New York State Department of Health
Office of Quality and Patient Safety

2017

Health Plan

Care Management Report

Table of Contents

Introduction 3
Data/Methodology 4
Limitations 6
Measures 7
Outreach 9
Enrollment 13
Quality Measures 17
Utilization 19
High-Risk Obstetrics (HROB) 21
Appendix 26
  Quality Measures 26
  Mainstream Plan Covered Counties 31

Introduction

Plan-led care management, also referred to as case management, is an intervention-based program intended to improve the health plan members' health outcomes. In this context, care management includes: a comprehensive assessment of a member's needs, an individualized care plan, and interventions. The care plan is developed from the assessment, and the interventions are designed to achieve the care plan goals. The aim is to provide coordinated, efficient, quality care, and optimize health outcomes for people with complex health issues. Medicaid managed care (MMC) health plans are required to provide case management and disease management services for their members with chronic health conditions, or complex health issues or situations. MMC is a Medicaid health insurance plan that coordinates the provision, quality, and cost of care for its membership. With this kind of information, over the past 10 years there have been gains in building a foundation to: 1) explore the effectiveness of care management on health service use and outcomes, 2) determine which populations or members benefit the most, and 3) understand if any program models are associated with more effective results.

In New York State, plans have been required to provide case management and disease management services since the 1997 Partnership Program implementation. In 2008, the Medicaid managed care contract requirement for case management and disease management services (section 10.19 and 10.20 of the Medicaid contract) was amended to include specific data requirements for the evaluation of care management by the New York State Department of Health (NYSDOH). Since 2011 (measurement year 2010), NYSDOH has collected and evaluated case management and disease management services and outcomes through standardized measures. Plans are required to submit specific information for all Medicaid members involved in plan-administered care management programs during each calendar year. The collection of this standardized data provides NYSDOH with information that is used to evaluate care management programs, including the number of individuals receiving these services, the types of conditions individuals have, and the impact of care management services on outcomes.

The Department is committed to sharing information about care management services with the public, plans, and stakeholders. Therefore, this report provides a summary of each plan's most recent care management data submission. This submission included data about member and program characteristics for all members who received care management services administered by health plans during measurement year 2017. The goal of this annual report is 1) to provide information about plan care management programs, the members identified for care management, and the efficiency of their programs, 2) to describe utilization patterns for emergency department visits, inpatient stays, and outpatient services for members in care management, and 3) to describe quality results for members in care management.

Data/Methodology

This report is principally based on two data sources, the Health Plan Care Management Assessment Reporting Tool (CMART) and the New York State Medicaid Data. These data provide information regarding which members received care management services; the scope and nature of those services; and claims, encounters, and demographic details. To understand outcomes of members receiving plan-led care management, two additional data sources were used: The Vital Statistics Birth file for High-Risk Obstetrics (HROB) was used to calculate birth outcomes of pregnancies receiving HROB care management and the Clinical DataMart was used for quality measures.

The Health Plan CMART is submitted annually to the Department of Health. This data documents the process of plan-led care management services which include:

- Members triggered to receive care management
- Date members are triggered to receive management
- For those who enroll in plan-led care management, CMART includes:
    - Start and end date of care management
    - Type of care management service received
    - Number of interventions
    - Type of interventions: letter, phone, in-person intervention

The Medicaid Data contains all claims and encounters data as well as demographics, diagnoses, etc. regarding health plan members. The Clinical Risk Groups (CRGs) (developed by 3M®) used for stratifications are also from this data source.

The Vital Statistics Birth file consists of all live births that occur in NYS during each calendar year. This data provides the following information about the infants and mothers, which is not recorded in CMART:

- Mother characteristics
    - Demographics (nationality, race/ethnicity, Medicaid aid category, education level, age at time of delivery, region of NYS child was delivered)
    - Gestational weeks at delivery
    - Number of prenatal visits
    - Maternal risk factors
        - Diabetes
        - Gestational diabetes
        - Hypertension
        - Gestational hypertension
    - Referral to High-Risk OB provider
    - Number of times hospitalized during the pregnancy
    - Number of previous live births
- Infant characteristics
    - Neonatal Intensive Care Unit (NICU) use
    - Sex
    - Birthweight

The DOH Clinical DataMart is utilized to calculate quality measures consistent with Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures from the National Committee for Quality Assurance, and Prevention Quality Indicators (PQIs) from the Agency for Healthcare Research and Quality. PQIs can be used to identify potential problem areas in health care quality. These quality measures and quality indicators are used to better understand the quality of care provided by health plan care management.

Limitations

The tables provided in this report are for comparison to the statewide rates/numbers only. These comparisons tell us many characteristics about the care managed recipients, however, the data does not tell us the reason(s) why the recipients are enrolled in the care management program. Program variation between plans/programs limits the ability to compare one plan to another. Plans differ in their methods to identify members as eligible for care management services and plans differ in how care management services are carried out. Trends over time for a single plan may be useful, but because plans can change their internal policies, discontinuities in the data may or may not reflect changes in practice. The variation in plan-led care management programs may create differences in results that would not be apparent.

Variation and/or extreme values in results are difficult to interpret where numbers are small. Therefore, results with fewer than 30 eligible individuals are reported in the tables as SS (small sample).

It is important to note that data in this report includes only plan-administered care management. Members of health plans may receive care management services from other providers such as Health Homes, and that information would not be included in this report.

Measures

This report represents the health plan population during 2017 and contains the following four sections:

- **Outreach:** Descriptive statistics and process measures for members contacted for acute/active care management services.
- **Enrollment:** Descriptive statistics and process measures for members enrolled in acute/active care management services.
- **Quality Measures:** quality measures for members enrolled in care management services at any point in the calendar year.
- **HROB:** Pregnancy/birth outcomes for live-birth infants and mothers who triggered for the HROB Care Management programs.

The Outreach, Enrollment, and Quality Measures sections do not include members who are in the HROB care management program; these members are in the HROB section only.

Data presented in this report are often stratified by Clinical Risk Group (CRG). CRGs are a categorical clinical model (developed by 3M®) which assigns each member of a population to a single mutually exclusive risk category. The CRGs provide a way to consider illness and resource utilization of a full range of patient types, including low income, elderly, commercial beneficiaries, and those with disabilities. CRGs use standard claims data, and when available, additional data such as pharmaceutical data and functional health status which is collected longitudinally. Each CRG is clinically meaningful and correlates with health care utilization and cost. The Standard Model set of CRGs was used, which removes the effects of pregnancy/delivery during the calendar year.

We have combined the Standard Model CRGs as shown below. Each CRG group is defined and includes examples of conditions which could qualify a member for that CRG group.

- **Healthy:** Non-User and CRG number 1 (Healthy)
  - **Non-User:** No medical care encounters
  - **CRG #1:** Uncomplicated upper respiratory infection
- **Stable:** CRG numbers 2 (Significant acute disease) and 3 (Single minor chronic disease)
  - **CRG #2:** Pneumonia
  - **CRG #3:** Migraine Headache
- **Simple Chronic:** CRG numbers 4 (Minor chronic disease in multiple organ systems) and 5 (Single dominant or moderate chronic disease)
  - **CRG #4:** Migraine Headache and Hyperlipidemia
  - **CRG #5:** Diabetes
- **Complex Chronic:** CRG numbers 6 (Pairs – significant chronic disease in multiple organ systems) and 7 (Triples – dominant chronic disease in three or more organ systems)

CRG #6: Diabetes and Congestive Heart Failure (CHF)

CRG #7: Diabetes and CHF and Chronic Obstructive Pulmonary Disorder

- **Critical/HIV:** CRG numbers 8 (Malignancies – dominant, metastatic, and complicated) and 9 (Catastrophic conditions, HIV)

  CRG #8: Metastatic Colon Malignancy, under active treatment

  CRG #9: History of Major Organ Transplant

Outreach

Table 1 shows the enrollment in mainstream health plans as of December 31, 2017, and the total number of triggered care management episodes for the entire year of 2017.

Table 1: Enrollment and total episodes for each health plan

	Enrollment	Total Episodes
Affinity Health Plan	222,415	1,479
CDPHP	81,460	2,279
Empire BlueCross BlueShield Health Plus	330,628	10,519
Excellus BlueCross BlueShield	166,552	8,693
Fidelis Care New York, Inc.	1,207,268	15,248
HealthFirst PHSP	956,600	20,035
HealthNow New York Inc.	28,650	4,407
HIP (EmblemHealth)	140,028	4,933
Independent Health's MediSource	58,575	1,883
MetroPlus Health Plan	391,457	6,441
Molina Healthcare	29,722	922
MVP Health Care	210,902	7,894
UnitedHealthCare Community Plan	471,856	31,961
WellCare of New York	106,000	5,862
YourCare Health Plan	40,900	1,384
Statewide	4,444,587	123,940

Plans identify members in need of care management services throughout the year; the State does not identify members for plan-led care management. The first step in the plan-led care management process is outreach, which starts with the trigger. Criteria for care management eligibility and the trigger varies by plan and may include utilization patterns, diagnoses, or other healthcare metrics. Members who trigger and do not enroll are referred to as “triggered only.” In general, the process is as follows:

- Outreach is a process that occurs between the trigger date and when the plan contacts the member. Not all triggered members are contacted by the plans.
- The plan identifies and triggers the eligible member, which initiates the plan’s care management protocol. A member may trigger more than one time during a measurement year. If a Medicaid member changes plans during the calendar year, one or more plans may trigger that member for plan-led care management services.
- Plans may have additional information which can further refine members they attempt to outreach.

Table 2 shows the number of care management triggered episodes, stratified by CRG.

Table 2: Triggered episodes by CRG for each health plan

	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/HIV	
	N	%	N	%	N	%	N	%	N	%
Affinity Health Plan	66	4	59	4	215	15	882	60	257	17
CDPHP	108	5	94	4	399	18	1,432	63	246	11
Empire BlueCross BlueShield Health Plus	257	2	236	2	2,327	22	6,498	62	1,201	11
Excellus BlueCross BlueShield	238	3	219	3	1,521	17	5,632	65	1,083	12
Fidelis Care New York, Inc.	728	5	459	3	1,817	12	8,900	58	3,344	22
HealthFirst PHSP	1,984	10	811	4	5,299	26	9,698	48	2,243	11
HealthNow New York Inc.	283	6	228	5	1,210	27	2,470	56	216	5
HIP (EmblemHealth)	311	6	124	3	852	17	2,997	61	649	13
Independent Health's MediSource	215	11	66	4	247	13	1,058	56	297	16
MetroPlus Health Plan	513	8	236	4	1,197	19	3,335	52	1,160	18
Molina Healthcare	36	4	23	2	213	23	527	57	123	13
MVP Health Care	355	4	376	5	1,447	18	4,929	62	787	10
UnitedHealthCare Community Plan	6,894	22	3,630	11	5,872	18	13,147	41	2,418	8
WellCare of New York	1,492	25	587	10	1,454	25	1,867	32	462	8
YourCare Health Plan	53	4	50	4	209	15	860	62	212	15
Statewide	13,533	11	7,198	6	24,279	20	64,232	52	14,698	12

Note: CRG % by plan may not sum to 100% because of missing data

Members in the Complex Chronic CRG, significant chronic disease in multiple organ systems and dominant chronic disease in three or more organ systems, account for just over 50 percent of triggered Statewide.

Members in the Healthy CRG may have acute events or have onset of new conditions that have not yet been fully represented in the 12 months of data used for the CRG.

Once the member is triggered, the plan’s care management program will attempt to contact the member and offer care management services. This is the outreach phase. Outreach is usually conducted by phone, but occasionally is conducted in-person.

Table 3 shows the percentage of triggered members who were contacted. The percentage contacted is the number of members successfully contacted by the plan divided by the number triggered during the calendar year. The percentage contacted same day, contacted 1-30 days, and contacted 31+ days is the number of members successfully contacted by the plan in each time frame divided by the total number contacted. The percentage of members contacted varies across plans because of differences in eligibility criteria, outreach strategies, and other factors.

Table 3: Triggered members contacted and the contact timing for each health plan

	Triggered	Contacted Total		Contacted Same Day		Contacted 1-30 Days		Contacted 31+ Days	
	N	N	%	N	%	N	%	N	%
Affinity Health Plan	1,479	609	41	218	36	352	58	39	6
CDPHP	2,279	1,998	88	1,619	81	347	17	32	2
Empire BlueCross BlueShield Health Plus	10,519	3,993	38	2,009	50	1,688	42	296	7
Excellus BlueCross BlueShield	8,693	6,726	77	3,633	54	2,260	34	833	12
Fidelis Care New York, Inc.	15,248	11,272	74	3,379	30	3,531	31	4,362	39
HealthFirst PHSP	20,035	6,927	35	711	10	3,481	50	2,735	39
HealthNow New York Inc.	4,407	575	13	228	40	278	48	69	12
HIP (EmblemHealth)	4,933	3,389	69	1,620	48	1,350	40	419	12
Independent Health's MediSource	1,883	1,084	58	917	85	108	10	59	5
MetroPlus Health Plan	6,441	3,727	58	1,591	43	1,413	38	723	19
Molina Healthcare	922	619	67	93	15	406	66	120	19
MVP Health Care	7,894	3,849	49	2,558	66	1,207	31	84	2
UnitedHealthCare Community Plan	31,961	4,334	14	780	18	2,001	46	1,553	36
WellCare of New York	5,862	5,140	88	4,288	83	670	13	182	4
YourCare Health Plan	1,384	920	66	402	44	428	47	90	10
Statewide	123,940	55,162	45	24,046	44	19,520	35	11,596	21

Note: This table excludes 11 enrollments for which contact timeframe could not be calculated.

Statewide, a little less than half of outreach efforts end in a successful contact. Most successful contacts occur within the first month after the member is triggered.

Once the plan contacts the member, the member may choose to engage in care management or decline the offer.

Table 4 shows the percentage of contacted members who enroll in plan-led care management services. The percentage enrolled is the number of members enrolled by the plan divided by the number successfully contacted during the calendar year. The percentage enrolled same day, enrolled 1-30 days, and enrolled 31+ days is the number of members enrolled by the plan in each time frame divided by the total number successfully contacted.

Table 4: Member enrollment and timing for each health plan

	Contacted	Enrolled Total		Enrolled Same Day		Enrolled 1-30 Days		Enrolled 31+ Days	
	N	N	%	N	%	N	%	N	%
Affinity Health Plan	609	529	87	99	19	348	66	82	16
CDPHP	1,998	1,981	99	1,619	82	333	17	29	1
Empire BlueCross BlueShield Health Plus	3,993	1,026	26	313	31	670	65	43	4
Excellus BlueCross BlueShield	6,726	5,233	78	2,598	50	1,415	27	1,220	23
Fidelis Care New York, Inc.	11,272	9,507	84	9,424	99	75	1	8	0
HealthFirst PHSP	6,927	6,346	92	660	10	3,093	49	2,593	41
HealthNow New York Inc.	575	303	53	101	33	159	52	43	14
HIP (EmblemHealth)	3,389	849	25	232	27	399	47	218	26
Independent Health's MediSource	1,084	1,058	98	911	86	103	10	44	4
MetroPlus Health Plan	3,727	2,845	76	638	22	1,420	50	787	28
Molina Healthcare	619	491	79	82	17	323	66	86	18
MVP Health Care	3,849	2,589	67	2,535	98	38	1	16	1
UnitedHealthCare Community Plan	4,334	3,893	90	1,679	43	876	23	1,338	34
WellCare of New York	5,140	941	18	353	38	464	49	124	13
YourCare Health Plan	920	568	62	307	54	199	35	62	11
Statewide	55,162	38,159	69	21,551	56	9,915	26	6,693	18

Note: This table excludes 72 enrollments for which enrollment timeframe could not be calculated.

Statewide, almost 70% of contacted members enroll in health plan care management, with a little more than half enrolling on the day of contact.

Enrollment

Members who are enrolled in plan-led care management services receive interventions. Services and referrals made to the enrolled member are based on an individualized plan of care.

Table 5 shows the number of care management enrolled episodes, stratified by CRG. An episode is a distinct unit of care management with a begin date and an end date. A member may trigger for and enroll in a care management episode more than one time during the measurement year, and therefore have more than one episode during the measurement year. The percentage enrolled in each CRG group is the number of members enrolled in each CRG group divided by the total number enrolled in care management episodes by plan.

Table 5: Enrolled episodes by CRG for each health plan

	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/HIV	
	N	%	N	%	N	%	N	%	N	%
Affinity Health Plan	30	6	17	3	51	10	309	58	125	23
CDPHP	99	5	92	5	362	18	1,287	65	141	7
Empire BlueCross BlueShield Health Plus	19	2	43	4	110	11	615	60	239	23
Excellus BlueCross BlueShield	105	2	87	2	719	14	3,510	67	812	16
Fidelis Care New York, Inc.	146	2	121	1	774	8	6,307	66	2,159	23
HealthFirst PHSP	72	1	64	1	1,049	17	4,047	64	1,114	18
HealthNow New York Inc.	0	-	2	1	42	14	232	77	27	9
HIP (EmblemHealth)	7	1	8	1	95	11	507	60	232	27
Independent Health's MediSource	27	3	19	2	104	10	667	63	241	23
MetroPlus Health Plan	218	8	113	4	384	13	1,314	46	847	29
Molina Healthcare	17	3	17	3	87	18	295	60	75	15
MVP Health Care	118	5	128	5	359	14	1,588	61	396	15
UnitedHealthCare Community Plan	197	5	262	7	456	12	2,335	59	680	17
WellCare of New York	116	12	74	8	200	21	430	46	122	13
YourCare Health Plan	10	2	16	3	55	10	392	69	95	17
Statewide	1,181	3	1,063	3	4,847	13	23,835	62	7,305	19

As in Table 2 Triggered by CRG, the Complex Chronic CRG is the largest group.

Services offered to members within care management programs will differ by plan and by member needs. These differences impact the duration of enrollment and the number of interventions provided to enrolled members. Of the 38,231 enrolled episodes in 2017, 17,742 episodes remained open while 330 enrolled and closed the same day and 20,159 closed one or more days after enrollment. Table 6 shows the median number of days enrolled in care management and mean number of interventions, stratified by the number of days to closure per each episode.

Table 6: Median number of days and mean interventions by episode duration for each health plan

	1-30 Days			31+ Days		
	# Enrolled Episodes	Median days	Mean Interventions	# Enrolled Episodes	Median days	Mean Interventions
Affinity Health Plan	105	23.0	3.6	264	53.0	6.0
CDPHP	196	25.0	3.3	1,188	72.0	6.3
Empire BlueCross BlueShield Health Plus	68	22.5	5.8	646	94.0	8.5
Excellus BlueCross BlueShield	334	16.0	2.9	2,513	155.0	8.8
Fidelis Care New York, Inc.	560	19.0	2.6	2,252	201.0	3.9
HealthFirst PHSP	1,130	19.0	11.8	2,363	63.0	18.5
HealthNow New York Inc.	101	19.0	2.2	140	54.0	3.0
HIP (EmblemHealth)	68	16.0	3.2	383	96.0	6.0
Independent Health's MediSource	249	15.0	2.4	353	73.0	4.0
MetroPlus Health Plan	476	14.0	3.0	1,528	101.0	4.8
Molina Healthcare	34	16.0	4.2	296	82.0	7.8
MVP Health Care	1,438	14.0	4.0	876	51.0	9.5
UnitedHealthCare Community Plan	276	27.0	2.4	1,204	69.0	4.9
WellCare of New York	428	16.0	8.8	412	48.0	11.5
YourCare Health Plan	24	22.0	4.8	254	112.0	9.0
Statewide	5,487	17.0	5.5	14,672	91.0	8.5

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table

The plans vary in both the median number of days enrolled in care management and the mean number of interventions. The variation is largely driven by differences in member's needs to successfully meet the goals of their care plan. One method used to determine the success of care management is to look at the reason the episode closed.

Table 7 shows the number of closed episodes by reason for closure, the median number of days enrolled in care management, and the mean number of interventions for each reason for closure.

Table 7: Reasons for closure

	N	%	Median # days	Mean Interventions
Met program goals	7,536	37	47.0	7.9
Lost to follow up	6,275	31	54.0	9.3
Disenrolled from plan	3,933	20	121.0	6.6
Refused to continue	1,830	9	51.0	4.6
Missing	585	3	122.0	4.7

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table

An episode that met program goals is considered a success. Table 8 shows the percentage of episodes that closed with goals met. The total percentage of closure is the number of episodes that met program goals divided by the total number of episodes that closed. The percentage closed by CRG is the number of episodes closed in each CRG divided by the total number of episodes closed for each health plan.

Table 8: Episodes closed for met program goals by CRG for each health plan

	Total % of Closure	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/HIV	
		N	%	N	%	N	%	N	%	N	%
Affinity Health Plan	69	23	9	12	5	24	9	154	61	40	16
CDPHP	47	22	3	32	5	123	19	447	69	28	4
Empire BlueCross BlueShield Health Plus	48	6	2	13	4	36	10	218	64	70	20
Excellus BlueCross BlueShield	28	10	1	9	1	64	8	507	64	198	25
Fidelis Care New York, Inc.	8	6	3	4	2	21	9	138	59	63	27
HealthFirst PHSP	23	24	3	13	2	212	26	463	57	95	12
HealthNow New York Inc.	21	0	0	0	0	5	10	38	75	8	16
HIP (EmblemHealth)	24	0	0	1	1	14	13	70	64	25	23
Independent Health's MediSource	40	10	4	4	2	39	16	166	69	21	9
MetroPlus Health Plan	35	53	8	40	6	125	18	405	58	75	11
Molina Healthcare	34	4	4	4	4	15	14	71	64	17	15
MVP Health Care	82	87	5	82	4	288	15	1,191	63	254	13
UnitedHealthCare Community Plan	55	125	15	181	22	112	14	295	36	96	12
WellCare of New York	51	50	12	38	9	85	20	199	46	59	14
YourCare Health Plan	39	0	0	3	3	10	9	74	68	22	20
Statewide	37	420	6	436	6	1,173	16	4,436	59	1,071	14

Note: Only episodes that closed in the calendar year are included; episodes with the same enrolled and closed date are excluded from this table

Statewide, most of the members that ended care management because they met episode program goals were in the complex chronic CRG group (almost 60%). Please note, this does not include episodes that are not closed within the measurement year. There may be episodes which successfully meet goals and close in the subsequent year.

Quality Measures

In New York State, quality measures and PQIs are used to measure performance across health plans, identify problems, and ascertain opportunities for improvement. They are used as a first step to establishing performance benchmarks for the care management group. Table 9 shows the quality measure performance among enrolled care management members by CRG. These measures are expressed as the percentage of members meeting the criteria definition for the quality measures.

Table 9: Percent of members meeting quality measures by CRG

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Adult BMI Assessment (ABA)	0	0	0	90	0
Breast Cancer Screening (BCS)	0	0	59	68	61
Cervical Cancer Screening (CCS)	76	84	73	64	64
Chlamydia Screening (CHL)	76	85	77	73	60
Colorectal Cancer Screening (COL)	23	34	44	59	56
Comprehensive Diabetes Care - HbA1c Test (CDC)	0	0	80	89	81
HIV/AIDS Comprehensive Care - Syphilis Screening	0	0	0	43	74
HIV/AIDS Comprehensive Care - Viral Load Monitoring	0	0	0	2	70
HIV/AIDS Comprehensive Care - Engaged in Care	0	0	0	98	94
Medication Management for People with Asthma - 50% Days covered (MMA)	0	0	54	69	79
Medication Management for People with Asthma - 75% Days covered (MMA)	0	0	25	45	52
Antidepressant Medication Management - Acute Phase (84 days) (AMM)	0	31	39	58	53
Antidepressant Medication Management - Continuation Phase (180 days) (AMM)	0	19	27	46	42
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)	0	0	66	63	47
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)	0	0	80	79	67
Initiation of Alcohol and Other Drug Dependence Treatment (IET)	0	0	63	57	56
Engagement of Alcohol and Other Drug Dependence Treatment (IET)	0	0	22	14	11
Follow Up After ED Visit for Alcohol Use - 7 days (FUA)	0	0	32	26	25
Follow Up After ED Visit for Alcohol Use - 30 days (FUA)	0	0	40	35	30
Follow Up After ED Visit for Mental Illness - 7 days (FUM)	0	0	67	70	61
Follow Up After ED Visit for Mental Illness - 30 days (FUM)	0	0	76	83	73

The measures in Table 10 are rates of potentially preventable hospitalizations for specific chronic conditions. These chronic conditions are prevalent for many of the members enrolled in care management. The measures are expressed as the rate of events per 100,000 members.

Table 10: Prevention Quality Indicator rates per 100,000 enrollees by CRG

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Diabetes Short-Term Complications Admission Rate (PQI #1)	0	0	33	1,114	2,565
Diabetes Long-Term Complications Admission Rate (PQI #3)	0	0	16	2,008	2,342
COPD or Asthma in Older Adults Admission Rate (PQI #5)	0	0	152	6,571	9,218
Hypertension Admission Rate (PQI #7)	0	0	16	552	1,498
Heart Failure Admission Rate (PQI #8)	0	0	181	3,186	6,149
Dehydration Admission Rate (PQI #10)	0	0	82	762	1,306
Bacterial Pneumonia Admission Rate (PQI #11)	0	0	82	853	1,816
Urinary Tract Infection Admission Rate (PQI #12)	83	96	33	748	924
Uncontrolled Diabetes Admission Rate (PQI #14)	0	0	0	602	1,370
Asthma in Younger Adults Admission Rate (PQI #15)	0	0	170	1,533	497
Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16)	0	0	0	388	478

Utilization

Utilization of medical services is a major component of the total cost of health care. One of the goals of care management is to lower utilization cost by decreasing emergency department (ED) and inpatient use, while simultaneously increasing outpatient use. The shift from ED and inpatient treatment of acute episodes to outpatient long-term management and prevention is also expected to improve outcomes. Tables 11 through 13 show the utilization rates of emergency department, inpatient care, and outpatient care for anytime during the calendar year that the care management episode occurred.

Emergency department utilization is defined as visits to the ED that do not transfer to an inpatient stay. Inpatient utilization is defined as hospitalizations. Outpatient utilization is defined as ambulatory visits to providers.

Table 11: Emergency Department rates per 1,000 member years by CRG for each health plan

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity Health Plan	778	1,816	1,581	1,731	1,155
CDPHP	866	1,380	1,085	1,992	2,038
Empire BlueCross BlueShield Health Plus	971	1,353	1,401	1,626	1,439
Excellus BlueCross BlueShield	629	1,130	1,103	1,779	1,481
Fidelis Care New York, Inc.	470	578	674	1,392	1,302
HealthFirst PHSP	947	1,422	1,227	2,030	1,815
HealthNow New York Inc.	308	873	860	2,621	3,623
HIP (EmblemHealth)	264	1,895	768	1,033	891
Independent Health's MediSource	766	1,832	1,535	1,868	1,623
MetroPlus Health Plan	812	1,658	1,486	1,641	1,100
Molina Healthcare	503	1,082	926	2,403	3,506
MVP Health Care	1,063	2,235	1,747	2,685	2,924
UnitedHealthCare Community Plan	514	825	847	1,113	956
WellCare of New York	736	1,217	1,072	1,751	1,378
YourCare Health Plan	716	1,591	918	1,828	1,781
Statewide	739	1,330	1,148	1,720	1,474

Table 12: Inpatient rates per 1,000 member years by CRG for each health plan

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity Health Plan	960	941	989	1,887	2,684
CDPHP	213	288	214	706	2,305
Empire BlueCross BlueShield Health Plus	783	790	802	1,448	2,521
Excellus BlueCross BlueShield	498	485	388	836	1,606
Fidelis Care New York, Inc.	252	317	193	789	1,483
HealthFirst PHSP	588	707	402	979	2,239
HealthNow New York Inc.	308	1,091	194	823	1,849
HIP (EmblemHealth)	527	711	296	876	1,999
Independent Health's MediSource	536	644	730	1,382	1,475
MetroPlus Health Plan	303	841	652	1,123	997
Molina Healthcare	251	541	286	1,127	3,977
MVP Health Care	760	641	649	1,121	2,650
UnitedHealthCare Community Plan	546	509	516	872	1,965
WellCare of New York	376	547	439	807	1,265
YourCare Health Plan	239	265	416	837	2,491
Statewide	513	570	448	937	1,779

Table 13: Outpatient rates per 1,000 member years by CRG for each health plan

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity Health Plan	14,650	16,962	16,953	25,117	29,651
CDPHP	4,202	6,589	6,306	11,508	18,133
Empire BlueCross BlueShield Health Plus	9,932	13,025	11,752	17,951	23,264
Excellus BlueCross BlueShield	5,109	8,518	8,075	14,749	14,703
Fidelis Care New York, Inc.	4,711	6,654	8,294	18,407	49,493
HealthFirst PHSP	9,500	12,733	8,519	18,955	23,603
HealthNow New York Inc.	8,308	5,455	5,484	12,809	12,377
HIP (EmblemHealth)	6,989	6,237	9,126	19,297	22,287
Independent Health's MediSource	3,161	5,777	4,957	11,302	10,316
MetroPlus Health Plan	4,861	9,930	8,536	16,823	15,127
Molina Healthcare	4,147	8,754	4,686	11,297	15,035
MVP Health Care	10,327	11,719	11,614	17,860	21,434
UnitedHealthCare Community Plan	7,826	9,586	10,124	17,888	19,187
WellCare of New York	8,403	12,835	11,374	15,652	17,878
YourCare Health Plan	3,940	8,420	8,104	14,489	15,189
Statewide	7,151	9,882	8,884	17,046	19,065

High-Risk Obstetrics (HROB)

The Health Plan CMART has a total of ten program type choices. Not all plans have all ten programs; however, all plans offer the HROB program. This section describes the HROB population served by the plans and the population's health outcomes. The HROB care management program is different from the other program types, because there is a definitive closure day to each person's time in the program (either the birth of the child or two weeks after the birth). In this section, measures are based on women who were referred to an HROB care management group and numbers and percentages are based on a rolling three years. For this report, 2014-2016 data is included.

The HROB care management program is not included in the counts, percentages, or rates in any other section of this Report.

Table 14 shows the distribution of HROB pregnancies across the plans by enrollment. The percentage contacted is the number of pregnancies for which the mothers were successfully contacted divided by the total number of pregnancies triggered during the calendar year. The percentage enrolled is the number of pregnancies for which the mothers enrolled in care management services divided by the total number successfully contacted.

Table 14: High-risk pregnancies triggered, contacted, and enrolled in HROB care management services for each health plan

	Triggered Pregnancies	Contacted		Enrolled*	
		N	%	N	%
Affinity Health Plan	2,401	1,878	78	1,430	76
CDPHP	595	388	65	354	91
Empire BlueCross BlueShield Health Plus	2,201	1,322	60	1,059	80
Excellus BlueCross BlueShield	2,061	1,068	52	648	61
Fidelis Care New York, Inc.	1,347	1,050	78	386	37
HealthFirst PHSP	15,942	3,420	21	3,213	94
HealthNow New York Inc.	216	186	86	184	99
HIP (EmblemHealth)	2,239	1,956	87	828	42
Independent Health's MediSource	2,462	1,503	61	1,418	94
MetroPlus Health Plan	1,434	1,328	93	1,284	97
Molina Healthcare	222	160	72	122	76
MVP Health Care	3,283	1,878	57	1,096	58
UnitedHealthCare Community Plan	2,369	1,689	71	1,586	94
WellCare of New York	140	115	82	115	100
YourCare Health Plan	441	391	89	335	86
Statewide	37,353	18,332	49	14,058	77

* Enrolled N does not include 837 women who enrolled in HROB care management services after infant birth

Although CMART provides basic demographic information about the mothers, it does not provide any demographic data about the infants. The CMART data is matched to the Vital Statistics Birth file to provide additional information on the mother and infant.

Table 15 shows the maternal demographics and other characteristics for members who triggered compared to those who enrolled in HROB care management services during the measurement year.

Table 15: HROB maternal demographics and characteristics

Demographic	Triggered		Enrolled Only	
	N	%*	N	%*
Place of Birth				
USA	19,120	52	7,774	54
Other	17,414	48	6,554	46
Region of NYS				
Central	949	3	447	3
Hudson Valley	2,712	8	1,428	10
Long Island	3,810	11	1,439	10
Northeast	708	2	366	3
NYC	21,651	60	7,428	53
Western	6,174	17	2,960	21
Aid Category				
SSI	809	2	369	3
TANF	35,334	98	13,784	97
Education Level				
Not HS Graduate	10,764	30	4,128	29
HS Graduate	11,537	32	4,513	31
College	14,021	39	5,610	39
Age				
< 18 Years	834	2	300	2
18 - 19 Years	1,328	4	499	3
20 - 29 Years	18,369	50	6,930	48
> 29 Years	16,003	44	6,599	46
Race				
White	10,756	29	4,245	30
Black	8,769	24	3,730	26
Hispanic	2,738	7	1,129	8
Other	14,271	39	5,224	36

Table 15 (Cont.): HROB maternal demographics and characteristics

Demographic	Triggered		Enrolled Only	
	N	%*	N	%*
CRG Group				
Healthy	7,643	21	2,574	18
Stable	9,828	27	3,715	26
Simple Chronic	10,079	28	3,992	28
Complex Chronic	8,134	22	3,690	26
Critical/HIV	527	1	244	2
Risks				
Diabetes	695	2	362	3
Gestational Diabetes	3,787	10	1,616	11
Hypertension	1,829	5	754	5
Gestational Hypertension	2,059	6	956	7
Characteristics				
High-Risk Referral	3,488	10	1,354	9
Hospitalized during Pregnancy	1,857	5	824	6
Number Previous Pregnancies				
0	295	1	89	1
1 - 2	16,052	44	6,316	44
3 - 4	7,645	21	3,192	22
5 +	4,104	11	1,676	12

* Category % may not sum to 100% because of missing data

Note: Population is number of unique mothers per year.

Table 16 reports demographic data for infants born to the women triggering and enrolling in HROB care management.

Table 16: Infant demographics and characteristics

Demographic	Triggered		Enrolled Only	
	N	%	N	%
Sex				
Female	18,259	49	7,273	49
Male	19,093	51	7,621	51
Gestational Age				
< 33 weeks	1,204	3	543	4
33 - 35 weeks	1,943	5	866	6
36 - 38 weeks	11,419	31	4,827	32
39 + weeks	22,787	61	8,659	58
NICU Use	5,781	15	2,478	17
Birthweight				
Very Low Birthweight	814	2	368	2
Low Birthweight	3,418	9	1,466	10
Large for Gestational Age	2,309	6	981	7
Macrosomia	2,498	7	997	7
Modified Kessner Index*				
Intensive	4,346	12	1,864	13
Adequate	19,512	53	7,955	54
Intermediate	9,581	26	3,731	25
Inadequate	2,261	6	708	5
No Care	120	0	39	0
Missing	1,120	3	443	3
Statewide	37,353		14,895	

* Adequacy of prenatal care is defined in terms of timing and quantity of prenatal visits, adjusted for gestation length.

Note: Demographic groups may not total the Statewide total due to missing data.

The amount of time the women are in the HROB program is an important piece of the high-risk pregnancy care management program. The shorter the time the woman is enrolled in the HROB care management program, the less time there is to provide interventions that could increase positive outcomes.

Table 17 shows the number and percentage of time women are enrolled in the HROB program prior to delivery. The percentage of mothers who were triggered and enrolled after the infant was born were most likely members of a mom and infant oriented care management program that occurs during the first two weeks of the infants' lives.

Table 17: Time in care management prior to delivery

	Enrolled Only	
	N*	**%**
Length of Time Before Delivery		
More than 8 Months	37	0
8 Months	530	4
7 Months	1,706	11
6 Months	2,255	15
5 Months	2,346	16
4 Months	2,137	14
3 Months	2,219	15
2 Months	1,665	11
1 Month	1,089	7
Same Day Delivery	74	0
After Delivery	837	6
	Mean	
Mean Number of Months	3.6	

* Number of women enrolled in HROB care management program

Appendix

Quality Measures

Improving Preventive Care

Adult BMI Assessment (ABA): Percent of members, with an outpatient visit, who had their BMI documented during the measurement year or the year prior to the measurement year.

Breast Cancer Screening (BCS): Percent of women who had one or more mammograms to screen for breast cancer at any time two years prior up through the measurement year.

Cervical Cancer Screening (CCS): Percent of women, who had cervical cytology performed every 3 years or who had cervical cytology/human papillomavirus co-testing performed every 5 years.

Chlamydia Screening (CHL): Percent of sexually active young women who had at least one test for Chlamydia during the measurement year.

Colorectal Cancer Screening (COL): Percent of adults who had appropriate screening for colorectal cancer during the measurement year.

Improving Disease-related Care for Chronic Conditions

Comprehensive Diabetes Care - HbA1c Test (CDC): The percent of members with diabetes who received at least one Hemoglobin A1c (HbA1c) test within the year.

HIV/AIDS Comprehensive Care - Syphilis Screening: The percent of members with HIV/AIDS who were screened for syphilis in the past year.

HIV/AIDS Comprehensive Care - Viral Load Monitoring: The percent of members with HIV/AIDS who had two viral load tests performed with at least one test during each half of the past year.

HIV/AIDS Comprehensive Care - Engaged in Care: The percent of members with HIV/AIDS who had two visits for primary care or HIV-related care with at least one visit during each half of the past year.

Medication Management for People with Asthma - 50% Days covered (MMA): The percent of members with persistent asthma who filled prescriptions for asthma controller medications during at least 50% of their treatment period.

Medication Management for People with Asthma - 75% Days covered (MMA): The percent of members with persistent asthma who filled prescriptions for asthma controller medications during at least 75% of their treatment period.

Improving Outcomes for Persons with Mental Illness

Antidepressant Medication Management - Acute Phase (84 days) (AMM): The percent of members who remained on antidepressant medication during the entire 12-week acute treatment phase.

Antidepressant Medication Management - Continuation Phase (180 days) (AMM): The percent of members who remained on antidepressant medication for at least six months.

Follow Up After Hospitalization for Mental Illness - 7 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of discharge.

Follow Up After Hospitalization for Mental Illness - 30 days (FUH): The percent of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 30 days of discharge.

Improving Outcomes for Persons with Substance Use Disorders

Initiation of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment within 14 days of the diagnosis.

Engagement of Alcohol and Other Drug Dependence Treatment (IET): The percent of members who, after the first new episode of alcohol or drug dependence, initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Improving Outcomes for Persons with Emergency Department Visits

Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7 days (FUA): The percent of ED visits for members with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow-up visit for AOD within 7 days of ED visit.

Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 days (FUA): The percent of ED visits for members with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow-up visit for AOD within 30 days of ED visit.

Follow Up After Emergency Department Visit for Mental Illness - 7 days (FUM): The percent of ED visits for members with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days of ED visit.

Follow Up After Emergency Department Visit for Mental Illness - 30 days (FUM): The percent of ED visits for members with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of ED visit.

Prevention Quality Indicators; Reducing Avoidable Hospitalizations

Diabetes Short-Term Complications Admission Rate (PQI #1): Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population; excludes obstetric admissions.

Diabetes Long-Term Complications Admission Rate (PQI #3): Admissions for a principal diagnosis of diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified) per 100,000 population; excludes obstetric admissions.

COPD or Asthma in Older Adults Admission Rate (PQI #5): Admissions with a principal diagnosis of COPD or asthma per 100,000 population, ages 40 and older; excludes obstetric admissions.

Hypertension Admission Rate (PQI #7): Admissions with a principal diagnosis of hypertension per 100,000 population; excludes kidney disease combined with dialysis access procedure admissions, cardiac procedure admissions, and obstetric admissions).

Heart Failure Admission Rate (PQI #8): Admissions with a principal diagnosis of heart failure per 100,000 population; excludes cardiac procedure admissions and obstetric admissions.

Dehydration Admission Rate (PQI #10): Admissions with a principal diagnosis of dehydration per 100,000 population; excludes obstetric admissions.

Bacterial Pneumonia Admission Rate (PQI #11): Admissions with a principal diagnosis of bacterial pneumonia per 100,000 population; excludes sickle cell or hemogobin-5 admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Urinary Tract Infection Admission Rate (PQI #12): Admissions with a principal diagnosis of urinary tract infection per 100,000 population; excludes kidney or urinary tract disorder admissions, other indications of immunocompromised state admissions, and obstetric admissions.

Uncontrolled Diabetes Admission Rate (PQI #14): Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 population; excludes obstetric admissions.

Asthma in Younger Adults Admission Rate (PQI #15): Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years; excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system and obstetric admissions.

Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16): Admissions for any-listed diagnosis of diabetes and any-listed procedure of lower-extremity amputation per 100,000 population; excludes any-listed diagnosis of traumatic lower-extremity amputation admissions, toe amputation admissions, and obstetric admissions.

Reducing Utilization Associated with Avoidable IP stays and ED visits

Ambulatory Care - Emergency Department (AMB-ED): Utilization of ambulatory care ED visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

Ambulatory Care - Outpatient (AMB-OP): Utilization of ambulatory care OP visits per 1,000 member years. Does not include mental health- or chemical dependency-related services.

Inpatient Utilization (IPU): Utilization of total acute inpatient stays per 1,000 member years. Does not include mental health- or chemical dependency-related inpatient stays.

Mainstream Plan Covered Counties

Counties* in NYS each Mainstream plan cover			
Affinity Health Plan			
Bronx	Kings	Nassau	New York
Orange	Queens	Richmond	Rockland
Suffolk	Westchester		
CDPHP			
Albany	Broome	Columbia	Fulton
Greene	Montgomery	Rensselaer	Saratoga
Schenectady	Schoharie	Tioga	Washington
Empire BlueCross BlueShield Health Plus			
Bronx	Kings	Nassau	New York
Putnam	Queens	Richmond	
Excellus BlueCross BlueShield			
Broome	Herkimer	Livingston	Monroe
Oneida	Ontario	Orleans	Otsego
Seneca	Wayne	Yates	
Fidelis Care New York, Inc.			
Albany	Allegany	Bronx	Broome
Cattaraugus	Cayuga	Chautauqua	Chemung
Chenango	Clinton	Columbia	Cortland
Delaware	Dutchess	Erie	Essex
Franklin	Fulton	Genesee	Greene
Hamilton	Herkimer	Jefferson	Kings
Lewis	Livingston	Madison	Monroe
Montgomery	Nassau	New York	Niagara
Oneida	Onondaga	Ontario	Orange
Orleans	Oswego	Otsego	Putnam
Queens	Rensselaer	Richmond	Rockland
Saratoga	Schenectady	Schoharie	Schuyler
Seneca	St. Lawrence	Steuben	Suffolk
Sullivan	Tioga	Tompkins	Ulster
Warren	Washington	Wayne	Westchester
Wyoming	Yates		
HealthFirst PHSP			
Bronx	Kings	Nassau	New York
Queens	Richmond	Suffolk	
HealthNow New York, Inc.			
Allegany	Cattaraugus	Chautauqua	Erie
Orleans	Wyoming		

Counties* in NYS each Mainstream plan cover (continued)			
HIP (EmblemHealth)			
Bronx	Kings	New York	Nassau
Queens	Richmond	Suffolk	Westchester
Independent Health's MediSource			
Erie			
MetroPlus Health Plan			
Bronx	Kings	New York	Queens
Staten Island			
Molina Healthcare			
Cortland	Onondaga	Tompkins	
MVP Health Care			
Albany	Columbia	Dutchess	Genesee
Greene	Jefferson	Lewis	Livingston
Monroe	Oneida	Ontario	Orange
Putnam	Rensselaer	Rockland	Saratoga
Schenectady	Sullivan	Ulster	Warren
Washington	Westchester		
UnitedHealthCare Community Plan			
Albany	Bronx	Broome	Cayuga
Chautauqua	Chemung	Chenango	Clinton
Columbia	Dutchess	Erie	Essex
Franklin	Fulton	Genesee	Greene
Herkimer	Jefferson	Kings	Lewis
Livingston	Madison	Monroe	Nassau
New York	Niagara	Oneida	Onondaga
Ontario	Orange	Orleans	Oswego
Queens	Rensselaer	Richmond	Rockland
Schenectady	Seneca	St. Lawrence	Suffolk
Tioga	Ulster	Warren	Wayne
Westchester	Wyoming	Yates	
WellCare of New York			
Albany	Bronx	Kings	Dutchess
Erie	New York	Nassau	Niagara
Orange	Queens	Rensselaer	Rockland
Schenectady	Schuyler	Steuben	Ulster
YourCare Health Plan			
Allegany	Cattaraugus	Chautauqua	Erie
Monroe	Ontario	Wyoming	

* Not every plan may be accepting new enrollment. Please call the plan to confirm availability.