table 6: CAHPS®—2013, 2015, 2017

Measure	2013		2015		2017	
	VNS Choice	Statewide Average	VNS Choice	Statewide Average	VNS Choice	Statewide Average
			Medicaid			
Flu Shots for Adults Ages 18-64	73	**78**	76	**74**	77	**74**
Advising Smokers to Quit	92	**93**	89	**91**	95	**92**
Getting Care Needed[1]	77	**80**	83	**82**	82	**80**
Getting Care Quickly[1]	80 ▼	**84**	86	**86**	86	**86**
Customer Service[1]	77	**81**	88	**89**	92	**90**
Coordination of Care[1]	88	**87**	88	**87**	92	**89**
Collaborative Decision Making[1]	55 ▼	**61**	81	**83**	84	**84**
Rating of Personal Doctor[1]	88	**90**	88	**89**	90	**88**
Rating of Specialist	75	**74**	76	**75**	78	**79**
Rating of Healthcare	77	**79**	78	**77**	78	**79**
Satisfaction with Provider Communication[1]	93	**94**	95	**94**	94	**93**
Wellness Discussion	88	**88**	84	**84**	83	**84**
Getting Needed Counseling/Treatment	74	**76**	77	**79**	77	**77**
Rating of Counseling/Treatment	64	**66**	64	**63**	63	**64**
Rating of Health Plan—High Users	71	**76**	74	**76**	79	**79**
Overall Rating of Health Plan	71 ▼	**75**	73 ▼	**77**	79	**79**
Recommend Plan to Family/Friends	78 ▼	**86**	85 ▼	**89**	91	**90**

[1] These indicators are composite measures.

Quality Performance Matrix—Measurement Year 2017

Table 7 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Utilization and Access to Care measures reported annually in the New York State Managed Care Plan Performance Report. Twenty-four measures were included for the Measurement Year (MY) 2017 SNP Quality Performance Matrix. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid MCOs through a percentile ranking.

The Quality Performance Matrix is partitioned into cell categories (A-F). The cell category in which the measures are placed is determined by year-over-year performance on the horizontal axis and an evaluation of the MCO's performance based on a percentile ranking on the vertical axis. The percentile ranking is partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. For MY 2017, the MCO was required to follow up on no more than three measures from the D and F categories of the Matrix. If the MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow up.

Table 7: Quality Performance Matrix—Measurement Year 2017

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Follow-Up After Emergency Department Visit for Mental Illness—7 Days	**A** Antidepressant Medication Management—Effective Acute Phase Treatment
No Change	**D** Breast Cancer Screening Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Meds Use of Spirometry Testing in the Assessment and Diagnosis of COPD	**C** Cervical Cancer Screening Colon Cancer Screening Engagement of Alcohol and Other Drug Dependence Treatment—Total Rate	**B** Antidepressant Medication Management—Effective Continuation Phase Treatment Follow-Up After Hospitalization for Mental Illness—7 Days Initiation of Alcohol and Other Drug Dependence Treatment—Total Rate Medication Management for People with Asthma 75% of Days Covered (Ages 19-64) Statin Therapy for Patients with Cardiovascular Disease—Adherence HIV Viral Load Suppression
↓	**F** Controlling High Blood Pressure Managing Diabetes Outcomes—HbA1c Control (<8.0%) Monitoring Diabetes—Received All Tests	**D** Discussing Smoking Cessation Medications Discussing Smoking Cessation Strategies Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence—7 Days	**C** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Advising Smokers to Quit Flu Shots for Adults (Ages 18-64) Medication Management for People with Asthma 50% of Days Covered (Ages 19-64)

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 2017-2018 was Inpatient Care Transitions.

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; and 4) feedback on drafts of the MCOs' final reports.

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.

VNS Choice's 2017-2018 PIP topic was *"Reducing 30-day Re-Admissions by Improving Inpatient Care Transitions"*. During 2017, the MCO implemented the following interventions:

Member-Focused Interventions:

- Educate patients on the importance of adhering to aftercare treatment and discharge plan, remind patients of outpatient appointments, assess patients' understanding of discharge using teach-back methods, ensure regular communication with patients to ensure needs are being met, and assess if patients are receiving appropriate care and make recommendations as needed.
- Case managers review and reconcile medications with members.
- Have members sign release forms to include family, friends, and/or caregivers in discharge planning and decision making. Staff educates members on the importance of releasing HIPPA information with caregivers and involving them in decisions.

Provider-Focused Interventions:

- Care Managers will have discussions with facilities about the importance of members consenting to the MCO's RHIO.

MCO-Focused Interventions:

- Identify if discharge information received is late or not received at all, and track which institution is not providing information.
- Medical Management case managers complete a transitional care checklist, which includes medication reconciliation, home visit or call within 48 hours of need or discharge from the facility, and schedule visits with the PCP or treating specialist within 7 days of discharge. If case managers have a discharge summary, the summary is faxed to the PCP.
- Beacon provides presentations to SNP member Designated AIDS centers staff to promote services and increase identification of members who may qualify for HCBS services and home-based therapy services.

Table 8 presents a summary of VNS Choice's 2017-2018 PIP.

Table 8: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal[1]	Results
30-day Readmission Rate	15%		10%	
Follow-Up After Hospitalization for Mental Illness—30 Days	71.1%		≥3% increase	
Follow-Up After Hospitalization for Mental Illness—7 Days	32.7%		≥3% increase	
SUD Follow-Up[2]	TBD		TBD	

SUD: Substance Use Disorder; TBD: To Be Determined

[1] Goals were slated to be reassessed on publication of statewide rates.

[2] The baseline rates for the Substance Use Follow-Up measure were pending finalization of measure specifications and calculation by the NYSDOH. Therefore, baseline rates and target rates are pending availability of these data.

VI. Structure and Operation Standards[6]

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

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO with Article 44 of the Public Health Law and Part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories listed in **Table 10**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO was not in compliance.

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

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

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of compliance with structure and operation standards. The focused review types are summarized in **Table 9**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 10 reflects the total number of citations for the most current operational survey of the MCO, if applicable, as well as from focused reviews conducted in 2017. This table reflects the findings from reviews of the MCO as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can result in multiple citations.

VNS Choice was in compliance with 9 of the 14 categories. The categories in which VNS Choice was not compliant were Disclosure (3 citations), Organization and Management (3 citations), Quality Assurance (1 citation), Service Delivery Network (3 citations), and Utilization Review (3 citations).

[6] External Appeals data are reported in the Full EQR Technical Report prepared every third year.

Table 9: 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 do 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 10: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	0	0
Disclosure	0	3
Member Services Phone Calls		*1*
Provider Directory Information		*1*
Provider Participation—Directory		*1*
Family Planning	0	0
HIV	0	0
Management Information Systems	0	0
Medicaid Contract	0	0
Medical Records	0	0
Member Services	0	0
Organization and Management	0	3
Access and Availability		*2*
Provider Participation—Directory		*1*
Prenatal Care	0	0
Quality Assurance	1	0
Service Delivery Network	0	3
Provider Directory Information		*2*
Provider Participation—Directory		*1*
Utilization Review	3	0
Total	**4**	**9**

VII. Strengths and Opportunities for Improvement[7]

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

Strengths:

- In the HEDIS®/QARR Acute and Chronic Care domain, the MCO reported rates above the statewide average for *Pharmacotherapy Management of COPD Exacerbation—Corticosteroids* and *HIV Viral Load Suppression*.

Opportunities for Improvement:

- The MCO has reported rates below the statewide average for at least three consecutive reporting years for the HEDIS®/QARR *Board Certification* measure for *Family Medicine, Pediatricians,* and *Other Physician Specialists*. Additionally, the MCO's rates for *Internal Medicine* and *Geriatricians* were reported below the statewide average for 2017. *(Note: board certification was an opportunity for improvement in the previous year's report.)*
- The MCO demonstrates opportunities for improvement in the HEDIS®/QARR Effectiveness of Care and Acute and Chronic Care domains. The MCO has reported a rate below the statewide average for at least three consecutive reporting years for the *Asthma Medication Ratio (Ages 19-64)* measure, while rates for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* were reported below the statewide average for 2017. *(Note: Asthma Medication Ratio (Ages 19-64) and Comprehensive Diabetes Care—HbA1c Control (<8.0%) were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 13 citations from the operational and focused review surveys related to Disclosure, Organization and Management, Quality Assurance, Service Delivery Network, and Utilization Review. *(Note: compliance with structure and operation standards was an opportunity for improvement in the previous year's report.)*

Recommendations:

- The MCO should re-evaluate its current strategies, which focus primarily on passive education and data reporting, aimed at improving HEDIS®/QARR diabetes and asthma measures that consistently perform below the average. The MCO should conduct a thorough root cause analysis to identify factors that drive low performance and develop active strategies targeting improvement. Such strategies to consider, if feasible, could include initiation of home-visits for diabetic screenings, implementation of a Diabetes Self-

[7] 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.

Management Educational program for members, and automatic home deliveries of asthma medications for asthmatic members. *[Repeat recommendation.]*

- The MCO should conduct the following activities in order to address issues identified in the operational and focused review surveys: *[Repeat recommendation.]*
    - The MCO should revise policies and procedures surrounding the preparation of Utilization Review letters to ensure all letters contain the required information and that the information is correct.
    - The MCO should ensure that it follows protocols when required to report a new hire to the NYSDOH.
    - The MCO should re-train its Member Services staff on proper protocols for responding to member requests for information.
    - The MCO should continue to identify innovative ways to ensure the accuracy of provider data to ensure appropriate access to care for members.

Response to Previous Year's Recommendations:
Note: The responses below are taken directly from the MCO and are not edited for content.

- **2016 Recommendation:** As the MCO experienced issues with the medical record review process, the MCO should take steps to ensure that policies and procedures are defined for this process and to monitor adherence to the procedures.

  MCO Response: In 2017, the Plan contracted with a vendor to perform both medical record collection and record review. This was a change from the prior year where all medical record review was completed internally. The training materials are updated by the vendor annually and are approved by multiple auditors prior to release. The medical record review vendor is required to perform quality assurance checks on all records resulting in a numerator positive hit and performs 20% over-read throughout the project. The vendor's abstraction personnel are tested at the conclusion of training and must achieve a minimum accuracy score of 95% to be eligible to participate in the HEDIS® project. The comprehensive training includes but is not limited to:
    - HEDIS® overview
    - Data collection requirements
    - On-site and fax/mail record retrieval processes
    - Medical record review activities
    - HEDIS® Hybrid Technical Specifications updates and measure instruction
    - MedCapture data entry instruction

  The Plan's internal medical record review staff are required to participate in the web-based trainings held by the medical record review vendor annually for instruction on the measures, data abstraction, and software navigation. Additionally, the internal medical record review staff performs quality assurance checks on 50% of the charts reviews to ensure that data abstraction completed by the vendor is performed in accordance to the measure specifications. Throughout the medical record review process, Quality Management holds weekly calls with the vendor to discuss the project status, address any inconsistencies noted during quality assurance for continued monitoring of adherence to the medical record review procedures. Any outstanding inquiries regarding data abstraction compliance is communicated to the auditor for further clarification prior to final approval.

  As a result of these abstraction and retrieval policies and procedures, the Plan ensured timely capture of relevant data, which adhered to industry standards, and enabled reliable and accurate data collection. The Plan successfully passed final medical record validation during primary review in 2018, and no errors

were reported by the auditor. We will continue to monitor medical record review processes to ensure continued data collection in accordance with HEDIS®/QARR standards and a successful medical record review validation.

- **2016 Recommendation:** As the MCO did not meet the 75% compliance threshold for any call types included in the Primary Care and OB/GYN Access and Availability Survey, the MCO should ensure that all providers in its network are aware of the timeliness standards, are providing appointments within contractual timeframes, and have adequate after-hours access in place for members.

  MCO Response: In 2017, the Plan addressed the Access and Availability deficiency identified from the survey by making outbound calls to providers to verify demographic information and then made appropriate updates where necessary. In addition, our Provider Relations team educated providers on appointment timeframes and after-hour access for our members.

  Throughout 2017, in efforts to improve Access and Availability the Plan implemented ad hoc projects which included outreach to providers via E-Fax Blast and making outbound phone calls to provider offices. During the E-Fax Blast project, prefilled forms with provider information were sent to providers along with a provider information change form. When the form was returned to us, the form was reviewed and provider information was corrected. On an ad hoc basis, Access and Availability phone calls were conducted to verify provider information. When making these calls, the caller identified themselves as VNSNY CHOICE employees and was calling to verify provider information.

  Beginning of May 2018, the Plan's Provider Operations Department started making outbound calls to providers on a regular basis. At the beginning, we identified ourselves as VNSNY CHOICE employees and was calling to verify provider information. We received a lot of pushback from providers' offices during these calls—most stating they could not verify information or was too busy to respond. After a few months, we decided to change our method and began making phone calls utilizing the "Secret Shopper" method. Our compliance is expected to improve as we continue to make phone calls to provider's offices. During the phone calls, we identify which providers are not meeting standards set by our plan, notifying Provider Relations team to coordinate outreach and education to the referenced providers.

- **2016 Recommendation:** The MCO should continue to work to improve HEDIS®/QARR measure performance. As several of the measures for which the MCO performed below average are related to care for diabetic and asthmatic members, the MCO should conduct a barrier analysis for these populations to determine factors preventing these members from seeking or receiving the necessary care for their condition. *[Repeat recommendation.]*

  MCO Response: The actions taken as a response to the 2015 recommendation are still current, additionally, as part of the 2019 Quality Work Plan, the Plan will be implementing several new and/or enhanced reports and cross-functional workgroups for continued quality improvement on HEDIS®/QARR measures. One such report is an enterprise wide interactive dashboard that provides performance rates against industry benchmarks for HEDIS®/QARR measures and allows for drilldown to member level detail for development of gap closure strategies and outreach. During the fourth quarter of 2018, existing monthly reports were updated to include the members' attributed care manager, to allow for monitoring of quality performance by care manager, identifying high-performers who can share best practices as well as identify training opportunities. In addition to enhancing internal reports the Plan is collaborating with our Designated AIDS Centers to understand their reporting needs and develop reports that will allow providers to be more actionable in addressing member gaps in care.

In 2019, the plan will engage in quarterly visits with Designated AIDS Centers to provide training on HEDIS®/QARR measures, sharing evidenced based best practices that providers can implement to impact their performance. Gaps in care reports will continue to be shared monthly with providers to allow for timely outreach to their patients regarding non-compliant measures. In addition to the gaps in care reporting, additional measure specific communications will be shared with providers for targeted outreach to their patients. For the *Asthma Medication Ratio* measure, focused education and outreach will be conducted with providers to ensure member compliance with controller medication refills. In coordination with outreach to the providers, members will also receive refill reminders to enforce monthly medication adherence. For improvement of the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure the Plan will identify members who were not compliant at the end of 2018 for targeted education and appointment scheduling assistance for completion of required screenings in 2019.

- **2016 Recommendation:** The MCO should continue evaluating its efforts toward improving the accuracy of the information included in the provider directories and modify and enhance its strategy where necessary. *[Repeat recommendation.]*

  MCO Response: June 2017, the Plan welcomed a new Director of Provider Operations and Manager of Provider Data Integrity. Under new leadership, Provider Operations became a data-driven team. For the second half of the year, the Plan focused on gaining a deeper understanding of provider data and provider directory information. We have spent much effort and time cleaning up our provider data and we continue to perform testing to ensure that our data is accurate. We continuously modify and enhance the way we collect and analyze provider data. With our growing team, provider directory compliance will improve. An enhancement that we have implemented to improve provider data include an Online Provider Update Request Form. The implementation of the electronic form allows providers to easily submit a request to update information on their provider profile. The online submissions are stored in our system and the Provider Operations Coordinator reviews the form and makes the requested update.

  Initiatives that were previously taken are still current. The Manager of Provider Integrity oversees the integrity testing and accuracy testing done by our Data Specialists and Reconciliation Specialists, respectively. New initiatives that we have taken to improve provider directory is to make phone calls to provider offices on a regular basis. The Reconciliation Specialist analyzes results from outbound calls and makes modifications to the provider's information to ensure accuracy. Through our analysis, we've identified an issue with our specialty crosswalk to our directory and we are working with our directory vendor to address the problem. In addition, our analysis allowed us to correctly identify which providers should be published and providers that should be removed from the directory.

VIII. 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:*
  - NYSDOH OMC Membership Data, 2016-2017
- *Provider Network:*
  - State Model Contract
  - QARR Measurement Year 2017

C. Utilization

- *QARR Use of Services:*
  - QARR Measurement Year 2017

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
  - QARR Measurement Year 2017
- *CAHPS® 2017:*
  - QARR Measurement Year 2017
- *NYSDOH Quality Incentive:*
  - Quality/Satisfaction Points and Incentive, 2017
- *Performance Improvement Project:*
  - 2017-2018 PIP Reports

E. Structure and Operations

- MMC Operational Deficiencies by Plan/Category, 2017
- Focused Deficiencies by Plan/Survey Type/Category, 2017