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

External Quality Review
Technical Report for:
Community Blue: BCBS of Western New York
[HealthNow New York]

Reporting Year 2018

FINAL REPORT

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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 (C): *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 (M): *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*
OPMC: *Office of Professional Medical Conduct*
OP: *Optimal Practitioner Contact*
OQPS: *Office of Quality and Patient Safety*

PCP: *Primary Care Practitioner/Provider*
PHSP: *Prepaid Health Services Plan*
PIP: *Performance Improvement Project*
PIHP: *Prepaid Inpatient Health Plan*
PNDS: *Provider Network Data System*
POC: *Plan of Corrective Action*
PMPY: *Per Member Per Year*
PTMY: *Per Thousand Member Years*
PQI: *Prevention Quality Indicator*

Q1: *First Quarter (Jan.—March)*
Q2: *Second Quarter (Apr.—June)*
Q3: *Third Quarter (July—Sept.)*
Q4: *Fourth Quarter (Oct.—Dec.)*
QARR: *Quality Assurance Reporting Requirements*

ROS: *Rest of State*
RY: *Reporting Year*

SN: *Safety Net*
SOD: *Statement of Deficiency*
SS: *Small Sample (less than 30)*
SSI: *Supplemental Security Income*
SWA: *Statewide Average*

TANF: *Temporary Aid to Needy Families*
TR: *Technical Report*

UR: *Utilization Review*

I. About This Report

Purpose of This Report

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. MCO Corporate Profile

Community Blue: BCBS of Western New York (BCBS WNY) is an assumed name of HealthNow New York, Inc.'s operations in the Western Region. BCBS WNY is a regional, not-for-profit health maintenance organization (HMO) that serves Medicaid (MCD), Child Health Plus (CHP), Commercial (COM), and Medicare populations. Community Blue: Blue Shield of Northeastern New York serves COM and Medicare populations in the Northeast region. On December 30, 2017, HealthNow withdrew from the COM product line in Central New York. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP and Commercial product lines.

HealthNow Web Page: https://www.bcbswny.com

***Participating Regions and Products**[1]			
Central[2]:			COM
Northeast[3]:			COM
Western[4]:	MCD	CHP	COM

* 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

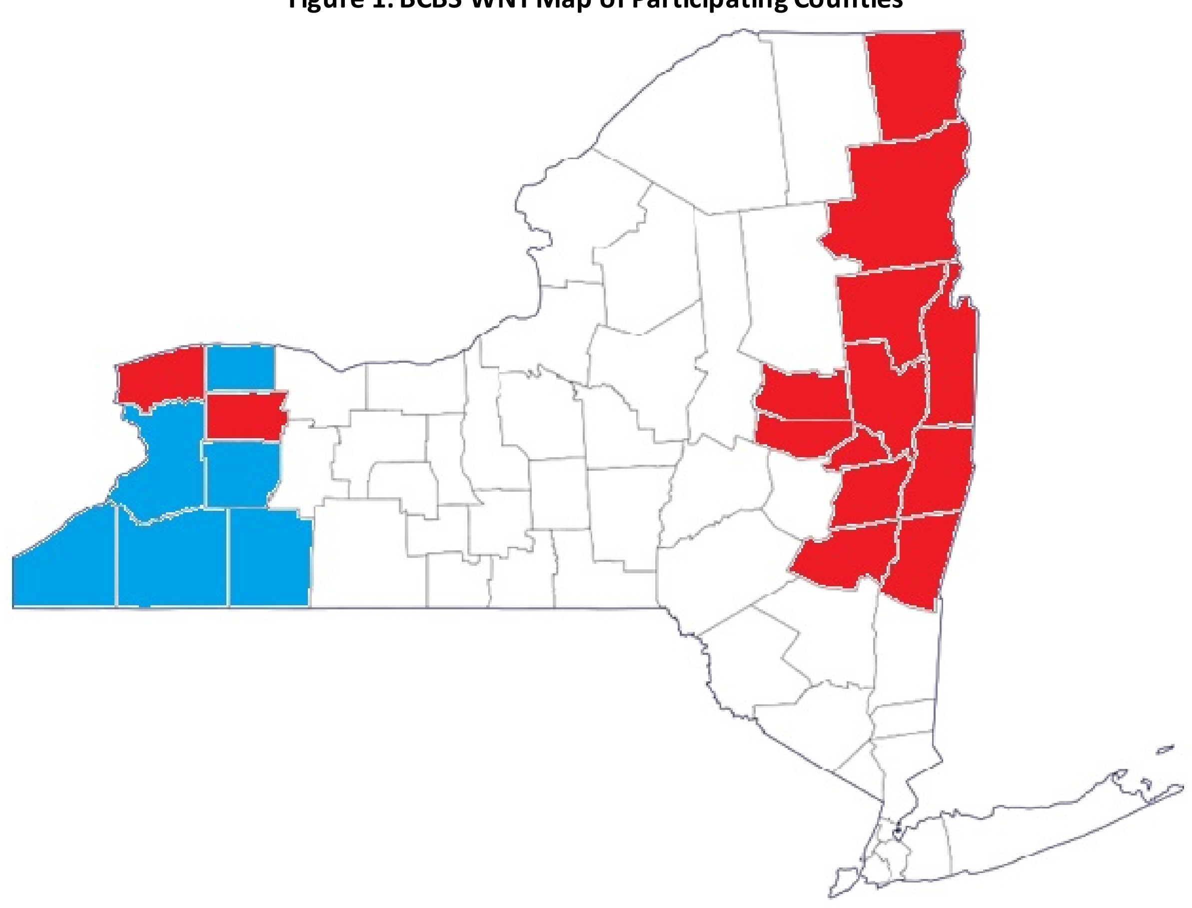
[1]Note that the HARP product line is available in all counties that serve the Medicaid population.

[2]HealthNow participates in Onondaga and Oswego counties only.

[3]HealthNow participates in Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren and Washington counties.

[4]Chemung, Monroe, and Wayne counties participate in COM only. Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties participate in MCD, CHP and COM.

Figure 1: BCBS WNY Map of Participating Counties



Note: Counties shaded in blue serve the Medicaid and Child Health Plus populations, while counties shaded in red serve the Commercial population only. The Commercial product line is also available in counties serving Medicaid and Child Health Plus.

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 17.3%. BCBS WNY membership represents .8% 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	21,421	28,764	33,738
% Change from Previous Year	-20.0%	34.3%	17.3%
Statewide Total[1]	4,349,457	4,378,153	4,352,116
% of Total Medicaid Enrollment	0.5%	0.6%	.8%

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	1,560	2,563	3,198
Commercial	252,916		350,418

Data Source: NYSDOH OHIP Child Health Plus Program

Figure 2: BCBS WNY Enrollment Trends—All Product Lines

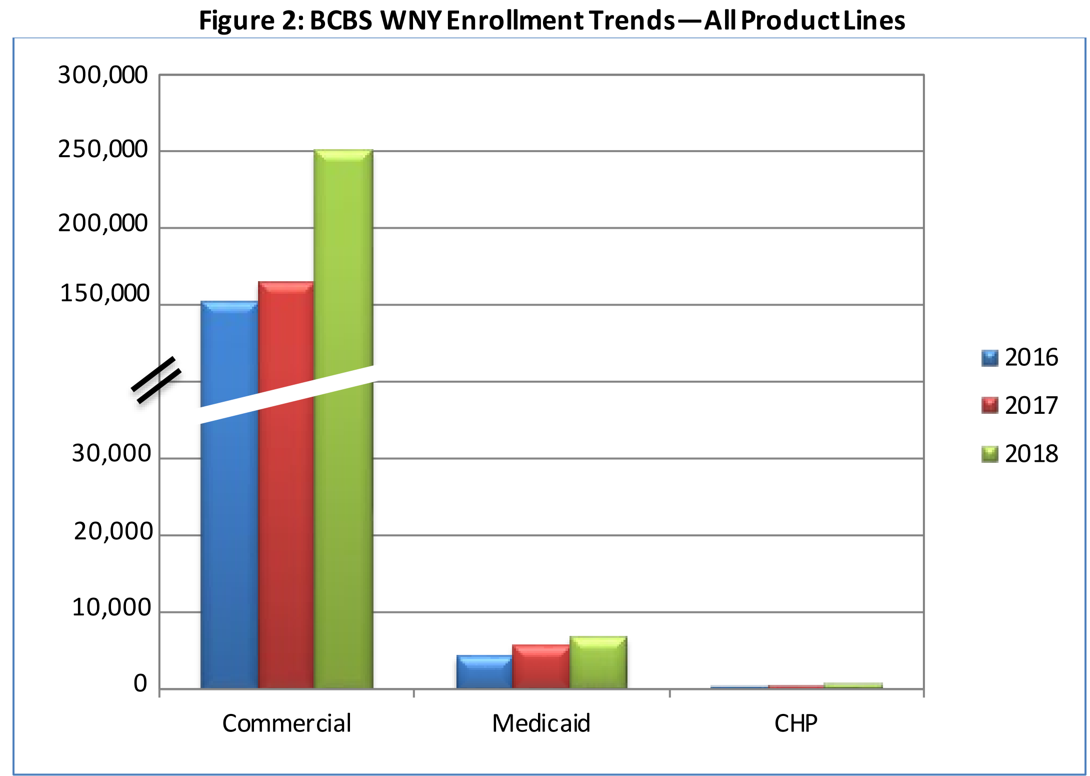


Table 3 and **Figure 3** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2018, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average (SWA). The largest age group in the MCO's Medicaid membership is 20-44 year olds. The MCO had rates above the SWA for members aged 20-44 and for females 15-64 years old.

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

Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	617	564	1181	3.5%	3.6%
1-4	1317	1251	2568	7.6% ▼	9.7%
5-14	3586	3442	7028	20.8%	22.8%
15-19	1643	1635	3278	9.7%	9.9%
20-44	5260	7306	12566	37.2% ▲	33.3%
45-64	3292	3723	7015	20.8%	19.1%
65 and Over	53	74	127	0.4% ▼	1.4%
Total	15768	17995	33763		
Under 20	7163	6892	14055	41.6%	46.1%
Females 15-64		12664		37.5% ▲	34.7%

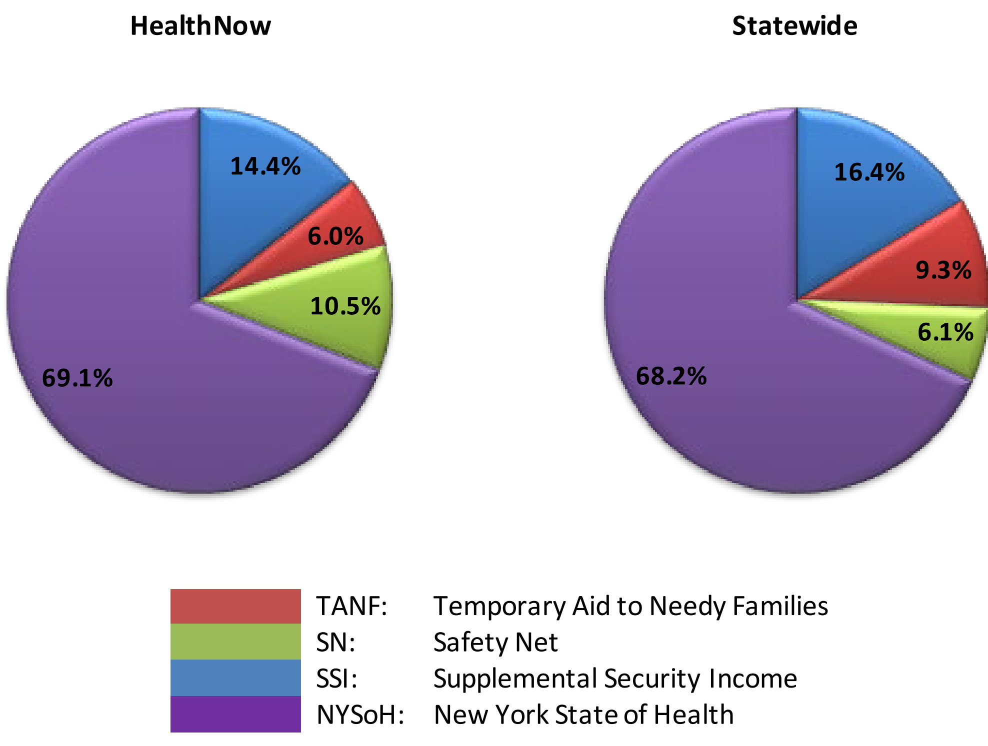
Note: Enrollment totals do not include membership that was indicated as unknown gender by the MCO.

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 Medicaid/CHP product line had an improvement in rates for 83% of the measures 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*[5].

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

Provider Type	2016		2017		2018	
	BCBS WNY	Statewide Average	BCBS WNY	Statewide Average	BCBS WNY[1]	Statewide Average
Medicaid/CHP						
Family Medicine	67%	71%	75%	72%	73%	74%
Internal Medicine	72%	75%	76%	76%	75%	76%
Pediatricians	76%	78%	82%	79%	82%	80%
OB/GYN	68%	75%	78%	77%	82%	80%
Geriatricians	72%	63%	68%	63%	71%	63%
Other Physician Specialists	76%	75%	81% ▲	76%	82%	77%
Commercial						
Family Medicine	81% ▲	74%	67% ▼	77%	33%	72%
Internal Medicine	80% ▲	73%	73% ▼	77%	57%	73%
Pediatricians	83% ▲	77%	70% ▼	79%	29%	75%
OB/GYN	75%	78%	66% ▼	79%	59%	78%
Geriatricians	62%	63%	58%	69%	54%	66%
Other Physician Specialists	73% ▼	78%	69% ▼	79%	59%	77%

[1]Level of significance was unaudited.

[5] 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 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 ▼. The MCO had rates below the statewide average for 40% of the provider types.

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

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	968	12.6% ▼	19.5%
Pediatrics	251	3.3%	3.8%
Family Practice	349	4.6%	3.5%
Internal Medicine	341	4.5% ▼	8.4%
Other PCPs	27	0.4% ▼	3.8%
OB/GYN Specialty[1]	314	4.1%	3.8%
Behavioral Health	675	8.8% ▼	17.2%
Other Specialties	3,769	49.2%	46.0%
Non-PCP Nurse Practitioners	1,643	21.4% ▲	8.7%
Dentistry	293	3.8%	4.9%
Total	7,662		

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

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

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)

	BCBS WNY			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	35:1	1,116	30:1	42:1	80,986	42:1
Pediatrics (Under age 20)	56:1			70:1		
OB/GYN (Females age 15-64)	40:1			59:1		
Behavioral Health	50:1			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 ▼. The MCO had 100% of Medicaid PCPs with an Open Panel in 2017 and 2018.

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

	2016			2017			2018		
	BCBS WNY		Statewide	BCBS WNY		Statewide	BCBS WNY		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	955	69.5 ▼	85.0	511	100.0	95.7	925	100.0	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 BCBS WNY 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
50	35	**70%**

Table 9 displays the appointment availability and after-hours access rates for the providers surveyed. The sample size was 29 providers (total number of providers who were compliant for participation (35), 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

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Internist/Family Practitioner	1	1	100.0%
	Pediatrician	5	5	100.0%
	OB/GYN	2	2	100.0%
	Total Routine	**8**	**8**	**100.0%**
Non-Urgent "Sick"	Internist/Family Practitioner	3	3	100.0%
	Pediatrician	3	2	66.7%
	OB/GYN	2	2	100.0%
	Total Non-Urgent	**8**	**7**	**87.5%**
After-Hours Access	Internist/Family Practitioner	5	2	40.0%
	Pediatrician	5	4	80.0%
	OB/GYN	3	2	66.7%
	Total After-Hours	**13**	**8**	**61.5%**

[1]Timeliness was not considered when determining appointment availability rates.

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 ▼. The MCO had a rate below the statewide average for PCPs and OB/GYNs.

Table 10: Medicaid Encounter Data—2016-2018

	Encounters (PMPY)					
	2016		2017		2018	
	BCBS WNY	Statewide Average	BCBS WNY	Statewide Average	BCBS WNY	Statewide Average
PCPs and OB/GYNs	3.36	3.85	2.84	3.56	2.82 ▼	3.50
Specialty	2.88 ▲	2.45	2.19	2.30	2.28	2.33
Emergency Room	0.63	0.54	0.62	0.55	0.61	0.53
Inpatient Admissions	0.15	0.14	0.09	0.14	0.10	0.13
Dental	1.02	1.03	0.88	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 trended upwards from 2016 to 2018.

Table 11: Health Screenings—2016-2018

	2016		2017		2018	
	BCBS WNY	SWA	BCBS WNY	SWA	BCBS WNY	SWA
	Medicaid					
Enrollee Health Screenings	11.5%	12.5%	16.4%	12.7%	18.1%	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 ▼). The MCO had rates above the statewide average for 3 out of 10 measures in 2018.

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

Measure	Medicaid/CHP 2016	Medicaid/CHP 2017	Medicaid/CHP 2018	Medicaid/CHP 2018 Statewide Average	Commercial 2016	Commercial 2017	Commercial 2018	Commercial 2018 Statewide Average
Outpatient Utilization (PTMY)								
Visits	4,354 ▼	4,251	4,090 ▼	5,317	4,105	4,189	4,184	4,209
ER Visits	687	656	615	492	193	212	208	204
Inpatient ALOS								
Medicine	3.8	4.3	4.0	4.5	3.6	3.8	3.3	3.5
Surgery	7.2 ▲	7.6	8.2 ▲	7.0	4.0	4.1	4.3	4.4
Maternity	2.6 ▼	2.7	2.8	2.9	2.7	2.7	2.7	2.6
Total	4.6 ▲	4.9 ▲	4.9 ▲	4.4	3.5	3.6	3.5	3.6
Inpatient Utilization (PTMY)								
Medicine Cases	39	37	35	30	16	17	14 ▼	17
Surgery Cases	24 ▲	22 ▲	22 ▲	12	15	16	16	15
Maternity Cases	20 ▼	23 ▼	28	32	10	12	12	12
Total Cases	78	76	79	66	41	43	41	42

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

V. Performance Indicators

To measure the quality, accessibility, and timeliness of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of performance indicators. This section is a summary of findings from those reports, including HEDIS®/QARR 2019 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 BCBS WNY indicated that the MCO had no significant issues in any areas related to reporting. BCBS WNY demonstrated compliance with all areas of Information Systems and all areas of Measure Determination required for successful HEDIS® reporting. The MCO was able to report rates for all measures for all applicable product lines. The MCO passed Medical Record Review for the six measures validated, as well.

BCBS WNY 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.[6]

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.

[6] 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 4 out of 14 measures with a reported rate above the SWA.

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

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Adult BMI Assessment	96 ▲	99 ▲	96 ▲	**89**	94 ▲	94 ▲	89	**89**
WCC—BMI Percentile	91 ▲	84	85	**86**	91 ▲	90 ▲	90	**90**
WCC—Counseling for Nutrition	87 ▲	83	86 ▲	**83**	90 ▲	92 ▲	92 ▲	**87**
WCC—Counseling for Physical Activity	80 ▲	76	81 ▲	**74**	83 ▲	84 ▲	86 ▲	**80**
Childhood Immunizations—Combo 3	80 ▲	74	78 ▲	**73**	91 ▲	91 ▲	86	**84**
Lead Screening in Children	82 ▼	87	90	**89**	94 ▲	90	95 ▲	**88**
Adolescent Immunizations—Combo 2[2]		28 ▼	35 ▼	**43**		30	32	**31**
Adolescents—Alcohol and Other Drug Use[3]	76 ▲	76 ▲	77	**70**	84 ▲	82 ▲	84	**78**
Adolescents—Depression[3]	67	65	71	**67**	74 ▲	73	71	**70**
Adolescents—Sexual Activity[3]	73	68	67	**67**	84 ▲	74	80	**74**
Adolescents—Tobacco Use[3]	86 ▲	84 ▲	80	**74**	86 ▲	86 ▲	90 ▲	**82**
Breast Cancer Screening	57 ▼	59 ▼	57 ▼	**71**	76 ▲	78 ▲	78 ▲	**77**
Colorectal Cancer Screening	49 ▼	50 ▼	49 ▼	**63**	68	68	70	**71**
Chlamydia Screening (Ages 16-24)	58 ▼	62 ▼	63 ▼	**76**	61 ▲	62 ▲	65 ▲	**59**

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 noted otherwise.

[2] Prior to Reporting Year 2017, rates for *Immunizations for Adolescents—Combination 1* and *HPV* were reported separately; however, for Reporting Year 2018, *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 regards to the Medicaid/CHP product line, the MCO had rates below the SWA for 20% of the measures in 2018.

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

	Medicaid/CHP				Commercial			
Measure	**2016**	**2017**	**2018**	**2018 SWA**	**2016**	**2017**	**2018**	**2018 SWA**
Testing for Children with Pharyngitis	81 ▼	92	95 ▲	**91**	86 ▼	92	92	**93**
Spirometry Testing for COPD	39 ▼	30 ▼	36 ▼	**56**	49	46	46	**45**
Use of Imaging Studies for Low Back Pain	74	75	72	**77**	81 ▲	82 ▲	82 ▲	**80**
Pharmacotherapy Management for COPD—Bronchodilators	87	88	83	**89**	86 ▲	81	82	**80**
Pharmacotherapy Management for COPD—Corticosteroids	73	79	77	**76**	85 ▲	81	80	**78**
Medication Management for People with Asthma 50% (Ages 19-64)	67	70	75	**71**	68	73 ▼	70 ▼	**76**
Medication Management for People with Asthma 50% (Ages 5-18)	53	51	60	**59**	50	54 ▼	57 ▼	**63**
Asthma Medication Ratio (Ages 19-64)	56	56	62	**60**	75	78 ▼	79 ▼	**81**
Asthma Medication Ratio (Ages 5-18)	69	68	72	**68**	78	82	84	**85**
Persistence of Beta-Blocker Treatment After a Heart Attack	*SS*	*SS*	*SS*	**80**	85	93	86	**83**
CDC—HbA1c Testing	88 ▼	88 ▼	85 ▼	**92**	89	90	91	**92**
CDC—HbA1c Control (<8%)	55	56	52 ▼	**60**	65	64	62	**61**
CDC—Eye Exam Performed	59 ▼	66	67	**67**	64 ▲	67	69 ▲	**63**
CDC—Nephropathy Monitor	92	91	90	**92**	92	89	91	**89**
CDC—BP Controlled (<140/90 mm Hg)	67	68 ▲	67	**66**	78 ▲	73	73	**69**
Drug Therapy for Rheumatoid Arthritis	73	74	77	**83**	82 ▼	83	85	**84**
Monitor Patients on Persistent Medications—Total Rate	86 ▼	87 ▼	85 ▼	**92**	83 ▼	84	84	**84**
Appropriate Treatment for URI	90 ▼	93	94	**95**	92	92	93	**94**
Avoidance of Antibiotics for Adults with Acute Bronchitis	24	29	31	**36**	29 ▲	26 ▼	31 ▼	**34**
HIV Viral Load Suppression[1]	79	81	77	**77**				
Flu Shots for Adults (Ages 18-64)[3]	40	43			47	51	49 ▼	**56**
Advising Smokers to Quit[3]	83	83			84	88	81	**81**

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Smoking Cessation Medications[3]	59	64			54	62	60	**62**
Smoking Cessation Strategies[3]	51	50			45	54	57	**55**

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

SS: Sample size is too small to report.

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

[2] NYS-specific measure. The *HIV Viral Load Suppression* measure was introduced in Reporting Year 2017.

[3] 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 Effectiveness of Care: 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, the MCO's rates improved for all measures including rates above the SWA for the *Follow-Up After Hospitalization for Mental Illness: 30 Days and 7 Days* measures.

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

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Antidepressant Medication Management—Effective Acute Phase	47	49	57	**53**	60 ▼	64 ▼	62 ▼	**68**
Antidepressant Medication Management—Effective Continuation Phase	32	34	43	**37**	44 ▼	50	47 ▼	**51**
Follow-Up Care for Children on ADHD Medication—Initiation	49	46 ▼	48	**59**	53 ▲	49	51	**45**
Follow-Up Care for Children on ADHD Medication—Continue	62	60	64	**66**	50	60	61	**51**
Follow-Up After Hospitalization for Mental Illness—30 Days	83	75	83 ▲	**74**	83 ▲	80 ▲	79 ▲	**68**
Follow-Up After Hospitalization for Mental Illness—7 Days	69	57	73 ▲	**63**	66 ▲	67 ▲	71 ▲	**52**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	75 ▼	76 ▼	79	**82**				
Diabetes Monitoring for People with Diabetes and Schizophrenia	66	56 ▼	65	**80**				
Antipsychotic Medications for Schizophrenia	68	65	65	**63**				

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

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.[7]

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 ▼). The MCO’s Medicaid/CHP product line had rates statistically better than the SWA for 1 out of 3 measures in this domain.

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	74	88 ▲	**81**
Well-Child Visits—3 to 6 Year Olds	82	82 ▼	85	**86**
Adolescent Well-Care Visits	69	67	69	**68**
		Commercial		
Well-Child Visits—First 15 Months	88	91 ▲	97 ▲	**94**
Well-Child Visits—3 to 6 Year Olds	91 ▲	91 ▲	93 ▲	**88**
Adolescent Well-Care Visits	71 ▲	71 ▲	74 ▲	**67**

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

[7] 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 ▼). The MCO's Medicaid/CHP product line had rates above the SWA for 1 age group in the *Children and Adolescents' Access to PCPs* measure. The MCO's rate for the *Annual Dental Visit* has rates above the SWA for 3 consecutive years.

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

Measure	Medicaid/CHP				Commercial			
	2016	2017	2018	2018 SWA	2016	2017	2018	2018 SWA
Children and Adolescents' Access to PCPs (CAP)								
12-24 Months	99	97	98	**97**	99 ▲	100 ▲	99 ▲	**98**
25 Months-6 Years	93	93	92 ▼	**94**	98 ▲	97 ▲	97 ▲	**95**
7-11 Years	97	98	98	**97**	99 ▲	99 ▲	99 ▲	**97**
12-19 Years	96	96 ▲	96 ▲	**95**	97 ▲	97 ▲	97 ▲	**95**
Adults' Access to Preventive/Ambulatory Services (AAP)								
20-44 Years	86 ▲	85 ▲	82	**81**	95 ▲	95 ▲	95 ▲	**94**
45-64 Years	90	89	89	**89**	97 ▲	97 ▲	97 ▲	**96**
65+ Years	82	84	88	**91**	97	97	98 ▲	**97**
Access to Other Services								
Timeliness of Prenatal Care	86	88	87	**88**	95 ▲	98 ▲	97 ▲	**92**
Postpartum Care	66	68	72	**70**	89 ▲	91 ▲	90 ▲	**83**
Annual Dental Visit[2]	68 ▲	68 ▲	65 ▲	**61**				

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

[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 as 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 2015 through 2017 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—2015-2017

Measure	2015		2016		2017	
	BCBS WNY	ROS Average	BCBS WNY	ROS Average	BCBS WNY	ROS Average
Medicaid						
Risk-Adjusted Low Birth Weight[1]	9%	7%	9%	7%	-	-
Prenatal Care in the First Trimester	74%	74%	69%	74%	69%	75%
Risk-Adjusted Primary Cesarean Delivery[1]	14%	14%	11%	13%	-	-
Vaginal Birth After Cesarean	11%	14%	11%	14%	-	-
Commercial						
Risk-Adjusted Low Birth Weight[1]	4%	4%	4%	4%	-	-
Prenatal Care in the First Trimester	84% ▼	88%	86%	88%	86%	88%
Risk-Adjusted Primary Cesarean Delivery[1]	20%	19%	17%	18%	-	-
Vaginal Birth After Cesarean	9%	11%	9%	11%	-	-

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

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 ▼). The MCO's Medicaid rate for *Getting Care Quickly* was above the statewide average in 2018.

Table 16: CAHPS®—2014, 2016, 2018

Measure	Medicaid						Commercial					
	2014		2016		2018		2014		2016		2018	
	BCBS WNY	SWA	BCBS WNY	SWA	BCBS WNY	SWA	BCBS WNY	SWA	BCBS WNY	SWA	BCBS WNY	SWA
Flu Shots for Adults Ages 18-64							51	**52**	47	**52**	47 ▼	**56**
Advising Smokers to Quit							80	**84**	84	**80**	81	**81**
Getting Care Needed[1]	87	**83**	90 ▲	**85**	88	**84**	92 ▲	**88**	93 ▲	**88**	91	**89**
Getting Care Quickly[1]	92	**87**	92 ▲	**88**	92 ▲	**88**	89	**88**	92 ▲	**87**	91 ▲	**87**
Customer Service[1]	88	**82**	89	**86**	87	**86**	92	**88**	94 ▲	**89**	92	**91**
Coordination of Care[1]	80 ▲	**74**	80 ▲	**74**	77	**75**	91 ▲	**84**	88	**83**	87	**87**
Collaborative Decision Making[1]	58	**53**	76	**74**	80	**76**	81	**80**	82	**80**	82	**80**
Rating of Personal Doctor[1]	90 ▲	**89**	88	**90**	89	**90**	85	**84**	84	**86**	87	**86**
Rating of Specialist	84	**81**	86	**83**	83	**84**	88 ▲	**83**	87	**84**	84	**84**
Rating of Healthcare	90 ▲	**85**	81	**86**	88	**87**	77	**78**	76	**80**	84	**81**
Satisfaction with Provider Communication[1]	95 ▲	**93**	94	**93**	94	**93**	97	**96**	96	**96**	98 ▲	**96**
Wellness Discussion							83 ▲	**77**	81	**76**	77	**77**
Getting Needed Counseling/ Treatment												
Rating of Counseling/ Treatment	56	**64**	62	**68**	67	**69**						
Rating of Health Plan—High Users	88	**84**	87	**85**	80	**84**	70	**68**	73	**68**	72	**72**
Overall Rating of Health Plan	87 ▲	**83**	86	**85**	82	**85**	67	**67**	68	**66**	72	**71**
Recommend Plan to Family/Friends												

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

[1] These indicators are composite measures.

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

BCBS WNY's 2017-2018 PIP topic was *"Perinatal Care"*. During 2018, the MCO implemented the following interventions:

Member-Focused Interventions:

- Members received prenatal/postpartum education via IVR and formal mailings
- OB and high-risk case management provided education, risk assessments and care coordination services to members.
- Implementation of a member rewards program to help improve timeliness of prenatal and postpartum services.

Provider-Focused Interventions:

- Education focused on how to utilize the Maternal Child programs, treatment options, and the importance of early prenatal care.
- Improve collaboration with BCBS WNY OB case management staff.

MCO-Focused Interventions:

- Internal staff education on corporate maternal child programs to assist in provider education.
- Development and implementation of pharmacy (prenatal vitamin and Makena) and ER claim files to assist in identification of early pregnancy and case management outreach.
- Participated in 5 WNY Community Health Events where prenatal and postpartum educational materials were provided. The plan collaborated with various community agencies and health care providers to host a community baby shower and baby expo.

Table 18 presents a summary of BCBS WNY's 2017-2018 PIP. The MCO demonstrated an improvement for 10 out of 14 indicators.

Table 18: Performance Improvement Project Results—2017-2018

Indicator	Baseline Rate	Final Rate	Target/Goal	Results
Timeliness of Prenatal Care	**86%**	**87%**	91%	Demonstrated improvement
Postpartum Care	**66%**	**72%**	72%	Demonstrated improvement
Received at least one 17P injection	*	**50%**	37%	Demonstrated improvement from Interim to Final
Depression Screening	**45%**	**58%**	50%	Demonstrated improvement
Tobacco Screening	**83%**	**91%**	88%	Demonstrated improvement
Tobacco Screening Follow-Up	**47%**	**83%**	47%	Demonstrated improvement
Received most effective or moderately effective FDA methods of contraception				
Age 15-20 years; within 3 days	**0%**	**0%**	5%	Performance level was maintained
Age 15-20 years; within 60 days	**33%**	**39%**	38%	Demonstrated improvement
Age 21-44 years; within 3 days	**1%**	**7%**	6%	Demonstrated improvement
Age 21-44 years; within 60 days	**32%**	**32%**	37%	Performance level was maintained
Received a long acting reversible method of contraception (LARC)				
Age 15-20 years; within 3 days	**0%**	**0%**	5%	Performance level was maintained
Age 15-20 years; within 60 days	**2%**	**3%**	6%	Demonstrated improvement
Age 21-44 years; within 3 days	**0%**	**.5%**	5%	Performance level was maintained
Age 21-44 years; within 60 days	**4%**	**8%**	9%	Demonstrated improvement

* Not available due to data limitations.

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.

BCBS WNY reported that due to the newness of the plan, the MCO did not have enough data to complete the New York State Disparities Analysis.

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)[8]
- 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%

8 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.

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

- Secure electronic transfer of protected health information to patients and/or providers:
  - Members have view only access via a secure portal.
  - Providers utilize the Availity Digital provider portal as a web portal, as a SFTP or FTP interfaces. The Availity clearinghouse utilizes secure file transfer protocols.
  - Providers utilize Patient360, a real-time dashboard of member health information.
  - Provider Online Reporting (POR) is a reporting dashboard that allows BCBS WNY to share with providers member-centric data.

- Use of telecommunications technologies:
  - Utilize SIP technologies enables seamless queuing and transfer of calls regardless of location,
  - Genesys IVR IDS platform enables maximum flexibility for the caller's experience:
  - End-to-end solution supports multi-channel capabilities (web, mobile, chat, text, email, outbound, etc.)
  - Dialer solution supports robust, flexible campaign design and management
  - Call recording and analytics platform enhances operations and IT support.
  - WDE softphone integrated directly with our desktop CRM application and passes caller data during transfers.

- Use of Electronic Health Records (EHR):
  - EHR is used for HEDIS/QARR medical record review and Performance Improvement Plan interventions.

- Use of clinical risk group (CRG) or similar software:
  - Use of predictive risk model to rank order the highest risk members enrolled in a health home.

- Secure electronic transfer of member data between the MCO, its vendors, and/or network providers:
  - Member data shared using the following methods: sFTP, TCPIP, SSLTLS (Internet protocol).
  - Vendors utilize SFTP transactions
  - Providers utilize Availity secure web portal and Electronic Data Interchange (EDI).

- Electronic communication with providers:
  - Utilizes SFTP, Business to Business Application Programming Interfaces (API), email notification, non-secure web portal, and secure Availity digital provider portal.

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE):
  - BCBS WNY did not indicate participation in a RHIO.

- Participation in a medical home pilot or program:
    - BCBS WNY does not participate in any of the pilot programs and only supports medical homes through the pass through payment.

- Future plans to implement HIT:
    - BCBS WNY continuously reviews HIT opportunities such as collaborating with a RHIO or HIE.

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.

In regards to the operational review, BCBS WNY was in compliance with 11 of the 14 categories. The categories in which BCBS WNY was not compliant were Credentialing (1 citation), Organization and Management (4 citations), and Service Delivery Network (1 citations). The MCO was in compliance for all of the focused review types 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 does not correspond with the available focused review types.

AO: Area Office; HCS: Health Commerce System; MEDS: Medicaid Encounter Data Set; SOD: Statement of Deficiency; QARR: Quality Assurance Reporting Requirements

Table 21: Summary of Citations

Category	Operational Citations	Focused Review Citations
Complaints and Grievances	0	0
Credentialing	1	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	4	0
Prenatal Care	0	0
Quality Assurance	0	0
Service Delivery Network	1	0
Utilization Review	0	0
Total	**6**	**0**

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, 33% of the MCO's external appeals were overturned.

Table 22: External Appeals—2016-2018

	2016	2017	2018
		Medicaid	
Overturned	0	0	1
Overturned in Part	0	0	0
Upheld	0	0	2
Medicaid Total	**0**	**0**	**3**
		CHP	
Overturned	0	0	0
Overturned in Part	0	0	0
Upheld	0	0	1
CHP Total	**0**	**0**	**1**

VIII. Strengths and Opportunities for Improvement[9]

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:

- In regards to the Provider Network indicator, the MCO had an improvement in the HEDIS®/QARR *Board Certification* rates for *OB/GYN* and *Other Physician Specialists*. The MCO also had a rate above the statewide average for the number of Non-PCP Nurse Practitioners.
- In regards to the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO performed above the threshold for Routine (100%) and Non-Urgent "sick" (87.5%) call types.
- The MCO's rates regarding health screenings for new enrollees within 30 days of enrollment has improved from 11.5% in 2016 to 18.1% in 2018.
- In 2018, the MCO had rates above the statewide average for the following QARR Use of Services measures: *Inpatient ALOS – Surgery and Total* and *Inpatient Utilization – Surgery Cases.*
- In regards to HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain, the MCO has reported a rate above the statewide average for at least three consecutive reporting years for the *Adult BMI Assessment* measure. Additionally, rates for the following measures were reported above the statewide average for 2018: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, and Childhood Immunizations – Combo 3.*
- In regards to the Effectiveness of Care: Acute and Chronic Care domain, the MC's rate for *Testing for Children with Pharyngitis* was above the statewide average in 2018.
- The MCO had an improvement for all measures in the HEDIS®/QARR Behavioral Health domain. The MCO's rates for *Follow-Up After Hospitalization for Mental Illness (30 Days and 7 Days)* were above the statewide average in 2018.
- In the HEDIS®/QARR Utilization domain, The MCO's rate for *Well-Child Visits in the First 15 Months* was above the statewide average in 2018.

[9] 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.

- In the HEDIS®/QARR Access to Care domain, the MCO has reported rates above the statewide average for at least three consecutive reporting years for *Annual Dental Visit (Ages 2-20).* Additionally, the MCO's rate for the *12-19 Years* age group of the *Children and Adolescents' Access to Primary Care Practitioners* measure was reported above the statewide average for 2018.
- On the CAHPS® member satisfaction survey, the MCO's rates for *Getting Care Quickly* was reported above the statewide average for the 2018 survey cycle.

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:

- The MCO demonstrates an opportunity for improvement with the number of providers in the MCO's Medicaid product line. The MCO had rates below the statewide average for the following provider types: *Internal Medicine, Other PCPs,* and *Behavioral Health.*
- In the 2018 Primary Care and OB/GYN Access and Availability Survey, the MCO had an After-Hours total appointment rate of 61.5%, which is below the 75% threshold.
- The MCO continues to demonstrate opportunities for improvement in the HEDIS®/QARR Effectiveness of Care: Prevention and Screening domain. The MCO's rates have been reported below 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 rate for *Immunizations for Adolescents—Combination 2* was reported below the statewide average for 2018. *(Note: Breast Cancer Screening, Colorectal Cancer screening,* and *Chlamydia Screening in Women (Ages 16-24, were opportunities for improvement in the previous year's report.)*
- The MCO continues to demonstrate opportunities for improvement in the Effectiveness of Care: Acute and Chronic Care domain. The MCO's rates for HEDIS®/QARR *Spirometry Testing for COPD, Comprehensive Diabetes Care—HbA1c Testing* and *Annual Monitoring for Patients on Persistent Medications—Total Rate* have been reported below the statewide average for at least three consecutive reporting years. *(Note: Comprehensive Diabetes Care—HbA1c Testing and Annual Monitoring for Patients on Persistent Medications—Total Rate were opportunities for improvement in the previous year's report.)*
- The MCO demonstrates an opportunity for improvement in regard to *Children and Adolescents' Access to PCPs* for 25 Months to 6 Years old. The MCO had a reported rate of 92% which is below the statewide average.
- The MCO demonstrates an opportunity for improvement in regard to compliance with NYSDOH structure and operation standards. The MCO received 6 citations from the operational review survey related to Credentialing, Organization and Management, and Service Delivery Network.

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.

Recommendations:

- As HealthNow's 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 20-44 years, the MCO should consider increasing the number of providers that service this age group, such as Internal Medicine and other Primary Care Providers.
- 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.
- HealthNow continues to struggle to improve rates for chlamydia screenings, breast and colorectal cancer screenings. HealthNow should conduct a root cause analysis to determine the reason these rates have not improved. Interventions should target the barriers of access to providers, member education and any social disparities regarding these screenings. The MCO implemented an incentive program that allows members to earn points that can be redeemed for merchandise. The MCO should evaluate if this method of incentive has been effective by analyzing how many members have redeemed points. The MCO should consider an incentive program with monetary rewards. *[Repeat recommendation.]*
- The MCO continues to demonstrate opportunities for improvement for several measures related to monitoring chronic conditions such as COPD, diabetes, and monitoring of patients on persistent medications. The MCO should consider offering an evidence based self-management program to members in addition to the current educational efforts made by case management and the diabetes management team. The MCO should also consider the use of Pharmacists to assist with educating members on medications used to treat chronic conditions.
- The efforts made to address the citations received from the 2017 operational and focused review surveys have been successful. The MCO should continue with the steps taken to address the identified issues in the different categories in which citations were noted in the 2018 operational survey.

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: As the MCO continues to struggle to improve rates for certain cancer screenings, the MCO should consider more proactive initiatives to get members appropriate and timely screenings. Some initiatives could include community health fairs where members can get a breast cancer screen or assistance with scheduling an appointment, or in-home colon cancer testing kits for members who would benefit from this type of screening. The MCO should also consider tracking the number of screening gaps in care that are filled following educational and reminder mailings to evaluate the effectiveness of these initiatives. *[Repeat recommendation.]*

MCO Response:

In November 2016, HealthNow New York Inc. (HNNY) partnered with Amerigroup Partnership Plan, LLC (Amerigroup) to manage the Medicaid membership. RY 2017 HEDIS®/QARR measures were implemented by Amerigroup with oversight from HNNY.

At our HNNY and Amerigroup sub-team meetings we review the monthly HEDIS/QARR performance dashboard to monitor and evaluate measure performance throughout the measurement year.

Collaboratively we focus on interventions and strategies to address those lower performing HEDIS /QARR measures. Upon analysis we have implemented strategically targeted interventions that would lead to improvements in the areas identified as consistently reporting below Statewide Average or a decrease from the prior year.
The following cancer screening interventions focused on Breast Cancer Screening, Colorectal Cancer Screening, and Cervical Cancer Screening.

For Breast Cancer Screening we incentivize members who get their Breast Cancer Screenings using a Healthy Rewards program that allows members to earn reward points for healthy choices and redeem for merchandise. In addition, we have a member outreach campaign that uses both automated phone call reminders and member letters for gaps in preventive services. We have also partnered with the Mobile Mammogram Units to assist with scheduling appointments for members who have transportation or access issues. We have used the Pink bus mobile mammogram unit for our annual Wellness fairs. New in 2019: Members also receive text message reminders for women's health preventive services using HealthCrowd our new SMS messaging program. In addition to member outreach we work with our providers to get our members in for their cancer screenings utilizing Provider Gap in Care Reports distributed by our provider outreach team.

Colorectal Cancer Screening also uses the member Healthy Rewards program to earn points for completing screenings. We outreach to members who have not seen their primary care physicians in a year to help facilitate preventive services and cancer screenings. In addition these members will receive an educational letter on Colorectal Cancer Screening. We have collaborated with Quest laboratories to send our non-compliant members FIT DNA test kits. Our provider outreach team distributes Provider Gap in Care Reports and provider education on Cologuard.

Cervical Cancer Screening is also part of the Healthy Rewards program. We utilize our member outreach campaign and members will get an automated phone call reminder and a member letter for any gaps in preventive services and cancer screenings. Our provider outreach team distributes Provider Gap in Care Reports to the providers to assist in getting the members in to see their providers to receive services.

The HEDIS /QARR performance for the above cancer screening measures are reviewed monthly and the effectiveness of the interventions is reviewed annually.

Performance Goals:
Breast Cancer Screening: 50th Percentile/ 68.42%
Colorectal Cancer Screening: 50th Percentile/ 55.96%
Cervical Cancer Screening: 50th Percentile / 71.63%

2017 Recommendation: The MCO continues to demonstrate opportunities for improvement for several measures related to monitoring chronic conditions such as diabetes, as well as monitoring and follow-up for several behavioral health measures. The MCO should conduct thorough barrier analyses to identify factors preventing members with chronic and/or behavioral health conditions from receiving necessary monitoring tests and follow-up care and implement initiatives designed to remove or reduce those barriers. The MCO should also ensure that providers are aware of current clinical guidelines and that providers are receiving, reviewing, and taking action on information provided to them in gap-in-care reports. *[Repeat recommendation.]*

MCO Response:

Annual outreach is conducted for diabetic members focusing on HbA1c and Diabetic Retinal Exams. This intervention includes wellness outreach calls, making appointments, and addressing barriers to diabetic care such as transportation. In addition, our Diabetes Management team provides education, assists with setting goals, and coordinating care and services. To address barriers, in home services are being offered for diabetic retinal exams and HbA1c testing.
A Healthy Rewards program is offered for members who get their diabetic services completed (HbA1C, retinal exam, and nephropathy screening). Educational mailings are sent out focusing on diabetes and hypertension. In addition, our pharmacy team has a diabetic polypharmacy program that outreaches to members who have a diagnosis of diabetes and are taking 15 or more medications.

The provider outreach team works with our providers to close gaps in care by distributing reports and assisting in getting members services.

Behavioral Health Interventions:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA): The Behavioral Health team makes outreach calls to all members with a schizophrenia diagnosis and prescribed clozapine. Member outreach is performed to ensure medications are being refilled and taken properly, that members are linked with an outpatient provider and have a follow up appointment, if needed members are referred to a health home case manager or case manager.
- Follow-Up Care for Children Newly Prescribed ADHD Medication (ADD): Claim reports are utilized for all initiation medications that were started and for members that met initiation, but not for continuation. Outreach calls are made to the parents, and education is also provided. If needed members are enrolled with a case manager and a follow up call is made after 30 days.
- Antidepressant Medication Management (AMM): In 2018 automatic reminder calls to the member with a call back number to the pharmacy care center was initiated. The pharmacy uses the New Start Program and sends educational mailings and outreach calls to members.
  Behavioral health staff sends faxes to the providers, provides member outreach, member education, and tips on taking medications.
- Follow- Up after Discharge from the ED for Alcohol or Other Drug Dependence (AOD) - 7 Day (FUA): Behavioral Health uses emergency department reports in order to reach out to all members in a timely manner to ensure: education regarding 7 day follow up appointment, medications, and transportation. The behavioral health team is collaborating with our largest volume provider ECMC to obtain daily Emergency Department census, discharge planner, and social worker to ensure members are linked with a provider, have a 7 day follow up appointment, medications, and transportation needed.

The above behavioral health measures offer a provider quality incentive.

Performance Goals:

HbA1c Testing, Goal: 50th Percentile / 64.52%,
Diabetic Retinal Exam, Goal: 50th Percentile / 64.52%
Medical Attention for Nephropathy, Goal: 50th Percentile / 91.67%
Comprehensive Diabetes Care - BP Control < 140/90, Goal: 50th Percentile / 64.75%
HbA1c Control <8.0%, Goal: 50th Percentile / 55.07%
Antidepressant Medication Management (AMM), Goal: Acute Phase: 50th Percentile / 49.26%, Continuation Phase: Goal: 50th Percentile / 34.79%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA), Goal: 75th Percentile / 64.71%

Follow-Up Care for Children Newly Prescribed ADHD Medication (ADD), Initiation Phase Goal: 47.14% /Continuation Phase Goal: 58.19%
Follow- Up after Discharge from the ED for Alcohol or Other Drug Dependence (AOD) - 7 Day (FUA), Goal: 90th Percentile / 23.64%

The HEDIS /QARR performance for the above measures are reviewed monthly and the effectiveness of the interventions are reviewed annually.

2017 Recommendation: The MCO should take steps to address the low-performing CAHPS® measures by identifying the areas in which members reported unfavorably and take steps to address any issues.

MCO Response:

Data from customer service member satisfaction surveys are reviewed to identify issues with member interaction. Additional customer service training is provided to improve member satisfaction.

In the fall of 2018, the Amerigroup Partnership Plan, LLC partnered with Research and Marketing Strategies, Inc. (RMS) to conduct focus group research to uncover patient insights regarding the BlueCross BlueShield of Western New York Medicaid Health plan as well as triggers to improve patient engagement. Pharmacy was identified as an area that was decreasing member satisfaction. Working with Pharmacy and the National Call Center (NCC), a direct line was developed for both members and providers to obtain the assistance from a Pharmacy Account Manager decreasing multiple transfers and increasing satisfaction.

In 2019, a corporate effort was implemented to "clean" provider data, to ensure members and providers receive the correct information whether online or in the provider directory.

A new CME online course is offered to providers, "What Matters Most: Improving the Patient Experience" to improve member satisfaction in the Rating of PCP and Specialists.

CAHPS® surveys are reviewed to address low-performing measures.

2017 Recommendation: The MCO received a large number of citations from the operational and focused review surveys. The MCO should take necessary steps to address the identified issues in the different categories in which citations were noted, as follows: *[Repeat recommendation.]*

- Complaints and Grievances: The MCO should review and revise its process for preparing Initial Adverse Determination letters to ensure they include the detailed reasons for the determination. Additionally, the MCO should revise its Explanation of Benefits to ensure it includes all required information.
- Credentialing: The MCO should review its process for credentialing and re-credentialing providers in its network to ensure providers are appropriately vetted and re-credentialed in a timely manner.
- Member Services: The MCO should ensure all Member Services staff are appropriately trained to respond to requests, questions, and issues members have when calling in.
- Organization and Management: The MCO should ensure that all contracts with providers are filed and implemented appropriately, that providers in the network understand and adhere to all access and availability requirements, and ensure its management vendor complies with structure and operation standards.
- Services Delivery Network: The MCO should ensure the Provider Manual includes all required information, and that the information in the provider directory is accurate.
- Utilization Review: The MCO should review all utilization review procedures and documentation to ensure that all required language and information is included and that the MCO's procedures comply with structure and operation standards.

MCO Response:

Non-UR Complaints and Grievances: This deficiency occurred while HealthNow was managing the day-to-day operations of the Medicaid line of business internally. The day-to-day operations of the Medicaid line of business were shifted to Amerigroup as part of an ongoing partnership effective 11/1/16. During the course of the survey, the files managed by Amerigroup were not found to have this deficiency. HealthNow will continue to monitor and provide oversight of Amerigroup for the Medicaid line of business for continued compliance.
Below are the actions that are being taken:

- Initial Adverse Determination letter determinations were revised to increase specificity in 2018 in accordance with the NYS-mandated Medicaid Managed Care rules that took effect on 5/1/18.
- Initial Adverse Determination letters are continuously monitored to ensure regulatory requirements are being met and associates are re-trained when errors are found.
- Appeal timeframes on EOBs are reviewed and revised to ensure they meet regulatory requirements.

Credentialing: HealthNow New York Inc Implemented the review of the Social Security Death Master Listing ("DML") in July 2015. The review for both credentialing and re-credentialing files is completed using an interactive web based service.
Effective June 2017, HealthNow is using an interactive web based service to query the DML. The queries are logged and saved in the background data tables of the tool. Review results are documented on the credentialing worksheet and a report generated then uploaded into the Cactus credentialing software system. An electronic record of the query is also archived within the WatchDOG software database. The log can be used for audit purposes to ensure that staff are following the correct process. It can also be used to retrieve detail for a specific search in the unlikely event that staff fail to upload a copy of the report into the credentialing file.
To ensure more timely follow-up by the credentialing staff and response from a non-compliant provider, HealthNow has implemented a standard operating procedure; non-compliant provider checklist.
Effective July 24, 2017. The checklist will be utilized for all provider types who require an outreach call/email/fax for additional information related to the credentialing event.
The checklist outlines the following:

- Use the contact method that will lead to the highest response rate from the provider. Leaving a message on a provider's voice mail does not constitute a contact.
- Contact the provider no less than 3 times and wait no longer than 3 business days between contacts.
- If unsuccessful after 3 contacts: for providers who fail to respond after 3 contacts:,
    - Re-credentialing file: Send termination notice.
    - New credentialing file: Close the application and notify the provider.

In accordance with the HealthNow New York Inc. Credentialing Policy and Procedure for Delegated Credentialing and Re-credentialing, the performance of the Contracted Delegated Entity is monitored on an ongoing basis and is formally evaluated annually.
Amerigroup is checking the Social Security Administration Death Master List as required primary source verification and is a required step in their credentialing and re-credentialing processes.

HealthNow will audit the process followed by the credentialing specialists and the credentialing files monthly to ensure compliance with the credentialing process, any errors found are reviewed with the staff and desk level education is conducted. Audit findings are reported monthly to the Director of Provider Network Operations & System Configuration.

Member Services: The National Call Center (NCC) has reviewed and will continue to review all available resources and documents to ensure that materials contain the most up to date information. Any updates or

changes to market material will be communicated immediately. Refresher training is provided periodically as needed.
The NCC will ensure that all Member Service associates are utilizing all tools and resources to provide accurate and complete information to our members/potential members. This will be done through call auditing and side by sides. The NCC will ensure that information is readily accessible to associates in tool banks.

The Behavioral Health Call (BH) Center has reviewed all training materials for Western New York to assess any potential gaps. Based on the assessment, the call center management team will be conducting additional training including but not limited to: Virtual e-cast, weekly huddle updates, email communications, and individual associate coaching.
BH Call Center Management is working currently with our learning department and workforce management team to roll out the e-cast training. The material is developed, and associates are being scheduled to take the assessment. Huddles are held on a weekly basis with all associates. Question and answer sessions will be held at each staff huddle to ensure sufficient comprehension of material.
Based on the BH Call Center management plan, staff will be sufficiently knowledgeable in WNY benefits, caveats and procedures. They should be able to answer any questions from members or providers utilizing internal resources and documents.
BH Call Center Managers will be monitoring their associate's progress along with our internal quality team. Any risks presented will be addressed immediately.

Organization and Management: A new contract repository system to help maintain standardization across contracts was implemented.
Audits on contracts to ensure correct configuration are scheduled. During the audits, a subset of facility and physician contracts are selected for review. The audit examines each contract, the loaded configuration, and the resulting payment to ensure that all aspects of reimbursement in the contract are adhered to.
Network reviews are done on a quarterly basis in order to assess needs and deficiencies. Ongoing outreach is used in order to recruit provider specialties where a deficiency is observed.
A third-party vendor was hired to conduct outreach phone calls to ensure that providers are compliant with availability standards outlined in the provider manual, policies, and contracts. If any provider does not comply with standards, the provider office is contacted to reinforce expectations and requirements. Providers who are repeatedly non-compliant even with corrective action plans will be considered for termination.
Management vendors are vetted thoroughly through an extensive process. Ongoing oversight committee meetings will occur to ensure all aspects of agreement are adhered to. All vendor management contracts include terms on responsibilities and expectations.

Services Delivery Network: A yearly review and update of the provider manual is conducted in order to maintain clear and current guidelines for providers. In addition to the yearly update, there is a process for adding content off-cycle when a deficiency is determined or new guidelines are implemented.
Providers are informed of the updated manual through the online portal and via fax if any off cycle changes occur.
The provider directory is reviewed and updated with regularity. The printed version of the provider directory is updated on a quarterly basis while the online resource is updated within 30 days of any changes.

The Network Relations & Claims Joint Operating Committee meeting is conducted monthly with HealthNow and Amerigroup staff. As a standing agenda item, Amerigroup will give updates as to the status of their provider manual, and changes thereof. By doing so, the monthly discussion will support ongoing monitoring of Amerigroup's provider manual and their compliance with regulatory requirements.

Utilization Review: Daily reporting is performed that identifies all adverse determinations to confirm that the appropriate information was communicated to the member and provider. Refresher training will be provided for each error with root cause identification. In addition, we will run monthly audits to confirm compliance with adverse determination notification, documentation requirements, weekly reporting of adverse determination decisions and notification turnaround times. Associates not meeting the requirements will be provided individual education, training, and or performance improvement plans if necessary.

The plan and its delegates will ensure that all Initial Adverse Determination (IAD) notices include a clear statement for the denial which includes the reasons for the determination and the enrollee-specific clinical rationale. We will provide education, training and annual criteria refreshers.

HealthNow Utilization Management performs monthly audits on internal files as well as its delegates. In these monthly/quarterly audits, letter requirements are reviewed. Internal and delegate audit results are shared on multiple levels including Vendor Joint Oversight Team meetings.

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