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

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

Reporting Year 2017

FINAL REPORT

Published April 2019

Table of Contents

List of Tables

Acronyms Used in This Report

ALOS: *Average Length of Stay*
AO: *Area Office*

CFR: *Code of Federal Regulations*
CHP: *Child Health Plus*
CMS: *Centers for Medicare and Medicaid Services*
COM: *Commercial*

DBA: *Doing Business As*

EQR: *External Quality Review*
EQRO: *External Quality Review Organization*

F/A: *Failed Audit*
FAR: *Final Audit Report*
FFS: *Fee-For-Service*
FIDA: *Fully Integrated Duals Advantage*
FTE: *Full Time Equivalent*

HARP: *Health and Recovery Plan*
HCS: *Health Commerce System*
HEDIS: *Healthcare Effectiveness Data and Information Set*
HIE: *Health Information Exchange*
HIT: *Health Information Technology*
HMO: *Health Maintenance Organization*
HPN: *Health Provider Network*

MAP: *Medicaid Advantage Plus*
MCD: *Medicaid*
MCO: *Managed Care Organization*
MLTC: *Managed Long-Term Care*
MMC: *Medicaid Managed Care*
MMCOR: *Medicaid Managed Care Operating Report*
MRT: *Medicaid Redesign Team*
MY: *Measurement Year*

N: *Denominator*
N/A: *Not Available*
NCQA: *National Committee for Quality Assurance*
NP: *Not Provided*
NR: *Not Reported*
NV: *Not Valid*
NYC: *New York City*
NYCRR: *New York Code of Rules and Regulations*
NYS: *New York State*
NYSDOH: *New York State Department of Health*

OB/GYN: *Obstetrician/Gynecologist*
OHIP: *Office of Health Insurance Programs*
OPMC: *Office of Professional Medical Conduct*
OP: *Optimal Practitioner Contact*
OQPS: *Office of Quality and Patient Safety*

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

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

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

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

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

UR: *Utilization Review*

I. About This Report

Purpose of This Report

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

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

History of the New York State Medicaid Managed Care Program

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

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

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

Scope of This Report

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

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

Structure of This Report

This report is organized into the following domains: MCO Corporate Profiles, Enrollment and Provider Network, Utilization, Performance Indicators, and Structure and Operation Standards. When available and appropriate, the MCOs' data are compared to the Special Needs Plan (SNP) benchmark rate, which is the combined rate of all HIV SNPs. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the benchmark rate.

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

In an effort to provide the most consistent presentation of this varied information, the technical reports are prepared based on data for the most current calendar year available. This report includes data from Reporting Year 2017.

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

II. MCO Corporate Profiles

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

NCQA Accreditation Survey Key:		
★★★★	**Excellent**	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS® results are in the highest range of national performance.
★★★	**Commendable**	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
★★	**Accredited**	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
★	**Provisional**	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
No stars	**Denied**	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

Table 1: MCO Corporate Profiles

MCO	Medicaid Managed Care Start Date	Product Line(s)	NCQA Accreditation Rating (as of 10/15/18)	Medicaid Dental Benefit Status
Amida Care	04/15/03	Medicaid SNP	Did not apply	Mandatory
MetroPlus SNP	02/14/03	Medicaid SNP	Did not apply	Mandatory
VNS Choice	12/23/11	Medicaid SNP	Did not apply	Mandatory

III. Enrollment and Provider Network

Enrollment

Table 2 displays total enrollment for the MCOs' Medicaid SNP product line for Calendar Years 2015, 2016, and 2017, as well as the percent change between 2016 and 2017.

Table 2: Medicaid SNP Enrollment—2015-2017

MCO	2015	2016	2017	% Change from 2016-2017
Amida Care	4,971	6,171	6,266	1.5%
MetroPlus SNP	4,530	4,471	4,156	-7.0%
VNS Choice	3,932	3,542	3,364	-5.0%
Statewide Total	**14,433**	**14,184**	**13,786**	**-2.8%**

Data Source: MEDS II

Provider Network

This section of the report examines the MCOs' provider networks through HEDIS®/QARR Board Certification rates and MCO performance on the Primary Care and OB/GYN Access and Availability Survey[2]. This section also includes an overview of network adequacy standards.

Network Adequacy Standards

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

Section 15.1 of the Contract states *"The Contractor shall establish and implement mechanisms to ensure Participating Providers comply with timely access requirements, monitor regularly to determine compliance, and take corrective action if there is a failure to comply."* In order to determine compliance with access standards, the NYSDOH utilizes several different methodologies.

Appointment Availability/Timeliness Standards

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

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

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

Travel Time and Distance Standards

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

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

Board Certification

Board certification ensures physicians meet rigorous criteria. In order to maintain an "active" board certification, providers must have evidence of professional standing, commitment to lifelong learning and self-assessment, cognitive expertise, and evaluation of practice performance. The American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) member boards require participation in a program of ongoing maintenance of certification[3].

The quality of the providers participating in an organization's network has a significant effect on the overall quality of care delivered to members. As a result, purchasers and consumers want information that helps them assess the quality of an organization's physicians, though HEDIS® *Board Certification* does not directly measure the quality of every provider in an organization. The changing scope of medical information, increased public concern for the need to recredential physicians, and evidence that knowledge and skills of practicing physicians decays over time motivated specialty boards to limit the duration of certificates[4]. To date, all ABMS member boards have agreed to issue time-limited certificates that necessitate subsequent re-certification, usually at intervals of 10 years or less.

Board certification shows what percentage of the organization's physicians have sought and obtained board certification. While there are valid reasons why physicians may not have done this, and board certification alone is not a guarantee of quality, certification provides a baseline established by standardized, specialty-specific competency testing. HEDIS®/QARR *Board Certification* rates represent the percentage of physicians in the MCOs' provider networks that are board-certified in their specialty. **Table 3** displays HEDIS®/QARR *Board Certification* rates of providers in the MCOs' networks for 2017, as well as the statewide averages. The table also indicates whether the MCOs' rates were significantly above (indicated by ▲) or significantly below (indicated by ▼) the statewide average.

Table 3: HEDIS®/QARR Board Certification Rates—2017

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

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

MCO	Family Medicine	Internal Medicine	Pediatricians	OB/GYN	Geriatricians	Other Physician Specialists
Amida Care	89 ▲	86 ▲	71 ▲	86 ▲	92 ▲	87 ▲
MetroPlus SNP	68 ▲	66 ▲	67 ▲	67 ▼	55 ▼	52 ▲
VNS Choice	15 ▼	23 ▼	11 ▼	*SS*	36 ▼	20 ▼
Statewide Average	**55**	**58**	**52**	**78**	**65**	**44**

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

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

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

Section 15.2 of the Medicaid Managed Care Contract outlines the timeliness standards for various types of services. For routine office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(vi) states *"Routine, non-urgent, preventive appointments… within four (4) weeks of request."* For non-urgent "sick" office hour appointments with PCPs and OB/GYNs, Section 15.2(a)(v) states that appointments must be scheduled *"…within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated."* Note that the timeliness standard for these types of appointments excludes weekends and holidays. The timeliness standard for prenatal appointments 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."* Section 15.3(b) of the Contract also states that MCOs can satisfy this requirement *"…by requiring their PCPs and OB/GYNs to have primary responsibility for serving as after-hours "on-call" telephone resources to members with medical problems."* For the purposes of the Survey, after-hours access is considered compliant if a "live voice" representing the named provider is reached or if the provider's beeper number is reached.

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

IV. Utilization

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

QARR Use of Services Measures

For this domain of measures, performance is assessed by indicating whether the MCOs' rates reached the 90th or 10th percentile. **Table 4** lists the Use of Services rates for 2017. The table displays whether the MCOs' rates were higher than 90% of all rates for that measure (indicated by ▲) or whether the MCOs' rates were lower than 90% of all rates for that measure (indicated by ▼).

Table 4: QARR Use of Services Rates—2017

	Outpatient Utilization (PTMY)		Inpatient ALOS			Inpatient Utilization (PTMY)		
MCO	**Visits**	**ER Visits**	**Medicine**	**Surgery**	**Maternity**	**Medicine**	**Surgery**	**Maternity**
Amida Care	12,309 ▲	1,285 ▲	4.8	8.8 ▲	*SS*	279 ▲	54	*SS*
MetroPlus SNP	7,895 ▼	985	7.5 ▲	7.2	*SS*	248	30 ▼	*SS*
VNS Choice	10,622	920 ▼	4.7 ▼	6.3 ▼	*SS*	65 ▼	75 ▲	*SS*
Statewide Average	**10,544**	**1,104**	**5.8**	**7.6**	**4.3**	**217**	**52**	**4**

SS: Sample size too small to report (less than 30 members), but included in the statewide average.
PTMY: Per Thousand Member Years
ER: Emergency Room
ALOS: Average Length of Stay. These rates are measured in days.

V. Performance Indicators

To measure the quality, accessibility, and timeliness of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of performance indicators. This section is a summary of findings from those reports, including HEDIS®/QARR 2018 findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

Validation of Performance Measures

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data to the NYSDOH for several measures. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2018 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS® 2018 Compliance Audit™ are summarized in its Final Audit Report (FAR).

Summary of HEDIS® 2018 Information System Audit™

As part of the HEDIS® 2018 Compliance Audit™, auditors assessed the MCOs' compliance with NCQA standards in the six designated information system categories, as follows:

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

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

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

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

Note: MCO summaries of the HEDIS® 2018 Final Audit Reports are available within the individual, MCO-specific technical reports.

HEDIS®/QARR Performance Measures

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

- Effectiveness of Care
- Acute and Chronic Care
- Behavioral Health
- Access to Care

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

Quality Indicators

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

Effectiveness of Care

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

Effectiveness of Care Performance Measures[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.
HEDIS®	Breast Cancer Screening (BCS)	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
HEDIS®	Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.
HEDIS®	Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
HEDIS®	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.
HEDIS®	Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.
CAHPS®	Flu Vaccinations for Adults Ages 18-64 (FVA)	The percentage of members 18-64 years of age who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS® 5.0H survey was completed.
CAHPS®	Advising Smokers and Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
CAHPS®	Discussing Cessation Medications	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
CAHPS®	Discussing Cessation Strategies	The percentage of members 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods and strategies during the measurement year.

COPD: Chronic Obstructive Pulmonary Disease

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

Table 5a displays HEDIS®/QARR performance rates for Measurement Year 2017 for the Effectiveness of Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼).

Table 5a: HEDIS®/QARR MCO Performance Rates 2017—Effectiveness of Care[1]

Measure	Amida Care	MetroPlus SNP	VNS Choice	2017 SWA
Adult BMI Assessment	74	91 ▲	67 ▼	**77**
Breast Cancer Screening	66	73 ▲	66	**68**
Colorectal Cancer Screening	56 ▼	67 ▲	63	**61**
Chlamydia Screening (Ages 16-24)	*SS*	77	*SS*	**77**
Spirometry Testing for COPD	22	40 ▲	21	**26**
Use of Imaging Studies for Low Back Pain	*SS*	*SS*	*SS*	**—**
Flu Shots for Adults (Ages 18-64)[2]	73	73	77	**74**
Advising Smokers to Quit[2]	91	91	95	**92**
Smoking Cessation Medications[2]	79	85	80	**81**
Smoking Cessation Strategies[2]	75	76	75	**75**

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

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

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

[2] CAHPS® measure.

Acute and Chronic Care

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

Acute and Chronic Care Performance Indicators[1]		
Measure Type	**Measure Name**	**Measure Description**
HEDIS®	Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement period and who were dispensed appropriate medications.
HEDIS®	Medication Management for People with Asthma (MMA)	The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medication, and remained on an asthma controller medication for at least 50% of their treatment period.
HEDIS®	Asthma Medication Ratio (AMR)	The percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
HEDIS®	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.
HEDIS®	Comprehensive Diabetes Care (CDC)	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c testing, HbA1c control (<8.0%); eye exam (retinal) performed; medical attention for nephropathy; and BP control (<140/90 mm Hg).
HEDIS®	Annual Monitoring for Patients on Persistent Medications—Total Rate (MPM)	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
NYS-specific[2]	HIV Viral Load Suppression	The percentage of Medicaid enrollees confirmed HIV-positive who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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

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

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

Table 5b displays HEDIS®/QARR performance rates for Measurement Year 2017 for the Acute and Chronic Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼).

Table 5b: HEDIS®/QARR MCO Performance Rates 2017—Acute and Chronic Care[1]

Measure	Amida Care	MetroPlus SNP	VNS Choice	2017 SWA
Pharmacotherapy Management for COPD—Bronchodilators	96	91	92	**94**
Pharmacotherapy Management for COPD—Corticosteroids	57	54	73 ▲	**60**
Medication Management for People with Asthma 50% (Ages 19-64)	81	81	82	**82**
Asthma Medication Ratio (Ages 19-64)	41 ▲	36	29 ▼	**37**
Persistence of Beta-Blocker Treatment After a Heart Attack	*SS*	*SS*	*SS*	**—**
CDC—HbA1c Testing	94	96	94	**95**
CDC—HbA1c Control (<8.0%)	60 ▲	67 ▲	13 ▼	**50**
CDC—Eye Exam Performed	48	53	49	**50**
CDC—Nephropathy Monitor	93	93	91	**93**
CDC—BP Controlled (<140/90 mm Hg)	51	70 ▲	19 ▼	**48**
Monitor Patients on Persistent Medications—Total Rate	99	97 ▼	99	**99**
HIV Viral Load Suppression[2]	77 ▼	80	83 ▲	**79**

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

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

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

[2] NYS-specific measure.

Behavioral Health

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

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

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

Table 5c displays HEDIS®/QARR performance rates for Measurement Year 2017 for the Behavioral Health domain, as well as the statewide averages (SWAs), for the Medicaid and CHP populations. The table indicates whether the MCOs' rates were statistically better than the SWA (indicated by ▲) or whether the MCOs' rates were statistically worse than the SWA (indicated by ▼).

Table 5c: HEDIS®/QARR MCO Performance Rates 2017—Behavioral Health[1]

Measure	Amida Care	MetroPlus SNP	VNS Choice	2017 SWA
Antidepressant Medication Management—Effective Acute Phase Treatment	58	64	70	**62**
Antidepressant Medication Management—Effective Continuation Phase Treatment	41	45	54	**45**
Follow-Up After Hospitalization for Mental Illness—30 Days	NV	56	72	**63**
Follow-Up After Hospitalization for Mental Illness—30 Days	NV	37	42	**39**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	99	99	96	**98**
Diabetes Monitoring for People with Diabetes and Schizophrenia	92	*SS*	*SS*	**89**
Antipsychotic Medications for Schizophrenia	56	60	61	**58**

NV: Not valid. The MCO submitted invalid data for the reporting year.

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

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

Access/Timeliness Indicators

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

Access to Care

The HEDIS®/QARR Access to Care measures examine the percentage of children and adults who access certain services, including preventive services, prenatal and postpartum care, and dental services. The table below provides descriptions of the measure included in this domain.

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

[1] The measure description in the HEDIS® 2018 Technical Specifications for Health Plans, Volume 2 were used for HEDIS® measure.

Table 6 displays HEDIS®/QARR performance rates for Measurement Year 2017 for the Access to Care domain, as well as the statewide averages (SWAs). The table indicates whether the MCOs' rates were higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCOs' rates were lower than 90% of all MCOs for that measure (indicated by ▼).

Table 6: HEDIS®/QARR MCO Performance Rates 2017—Access to Care[1]

	Adults' Access to Preventive/Ambulatory Services		
MCO	**20-44 Years**	**45-64 Years**	**65+ Years**
Amida Care	97 ▲	99	98
MetroPlus SNP	95 ▼	98	99
VNS Choice	96	99	100
Statewide Average	**96**	**98**	**99**

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

Member Satisfaction

In 2017, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 7** displays the question category, the MCOs' rates, and the statewide averages (SWAs) for Measurement Year 2017. The table also indicates whether the MCOs' rates were significantly better than the SWA (indicated by ▲) or whether the MCOs' rates were significantly worse than the SWA (indicated by ▼).

Table 7: CAHPS®—2017

MCO	Getting Care Needed[1]	Getting Care Quickly[1]	Satisfaction with Provider Communication[1]	Customer Service[1]	Collaborative Decision Making	Rating of Personal Doctor	Rating of Specialist	Rating of Healthcare	Overall Rating of Health Plan
Amida Care	81	89 ▲	93	92	83	87	77	77	80
MetroPlus SNP	79	82 ▼	93	88	84	87	81	82	80
VNS Choice	82	86	94	92	84	90	78	78	79
Statewide Average	**80**	**86**	**93**	**90**	**84**	**88**	**79**	**79**	**79**

[1] These indicators are composite measures.

Performance Improvement Projects

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

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

The PIP should target improvement in either clinical or non-clinical services delivered by the MCOs. Study topics must reflect MCO enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over- or under-utilization that present a clear threat to health or functional status, as well. The topic should address a significant portion of enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may be categorized as infrequent conditions or services, and also exist for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special needs place them at high risk. The State may select the MCOs' study topic(s), or topics may be selected based on enrollee input. While MCOs have the option to select a study topic of their choosing, they are encouraged to participate collaboratively with other MCOs in conducting their PIPs. The common-themed PIP chosen for Reporting Years 2017-2018 was Inpatient Care Transitions.

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

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

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

VI. Structure and Operation Standards[5]

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

Compliance with NYS Structure and Operation Standards

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

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

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

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in **Table 8**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 9 reflects the total number of citations received by each MCO for the most current operational survey, where applicable, as well as from the focused reviews conducted in 2017.

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

Table 8: Focused Review Types

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

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

Table 9: Summary of Citations—2017

MCO	Operational Citations	Focused Review Citations	Total Citations
Amida Care	12	10	22
MetroPlus SNP	12	8	20
VNS Choice	4	9	13
Statewide Total	**28**	**27**	**55**

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

VII. Strengths and Opportunities for Improvement[6]

This section summarizes the accessibility, timeliness, and quality of services provided by the MCOs to Medicaid SNP recipients based on data presented in the various sections of the individual, MCO-specific technical reports. The MCOs' strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of health care are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCOs have 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 MCOs' responses to the previous year's recommendations, wherein the MCOs were given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas the MCO did not feel were within their ability to improve, is appended to this section of the MCO-specific technical reports.

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

[6] 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.

VIII. Appendix

References

A. MCO Corporate Profiles

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

B. Enrollment and Provider Network

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

C. Utilization

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

D. Performance Indicators

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

E. Structure and Operations

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