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

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

HEALTHFIRST PHSP, INC.

Reporting Year 2018

FINAL REPORT

Published April 2020

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Acronyms Used in This Report

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

I. I. About This Report

Purpose of This Report

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

Structure of This Report

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

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

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

II. II. MCO Corporate Profile

Healthfirst PHSP, Inc. (Healthfirst) is a regional, not-for-profit prepaid health services plan (PHSP) that serves Medicaid (MCD), Health and Recovery Plan (HARP), and Child Health Plus (CHP) populations. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

Healthfirst Web Page: https://www.healthfirst.org/

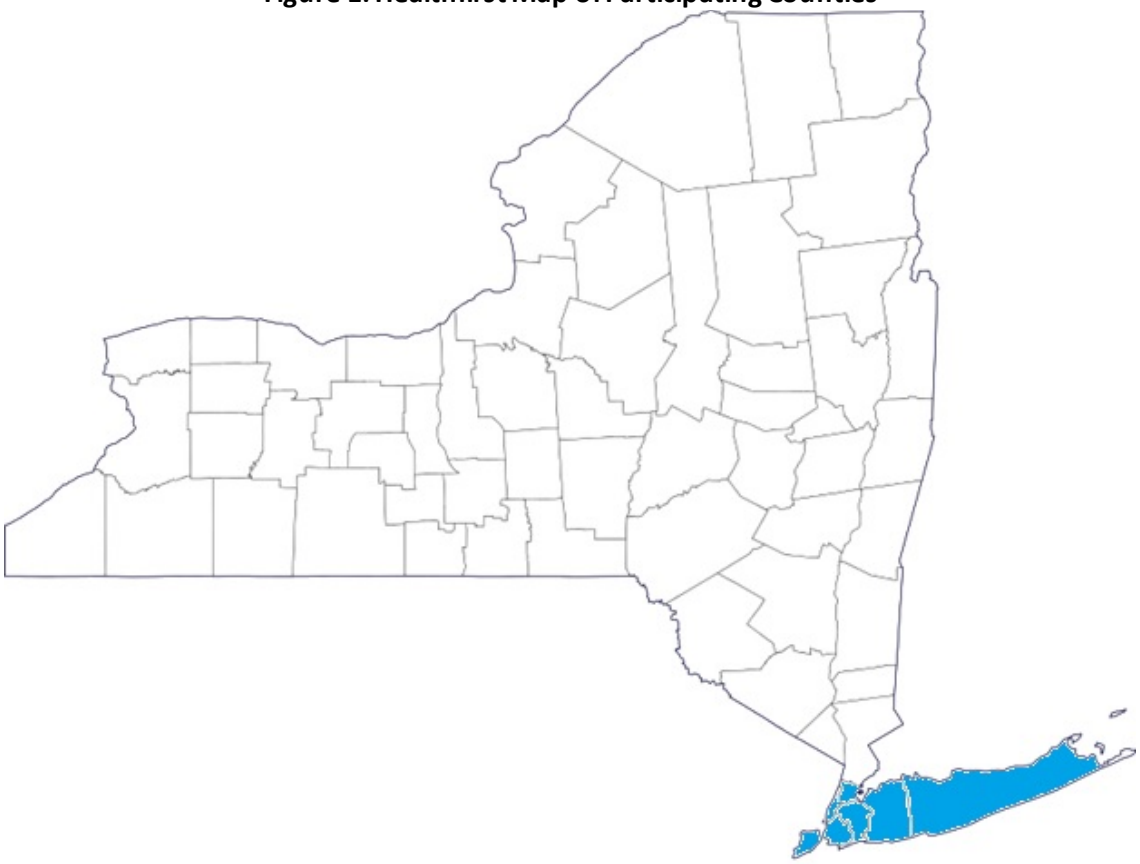
*Participating Regions and Products			
New York City:	MCD	CHP	HARP
Long Island:	MCD	CHP	HARP

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

Region Definitions

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

Figure 1: Healthfirst Map of Participating Counties



III. III. Enrollment and Provider Network

Enrollment

Table 1 displays enrollment for the MCO's Medicaid product line for 2016, 2017, and 2018, as well as the percent change from the previous year. Enrollment has increased from 2017 to 2018 by a rate of .5%. Healthfirst's membership represents 21.3% of total statewide Medicaid enrollment. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 2** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2016-2018

	2016	2017	2018
Number of Members	906,628	921,471	925,998
% Change from Previous Year	-4.8%	1.6%	.5%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	20.8%	21.0%	21.3%

Data Source: NYS OHIP Medicaid DataMart

[1] The statewide totals include MCOs that were operational during the measurement year, but did not have enough members to report sufficient data.

Table 2: Enrollment in Other Product Lines—2016-2018

	2016	2017	2018
CHP	34,750	40,650	51,285

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: Healthfirst Enrollment Trends—All Product Lines

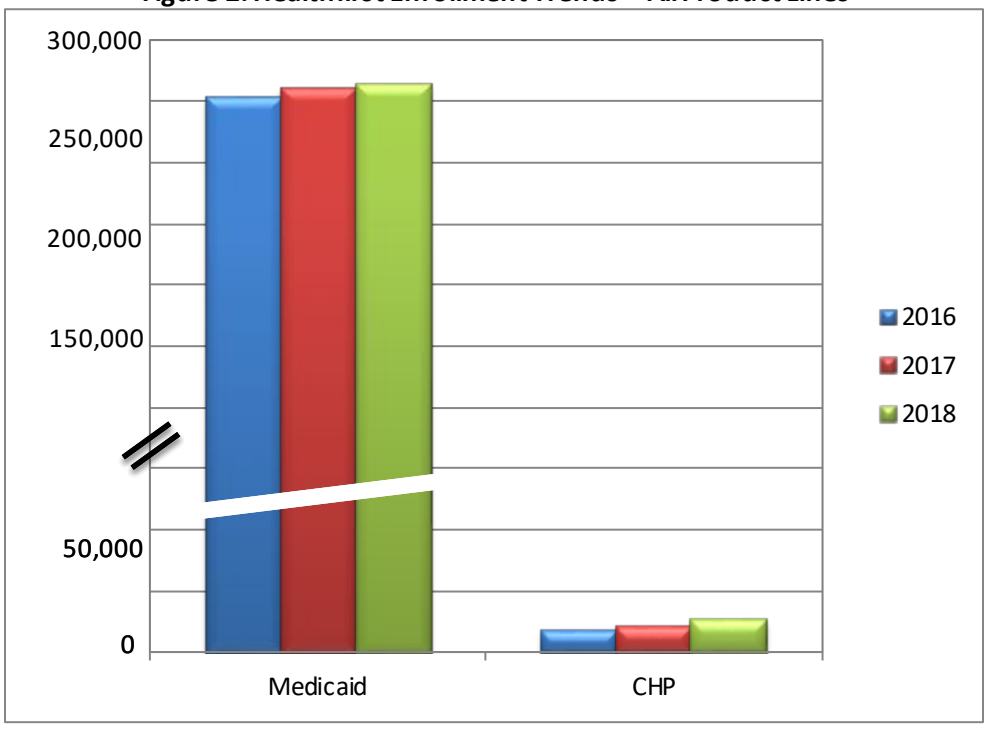


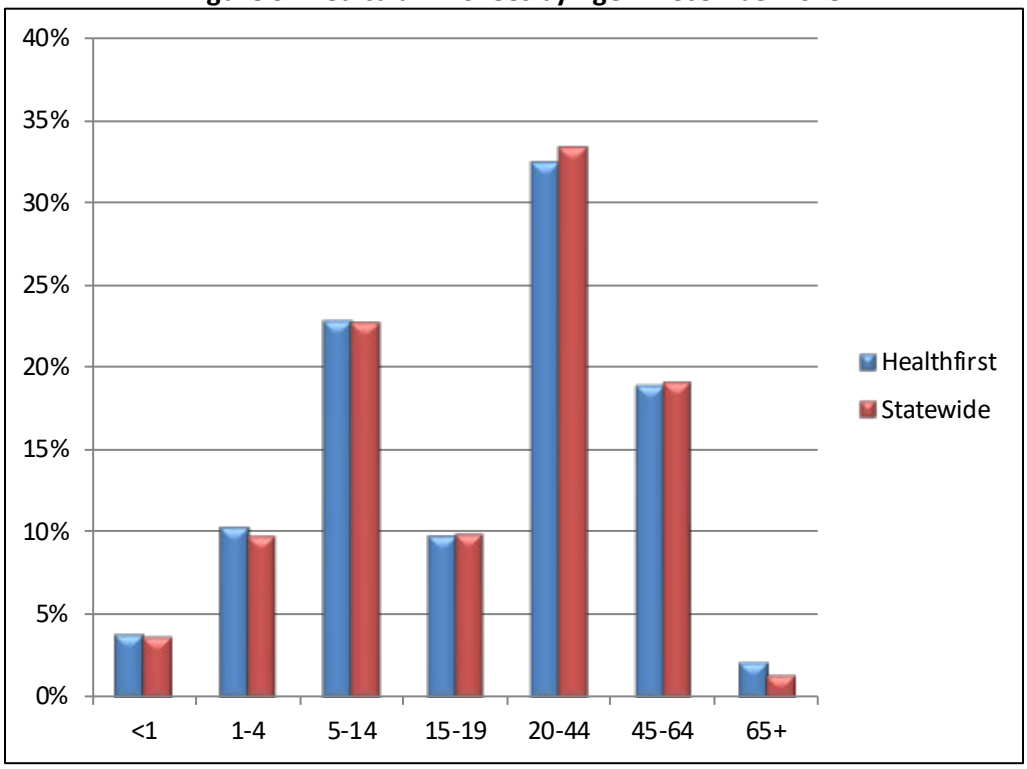
Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average. Healthfirst's rates were above the SWA for members aged 65 and over.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	17,995	17,036	35,031	3.8%	3.6%
1-4	48,370	46,334	94,704	10.3%	9.7%
5-14	107,559	102,580	210,139	22.8%	22.8%
15-19	45,194	44,719	89,913	9.7%	9.9%
20-44	113,313	185,894	299,207	32.4%	33.3%
45-64	73,990	100,804	174,794	18.9%	19.1%
65 and Over	7,451	12,144	19,595	2.1% ▲	1.4%
Total	413,872	509,511	923,383		
Under 20	219,118	210,669	429,787	46.5%	46.1%
Females 15-64		331,417		35.9%	34.7%

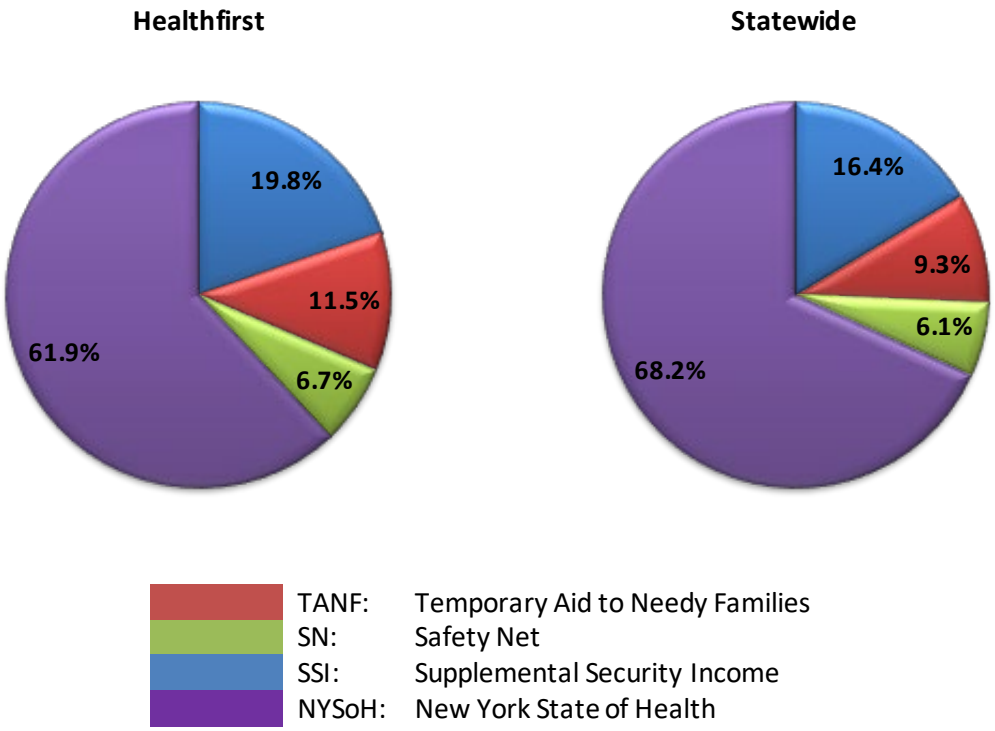
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.
Data Source: NYS OHIP Medicaid DataMart

Figure 3: Medicaid Enrollees by Age—December 2018



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

Figure 4: Medicaid Enrollees by Aid Category—December 2018



Provider Network

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

Table 4 displays HEDIS®/QARR Board Certification rates of providers in the MCO's network for 2016 through 2018, as well as the statewide averages. The table also indicates whether the MCO's rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average. The MCO's rates trended downwards for all provider types in 2018. For detailed information regarding board certification of providers, please see the *External Quality Review All Plan Summary Technical Report for: New York State Medicaid Managed Care Organizations*[1].

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

Provider Type	2016		2017		2018	
	Healthfirst	Statewide Average	Healthfirst	Statewide Average	Healthfirst[1]	Statewide Average
			Medicaid/CHP			
Family Medicine	73%	71%	72%	72%	69%	74
Internal Medicine	77% ▲	75%	80% ▲	76%	74%	76
Pediatricians	82% ▲	78%	81%	79%	77%	80
OB/GYN	82% ▲	75%	81% ▲	77%	70%	80
Geriatricians	71%	63%	73% ▲	63%	64%	63
Other Physician Specialists	83% ▲	75%	83% ▲	76%	77%	77

[1]Level of significance was unaudited.

Table 5 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2018 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼. Healthfirst had rates above the SWA for OB/GYN Specialists and Other Specialists.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	5,682	14.8	19.5
Pediatrics	1,711	4.4	3.8
Family Practice	1,118	2.9	3.5
Internal Medicine	2,820	7.3	8.4
Other PCPs	33	0.1	3.8
OB/GYN Specialty[1]	1,879	4.9 ▲	3.8
Behavioral Health	3,831	9.9	17.2
Other Specialties	20,414	53.0 ▲	46.0
Non-PCP Nurse Practitioners	3,517	9.1	8.7
Dentistry	3,192	8.3	4.9
Total	38,515		

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

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

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

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

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

	HealthFirst			Statewide		
Specialty Type	**Ratio of Enrollees to Providers**	**Total Number of FTEs**	**Ratio of Enrollees to FTEs**	**Median Ratio of Enrollees to Providers[1]**	**Total Number of FTEs**	**Median Ratio of Enrollees to FTEs**
Medicaid						
Primary Care Providers	163:1 ▲	5522	167:1 ▲	42:1	80986	39:1
Pediatrics (Under age 20)	251:1 ▲			70:1		
OB/GYN (Females age 15-64)	176:1 ▲			59:1		
Behavioral Health	242 ▲			73:1		

Data Source: Derived ratios calculated from NYS OHIP Medicaid DataMart and NYS Provider Network Data System (PNDS).

[1] The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers.

The number of Medicaid PCPs with an "Open Panel" is presented in **Table 7** for the fourth quarters of 2016 through 2018. Panels are considered "open" if a provider has fewer than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼. Healthfirst's rates have trended upwards from 2016 to 2018.

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

	2016			2017			2018		
	HealthFirst		Statewide	HealthFirst		Statewide	HealthFirst		Statewide
	Number	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**	**Number**	**% of Providers**	**% of Providers**
Medicaid									
Providers with Open Panel	6452	55.3	85.0	8035	70.3	95.7	8461	72.8	90.8

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

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

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

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

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

For call type categories in which compliance is below the 75% threshold, MCOs will receive a Statement of Deficiency (SOD) issued by the NYSDOH and will be required to develop a Plan of Correction (POC). POCs must be approved by the NYSDOH before implementation. Following an allowable time period for MCOs to execute their POCs, a resurvey of the failed providers is conducted.

Table 8: displays the Healthfirst provider participation rate. The total number of providers surveyed (or sample size) is based on MCO Medicaid enrollment size and provider network size. The total number of compliant providers is the number of providers that will be included in the Appointment Availability and After-Hours Access-Survey.

Table 8: MCO Provider Participation Rate

Total Providers Surveyed	Compliant Providers	Participation Rate
200	173	**86.5%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 167 providers (total number of providers who were compliant for participation (173), less total number of providers with closed panels (6)). The MCO performed above the threshold for Routine and Non-Urgent call types.

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

Region	Call Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	21	21	100.0%
	Pediatrician	20	20	100.0%
	OB/GYN	15	14	93.3%
	Total Routine	**56**[2]	**55**	**98.2%**
Non-Urgent "Sick"	Internist/Family Practitioner	20	20	100.0%
	Pediatrician	19	17	89.5%
	OB/GYN	17	16	94.1%
	Total Non-Urgent	**56**[3]	**53**	**94.6%**
After-Hours Access	Internist/Family Practitioner	18	10	55.6%
	Pediatrician	19	14	73.7%
	OB/GYN	16	11	68.8%
	Total After-Hours	**53**	**35**	**66.0%**

[1] Timeliness was not considered when determining appointment availability rates.
[2] Final routine sample less excluded providers. One (1) Provider was excluded because the survey could not be completed.
[3] Final non-urgent sample less excluded providers. One (1) Provider was excluded because the survey could not be completed.

IV. Utilization

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

Encounter Data

Table 10 depicts selected Medicaid encounter data for 2016 through 2018. Rates for this period are also compared to the statewide averages. For this table, rates significantly above the statewide average are indicated by ▲, while rates significantly below the statewide average are indicated by ▼.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	Healthfirst	Statewide Average	Healthfirst	Statewide Average	Healthfirst	Statewide Average
PCPs and OB/GYNs	5.28 ▲	3.85	4.55 ▲	3.56	2.82 ▼	3.50
Specialty	2.67	2.45	2.52	2.30	2.28	2.33
Emergency Room	0.61	0.54	0.60	0.55	0.61	0.53
Inpatient Admissions	0.15	0.14	0.14	0.14	0.10	0.13
Dental	0.99	1.03	0.98	1.02	0.91	1.02

Data Source: NYSDOH DataMart
PMPY: Per Member Per Year

Health Screenings

In accordance with 13.6(a) (ii) of the Medicaid Managed Care and Family Health Plus Model Contract, MCOs must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone, or by mail, and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 11** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2016 through 2018, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼. The MCO's rates have increased from 2016 to 2018.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	HealthFirst	SWA	HealthFirst	SWA	HealthFirst	SWA
	Medicaid					
Enrollee Health Screenings	15.1%	12.3%	16.5%	12.7%	17.6%	13.2%

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentile. **Table 12** lists the Use of Services rates for 2016 through 2018, as well as the statewide averages for 2018. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼). From 2016 to 2018, the MCO's rate for *Inpatient Utilization (PTMY)* has trended downwards.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 Statewide Average**
Outpatient Utilization (PTMY)				
Visits	5,509	5,489	5,610	5,317
ER Visits	613	545	532	492
Inpatient ALOS				
Medicine	4.0	4.2	4.3	4.5
Surgery	5.9	6.2	8.1	7.0
Maternity	3.0	3.0	3.0	2.9
Total	4.1	4.2	4.4	4.4
Inpatient Utilization (PTMY)				
Medicine Cases	38	35	33	30
Surgery Cases	16	15	12	12
Maternity Cases	38 ▲	37	36	32
Total Cases	84	79	71	66

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

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

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

The HEDIS® Final Audit Report prepared for HealthFirst indicated that the MCO had no significant issues in any areas related to reporting. HealthFirst demonstrated compliance all areas of Information Systems. In IS Standard 6.0 (data preproduction processing), there was a minimal impact finding noted by the auditor. An issue discovered during HEDIS 2018 was the Quantity Dispensed field was incorrectly hardcoded which affected the UOD and AMR measures. This was corrected for HEDIS 2019. HealthFirst demonstrated compliance with all areas of Measure Determination. .The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the five measures validated, as well.

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

HEDIS®/QARR Performance Measures

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

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

These domains were further categorized into Quality Indicators (Prevention and Screening, Acute and Chronic Care, and Behavioral Health) and Access/Timeliness Indicators (Utilization and Access to Care). Each of these domains include a variety of HEDIS®/QARR and CAHPS® measures, as well as several NYS-specific QARR measures for areas of importance to the State and for which there were no defined HEDIS® or other national measures. Many of these measures were calculated through the MCO's HEDIS® data submissions, while others are based on encounter data, prenatal data, and QARR submissions reported by the MCOs to the NYSDOH.[2]

Quality Indicators

This section of the report explores the quality of health care services provided by the MCOs. Performance in the Effectiveness of Care domain is examined.

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

Table 13a displays the HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Prevention and Screening measures, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, the MCO had rates above the SWA for 6 out of 14 measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Adult BMI Assessment	87	84	92	**89**
WCC—BMI Percentile	70 ▼	79 ▼	84	**86**
WCC—Counseling for Nutrition	82	81	82	**83**
WCC—Counseling for Physical Activity	67	69	73	**74**
Childhood Immunizations—Combo 3	75	80 ▲	79 ▲	**73**
Lead Screening in Children	91 ▲	90	92 ▲	**89**
Adolescent Immunizations—Combo 2[2]		51 ▲	54 ▲	**43**
Adolescents—Alcohol and Other Drug Use[3]	72	63	68	**70**
Adolescents—Depression[3]	60	54	68	**67**
Adolescents—Sexual Activity[3]	66	63	67	**67**
Adolescents—Tobacco Use[3]	71	64	69	**74**
Breast Cancer Screening	77 ▲	77 ▲	76 ▲	**71**
Colorectal Cancer Screening	64 ▲	69 ▲	73 ▲	**63**
Chlamydia Screening (Ages 16-24)	81 ▲	81 ▲	82 ▲	**76**

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

BMI: Body Mass Index; WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents; COPD: Chronic Obstructive Pulmonary Disease

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

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2017, *Combination 2* is reported, as it includes the HPV component.

[3] NYS-specific measure.

Table 13b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for Acute and Chronic Care, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Healthfirst's rates have trended upwards for 75% of the measures.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	86 ▼	86 ▼	88 ▼	**91**
Spirometry Testing for COPD	63 ▲	65 ▲	68 ▲	**56**
Use of Imaging Studies for Low Back Pai	100 ▲	81 ▲	82 ▲	**77**
Pharmacotherapy Management for COPD—Bronchodilators	86	89	90	**89**
Pharmacotherapy Management for COPD—Corticosteroids	62 ▼	68 ▼	71 ▼	**76**
Medication Management for People with Asthma 50% (Ages 19-64)	68	70	71	**71**
Medication Management for People with Asthma 50% (Ages 5-18)	53	59 ▲	59	**59**
Asthma Medication Ratio (Ages 19-64)	50 ▼	51 ▼	62 ▲	**60**
Asthma Medication Ratio (Ages 5-18)	55 ▼	54 ▼	67 ▼	**68**
Persistence of Beta-Blocker Treatment After a Heart Attack	82	84	79	**80**
CDC—HbA1c Testing	91	93	95 ▲	**92**
CDC—HbA1c Control (<8%)	57	59	64	**60**
CDC—Eye Exam Performed	68	70	72 ▲	**67**
CDC—Nephropathy Monitor	91	92	94	**92**
CDC—BP Controlled (<140/90 mm Hg)	64	61	64	**66**
Drug Therapy for Rheumatoid Arthritis	78	82	84	**83**
Monitor Patients on Persistent Medications—Total Rate	92	92	92	**92**
Appropriate Treatment for URI	95 ▲	95	95	**95**
Avoidance of Antibiotics for Adults with Acute Bronchitis	34 ▲	38 ▲	40 ▲	**36**
HIV Viral Load Suppression[2,3]	78	78	77	**77**
Flu Shots for Adults (Ages 18-64)[4]	44	48		
Advising Smokers to Quit[4]	76	77		
Smoking Cessation Medications[4]	56	50		
Smoking Cessation Strategies[4]	45	38		

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

COPD: Chronic Obstructive Pulmonary Disease; CDC: Comprehensive Diabetes Care; BP: Blood Pressure; URI: Upper Respiratory Infection

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

[2] NYS-specific measure.

[3] The *HIV Viral Load Suppression* measure was introduced in Reporting Year 2017.

[4] CAHPS® measure.

Behavioral Health

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

Table 13c displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Behavioral Health domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). In 2018, Healthfirst had 3 out of 9 measures with rates above the SWA.

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

	Medicaid/CHP			
Measure	**2016**	**2017**	**2018**	**2018 SWA**
Antidepressant Medication Management—Effective Acute Phase	52	53	54	**53**
Antidepressant Medication Management—Effective Continuation Phase	37	38	37	**37**
Follow-Up Care for Children on ADHD Medication—Initiation	68 ▲	66 ▲	67 ▲	**59**
Follow-Up Care for Children on ADHD Medication—Continue	78 ▲	78 ▲	74 ▲	**66**
Follow-Up After Hospitalization for Mental Illness—30 Days	84 ▲	85 ▲	73	**74**
Follow-Up After Hospitalization for Mental Illness—7 Days	72 ▲	74 ▲	62	**63**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	85 ▲	85 ▲	86 ▲	**82**
Diabetes Monitoring for People with Diabetes and Schizophrenia	83	84	82	**80**
Antipsychotic Medications for Schizophrenia	59	61	63	**63**

ADHD: Attention-Deficit/Hyperactivity Disorder

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

Access/Timeliness Indicators

This section of the report examines the accessibility and timeliness of health care services provided by the MCO to Medicaid recipients. CMS defines "access" in Federal Regulation 42 CFR §438.320 as *"the timely use of services to achieve optimal outcomes, as evidenced by managed care 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.[3]

Table 14a displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Utilization domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼). Healthfirst has rates above the SWA for three consecutive years.

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

Measure	2016	2017	2018	2018 Statewide Average
		Medicaid/CHP		
Well-Child Visits—First 15 Months	66 ▲	71 ▲	84 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	88 ▲	89 ▲	89 ▲	**86**
Adolescent Well-Care Visits	72 ▲	73 ▲	72 ▲	**68**

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

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

Access to Care

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

Table 14b displays HEDIS®/QARR performance rates for Measurement Years 2016, 2017, and 2018 for the Access to Care domain, as well as the statewide averages (SWAs) for 2018. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all MCOs for that measure (indicated by ▼). Healthfirst had rates above the SWA for three consecutive years for all age groups in the *Adults' Access to Preventative/Ambulatory Services* measure.

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

Measure	Medicaid/CHP			
	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	94% ▼	93% ▼	96 ▲	**97**
25 Months-6 Years	95% ▲	94%	94	**94**
7-11 Years	97%	97%	97	**97**
12-19 Years	96% ▲	95%	95	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	85% ▲	84% ▲	84 ▲	**81**
45-64 Years	92% ▲	92% ▲	91 ▲	**89**
65+ Years	92% ▲	93% ▲	93 ▲	**91**
Access to Other Services				
Timeliness of Prenatal Care	88%	90%	91	**88**
Postpartum Care	73%	75%	71	**70**
Annual Dental Visit[2]	57% ▼	58% ▼	59 ▼	**61**

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

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

NYSDOH-Calculated Prenatal Care Measures

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, and from NYSDOH's Vital Statistics Birth File. Since some health events, such a low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. Vital statistics data are used in the risk adjustment. **Table 15** presents prenatal care rates calculated by the NYSDOH for QARR 2017 through 2019 for the Medicaid product line. In addition, the table indicates if the MCO's rate was significantly better than the regional average (indicated by ▲) or if the MCO's rate was significantly worse than the regional average (indicated by ▼).

Table 15: QARR Prenatal Care Rates—2017-2019

Measure	2017		2018		2019	
	Healthfirst	Regional Average	Healthfirst	Regional Average	Healthfirst	Regional Average
NYC						
Risk-Adjusted Low Birth Weight[1]	N/A	N/A	6.2	6.3	-	-
Prenatal Care in the First Trimester	74 ▼	74	74 ▼	76	74 ▼	75
Risk-Adjusted Primary Cesarean Delivery[1]	N/A	N/A	14	14	-	-
Vaginal Birth After Cesarean	N/A	N/A	14.8 ▼	18.4	-	-
ROS						
Risk-Adjusted Low Birth Weight[1]	N/A	N/A	8.1	7.0	-	-
Prenatal Care in the First Trimester	78	74	78	74	78	74
Risk-Adjusted Primary Cesarean Delivery[1]	N/A	N/A	11	13	-	-
Vaginal Birth After Cesarean	N/A	N/A	12.3	14.3	-	-

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

NYC: New York City; ROS: Rest of State

[1] A low rate is desirable for this measure.

Member Satisfaction

In 2018, the Child CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 16** displays the question category, the MCO's rates, and the statewide averages for Measurement Years 2014, 2016, and 2018. The table also indicates whether the MCO's rate was significantly better than the statewide average (indicated by ▲) or whether the MCO's rate was significantly worse than the statewide average (indicated by ▼). Healthfirst's rates have trended upwards for 33% of the measures.

Table 16: CAHPS®—2013, 2016, 2018

Measure	2014		2016		2018	
	Healthfirst	Statewide Average	Healthfirst	Statewide Average	Healthfirst	Statewide Average
			Medicaid/CHP			
Getting Care Needed[1]	81	**83**	79 ▼	**85**	83 ▼	**84**
Getting Care Quickly[1]	81 ▼	**87**	87	**88**	83	**88**
Customer Service[1]	84	**82**	88	**86**	81	**86**
Coordination of Care[1]	70	**74**	76	**74**	73	**75**
Collaborative Decision Making[1]	50	**53**	73	**74**	72	**76**
Rating of Personal Doctor[1]	89	**89**	89	**89**	89	**90**
Rating of Specialist	78	**81**	83	**83**	87	**84**
Rating of Healthcare	83	**85**	86	**86**	87	**87**
Satisfaction with Provider Communication[1]	90	**93**	92	**93**	92	**93**
Rating of Counseling/Treatment	61	**64**	67	**68**	*SS*	**69**
Rating of Health Plan—High Users	84	**84**	85	**85**	90	**84**
Overall Rating of Health Plan	86 ▲	**83**	87	**85**	85	**85**

[1] These indicators are composite measures.

SS: Sample size too small to report

Quality Performance Matrix—Measurement Year 2018

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

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

Table 17: Quality Performance Matrix—Measurement Year 2018

Trend*	Percentile Ranking 0 to 49%	50% to 89%	90 to 100%
↑	**C**	**B** Asthma Medication Ratio (Ages 5-64)	**A**
No Change	**D** Annual Dental Visits (Ages 2-18) Antidepressant Medication Management-Effective Continuation Phase Treatment Controlling High Blood Pressure Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 7 Days Follow-Up After Emergency Department Visit for Mental Illness Within 7 Days Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement of AOD - Total Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD - Total Statin Therapy for Patients with Cardiovascular Disease - Adherent Weight Assessment for Children and Adolescents - BMI Percentile Weight Assessment for Children and Adolescents - Counseling for Nutrition Weight Assessment for Children and Adolescents - Counseling for Physical Activity Initiation of Pharmacotherapy upon New Episode of Opioid Dependence Viral Load Suppression	**C** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Antidepressant Medication Management-Effective Acute Phase Treatment Childhood Immunization Status (Combo 3) Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase Medication Management for People with Asthma 50% Days Covered (Ages 5-64) Medication Management for People with Asthma 75% Days Covered (Ages 5-64) Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits) Postpartum Care Timeliness of Prenatal Care	**B** Adolescent Immunization (Combo2) Breast Cancer Screening Cervical Cancer Screening Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Colon Cancer Screening Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds Managing Diabetes Outcomes - Poor HbA1C Control Metabolic Monitoring for Children and Adolescents on Antipsychotics Monitoring Diabetes - Eye Exams Use of Spirometry Testing in the Assessment and Diagnosis of COPD Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life
↓	**F**	**D**	**C**

Performance Improvement Project

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

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

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

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

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

Healthfirst's 2017-2018 PIP topic was *"Improving the Early Identification and Management of At-Risk Pregnant Members—A Pilot Study".* During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- Member education on 17P, perinatal depression, smoking cessation, and postpartum contraception.

Provider-Focused Interventions:

- Notification to providers regarding members who screened positively for depression or tobacco use and were not interested in a mental health or NYS Quitline referral.
- Provider group education on best practices, clinical guidelines, smoking cessation benefits, billing codes for screening, formulary, and resources .

MCO-Focused Interventions:

- Enhanced internal and external processes to identify, manage, and refer at-risk pregnant women who were eligible for 17P, were depressed, and/or smoked.
- Technological advancements in the development of screening tools for depression and tobacco use.
- Augmented care coordination to facilitate education and referrals for our at-risk pregnant members.

Table 18 presents a summary of Healthfirst's 2017-2018 PIP. Healthfirst demonstrated an improvement for 10 out of 12 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Received at least one 17P injection	2%	3%	5%	Demonstrated improvement
Depression Screening	79%	88%	82%	Demonstrated improvement
Tobacco Screening	95%	88%	97%	Performance declined
Frequency Prenatal Care	67%	N/A*	70%	Not measurable due to small denominators
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	13%	15%	16%	Demonstrated improvement
Age 15-20 years; within 60 days	22%	29%	25%	Demonstrated improvement
Age 21-44 years; within 3 days	11%	14%	14%	Demonstrated improvement
Age 21-44 years; within 60 days	22%	27%	25%	Demonstrated improvement
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	1%	3%	4%	Demonstrated improvement
Age 15-20 years; within 60 days	8%	11%	11%	Demonstrated improvement
Age 21-44 years; within 3 days	0.3%	1%	3%	Demonstrated improvement
Age 21-44 years; within 60 days	6%	9%	9%	Demonstrated improvement

LARC: Long-Acting Reversible Contraception

*The final rate is "N/A" because there were no pregnant members identified in the 2018 denominator. The corresponding baseline and interim rates were based on denominators of 3 and 2, respectively.

Health Disparities

For this year's technical report, the NYS EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

1. Characterization, identification, or analysis of the MCO's Medicaid population according to at-risk characteristics.
2. Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
3. Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
4. Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
5. Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

HealthFirst reported that the following activities were performed in 2018 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population:

- HealthFirst identified, analyzed and implemented initiatives regarding their Medicaid population by the following at-risk characteristics:
    - **Members Living with HIV/AIDS:** Healthfirst identified nearly 10,000 members living with HIV in our mainstream Medicaid managed care population. These members are more likely to be Black or Hispanic men. Members living with HIV were found to be more likely to experience multiple comorbidities than other Healthfirst members (89% vs. 66%) and need additional medications beyond antiretrovirals. The four top conditions are Cardiovascular disease (61% vs. 39%); substance use disorders (52% vs. 19%); mood disorders (42% vs. 18%), and diabetes (32% vs. 18%). Further, care is sometimes fragmented for members living with HIV; members see and receive HIV prescriptions from PCPs, HIV PCPs, and HIV Specialists, as well as other types of specialists. Based on these findings, Healthfirst convened two major initiatives in 2019. HealthFirst created incentive payments to the Alliance for Positive Change, a HIV peer outreach. In Q3 2019, HealthFirst selected Public Health Solutions to convene community and clinical providers in Brooklyn and Queens to develop a closed loop referral network.
    - **Severe Maternal Morbidity (SMM) and Mortality**: Healthfirst conducted an analysis to understand how many members are impacted by severe maternal morbidity (SMM) or mortality. Findings reflected 29% of women with SMM were African American. Postpartum coagulation defects, followed by sepsis, were the leading causes of SMM. Of the 1,477 mothers with SMM, 38 died, which is a large portion of maternal deaths in NYS overall. Dr. Susan Beane, Executive Medical Director at Healthfirst, served on an NYS Taskforce to make recommendations to prevent maternal mortality. Dr. Beane informed the recommendations, which were released in early 2019, including the design and implementation of a comprehensive training and education program for hospitals on implicit racial bias.
    - **Members Living with Respiratory Diseases in the Bronx:** HealthFirst studied the use of asthma and COPD services in the Bronx to uncover exacerbating or mitigating factors. Members with respiratory disease that were well aligned in care, especially specialty care, were much less likely to experience ED visits than members who did not see a specialty provider (mean of 1.8 visits vs. 4.0 visits). A similar trend was true for Inpatient admissions (1.3 average events for aligned

members, 2.5 events for unaligned members). Healthfirst worked with Bronx hospitals including Montefiore, BronxCare, Lincoln, and Jacobi to design and implement a warm handoff program to improve care alignment for members who are admitted to a hospital in the Bronx, especially the admission is related to respiratory disease.
    - **Children living in the Bronx:** Key challenges for children include asthma – children between the ages of 6-15 living in the Bronx are disproportionately burdened by asthma. These same children are not optimally aligned in care. Healthfirst convened an advisory to improve outcomes for Children, focusing on early recognition of the social determinants of health; improving access to dental care, and more effective management of asthma.
- HealthFirst identified high risk postpartum women as a population group that represented measureable gaps between the health plan's Medicaid population and other membership types. In 2018, Healthfirst evaluated results of the postpartum care navigation program, and found that mothers who received the intervention were much more likely to receive timely postpartum care (67% vs 56%) than a matched comparison group of other high-risk mothers.
- The gaps in quality of care identified for HealthFirst's Medicaid members and the interventions implemented included:
    - Improving access to care for young adults. Healthfirst data demonstrated that adolescents and younger adults are less likely to be engaged in PCP care. Young adults in Brooklyn and the Bronx received a mailing encouraging primary care access at the end of 2017; of these, 23% received primary care services in the following 5 months (November 2017 to April 2018).
    - Improving outcomes for minorities living with diabetes by utilizing Fit4D, telephonic coaching by certified diabetes educators. The program is offered in different languages to Medicaid and Medicare members with an A1c >8. The program will make sure members are connected to their PCPs and receiving all the evidence-based preventive care and monitoring appropriate for people living with diabetes.
    - Improving Cancer Screening Rates by partnering with Federally Qualified Health Centers (FQHCs) to outreach members via letters and phone outreach.
    - Improving the percentage of children who require antipsychotic medications are also receiving metabolic monitoring. Healthfirst targeted prescribers and PCPs to alert them of the need to conduct metabolic monitoring.
- Healthfirst identified determinants of gaps in health outcomes, health status, or quality of care for at-risk populations. The key findings and follow-up actions are listed below.
    - One subpopulation is South Asian immigrants living in NYC, including Indians, Bangladeshis, and Pakistanis. NYU's data demonstrates that biological factors lead to hypertension and cardiovascular disease at lower BMI, and cultural barriers impact access to care and hypertension management and control. In September of 2018, Healthfirst and NYU jointly held a forum for the public health community and Healthfirst providers on Innovations in Hypertension Management. HealthFirst reported findings from their community practice study – that the EHR tools alone improved practice-level hypertension control rates by 9%, after adjusting for age and sex. The CHW intervention had even greater results in impacting hypertension control (64% controlled vs 47% of control group).
    - HealthFirst developed and/or implemented the Claremont Healthy Village initiative to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for HealthFirst members identified with at-risk characteristics. The community-led health initiative continues through present day and includes partners such as the tenant associations, community centers, senior centers, local civic groups, schools, and Bronx Neighborhood Health Action Centers. As trust grows over time, referrals and linkages between CHVI organizations have also increased. Healthfirst has taken these findings to suggest that the steps taken to

engage the community in Claremont have been effective, and in 2019 launched a Healthy Communities strategy alongside our provider network, impacting many more of our high need communities with programming responsive to the needs articulated by the community.

VI. VI. Health Information Technology

According to the US Department of Health & Human Services, health information technology (HIT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT will improve health care quality, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.

In 2018, the NYS EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

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

Table 19 displays the statewide results of the HIT survey. Of the thirteen MCOs who responded to the survey, 100% utilized secure electronic transfer of member data between the MCO, its vendors, and/or network providers. Additionally, 100% of MCOs utilized electronic communication with providers and secure electronic transfer of PHI to patients and/or providers. Some of the other forms of HIT utilized by the majority of MCOs include telecommunications technologies, Electronic Health Records (EHR), and use of clinical risk group (CRG) or similar software. In addition, 77% of MCOs reported future plans to implement HIT.

Table 19: MCO Use of Health Information Technology—2018 Survey of NYS MCOs

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Electronic communication with providers	100%
Secure electronic transfer of protected health information to patients and/or providers	100%
Future plans to implement HIT	77%
Use of clinical risk group (CRG) or similar software	100%
Use of telecommunications technologies	100%
Use of Electronic Health Records (EHR)	92%

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

Health Information Technology	% of MCOs Reporting Use
Electronic communication with members	100%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	69%
Participation in a medical home pilot or program	46%
Use of electronic internal registries	46%
Participation in State, Federal or privately funded HIT initiatives	46%

Note: IHA and Affinity did not provide responses to the 2018 HIT questionnaire and therefore are not included in results.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Secure access through a member portal.

- Use of telecommunications technologies:
  - Utilize IVR system for health education for targeted members.

- Use of Electronic Health Records (EHR):
  - Encounter and clinical data is received in HL7 or SDA format from hospital EMR systems and stored within the Healthfirst HIE.

- Use of clinical risk group (CRG) or similar software:
  - Utilizes multiple sources of information to create predictive models that identify and then designate members at high risk for readmission or ER visits or other (preventable) services.
  - HF uses this predictive model to enroll people in clinical programs in our core medical management system.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Electronic files are transmitted to vendors via secure managed file transfers.

- Electronic communication with providers:
  - Healthfirst electronically transfers protected health information (PHI) to our providers through the provider portal and through our private health information exchange (HIE).
  - Within the HIE, data exchange is primarily done securely over VPN or HTTPS using standard data exchange formats such as HL7 or IHE protocols. Files are also exchanged using secure FTP.
  - Utilizes encrypted emails using secure file protocols to send information.
  - Use of a Quality APP where providers can access PHI.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - Healthfirst is in the process of becoming a participant and data provider of Healthix.

- Participation in a medical home pilot or program:
  - Healthfirst participates in a number of medical home as well as health home programs with a focus on dual diagnosis members.

- Future plans to implement HIT:
    - Future plans for HIT are to be determined.

VII. VII. Structure and Operation Standards

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

Compliance with NYS Structure and Operation Standards

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

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

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

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

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

For focused reviews, Healthfirst was in compliance with 13 of the 14 categories. The category in which Healthfirst was not compliant was Organization and Management (2 citations). Healthfirst was in compliance for all of the operational survey categories in 2018.

Table 20: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability for routine and urgent visits; re-audits are performed when results are below 75%.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination, or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information—Web	Review of MCOs' web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listings of primary, specialty, and ancillary providers for the enrolled population.
Provider Participation—Directory	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCPs with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent "sick", and urgent appointments.
Other	Used for issues that 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 21: Summary of Citations

Category	Operational Citations	Focused Review Citations	Focused Review Citation: Survey Type	
Complaints and Grievances	0	0		
Credentialing	0	0		
Disclosure	0	0		
Family Planning	0	0		
HIV	0	0		
Management Information Systems	0	0		
Medicaid Contract	0	0		
Medical Records	0	0		
Member Services	0	0		
Organization and Management	0	2	Contracts	2
Prenatal Care	0	0		
Quality Assurance	0	0		
Service Delivery Network	0	0		
Utilization Review	0	0		
Total	**0**	**2**		

External Appeals

Table 22 displays external appeals for 2016 to 2018 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment. In 2018, 75% of the MCO's external appeals were upheld.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	63	73	169
Overturned in Part	2	1	9
Upheld	205	245	521
Medicaid Total	**270**	**319**	**699**
		CHP	
Overturned	0	1	2
Overturned in Part	0	0	0
Upheld	1	0	3
CHP Total	**1**	**1**	**5**

VIII. Strengths and Opportunities for Improvement[5]

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

Strengths

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

Strengths:

- The MCO had rates above the statewide average for the number of *OB/GYN Specialty* and *Other Specialties* provider types
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed well with a rate of 98.2% for Routine call types and a rate of 94.6% for Non-Urgent call types.
- In regards to health screenings for new enrollees, the MCO has had an improvement in rates from 2016 (15.1%) to 2018 (17.6%).
- The MCO performed well in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO has reported rates above the statewide average for at least three consecutive reporting years for the following measures: *Breast Cancer Screening, Colorectal Cancer Screening,* and *Chlamydia Screening in Women (Ages 16-24)*. Additionally, the MCO's rates were reported above the statewide average in 2018 for *Childhood Immunization Status—Combination 3, Lead Screening in Children* and *Immunizations for Adolescents—Combination 2.*
- In the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for *Spirometry Testing for COPD*, *Use of Imaging Studies for Low Back Pain* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.* Additionally, the MCO's rates for *Asthma Medication Ratio (Ages 19-64), Comprehensive Diabetes Care - HbA1c Testing and Comprehensive Diabetes Care - Eye Exam* was reported above the statewide average for 2018.

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

- The MCO performed well for the HEDIS®/QARR Behavioral Health domain. The MCO has reported rates above the statewide average for at least three consecutive reporting years for the following measures: *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase, Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase,* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder using Antipsychotic Medications.*
- In regard to HEDIS®/QARR Access/Timeliness Indicators, the MCO has reported rates above the statewide average for at least three consecutive reporting years for *Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits,* as well as the following age groups of the *Adults' Access to Preventive/Ambulatory Health Services: 20-44 Years, 45-64 Years,* and *65+ Years*. The MCO also had a reported rate above the statewide average for *Children and Adolescents' Access to PCPs: 12-24 Months* in 2018.
- In regards to the Performance Improvement Project, the MCO demonstrated an improvement for 10 out of 12 indicators.

Opportunities for Improvement

An MCO's weaknesses are those resources or capabilities of an organization that are deficient and viewed as shortcomings in its ability or performance. IPRO identifies an organization's resource or capability as a weakness when that entity is not compliant with provisions of the NYS Medicaid Managed Care Contract, federal and State regulations, or it performs substantially below both the DOHs' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS PM rate below the national average.

Opportunities for Improvement:

- In regards to the ratio of enrollees to Medicaid providers, HealthFirst had rates above the statewide average for all specialty types. A higher percentile indicates fewer providers per enrollee.
- The MCO performed below the appointment availability and access threshold for After-Hours call types, with a total rate of 66.0% in 2018.
- The MCO continues to demonstrate an opportunity for improvement in the HEDIS®/QARR Effectiveness of Care: Acute and Chronic Care domain. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the *Testing for Children with Pharyngitis, Pharmacotherapy Management of COPD Exacerbation—Corticosteroids*, and *Asthma Medication Ratio (Ages 5-18)* measures.
- In regards to the HEDIS®/QARR Access to Care domain, the MCO has reported rates below the statewide average for at least three consecutive reporting years for the *Annual Dental Visit* measure.
- In 2017, the MCO's rate for *Prenatal Care in the First Trimester* was below the statewide average.
- Although the MCO's rate for *Getting Care Needed* has improved from 2016, the rate remains below the statewide average in 2018.

Recommendations:

- As HealthFirst's Medicaid enrollment continues to increase, the MCO should also accommodate this growth with additional providers. With a membership rate above the statewide average for members aged 65 and over, the MCO should also consider increasing the number of Geriatricians in its provider network.
- With the MCO's appointment rate below the 75% threshold for Primary Care and OB/GYN providers during after-hours calls, the plan should develop a process to identify providers who did not meet the requirements. The MCO should offer education on the access and availability standards to the identified providers. Ongoing reminders to providers can be given through existing provider communications such as; quarterly provider newsletters and fax blasts.

- The MCO should continue its efforts to address low performing HEDIS®/QARR measures. Although the MCO's rate for *Asthma Medication Ratio (5-18)* continues to be below the statewide average, the rates have improved in 2018. The MCO should continue with its current interventions to improve this measure. The MCO should consider collaborating with a Community Based Organization (CBO) that can assist with asthma education for all age groups within the communities identified with the greatest risk. Regarding the consistent low rates for the *Pharmacotherapy Management of COPD Exacerbation—Corticosteroids* measure, the MCO should consider utilizing Pharmacists to educate members on COPD medication management. The MCO should also continue with its member and provider focused dental initiatives to increase the rate of visits among its members. Continuous evaluation of the impact for all of the current interventions should be done to determine areas of improvement.

Response to Previous Year's Recommendations:

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

- **2017 Recommendation:** The MCO should work with its HEDIS® vendor to ensure all issues identified in the HEDIS® Final Audit Report are addressed.

  MCO Response: Healthfirst proactively works with our current HEDIS vendor as well as will also work with our future vendor to identify and address any issues that may arise with our HEDIS data and / or rate calculations. Issues are concurrently addressed as part of the Certified HEDIS Compliance Audit and a resolution is discussed with our audit firm.

- **2017 Recommendation:** The MCO should continue its efforts to address low performing HEDIS®/QARR measures. The MCO should continuously evaluate the impact of its planned in-home pharmacy vendor pilot project to determine its effectiveness and to see if the pilot can be expanded to include all members with gaps in care for asthma care, as well as if the pilot can be expanded to include other low performing measures. The MCO should also continue to work with its dental vendor to develop and implement initiatives to increase the rate of dental visits among its members. [Repeat recommendation.]

- **MCO Response:** In an effort to improve our HEDIS/QARR performance in the Asthma Medication Ratio (AMR) and Medication Management of Asthma (MMA) measures, Healthfirst has employed the following:
  - **Member Focused**: An in-home pharmacy vendor conducts home visits among a targeted population of our pediatric Medicaid members (2-18 years old) with a history of low medication adherence to educate the parent / child on the importance of taking medications as prescribed and proper inhaler use, in addition to providing them with a spacer. A telephonic peer monitoring service matches parents of our pediatric Medicaid members with a Certified Asthma Educator who outreaches the parent for up to 6 months to ensure that the child's asthma is well-controlled and makes referrals to Healthfirst's Care Management or health care providers when necessary. Healthfirst's Care Management team works closely with our pediatric members who have had a recent inpatient admission due to a diagnosis of asthma to prevent a readmission by creating individualized care plans post discharge, coordinating primary and specialty care services, and making referrals to community-based organization for environmental assessment / mitigation or integrated pest management. Live outreach calls are being done with a targeted group of members

to educate them on the use of controller medications versus rescue medications while Interactive Voice Response (IVR) calls are being conducted to remind the entire Medicaid population who are at risk for not filling their asthma medication to refill it timely. Healthfirst also reinforces the importance of medication adherence by offering our members health goal incentives for maintaining compliance with filling their asthma controller medications through the Member Reward Program.

- **Provider Focused**: PCPs receive a list of their non-adherent members and their AMR rates on a monthly basis that are accessible on the Healthfirst Quality APP. Healthfirst's Clinical Quality staff routinely conducts face-to-face meetings with our hospital and community-based providers to review their performance and recommend actions for improvement. PCPs that meet a minimum membership requirement are eligible to earn a bonus payment through the Healthfirst Quality Incentive Program (HQIP) when their AMR rate meets or exceeds a targeted rate.

- Below are the multi-modal initiatives Healthfirst has implemented to increase our HEDIS/QARR rate for Annual Dental Visit (ADV):
  - **Member Focused:** Healthfirst collaborates with our dental vendor to increase awareness about preventive dental care through live call campaigns that facilitate appointment scheduling; reminder letters, postcards, and emails that reinforce the importance of making a routine dental appointment. Healthfirst provides information about the member's home and enhanced our communication about annual dental benefits in Healthfirst's Welcome Packet and on Healthfirst's website. We also host community events that promote oral health education and dental screenings and maintain partnerships with school-based health centers that can provide comprehensive dental services. We also provide health goal incentives to a cohort of members who complete their routine dental check-up as well as those who achieve their preventive dental services through our Member Rewards Program.
  - **Provider Focused:** For providers participating in HQIP, Healthfirst's Clinical Quality staff reminds them to access their list of members missing services for ADV on the Quality APP monthly; reviews their ADV Performance Summary Reports; educates them on best practices; and develops action plans to close care gaps and improve their ADV rates. This ongoing collaboration ensures that our providers are actively involved in focusing on the areas of prevention that will positively impact our members' oral health outcomes. Similarly, our dental vendor is engaging our provider network through their "QARR Dental Center of Excellence Incentive" which financially incentivizes targeted hospitals, FQHCs, and community clinics to increase their delivery of preventive dental services. This awards program is being promoted by via emails, office site visits, and FAQs. Our vendor is also implementing efforts to assist Healthfirst's low performing providers by offering them data support, enhanced reporting, and negotiating improved financial terms. In addition, they are ensuring that our non-adherent members have easier access to preventive dental services by assigning them to a dental home that is near their medical PCP.

- **2017 Recommendation:** The MCO should take steps to address the issued identified in the operational and focused review surveys. As the MCO continues to receive citations surrounding the information included in provider directories, as well as access to and availability of providers, the MCO should continue to explore innovative and proactive ways to improve these areas, as well as evaluate the impact of the proposed automated data update system noted in the MCO's response to the previous year's recommendation. [Repeat recommendation.]

MCO Response: The Provider Operations and Delivery System Engagement (DSE) departments continue to work collaboratively to improve the quality and accuracy of the provider network data. In 2019, DSE and Provider Operations expanded their efforts to validate provider demographics by completing a full validation on all providers listed in the directory. This effort involved phoning every provider location in the directory to validate demographic information, enabling us to proactively identify inaccuracies sooner. Additionally in 2019, Healthfirst has begun exploring a phased approach to implement an automated solution to processing provider updates. The use of this technology will increase the accuracy and completion time of changes to provider profiles. In 2020, we will continue to further develop the capabilities of this automated solution to achieve many of our provider network updates.

Healthfirst has also enhanced the level of internal auditing by conducting additional Access & Availability Audits (ACAA) as well as monthly Online Provider Directory audits. The audits include multiple lines of business to give us a more comprehensive view of our network performance. We have simplified the way providers can respond to audit failures, which has allowed for better tracking and reporting. We believe that implementing this level of rigorous auditing has led to our improved performance in both the IPRO 2018 Access & Availability audit and IPRO 2018 PCP Ratio Audit.

DSE has implemented a monthly training series where we invite Providers to participate and learn about Access to Care measures on both ACAA and Consumer Assessment of Healthcare Providers and Systems (CAHCPS) surveys. This forum allows providers to raise questions about the measures, discuss any barriers, and provide a detailed explanation of the audits and their impact to members. The participation rates have been great and in 2020 we look to further enhance the series for folks to better understand direct ways they can improve their compliance scores.

IX. IX. Appendix

References

A. MCO Corporate Profiles

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory
- NCQA Accreditation website, https://reportcards.ncqa.org

B. Enrollment and Provider Network

- *Enrollment:*
  - NYS OHIP Medicaid DataMart, 2018
  - NYSDOH OHIP Child Health Plus Program, 2018
- *Provider Network:*
  - NYS Provider Network Data System (PNDS), 2018
  - QARR Measurement Year 2018

C. Utilization

- *Encounter Data:*
  - NYS OHIP Medicaid DataMart, 2018
- *QARR Use of Services:*
  - QARR Measurement Year 2018

D. Performance Indicators

- *HEDIS®/QARR Performance Measures:*
  - QARR Measurement Year 2018
- *CAHPS® 2018:*
  - QARR Measurement Year 2018
- *Performance Improvement Project:*
  - 2018-2019 PIP Reports

E. Structure and Operations

- MMC Operational Deficiencies by Plan/Category, 2018
- Focused Deficiencies by Plan/Survey Type/Category, 2018