New York State

Mainstream Medicaid Managed Care

2021 External Quality Review Annual Technical Report

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Prepared on behalf of:
The New York State Department of Health
Office of Quality and Patient Safety

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About This Report

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual, external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. The New York State Department of Health contracted with IPRO, an external quality review organization, to conduct the 2021 external quality review of the managed care plans that comprised New York's mainstream Medicaid managed care program. The results of this review are summarized in this report.

This external quality review technical report focuses on three federally required activities (performance improvement projects, performance measures, and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted between January 1, 2021, and December 31, 2021, or measurement year 2021.

Table 1: Mainstream Medicaid Managed Care Activities Performed for 2021

What Did the Department of Health Do?	What Did the Medicaid Managed Care Plans Do?	What Did IPRO Do?
Required all mainstream Medicaid managed care plans to conduct projects to improve the health of New Yorkers. These projects are called performance improvement projects.	Conducted performance improvement projects on improving preventative care during early childhood development.	Evaluated how the mainstream Medicaid managed care plans conducted performance improvement projects.
Required all mainstream Medicaid managed care plans to collect and report certain health data. These data are called performance measures.	Collected and reported performance measure data to the Department of Health.	Reviewed data collection methods used by the mainstream Medicaid managed care plans to calculate performance measures rates.
Required all mainstream Medicaid managed care plans to comply with federal and state Medicaid standards; and conducted an evaluation to determine mainstream Medicaid managed care plan compliance with these standards.	Presented evidence of compliance with Medicaid standards to the Department of Health.	Reviewed the results of an evaluation of mainstream Medicaid managed care plan compliance with Medicaid standards.
Sponsored a quality-of-care survey for all mainstream Medicaid managed care plans.	Used these findings in planning future activities to address or enhance member experience.	Reviewed data collection and analysis methods and results of a survey on member experience with mainstream Medicaid managed care plans.

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the managed care plan. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted managed care plans. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services.[1] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through *(d)* requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that managed care plans furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the managed care plans with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

To comply with *42 Code of Federal Regulations Section 438.364 External quality review results (a)* through *(d)* and *42 Code of Federal Regulations 438.358 Activities related to external quality review*, the Department of Health has contracted with IPRO, an external quality review organization, to conduct the 2021 external quality review of the mainstream managed care plans that are part of New York's Medicaid managed care program.

It is important to note that the provision of health care services to Medicaid and Child Health Plus enrollees is evaluated in this report.

2021 External Quality Review

This external quality review technical report focuses on three federally required activities (validation of performance improvement projects, validation of performance measures, and review of compliance with Medicaid standards) and one optional activity (quality-of-care survey) that were conducted for measurement year 2021. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[5] published in October 2019. The external quality review activities and corresponding protocols are described in Table 2.

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[1] The Centers for Medicare and Medicaid Services website: https://www.cms.gov/.
[2] prepaid inpatient health plan.
[3] prepaid ambulatory health plan.
[4] primary care case management.
[5] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

Table 2: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed mainstream Medicaid managed care plan performance improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS®[6]) audit results provided by the managed care plans' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance auditors, member-level files, and reported rates to validate that performance measures were calculated according to Department of Health specifications.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by the Department of Health of mainstream Medicaid managed care plan compliance with Medicaid standards. Specifically, this review assessed compliance with *Code of Federal Regulations Part 438 Subpart D*, *Code of Federal Regulations 438.330,* the *Medicaid Managed Care/ HIV Special Needs Plan/Health and Recovery Plan Model Contract*, *New York State Public Health Law*[7] *Article 44* and *Article 49*, and *New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*.[8]
Activity 6. Administration of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO subcontracted with DataStat, an NCQA-certified survey vendor, to administer the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS®[9]) survey to evaluate member experience with New York's mainstream Medicaid managed care program.

The results of IPRO's external quality review are reported under each activity section.

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that the Information Systems Capabilities Assessment is a required component of the mandatory external quality review activities, the Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of the NCQA HEDIS® Compliance Audit™ for External Quality Review Activity 2. Validation of Performance Measures may be substituted for an Information Systems Capabilities Assessment. IPRO's validation methodology included a review of the systems reviews summarized by each managed care plan's NCQA HEDIS Auditor in the HEDIS Final Audit Report for measurement year 2021.

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[6] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[7] New York State Legislature Website: http://public.leginfo.state.ny.us/navigate.cgi?NVMUO.
[8] New York State New York Codes, Rules, and Regulations Website: https://regs.health.ny.gov/volume-2-title-10/content/subpart-98-1-managed-care-organizations.
[9] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

New York State Medicaid Managed Care Program and Medicaid Quality Strategy

History of the New York State Medicaid Managed Care Program

The New York State Medicaid managed care program began in 1997 when New York State received approval from the Centers for Medicare & Medicaid Services to mandatorily enroll Medicaid members in a managed care program through a Section 1115 Demonstration Waiver.[10] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states 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 New York State Section 1115 Demonstration Waiver project began with these goals:

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

New York State's Medicaid managed care program offers a variety of managed care plans to coordinate the provision, quality, and payment of care for its enrolled members. Medicaid members not in need of specialized services are enrolled into health maintenance organizations or prepaid health services plans (referred to as "mainstream Medicaid"). Members with specialized health care needs can opt to join available specialized managed care plans. Current specialized Medicaid plans include HIV Special Needs Plans, Health and Recovery Plans, and Managed Long-Term Care plans.

New York State Medicaid Quality Strategy

New York maintains rigorous standards to ensure that approved health plans have networks and quality management programs necessary to serve all enrolled populations. The quality strategy developed by the Department of Health is intended to be the quality framework for the New York State Medicaid program and participating managed care plans. The Department of Health performs periodic reviews of its Medicaid quality strategy to determine the need for revision and to ensure managed care plans are compliant with regulatory standards and have committed adequate resources to perform internal monitoring and ongoing quality improvement. The Department of Health updates the Medicaid quality strategy as needed, but no less than once every three years.

New York State's 2020–2022 Medicaid Quality Strategy[11] focuses on achieving measurable improvement and reducing health disparities through ten high-priority goals. Based on the Triple Aim framework, the state organized its goals by these aims: 1) improved population health; 2) improved quality of care; and 3) lower per-capita cost. New York State's Medicaid quality strategy aims and corresponding goals are:

- Triple Aim 1: Improved Population Health
  Goal 1: Improve maternal health

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[10] Medicaid.gov About 1115 Demonstrations Website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html

[11] The New York State Medicaid/Child Health Plus Insurance Program Quality Strategy Website: https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-03-14_chplus_quality_strategy_final.pdf.

Goal 2: Ensure a healthy start
Goal 3: Promote effective and comprehensive prevention and management of chronic disease
Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings
Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Triple Aim 2: Improved Quality of Care
  Goal 6: Improve quality of substance use disorder and opioid use disorder treatment
  Goal 7: Promote prevention with access to high-quality care
  Goal 8: Support members in their communities
  Goal 9: Improve patient safety

- Triple Aim 3: Lower Per-Capita Cost
  Goal 10: Pay for high-value care

The state has further identified 24 metrics to track progress towards the ten goals listed above. These metrics were selected from the New York State Quality Assurance Reporting Requirements measurement set, the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System and Behavioral Risk Factor Surveillance System, the National Survey on Drug Use and Health, 3M's Potentially Preventable Admissions, the Centers for Medicare & Medicaid Services' *Early and Periodic Screening, Diagnostic and Treatment Annual Participation Report* and other New York State-specific measures. **Table 3** presents a summary of the state's Medicaid quality strategy measurement plan, including metric names, Medicaid populations included in the calculation of the metrics, baseline data, and targets. Unless indicated otherwise, baseline measurements are from measurement year 2019 (January 1, 2019 through December 31, 2019), year 1 re-measurement rates are from measurement year 2020 (January 1, 2020 through December 31, 2020), and year 2 re-measurement rates are from measurement year 2021 (January 1, 2021 through December 31, 2021).

Table 3: New York State Medicaid Quality Strategy Metrics and Performance Rates

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Triple Aim 1: Improved Population Health					
Goal 1: Improve maternal health	Postpartum care (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	83%	80%	81.33%	84%
	Maternal mortality rate per 100,000 live births (All New York State)	18.9[1]	18.1[3]	19.3[4]	16.0
Goal 2: Ensure a healthy start	Lead screening in children (Mainstream Medicaid, Child Health Plus)	89%	87%	81.18%	90%
	Members receiving oral health services by a non-dentist provider (Mainstream Medicaid)	0.8%	1.25%	1.38%	1.6%
Goal 3: Promote effective & comprehensive prevention and management of chronic disease	Comprehensive diabetes care – HbA1c testing (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	93%	86%	89.49%	94%
	Asthma medication ratio, 5-18 years (Mainstream Medicaid, Child Health Plus)	66%	68%	65.47%	67%
	Asthma medication ratio, 19-64 years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	55%	49%	49.59%	56%
	Controlling high blood pressure (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	67%	56%	64.82%	68%
	Follow-up after emergency department visit for mental illness – 30 days (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	72%	67%	66.53%	73%
Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings	Depression screening and follow-up for adolescents and adults (Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV-Special Needs Plan)	Not Applicable	Not Applicable	New Measure	To Be Determined

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder	High school students reporting current use of alcohol on at least one day during the past 30 days (Subset of high school students in New York State)	26.4%	Non-Survey Year	2021 Data Scheduled for 2023 Release	23.6%
	High school students reporting binge drinking on at least one day during the past 30 days (Subset of high school students in New York State)	12.7%	Non-Survey Year	2021 Data Scheduled for 2023 Release	10.8%
	High school students reporting current use of marijuana on at least one day during the past 30 days (Subset of high school students in New York State)	19.1%	Non-Survey Year	2021 Data Scheduled for 2023 Release	17.1%
	Adult alcohol binge drinking (All New York State)	25.48%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	24.0%
	Adult use of marijuana (All New York State)	10.05%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	9.14%
	Adult use of cocaine (All New York State)	2.82%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.37%
	Adult use of heroin (All New York State)	0.3%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	0.17%
	Adult use of illicit drug use other than marijuana (All New York State)	3.42%[2]	Not Available Due to Methodological Concerns	Data Not Yet Available	2.94%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
	Medicaid smoking prevalence (Mainstream Medicaid, Fee-For-Service)	23%	22.9%	19.1%	21.4%
Triple Aim 2: Improved Quality of Care					
Goal 6: Improve Quality of Substance Use Disorder and Opioid Use Disorder Treatment	Initiation of pharmacotherapy upon new episode of opioid dependence (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	37%	45%	42.68%	38%
	Initiation of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	50%	50%	48.99%	51%
	Engagement of alcohol and other drug dependence treatment (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	20%	20%	18.68%	21%
Goal 7: Promote Prevention with Access to High Quality Care	Mainstream Managed Care population impacted by patient-centered medical home sites with NCQA recognition of 2014 Level 3 and up, active sites (Mainstream Medicaid)	69%	72%	67%	70%
Goal 8: Support Members in Their Communities	Potentially avoidable hospitalizations for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection (Managed Long-Term Care)	2.76	No data due to COVID-19	No data due to COVID-19	2.7
	Members who rated the helpfulness of the plan in assisting them and their family to manage their illnesses such as high blood pressure or diabetes as good or excellent (Managed Long-Term Care)	86%	Non-Survey Year	87.3%	87%
Goal 9: Improve Patient Safety	Appropriate treatment for upper respiratory infections, 3 months-17 years (Mainstream Medicaid, Child Health Plus)	94%	94%	96.16%	95%
	Appropriate treatment for upper respiratory infection, 18-64 Years (Mainstream Medicaid, Health and Recovery Plan, HIV-Special Needs Plan)	72%	75%	81.18%	73%

Goal	Metric (Population)	Baseline Measurement Year 2019	Year 1 Re-Measurement Measurement Year 2020	Year 2 Re-Measurement Measurement Year 2021	Target by 2022
Triple Aim 3: Lower Per Capita Cost					
Goal 10: Pay for High-Value Care	Potentially preventable admissions per 100,000 members (Mainstream Medicaid)	1,153	847	916.84	1,124-1,181
	Potentially preventable admission expenditures/Total inpatient expenditures (Mainstream Medicaid)	9.97	8.29	8.55	7.47-12.47
	Potentially preventable admissions per 100,000 members (Mainstream Medicaid, Fee-For-Service)	1,097	820	834.95	1,069-1,124
	Potentially preventable admission expenditures/Total inpatient expenditures (Mainstream Medicaid, Fee-For-Service)	10.33	8.95	9.07	7.83-12.83

[1] Baseline rate is from measurement year 2015-measurement year 2017.

[2] Baseline rate is from measurement year 2017-measurement year 2018.

[3] Year 1 Remeasurement rate is from measurement year 2016-measurement year 2018.

[4] Year 2 Remeasurement rate is from measurement year 2017-measurement year 2019.

To achieve the overall objectives of the New York State Medicaid managed care program and to ensure New York Medicaid recipients have access to the highest quality of health care, the New York State Medicaid quality strategy focuses on measurement and assessment, improvement, redesign, contract compliance and oversight, and enforcement. The state targets improvement efforts through several activities such as clinical focus studies, clinical and non-clinical performance improvement projects, quality incentives, the quality performance matrix, performance reports, quality improvement conferences and trainings, and plan technical assistance. Descriptions of interventions planned by the Department of Health to achieve the goals of its Medicaid quality strategy are described below.

Triple Aim 1: Improved Population Health

Goal 1: Improve maternal health

- Conduct an administrative and medical record analysis of New York State Medicaid managed care and fee-for-service members who were diagnosed with maternal sepsis to inform strategies to reduce maternal mortality and morbidity. The analysis will evaluate the characteristics, identification, and management of sepsis associated with pregnancy, delivery, postpartum, and post-abortion obstetrical states. Results will be used to identify women at risk for maternal sepsis and modifiable factors associated with maternal sepsis morbidity and mortality.
- Launch a New York State birth equity improvement project, aimed at addressing bias, racism, and disparities impacting maternal health through a birthing-facility-based learning collaborative.
- Lead the New York State Perinatal Quality Collaborative to reduce pregnancy complications, improve maternal and neonatal outcomes, and reduce racial/ethnic and geographic disparities.
- Establish a perinatal data module to support access to perinatal outcome data through the state's All Payer Database.
- Prioritize the public health focus of the New York State regional perinatal system through adoption of updated regulations that strengthen the role of regional perinatal centers, increase focus on obstetrical care, and incorporate birthing centers and midwifery birth centers into the system.
- Increase the number of midwifery birth centers statewide as a first level of care for low-risk pregnancies.
- Update standards for Medicaid providers who provide maternity care.
- Evaluate potential strategies for expanding access to childbirth education classes for pregnant individuals.
- Support the expansion of perinatal telehealth access, with a focus on rural hospitals and health care providers.
- Implement the recommendations of the New York State Postpartum Workgroup.
- Ensure postpartum home visits are available to all individuals on Medicaid who agree to have them.
- Work with maternal/perinatal infant community health collaboratives to expand and enhance community health worker services to address key barriers that impact maternal outcomes.
- Support a perinatal mood, anxiety, and depression education campaign.

Goal 2: Ensure a healthy start

- Continue 2019–2021 Kids Quality Agenda performance improvement project that aims to increase blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.
- Continue to promote the use of fluoride varnish in the primary care setting.
- Develop tools and resources for fluoride varnish training at the local level through an Oral Health Workforce grant.
- Increase fluoride varnish application in the medical setting through public health detailing of pediatric and family medicine practitioners by local health departments.

Goal 3: Promote effective and comprehensive prevention and management of chronic disease

- Continue the National Diabetes Prevention Program as a covered benefit for New York State adult Medicaid members to address the increasing challenges of prediabetes and type 2 diabetes.
- Proceed with the integration of primary care and behavioral health services through a variety of mechanisms.
- Continue interventions of the New York State Asthma Control Program:
  - Provide clinical and quality improvement resources and training to clinical sites to support the delivery of guideline-based medical care, including working with health systems to develop and implement asthma templates into their electronic health record systems to increase the meaningful use of health information technology.
  - Engage home nursing agencies and community-based organizations delivering home-based asthma services to provide training and resources to ensure in-home asthma services include multi-component approaches to asthma trigger reduction and self-management education for high-risk patients.
  - Build cross-sector linkages between health, housing, and energy to advance New York's "health across all policies" approach and integrate related initiatives into New York's value-based payment framework, in partnership with managed care plans, to ensure sustainability.
  - Promote evidence-based approaches to delivery of asthma-self management education across providers and settings (clinical, home, school, or community).
  - Drive collaborations across settings (home, school, community, and clinical) to build bi-directional communication and referral systems structured to support care coordination for people with asthma.
  - Partner with stakeholders to facilitate and promote environmental policies designed to support asthma control (e.g., smoke-free school grounds, anti-idling, and clean diesel policies), regionally and statewide.
- Continue partnership with New York State Primary Care Association and Community Health Center Association of New York State to:
  - Support federally qualified health centers in monitoring and tracking patient- and population-level clinical quality measures for hypertension prevalence, hypertension control, and undiagnosed hypertension.
  - Support providers in the use of patient- and population-level hypertension registries that are stratified by age, gender, race, and ethnicity.
  - Support practices in implementing team-based approaches to care using patient hypertension registries and electronic pre-visit planning tools.
  - Support federally qualified health centers in referring patients to home blood pressure monitoring with provider follow-up.
  - Support federally qualified health centers in implementing bi-directional referrals to community-based programs that support patients in their chronic disease self-management.

Goal 4: Promote the integration of suicide prevention in health and behavioral healthcare settings

- New York State will be supporting the Zero Suicide model led by the Suicide Prevention Office at the Office of Mental Health. The Zero Suicide model approach calls for:
  - A fundamental commitment from health system leadership to reduce suicide attempts and deaths among those receiving care.
  - Systematic screening and assessment for the identification of those at-risk.
  - Delivery of evidence-based interventions by a competent and caring workforce.
  - Monitoring of those at risk between care episodes, especially care transitions.
  - Data-driven quality improvement to track and measure progress.
- Major demonstration projects are underway in Article 31 licensed mental health clinics, inpatient psychiatric units, substance use disorder settings, Comprehensive Psychiatric Emergency Programs, medical emergency departments, and primary care.

Goal 5: Prevent and reduce nicotine, alcohol, and substance use disorder

- Provide a comprehensive smoking cessation benefit for all Medicaid enrollees without cost sharing, prior authorization requirements, or limits on quit attempts. Enrollees are allowed concurrent use of products (two or more medications at once). Medicaid also pays for over-the-counter nicotine patches, gum, and lozenges (with a prescription from a provider).
- Continue providing access to the New York State Smokers' Quitline. The New York State Smokers' Quitline serves as a clinician treatment extender in New York's population-level, evidence-based approach to cessation, which focuses on health system changes to increase the delivery of tobacco dependence treatment, especially for subpopulations with high smoking prevalence, including Medicaid enrollees. The free and confidential Smokers' Quitline provides resources and technical assistance to assist Medicaid enrollees and other disparate populations in accessing and using cost-effective cessation benefits.
- Implementation of evidence-based, strategic, culturally appropriate, and high-impact paid media campaigns targeted at tobacco-related disparate populations to prevent initiation, increase cessation, increase awareness and use of Medicaid tobacco cessation benefits and the Smokers' Quitline, and prevent tobacco use relapse.
- Prevention of alcohol and substance use, misuse, and disorder through the Strategic Prevention Framework which includes a five-step, data-driven planning process designed to guide state and local communities in the selection, implementation, and evaluation of effective, culturally responsive, and sustainable prevention activities. Interventions included are:
    - Environmental change strategies
        - Policies (e.g., alcohol advertising restrictions, social host liability laws)
        - Enforcement (e.g., party patrols, compliance checks, sobriety checkpoints)
        - Media (e.g., social marketing campaign, media advocacy, social norms campaign)
    - Community-based substance use prevention coalitions
    - Family-focused prevention programming (e.g., Strengthening Families, Triple P – Positive Parenting Program®)
    - School-based prevention curricula
        - Universal (e.g., Too Good for Drugs, PAX Good Behavior Game®, Guiding Good Choices®, Positive Action®, LifeSkills® Training, Second Step®)
        - Selective/Indicated (e.g., Teen Intervene, PreVenture)
- New York State supports many strategies to address the opioid crisis and reduce opioid use such as:
    - Creation of policies
    - Provider and member education
    - Requirement of a written opioid treatment plan
    - Encourage the use of non-opioid alternatives
    - Increased access to drugs used for substance use disorder treatment
    - Participation in the Centers for Disease Control and Prevention's Prescription Drug Overdose Prevention initiative
    - Opioid use disorder/substance use disorder screening in primary care practices through the Delivery System Reform Incentive Payment program
    - Mandatory prescriber education program

Triple Aim 2: Improved Quality of Care

Goal 6: Improve quality of substance use disorder and opioid use disorder treatment

- Initiatives focused on improving treatment access to high-quality, evidence-based treatment for opioid use disorder and other substance use disorders. These include learning collaboratives for prescribing professionals to encourage increased access to buprenorphine-waivered professionals across the state; regulatory changes that require medication for opioid use disorder in all Office of Addiction Services and Supports-certified settings; and peers to provide linkage between levels of care and to connect people directly to care from emergency rooms or high-intensity care.
- Expansion of take-home methadone dosing program. Providing weekly, bi-monthly, or monthly take-home doses to patients who are stable will allow them to receive care in a more person-centered way, which should foster recovery and increase treatment retention.

Goal 7: Promote prevention with access to high-quality care

- Use of patient-centered medical homes to support the state's goal of improving primary care and promoting the Triple Aim: improving health, lowering costs, and improving patients' experience of care.
- Maximize workforce distribution by committing to consistent funding for Doctors Across New York. This will help to address workforce shortages with an annual cycle and predictable timeline for the application process and increase student exposure to rural and non-hospital settings through support of community rural training sites.
- Creation of a provider wellness survey that will seek to both establish baseline levels of burnout among New York State providers and uncover how the COVID-19 pandemic has affected providers' self-reported stress, burnout, and job satisfaction. Additionally, the survey will gauge the extent to which meeting regulatory reporting requirements for clinicians increases clinician burden and stress. Data will be shared between the Department of Health's Office of Quality and Patient Safety, the New York Chapter of American College of Physicians, and the Center for Health Workforce Studies.
- Promoting the use of community health workers to increase knowledge about the enrollee services and improve utilization among health care providers and agencies.
- Perform network adequacy analyses to ensure that managed care plans operating in New York State have an adequate number and variety of health care providers in their networks to provide appropriate access to care for their enrollees, which includes being geographically accessible (meeting time/distance standards based on geographic location), being accessible for the disabled, and promoting and ensuring the delivery of services in a culturally competent manner.
- New York State Medicaid has expanded coverage of telehealth services to include:
  - Additional originating and distant sites
  - Additional telehealth applications (store-and-forward telemedicine and remote patient monitoring)
  - Additional practitioner types
- Provide safe, reliable transportation through contracts with two professional transportation managers across five geographic regions to administer Medicaid's transportation benefit.
- The Department of Health strongly encourages plans to participate in collaborative studies with a common theme. Examples of common-themed performance improvement projects include Perinatal Care and The Kids Quality Agenda Performance Improvement Project for mainstream Medicaid managed care plans; Inpatient Care Transitions and Care Transitions after Emergency Department and Inpatient Admissions for Health and Recovery Plans; and Transitions of Care and Emergency Department/Hospitalization Reduction for managed long-term care plans.
- Focused clinical studies, conducted by the external quality review organization, usually involve medical record review, measure development, surveys, and/or focus groups. Managed care plans are typically required to participate in one clinical focus study a year. Studies are often population specific (Medicaid managed care/HIV Special Needs Plan, Managed Long-Term Care, Health and Recovery Plan). Upon completion, the

external quality review organization provides recommendations for improvement to the Department of Health, plans, and providers. Past studies have addressed frailty indices, the provision of advanced directives, functional assessment of inter-rater reliability, validation of vital statistics reporting, use of developmental screening tools, care transitions, and provision of prenatal care.

Goal 8: Support members in their communities

- Increase access to palliative care programs and hospice for persons with serious illnesses and life-threatening conditions to help ensure care and to understand, address, and meet end-of-life planning needs prior to decisions to seek further aggressive care.
- Use of the Integrated Palliative Care Outcomes Scale to measure access to palliative care services for patients most in need.
- Home- and community-based services are designed to allow enrollees to participate in a vast array of habilitative services. They are based on the idea that state services, programs, and activities should be administered in the most integrated and least restrictive setting appropriate to a person's needs. Home- and community-based services include managed long-term care services and supports, care coordination, skill building, family and caregiver support services, crisis and planned respite, prevocational services, supported employment services, community advocacy and support, youth support and training, non-medical transportation, habilitation, adaptive and assistive equipment, accessibility modifications, and palliative care.
- Nursing home transition and diversion waiver includes the following home- and community-based services: assistive technology, community integration counseling, community transitional services, congregate and home delivered meals, environmental modifications services, home- and community-support services, home visits by medical personnel, independent living skills training, moving assistance, nutritional counseling/educational services, peer mentoring, positive behavioral interventions and supports, respiratory therapy, respite services, structured day program services, and wellness counseling service.
- Community First Choice Option Waiver program is being phased in and includes the following home- and community-based services: assistive technology; activities of daily living and instrumental activities of daily living skill acquisition, maintenance, and enhancement; community transitional services; moving assistance; environmental modifications; vehicle modifications; and non-emergency transportation.
- Children's Home- and Community-Based Services program consolidates multiple 1915(c) children's waiver programs from different agencies, including:
  - The Department of Health's Care at Home Waiver for children with physical disabilities
  - The Office of Mental Health's Waiver for Children and Adolescents with Serious Emotional Disturbance
  - The Office for People with Developmental Disabilities' Care at Home Waiver
  - The Office of Children and Family Services' Bridges to Health Serious Emotional Disturbance Waiver, Bridges to Health Developmental Disability Waiver, and Bridges to Health Medically Fragile Waiver

Goal 9: Improve patient safety

- Improve appropriate use of antibiotics in outpatient healthcare settings to combat antibiotic resistance. Improvement in outpatient settings is done through targeted outreach to healthcare providers, development of clinician resources to support appropriate use of antibiotics, presentation of the data to clinicians to demonstrate the need for improvement, and the development of educational materials for patients. Additionally, collaborative efforts with stakeholders have helped promote the goal to reduce inappropriate antibiotic use.
- Continue to analyze Medicaid claims and pharmacy data, including a separate analysis of antibiotic prescribing for acute upper respiratory infection in pediatric and adult populations. Prescribing rates over time for each population by county of healthcare visit, in both tabular and map formats, have been made publicly available on the Health Data NY website. Data are prepared and presented by county to provide local data for local

action. Data are shared through broad public health messaging and direct presentation upon request of stakeholders.

- Require acute care hospitals in New York State that provide care to patients with sepsis to develop and implement evidence-informed sepsis protocols which describe their approach to both early recognition and treatment of sepsis patients. In addition, hospitals were required to report to the Department of Health sufficient clinical data to calculate each hospital's performance on key measures of early treatment and protocol use. Each hospital submits clinical information on each patient with severe sepsis and or septic shock to allow the Department of Health to develop a methodology to evaluate risk-adjusted mortality rates for each hospital. Risk adjustment permits comparison of hospital performance and takes into consideration the different mix of demographic and comorbidity attributes, including sepsis severity, of patients cared for within each hospital.
- The Medicaid Breast Cancer Selective Contracting policy was implemented in 2009 and mandates that Medicaid enrollees receive breast cancer surgery, i.e., mastectomy and lumpectomy procedures associated with a primary diagnosis of breast cancer, at high-volume hospital and ambulatory surgery centers. Research conducted by the Department of Health demonstrated improved 5-year survival for patients receiving breast cancer surgery at high-volume facilities.

Triple Aim 3: Lower Per-Capita Cost

Goal 10: Pay for high-value care

- Implement Medicaid reform and the move to value-based payments. This transformation promoted community-level collaboration and sought to reduce avoidable hospital use by 25% over the 5–year demonstration period, while financially stabilizing the state's safety-net providers. In just a few years, New York State has significantly moved its Medicaid program from almost exclusively fee-for-service to primarily value-based payment strategies.
- Continue to require certain value-based payment arrangements to include social determinants of health interventions and contractual agreements with one or more community-based organizations. New York State was the first state in the nation to require this. Every value-based payment risk arrangement (56% of Medicaid managed care expenditure) has a defined social determinants of health intervention and includes community-based-human and -social-services organizations.
- Continue to use the core measure set strategy implemented in 2018 which identifies the highest priorities for quality measurement and improvement and provides alignment with other national measurement sets such as the Merit-based Incentive Payment System.
- Promote data sharing via the Statewide Health Information Network for New York. The Statewide Health Information Network for New York "information highway" allows clinicians and consumers to make timely, fact-based decisions that can reduce medical errors, reduce redundant testing, and improve care coordination and quality. The successful implementation of the Statewide Health Information Network for New York is one of the drivers improving health care quality, reducing costs, and improving outcomes for all New Yorkers. Additionally, the Statewide Health Information Network for New York has been leveraged during the COVID-19 pandemic to support disease surveillance activities and assess hospital capacity. Work in this area continues, and the Statewide Health Information Network for New York will become an important component in all Department of Health emergency preparedness initiatives.
- Reduce avoidable hospital use by 25% over 5 years through New York State's Delivery System Reform Incentive Payment program. This program has a formal evaluation plan and state-contract independent evaluator. The final Summative Evaluation is currently being completed, with preliminary results not yet published, but demonstrating significant progress was made towards the achievement of targets.

IPRO's Assessment of the New York State Medicaid Quality Strategy

The 2020-2022 NYS Medicaid quality strategy generally meets the requirements of *42 Code of Federal Regulation 438.340 Managed Care State Quality Strategy,* and acts as a framework for the managed care plans to follow while aiming to achieve improvements in the quality of, timeliness of, and access to care. Goals and aims are clearly stated and supported by well-designed interventions, and methods for measuring and monitoring managed care plan progress toward improving health outcomes incorporate external quality review activities. The strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as performance improvement projects, financial incentives, value-based payments, health information technology, and other department-wide quality initiatives.

Between measurement year 2020 and measurement year 2021, statewide performance met or exceeded targets in areas related to the reduction of smoking prevalence, initiation of treatment for substance abuse, treatment for upper respiratory infection, member experience with health plan assistance managing chronic conditions, and the reduction of preventable admissions. Further findings from the 2021 external quality review activities highlight managed care plan commitment to achieving the goals of the New York State Medicaid quality strategy.

Opportunities to improve health outcomes exist statewide. As evidenced by measurement year 2021 performance, continued attention to population health and quality of care, is appropriate.

Opportunities to strengthen the effectiveness of the New York State Medicaid quality strategy also exist. The Department of Health is unable to trend its performance from baseline for nine quality strategy metrics due to data collection limitations. Additionally, there are two metrics for which no data has been captured and no target has been established.

Recommendations to the New York State Department of Health

Per *42 Code of Federal Regulation 438.364 External quality review results (a)(4)*, this report is required to include recommendations on how the Department of Health can target the goals and the objectives outlined in the state's quality strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to New York Medicaid managed care enrollees. As such, IPRO recommends the following to the Department of Health:

- To fully comply with *42 Code of Federal Regulation 438.340(b)(1)*, the Department of Health should consider updating the 2020-2022 Medicaid quality strategy to include New York State specific network adequacy and availability of services standards for Medicaid managed care plans.
- The Department of Health should consider extending the quality strategy target date for improvement beyond 2022 to allow itself more time to collect sufficient data for all metrics; and as data becomes available for newer metrics, the Department of Health should update the quality strategy to include baseline data and targets where applicable. If the Department of Health remains unable to collect data for certain metrics, the Department of Health should consider the use of alternative metrics.
- To increase the transparency and overall understanding of state-led compliance review activities, the Department of Health should consider revising related policies and procedures, and technical methods of data collection and analysis.
- Although quality rating protocols have not yet been issued by the Centers for Medicare & Medicaid Services, the Department of Health should include the results of its Consumer Guide Star Rating as a component of the annual external quality review report.

Mainstream Medicaid Managed Care Plan Profiles

At the beginning of 2021, the New York State Medicaid program was comprised of 13 managed care plans. By the end of the year, there were only 12 “mainstream” managed care plans as Affinity Health Plan, Inc. was acquired by Molina Healthcare of New York, Inc.

Table 4 displays an overview of each mainstream Medicaid managed care plan’s profile. For each mainstream Medicaid managed care plan, the table displays the product lines carried, total mainstream Medicaid and Child Health Plus enrollment for calendar year 2021, and the NCQA accreditation rating achieved, where available. The New York State Medicaid managed care program does not require NCQA accreditation; managed care plans voluntarily decide to seek accreditation. The NCQA accreditation survey includes an assessment of managed care plan systems and processes, and an evaluation of key dimensions of care and services provided by the managed care plan. NCQA awards health plans a rating based on these survey results.

Table 4: Managed Care Plan Corporate Profiles

Managed Care Plan	Product Line(s)	Medicaid Enrollment as of 12/2021[1]	Child Health Plus Enrollment as of 12/2021[1]	NCQA Accreditation Status[2]
Affinity Health Plan, Inc. (Affinity)[3]	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	No Enrollment[3]	No Enrollment[3]	Not Accredited
Capital District Physician’s Health Plan Inc. (CDPHP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	106,232	13,786	Accredited (Medicaid and Commercial)
Excellus Health Plan Inc. (Excellus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	221,623	31,239	Accredited (Medicaid and Commercial)
Healthfirst PHSP, Inc. (Healthfirst)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	1,194,313	65,338	Not Accredited
HealthPlus HP, LLC (Empire BCBS HealthPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	375,395	36,035	Accredited (Medicaid)
Health Insurance Plan of Greater New York, Inc. (HIP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	160,682	9,951	Accredited (Commercial)
Highmark Western and Northeastern New York, Inc. (Highmark BCBS WNY)	Mainstream Medicaid, Child Health Plus, Commercial	52,623	3,829	Provisional (Commercial)

Managed Care Plan	Product Line(s)	Medicaid Enrollment as of 12/2021[1]	Child Health Plus Enrollment as of 12/2021[1]	NCQA Accreditation Status[2]
Independent Health Association, Inc. (IHA)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	66,705	5,310	Accredited (Commercial)
MetroPlus Health Plan, Inc. (MetroPlus)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, HIV Special Needs Plan, Commercial	461,082	25,207	Not Accredited
Molina Healthcare of New York, Inc. (Molina)[3]	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	309,173	17,934	Not Accredited
MVP Health Plan, Inc. (MVP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan, Commercial	203,056	21,211	Accredited (Commercial)
New York Quality Healthcare Cooperation (Fidelis Care)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	1,687,604	132,167	Accredited (Medicaid)
UnitedHealthcare of New York, Inc. (UHCCP)	Mainstream Medicaid, Child Health Plus, Health and Recovery Plan	398,339	29,608	Accredited (Medicaid)
	Total Enrollment:	**5,236,827**	**391,615**	

[1] Data Source: New York State Office of Health Insurance Programs Medicaid DataMart.
[2] Status is as of 09/15/2022. For more detail on the managed care plans' accreditation status and ratings, please see the NCQA website: https://reportcards.ncqa.org/health-plans.
[3] Affinity Health Plan, Inc. was acquired by Molina Healthcare of New York, Inc. on 11/01/2021, and therefore had no Medicaid or Child Health Plus enrollment as of 12/2021. The external quality review results presented in this report for Affinity Health Plan, Inc. are based the managed care plan's Medicaid enrollment from 01/01/2021 to 10/31/2021.
NCQA: National Committee for Quality Assurance.
Accredited: Service and quality meet or exceed rigorous requirements for consumer protection and quality improvement.
Provisional: Service and quality meet some requirements; improvement is needed to achieve higher status.

External Quality Report Activity 1. Validation of Performance Improvement Projects

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans do projects to improve the value or quality of health care for New Yorkers. These types of projects are called performance improvement projects. The New York Medicaid managed care plans are required to conduct a performance improvement project every year. The New York State Department of Health and the managed care plans select the topics for the performance improvement project.

IPRO reviews these projects to verify if they were conducted in a logical way. This is called "validation." Each year, IPRO validates the performance improvement projects conducted by the managed care plans. IPRO decides if the projects make sense and if the results are accurate.

In 2021, the managed care plans all had the same topic for the performance improvement projects. The projects focused on blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.

2021 Performance Improvement Projects Summary

Validation Process

- Does the report have a topic, identify a population, have a clear and meaningful focus?
- There is a review of the managed care plan's sampling methods, data collection, and the results.
- Are the improvement strategies appropriate? Was there an improvement?

Validation Results

- All performance improvement projects passed validation.

Performance Improvement Project Results

- **Blood lead testing and follow-up**: Nine managed care plans met or exceeded target performance for one or more measures in this area.
- **Newborn hearing screening and follow-up**: Seven managed care plans met or exceeded target performance for one or more measures in this area.
- **Developmental screening:** Ten managed care plans met or exceeded target performance for one or more measures in this area.

For more information about validation of performance improvement projects, please read the rest of this section.

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid managed care plans to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by a managed care plan. Further, managed care plans are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by *Section 18.15 (a)(xi)(B) of the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, New York State Medicaid managed care plans must conduct at least one performance improvement project in a priority topic area of its choosing with the mutual agreement of the Department of Health and the external quality review organization, and consistent with federal requirements. Beginning in 2019 and continuing through 2021, the mainstream Medicaid managed care plans were required to conduct the state-developed Kids Quality Agenda Performance Improvement Project.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for the Kids Quality Agenda Performance Improvement Project.

The Kids Quality Agenda Performance Improvement Project aimed to improve preventative care during early childhood development in the Medicaid population. While interventions were managed care plan-specific, the performance improvement project focus areas were consistent across all managed care plans and included: blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.

Technical Methods for Data Collection and Analysis

The Centers for Medicare & Medicaid Services' *Protocol 1 – Validation of Performance Improvement Projects* was used as the framework to assess the quality of each performance improvement project, as well as to score the compliance of each performance improvement project with both federal and state requirements. IPRO's evaluation involves the following elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the managed care plan's enrollment and generalizable to the managed care plan's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.

8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the managed care plan achieved sustained improvement.

Following the review of the listed elements, the review findings were considered to determine whether the performance improvement project outcomes should be accepted as valid and reliable. The element is determined to be "met" or "not met."

A determination was made as to the overall credibility of the results of each performance improvement project, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
- The validation findings generally indicate that the credibility for the performance improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the performance improvement project results. The concerns that put the conclusion at risk are enumerated.

IPRO provided performance improvement project report templates to each managed care plan for the submission of project proposals, interim updates, and results. All data needed to conduct the validation were obtained through these report submissions.

Description of Data Received

For the 2021 external quality review, IPRO reviewed managed care plan performance improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of each managed care plan's performance improvement project methodology found that there were no validation findings that indicated that the credibility of the performance improvement project results was at risk. A summary of the validation assessments is in Table 5.

Performance indicator rates related blood lead screening are in Table 6; rates related to newborn hearing screening are in Table 7; and rates related to developmental screening are in Table 8.

Details of each managed care plan's performance improvement project activities are described in the Mainstream Medicaid Managed Care Plan-Level Reporting section of this report.

Table 5: Performance Improvement Project Validation Findings, Measurement Year 2021

	Performance Improvement Project Validation Elements									
Managed Care Plan	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Study Results	Improvement Strategies	Achieved Real Improvement[1]	Achieved Sustained Improvement[1]
Affinity	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
CDPHP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Excellus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Healthfirst	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Highmark BCBS WNY	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
HIP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
IHA	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
MVP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met
UHCCP	Met	Met	Met	Met	Not Applicable	Met	Met	Met	Met	Met

[1] When performance improvement was reported by the managed care plan, IPRO determined that the improvement was real and sustained based on its validation of the performance improvement project methodology; the “met determination” does not mean that all performance indicators demonstrated improvement.

Table 6: Performance Improvement Project Blood Lead Testing and Follow-up Rates, Measurement Year 2021

Blood Lead Testing and Follow-up Rates								
Managed Care Plan	Blood Lead Test at Age 1 Year	Blood Lead Test at Age 2 Years	Blood Lead Test at Ages 1 and 2 Years	Blood Lead Level ≥ 5 mcg/dl with a Confirmatory Venous Blood Lead Level Test Within 3 Months	Confirmed Venous Blood Lead Level ≥ 5 mcg/dl	Confirmed Venous Blood Lead Level ≥ 5 mcg/dl Follow-up Test Within 3 Months	Confirmed Venous Blood Lead Level ≥ 10 mcg/dl	Confirmed Venous Blood Lead Level ≥ 10 mcg/dl Follow-up Test Within 1 Month
Affinity	54.74%	71.97%	53.29%	84.95%	1.30%	86.11%	0.37%	79.05%
CDPHP	66.68%	62.22%	49.34%	58.73%	13.53%	31.07%	4.36%	20.69%
Empire BCBS HealthPlus	68.97%	75.55%	19.31%	43.33%	0.06%	42.86%	0.03%	38.46%
Excellus	81.21%	71.94%	54.80%	68.09%	0.12%	11.54%	0.05%	57.14%
Fidelis Care	64.21%	64.54%	42.66%	51.71%	1.38%	51.24%	0.30%	28.68%
Healthfirst	55.99%	63.11%	52.67%	44.00%	0.24%	44.61%	0.06%	35.63%
Highmark BCBS WNY	52.11%	63.58%	23.98%	60.87%	2.40%	50.35%	2.08%	26.23%
HIP	55.08%	60.22%	29.89%	43.75%	0.65%	38.46%	0.17%	66.67%
IHA	93.20%	84.98%	62.30%	38.38%	3.73%	22.97%	0.84%	5.45%
MetroPlus	60.04%	49.04%	40.97%	58.82%	0.20%	47.52%	0.04%	32.56%
Molina	64.64%	46.74%	15.25%	50.00%	3.13%	50.00%	0.13%	58.33%
MVP	67.65%	63.08%	42.73%	25.00%	0.00%	31.58%	0.00%	3.85%
UHCCP	44.77%	53.01%	40.27%	42.80%	1.28%	100.00%	0.57%	100.00%

Table 7: Performance Improvement Project Newborn Hearing Screening and Follow-up Rates, Measurement Year 2021

Newborn Hearing Screening and Follow-up Rates								
Managed Care Plan	Screening by Age 1 Month	Failed Screening by Age 1 Month	Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	Screening Before Age 3 Months	Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months
Affinity	76.96%	1.48%	47.73%	14.29%	100.00%	83.77%	32.76%	92.86%
CDPHP	82.24%	1.91%	5.41%	50.00%	100.00%	87.01%	17.65%	100.00%
Empire BCBS HealthPlus	87.01%	1.69%	11.76%	33.33%	75.00%	88.82%	15.75%	91.67%
Excellus	88.25%	0.40%	0.00%	Denominator=0	100.00%	94.48%	4.44%	0.00%
Fidelis Care	43.24%	1.91%	65.57%	37.50%	83.84%	73.60%	74.20%	89.63%
Healthfirst	95.35%	3.28%	34.30%	10.17%	11.84%	89.06%	34.89%	16.75%
Highmark BCBS WNY	98.52%	4.24%	96.30%	7.69%	0.00%	91.87%	100.00%	11.11%
HIP	83.45%	2.17%	38.89%	9.52%	12.17%	87.70%	35.71%	50.00%
IHA	90.70%	1.32%	37.50%	66.67%	100.00%	96.13%	25.00%	100.00%
MetroPlus	81.53%	13.42%	18.31%	17.46%	36.36%	86.07%	26.05%	Denominator=0
Molina	81.34%	2.51%	6.67%	33.33%	0.00%	88.02%	16.33%	0.00%
MVP	4.32%	0.89%	33.33%	0.00%	0.00%	5.62%	0.00%	0.00%
UHCCP	89.05%	1.56%	41.61%	17.54%	20.00%	88.44%	45.36%	18.97%

Table 8: Performance Improvement Project Developmental Screening Rates, Measurement Year 2021

Developmental Screening Rates						
Managed Care Plan	Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	Screening for Developmental, Behavioral, and Social Delays Using the American Academy of Pediatrics Well-Child Visit Guidelines	Screening for Autism by Age 30 Months: 1 Screening Claim	Screening for Autism by Age 30 Months: 2 Screening Claims
Affinity	60.27%	99.95%	42.01%	67.11%	11.99%	6.48%
CDPHP	12.80%	37.52%	30.53%	27.38%	14.48%	4.88%
Empire BCBS HealthPlus	16.85%	23.88%	28.52%	23.55%	6.96%	2.41%
Excellus	19.90%	51.04%	44.72%	38.48%	9.27%	4.21%
Fidelis Care	28.66%	34.97%	18.47%	27.40%	13.70%	11.91%
Healthfirst	22.07%	32.06%	20.43%	24.74%	6.88%	2.76%
Highmark BCBS WNY	29.36%	33.24%	27.68%	30.00%	22.87%	9.59%
HIP	15.26%	20.22%	9.94%	15.20%	1.01%	1.01%
IHA	39.78%	52.20%	50.13%	47.56%	28.76%	15.24%
MetroPlus	20.08%	26.15%	23.57%	23.32%	1.76%	1.01%
Molina	19.24%	20.24%	14.66%	18.10%	16.96%	8.09%
MVP	25.36%	42.90%	38.72%	35.89%	10.35%	4.64%
UHCCP	28.14%	41.47%	36.66%	35.91%	8.15%	3.33%

External Quality Review Activity 2. Validation of Performance Measures

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Managed care plans collect information on the health status of New Yorkers on Medicaid and the services they receive. They share this information with the New York State Department of Health and its partners in many ways. One way is through performance measures. A performance measure describes health care and health status using numbers. These numbers are percentages or rates. Performance measure rates often use the "%" symbol.

The information used to calculate the performance measure rates must be accurate. The information must also be complete. The managed care plans check that the rates are accurate and complete. This is called "validation." The person who does the validation is called an "auditor." Auditors are certified to do the validation. Each year, the managed care plans work with auditors to validate performance measures.

The performance measures show how well the managed care plans are caring for their members. For this reason, the New York State Department of Health monitors the performance measures regularly.

2021 Performance Measure Validation Summary

Validation Process

- Can managed care plans collect, store, analyze and report health information?
- Are reporting practices and performance measure specifications compliant?
- Is each performance measure accurate? Is it complete?

Validation Results

- Auditors validated performance measures of all 13 managed care plans.
- All managed care plans passed validation.
- All managed care plans met validation requirements to report performance measures to New York State.

Performance Measure Rates

- Of the managed care plan performance measure rates included in this report:
  - 28% performed significantly better than statewide mainstream Medicaid performance
  - 27% performed significantly worse than statewide mainstream Medicaid performance
  - 45% did not differ in performance from statewide mainstream Medicaid performance

For more information about validation of performance measures, please read the rest of this section.

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must identify standard performance measures relating to the performance of managed care plans and that the state requires each managed care plan to annually measure and report to the state on its performance using the standard measures required by the state.

As required by *Section 18.15 (a)(v) of the Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract,* New York State Medicaid managed care plans are required to report all applicable performance measures included in the Quality Assurance Reporting Requirements program and to follow NCQA HEDIS and New York State technical specifications for rate calculations. Further, the Office of Health Insurance Programs incorporates select Quality Assurance Reporting Requirements results into its methodology for the Quality Incentive Program.[12]

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Department of Health for measurement year 2021.

Technical Methods for Data Collection and Analysis

The 2021 Quality Assurance Reporting Requirements program consisted of measures developed by NCQA for HEDIS and CAHPS and by the Department of Health. Measures required for the 2021 Quality Assurance Reporting Requirements program are available in Appendix A of this report. The major domains of performance included in the 2021 Quality Assurance Reporting Requirements program for the mainstream Medicaid managed care plans were:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data

Each of these domains included NCQA HEDIS and CAHPS measures, as well as several New York State-specific measures for areas of importance to the Department of Health and for which there were no nationally recognized standard measures. Many of these measures were calculated through the managed care plans' NCQA HEDIS data submissions, while others were calculated by the Department of Health using encounter data, prenatal data, and Quality Assurance Reporting Requirements submissions reported by the managed care plans.

[12] New York's Medicaid Managed Care Quality Incentive Program began in early 2001. The Quality Incentive Program incorporates results from managed care plan Quality Assurance Reporting Requirements submissions and Medicaid CAHPS survey results.

For measurement year 2021, the New York State managed care plans were required to submit performance measure data to the Department of Health based on the *2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual.*[13]

To ensure compliance with reporting requirements, each managed care plan contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor. **Table 9** displays vendors and compliance auditors by managed care plan.

Table 9: HEDIS Vendors and Compliance Auditors

Managed Care Plan	NCQA-Certified HEDIS Vendor	NCQA-Certified HEDIS Compliance Auditor
Affinity	Cotiviti Inc.	Aqurate Health Data Management, Inc.
CDPHP	Cotiviti Inc.	Aqurate Health Data Management, Inc.
Empire BCBS HealthPlus	Inovalon, Inc. and Cotiviti Inc.	DTS Group
Excellus	Cotiviti Inc.	Advent Advisory Group
Fidelis Care	Cotiviti Inc.	Aqurate Health Data Management, Inc.
Healthfirst	Cotiviti Inc.	Aqurate Health Data Management, Inc.
Highmark BCBS WNY	Inovalon, Inc. and Cotiviti Inc.	DTS Group
HIP	Cognizant	Aqurate Health Data Management, Inc.
IHA	SPH Analytics	Attest Health Care Advisors
MetroPlus	Inovalon, Inc.	Aqurate Health Data Management, Inc.
Molina	Cognizant TriZetto Software Group, Inc.	Advent Advisory Group
MVP	Inovalon, Inc.	Aqurate Health Data Management, Inc.
UHCCP	SPH Analytics	Attest Health Care Advisors

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance.

The HEDIS vendor collected data and calculated performance measure rates on behalf of the managed care plan for measurement year 2021. The HEDIS vendor calculated rates using NCQA's HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans and the Department of Health's 2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual.

The HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement, and they also validated the managed care plan's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated the managed care plan's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities
2. HEDIS Specification Standards

HEDIS compliance auditors consider managed care plan compliance with the information system capabilities and HEDIS specification standards to fully assess the organization's HEDIS reporting capabilities.

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[13] New York State Department of Health 2020–2021 Quality Assurance Reporting Requirements Technical Specifications Manual (2020-2021 QARR/HEDIS 2020-2021) Website: https://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2021/docs/qarr_specifications_manual.pdf.

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed the managed care plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 10 displays these standards as well as the elements audited for the standard.

Table 10: Information System Capabilities Standards

Information System Capabilities Categories	Elements Audited
1.0 Medicaid Services Data	Sound Coding Methods and Data Capture, Transfer and Entry
2.0 Enrollment Data	Data Capture, Transfer and Entry
3.0 Practitioner Data	Data Capture, Transfer and Entry
4.0 Medical Record Review Processes	Training, Sampling, Abstraction and Oversight
5.0 Supplemental Data	Capture, Transfer and Entry
6.0 Data Preproduction Processing	Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
7.0 Data Integration and Reporting	Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the managed care plan had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

HEDIS Specification Standards

HEDIS compliance auditors use the HEDIS specification standards to assess the managed care plan's compliance with conventional reporting practices and HEDIS technical specifications. These standards describe the required procedures for specific information, such as proper identification of denominators and numerators, and verification of algorithms and rate calculations.

Performance Measure Validation

Each managed care plan's calculated rates for the NCQA HEDIS Measurement Year 2021 and New York State 2021 Quality Assurance Reporting Requirements measure sets were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 11 presents these outcome designations and their definitions. Performance measure validation activities included, but were not limited to:

- Confirmation that rates were produced with certified code or Automated Source Code Review approved logic
- Medical record review validation
- Review of supplemental data sources
- Review of system conversions/upgrades, if applicable
- Review of vendor data, if applicable
- Follow-up on issues identified during documentation review or previous audits

Table 11: Performance Measure Outcome Designations

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	**Reportable**. A reportable rate was submitted for the measure.
NA	**Small Denominator.** The organization followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures when the denominator is fewer than 30. b. For utilization measures that count member months when the denominator is fewer than 360 member months. c. For all risk-adjusted utilization measures when the denominator is fewer than 150. d. For electronic clinical data systems measures when the denominator is fewer than 30.
NB	**No Benefit.** The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	**Not Reported.** The organization chose not to report the measure.
NQ	**Not Required.** The organization was not required to report the measure.
BR	**Biased Rate.** The calculated rate was materially biased.
UN	**Unaudited.** The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

NCQA: National Committee for Quality Assurance.

Each managed care plan's HEDIS compliance auditor produced a Final Audit Report and Audit Review Table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each managed care plan submitted these documents, as well as other required Quality Assurance Reporting Requirements files, to the Department of Health and IPRO.

To augment the performance measure validation conducted by each managed care plan's HEDIS auditor, IPRO validated the files submitted by the managed care plans for the New York State Quality Assurance Reporting Requirements program.

IPRO reviewed each managed care plan's Final Audit Report and Audit Review Table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with Department of Health requirements. To assess the accuracy of the reported rates, IPRO:

- Recalculated performance measure rates using denominator and numerator member-level data and compared these recalculated rates to the rates reported by the managed care plan to NCQA via the Interactive Data Submission System tool;
- Compared each managed care plan's patient-level data files, enhancement files, and prenatal files to the tool;
- Compared performance measure rates reported by the managed care plans to NCQA's Quality Compass regional Medicaid benchmarks; and
- Analyzed performance-measure-rate–level trends to identify drastic changes in performance.

Lastly, IPRO reviewed source code used by the Department of Health to calculate rates for certain New York State-specific performance measures. The data used by the Department of Health to calculate these rates were validated by IPRO.

Description of Data Received

For the 2021 external quality review, IPRO obtained each managed care plan's Final Audit Report and a locked copy of the Audit Review Table that were produced by the HEDIS compliance auditor.

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; Table 11).

The Audit Review Table displayed performance-measure–level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the Audit Review Table: administrative rate before exclusions; minimum required sample size, and minimum required sample size numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

The Quality Assurance Reporting Requirements data file included the final validated rate for each performance measure reported by the mainstream Medicaid managed care plans, as well as the results of statewide calculations and statistical significance testing conducted by the Department of Health. Within the file, performance measures were presented by product line by managed care plan by domain. For each performance measure, the data file also presented data collection methodology, eligible population count, exclusion count, numerator event count, eligible population count, denominator count, numerator event count, and state mainstream Medicaid benchmarks when applicable.

Comparative Results

Validation of Performance Measures and Quality Assurance Reporting Requirements Rates for Quality Incentive Measures

Each managed care plan's HEDIS compliance auditor determined that the NCQA HEDIS and New York State Quality Assurance Reporting Requirements rates reported by the managed care plan for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditors for any managed care plan. Table 12 displays the results of the Information System Capabilities review for each managed care plan.

Further, the results of IPRO's performance measure validation activities determined that each Mainstream Medicaid managed care plan successfully calculated and reported rates to the Department of Health according to contractual requirements. There were no data collection or reporting issues identified by IPRO for any managed care plan.

Thirty-seven (37) measures from the 2021 Quality Assurance Reporting Requirements program were selected by the Department of Health for inclusion in its evaluation of mainstream Medicaid managed care plan performance under the 2021–2022 Quality Incentive Program. These measures cover primary care, HIV, children's health, substance use, mental health, and maternity care and fall into one of the following major domains:

- Effectiveness of Care,
- Access/Availability of Care, or
- Utilization and Risk Adjusted Utilization.

As the 2021 Quality Assurance Reporting Requirements measures included in the 2021–2022 Quality Incentive Program represent high-priority areas of care for mainstream Medicaid managed care plans, rates for these measures are presented in this report.

Table 13 through Table 18 display managed care plan rates, statewide averages, and national Medicaid benchmarks for measurement year 2021.

Table 12: Information Systems Capabilities Review Results

	NCQA's Information Systems Standards						
Managed Care Plan	1.0 Medical Services Data	2.0 Enrollment Data	3.0 Practitioner Data	4.0 Medical Record Review Processes	5.0 Supplemental Data	6.0 Data Preproduction Processing	7.0 Data Integration and Reporting
Affinity	Met	Met	Met	Met	Met	Met	Met
CDPHP	Met	Met	Met	Met	Met	Met	Met
Empire BCBS HealthPlus	Met	Met	Met	Met	Met	Met	Met
Excellus	Met	Met	Met	Met	Met	Met	Met
Fidelis Care	Met	Met	Met	Met	Met	Met	Met
Healthfirst	Met	Met	Met	Met	Met	Met	Met
Highmark BCBS WNY	Met	Met	Met	Met	Met	Met	Met
HIP	Met	Met	Met	Met	Met	Met	Met
IHA	Met	Met	Met	Met	Met	Met	Met
MetroPlus	Met	Met	Met	Met	Met	Met	Met
Molina	Met	Met	Met	Met	Met	Met	Met
MVP	Met	Met	Met	Met	Met	Met	Met
UHCCP	Met	Met	Met	Met	Met	Met	Met

NCQA: National Committee for Quality Assurance.

Table 13: Effectiveness of Care Performance Measures – Primary Care, Measurement Year 2021

Benchmark/Managed Care Plan	Effectiveness of Care – Primary Care Measures							
	Antidepressant Medication Management – Effective Acute Phase Treatment	Antidepressant Medication Management – Effective Continuation Phase Treatment	Asthma Medication Ratio (5–64 Years)	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women (16–20 Years)	Chlamydia Screening in Women (21–24 Years)	Colorectal Cancer Screening
Statewide Mainstream Medicaid Managed Care	58.36%	41.64%	56.86%	64.75%	69.19%	71.38%	74.13%	61.03%
National 2021 Medicaid Mean	60.80%	44.06%	64.86%	51.00%	56.26%	51.65%	60.60%	Not Available
National 2021 Medicaid 90th Percentile	71.26%	56.24%	74.21%	61.27%	66.88%	66.36%	70.29%	Not Available
Affinity	52.39%	35.31%	61.38%	70.21%	77.86%	78.57%	78.56%	70.32%
CDPHP	58.02%	42.08%	68.79%	57.82%	64.75%	63.70%	68.95%	62.72%
Empire BCBS HealthPlus	57.17%	41.81%	63.83%	65.42%	71.78%	74.76%	75.51%	56.93%
Excellus	56.29%	42.29%	57.33%	63.42%	71.26%	52.00%	67.26%	56.53%
Fidelis Care	59.92%	42.47%	53.19%	62.68%	65.69%	66.36%	70.26%	59.85%
Healthfirst	57.76%	40.81%	54.34%	69.38%	74.27%	80.59%	80.06%	69.34%
Highmark BCBS WNY	56.62%	42.80%	63.90%	53.54%	66.49%	58.43%	68.37%	49.88%
HIP	60.07%	42.15%	64.06%	66.34%	65.03%	74.10%	75.06%	61.79%
IHA	61.46%	42.70%	70.35%	61.27%	69.85%	67.40%	73.26%	60.80%
MetroPlus	58.65%	41.49%	54.60%	66.89%	64.72%	81.07%	79.34%	54.50%
Molina	48.30%	33.26%	58.26%	57.96%	63.75%	68.55%	71.72%	48.80%
MVP	54.88%	39.27%	62.55%	60.07%	67.40%	61.66%	70.57%	55.72%
UHCCP	61.33%	44.28%	60.50%	59.03%	68.37%	66.11%	71.30%	53.53%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 14: Effectiveness of Care Performance Measures (Continued) – Primary Care and HIV, Measurement Year 2021

	Effectiveness of Care – Primary Care Measures (Continued)						Effectiveness of Care – HIV Measure
Benchmark/Managed Care Plan	Comprehensive Diabetes Care - Eye Exam	Comprehensive Diabetes Care - HbA1c Poor Control (>9%)[1]	Controlling High Blood Pressure	Kidney Health Evaluation for Patients with Diabetes (Total)	Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	Viral Load Suppression
Statewide Mainstream Medicaid Managed Care	61.32%	34.74%	64.97%	41.36%	69.64%	40.16%	73.38%
National 2021 Medicaid Mean	50.81%	42.26%	58.63%	33.45%	70.21%	24.80%	Not Available
National 2021 Medicaid 90th Percentile	63.75%	30.90%	69.19%	46.76%	81.25%	33.97%	Not Available
Affinity	68.37%	24.33%	72.75%	68.35%	62.68%	49.41%	69.14%
CDPHP	54.68%	30.96%	72.81%	40.25%	72.65%	27.96%	78.06%
Empire BCBS HealthPlus	58.88%	36.25%	54.26%	42.47%	68.25%	46.15%	72.27%
Excellus	56.93%	31.63%	61.10%	42.00%	78.88%	27.94%	78.80%
Fidelis Care	58.15%	36.50%	61.31%	39.81%	70.33%	42.31%	72.82%
Healthfirst	63.99%	34.79%	72.02%	44.97%	67.16%	45.02%	74.42%
Highmark BCBS WNY	59.37%	35.77%	63.02%	35.81%	64.51%	30.43%	80.66%
HIP	61.31%	36.50%	66.58%	37.70%	72.41%	45.22%	71.78%
IHA	65.19%	26.42%	68.19%	41.42%	77.34%	30.43%	77.40%
MetroPlus	65.69%	27.98%	67.15%	34.13%	73.09%	35.73%	72.32%
Molina	56.69%	41.12%	62.29%	37.75%	64.20%	28.65%	79.88%
MVP	55.47%	51.09%	57.91%	35.81%	65.44%	37.65%	79.85%
UHCCP	64.23%	36.01%	63.26%	33.88%	70.38%	33.30%	70.48%

[1]Lower rate indicates better performance.

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 15: Effectiveness of Care Performance Measures (Continued) – Children's Health, Measurement Year 2021

	Effectiveness of Care – Children's Health Measures					Effectiveness of Care – Substance Use Measure
Benchmark/Managed Care Plan	Childhood Immunization Status – Combination 3	Immunizations for Adolescents – Combination 2	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days
Statewide Mainstream Medicaid Managed Care	66.71%	42.37%	85.12%	84.17%	80.25%	19.43%
National 2021 Medicaid Mean	63.03%	36.11%	76.11%	69.18%	65.72%	13.35%
National 2021 Medicaid 90th Percentile	74.45%	48.42%	88.31%	83.70%	81.27%	21.97%
Affinity	72.51%	52.07%	93.19%	92.46%	91.48%	24.16%
CDPHP	75.67%	33.39%	91.25%	88.75%	85.00%	16.38%
Empire BCBS HealthPlus	59.61%	38.67%	83.21%	81.27%	78.59%	17.47%
Excellus	75.06%	40.15%	80.56%	75.35%	72.57%	21.75%
Fidelis Care	61.31%	36.50%	83.21%	82.48%	77.86%	21.30%
Healthfirst	73.72%	53.60%	86.37%	88.56%	82.97%	17.30%
Highmark BCBS WNY	81.27%	41.85%	85.64%	86.13%	82.24%	29.92%
HIP	66.91%	35.52%	84.45%	83.54%	81.71%	20.23%
IHA	76.89%	44.04%	96.86%	94.97%	91.82%	25.35%
MetroPlus	69.34%	55.72%	89.29%	89.78%	87.59%	21.35%
Molina	73.48%	37.71%	82.73%	80.78%	76.40%	15.98%
MVP	70.32%	42.82%	83.21%	76.89%	74.70%	13.22%
UHCCP	55.96%	26.03%	84.43%	79.81%	76.40%	14.60%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 16: Effectiveness of Care Performance Measures (Continued) – Substance Use and Mental Health, Measurement Year 2021

	Effectiveness of Care – Mental Health Measures						
Benchmark/Managed Care Plan	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	Metabolic Monitoring for Children and Adolescents on Antipsychotics
Statewide Mainstream Medicaid Managed Care	61.63%	78.10%	53.37%	66.00%	53.28%	61.72%	39.35%
National 2021 Medicaid Mean	59.65%	79.20%	40.08%	38.44%	39.67%	50.00%	36.57%
National 2021 Medicaid 90th Percentile	72.94%	86.28%	60.58%	54.55%	50.00%	62.96%	51.69%
Affinity	53.04%	78.98%	62.60%	65.26%	62.73%	65.08%	42.53%
CDPHP	63.96%	77.24%	47.68%	64.81%	41.02%	51.42%	39.19%
Empire BCBS HealthPlus	61.77%	79.79%	61.98%	60.41%	53.75%	66.67%	49.74%
Excellus	64.29%	73.97%	54.37%	65.40%	39.78%	44.57%	28.04%
Fidelis Care	63.37%	78.00%	58.14%	65.11%	54.65%	66.03%	38.11%
Healthfirst	61.87%	80.32%	45.03%	75.43%	62.73%	76.00%	46.46%
Highmark BCBS WNY	60.00%	72.82%	72.99%	59.00%	55.73%	66.67%	27.23%
HIP	59.79%	74.93%	54.98%	59.47%	48.94%	60.00%	41.40%
IHA	59.17%	73.96%	79.22%	65.15%	54.03%	73.17%	31.40%
MetroPlus	60.87%	81.24%	53.48%	56.32%	59.75%	71.13%	51.55%
Molina	54.07%	73.16%	40.83%	58.11%	90.16%	61.11%	28.29%
MVP	58.37%	75.06%	48.87%	63.73%	38.30%	42.18%	38.43%
UHCCP	61.87%	78.50%	43.10%	67.47%	54.46%	60.68%	38.27%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 17: Access/Availability of Care Performance Measures, Measurement Year 2021

	Access/Availability of Care – Primary Care Measures		Access/Availability of Care – Children's Health Measure	Access/Availability of Care – Substance Use Measure	Access/Availability of Care – Maternity Measures	
Benchmark/Managed Care Plan	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	Annual Dental Visit (2–18 Years)	Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	Prenatal and Postpartum Care – Timeliness of Prenatal Care	Prenatal and Postpartum Care – Postpartum Care
Statewide Mainstream Medicaid Managed Care	46.67%	18.24%	53.29%	43.80%	87.20%	81.63%
National 2021 Medicaid Mean	44.16%	13.87%	Not Available	Not Available	83.53%	76.18%
National 2021 Medicaid 90th Percentile	52.81%	22.12%	Not Available	Not Available	91.89%	84.18%
Affinity	40.04%	11.58%	52.17%	25.24%	91.00%	88.32%
CDPHP	42.62%	17.02%	58.98%	49.35%	93.46%	79.23%
Empire BCBS HealthPlus	45.23%	15.05%	58.08%	38.46%	80.29%	79.56%
Excellus	43.83%	19.23%	49.72%	52.32%	89.25%	79.57%
Fidelis Care	50.52%	21.87%	54.30%	46.55%	86.86%	81.51%
Healthfirst	42.17%	14.53%	49.68%	30.98%	90.88%	83.11%
Highmark BCBS WNY	43.37%	16.19%	55.39%	55.77%	86.62%	77.37%
HIP	50.94%	21.66%	42.56%	33.86%	79.23%	80.51%
IHA	44.71%	16.75%	55.60%	37.13%	92.96%	81.85%
MetroPlus	55.73%	17.47%	50.88%	42.29%	86.62%	85.16%
Molina	38.31%	13.70%	69.72%	55.82%	82.00%	69.34%
MVP	43.97%	19.25%	58.02%	47.11%	87.59%	76.89%
UHCCP	42.87%	16.23%	54.75%	45.94%	81.02%	79.81%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Table 18: Utilization and Risk Adjusted Utilization Performance Measures – Children's Health, Measurement Year 2021

	Utilization and Risk Adjusted Utilization – Children's Health Measures		
Benchmark/Managed Care Plan	Well-Child Visits in the First 30 Months of Life – First 15 Months	Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	Child and Adolescent Well-Care Visits (Total)
Statewide Mainstream Medicaid Managed Care	66.69%	78.24%	69.73%
National 2021 Medicaid Mean	54.10%	65.93%	49.49%
National 2021 Medicaid 90th Percentile	67.56%	78.07%	62.70%
Affinity	75.59%	85.11%	81.27%
CDPHP	74.35%	81.58%	67.62%
Empire BCBS HealthPlus	63.29%	78.07%	70.74%
Excellus	74.42%	83.10%	69.57%
Fidelis Care	62.93%	76.45%	66.30%
Healthfirst	70.59%	80.53%	73.94%
Highmark BCBS WNY	68.77%	84.84%	70.52%
HIP	62.12%	74.79%	69.68%
IHA	75.15%	82.75%	72.80%
MetroPlus	67.50%	75.86%	71.15%
Molina	67.33%	75.37%	65.81%
MVP	72.57%	80.60%	70.22%
UHCCP	58.04%	73.31%	63.87%

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

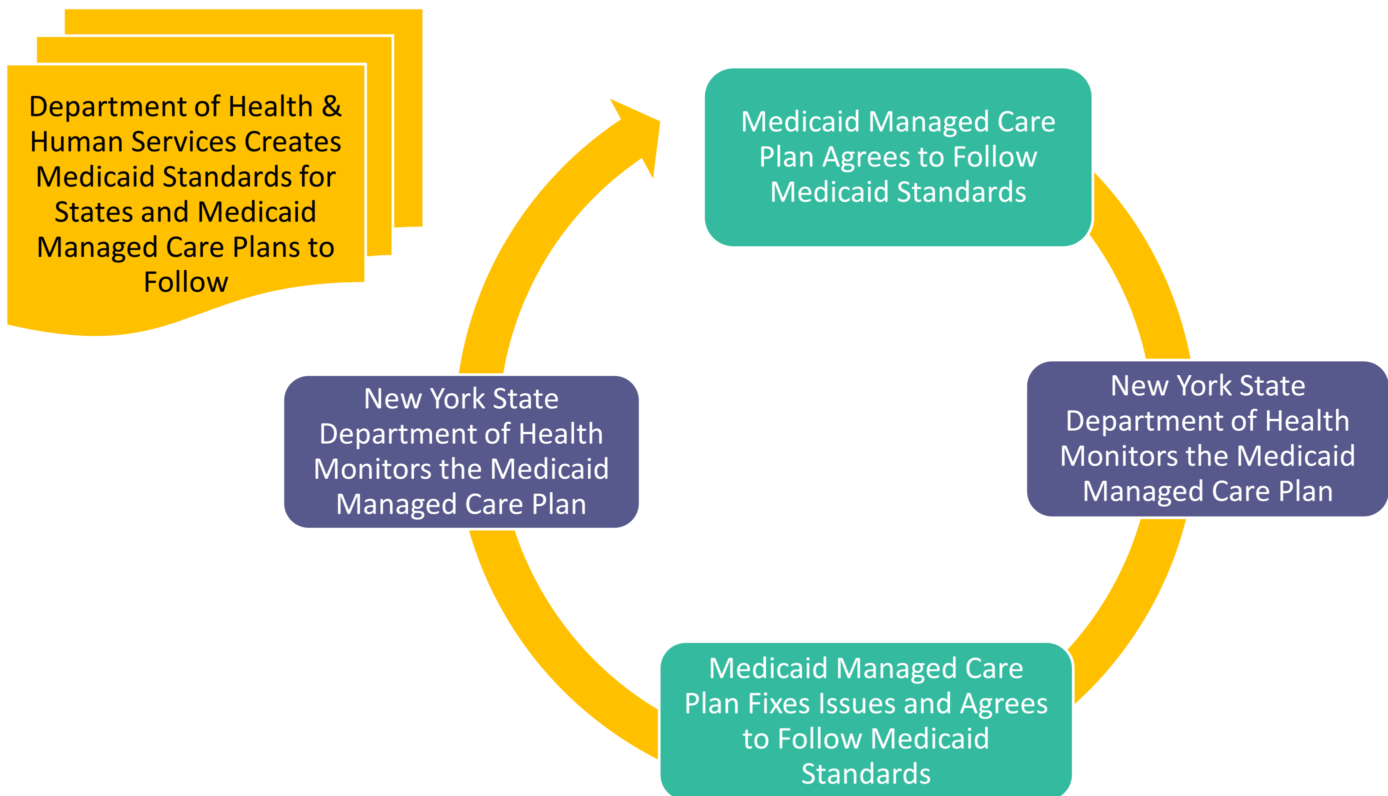
Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

The United States Department of Health & Human Services determines how the Medicaid program should work. The Department of Health & Human Services created a set of rules for states and Medicaid managed care plans to follow. These rules are called Medicaid standards. These Medicaid standards protect people who receive health care through state Medicaid programs. All Medicaid managed care plans in the country are required to follow these standards.

The Department of Health is responsible for making sure that the New York Medicaid managed care plans follow the Medicaid standards. The Department of Health continuously monitors the Medicaid managed care plans. The main way that the New York Medicaid managed care plans are monitored is through the Managed Care Operational Survey. During the survey, the Department of Health reviews Medicaid managed care plan documents and interviews staff. The Medicaid managed care plan is responsible for fixing any issues found during the survey.



Technical Summary – Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan's compliance with the standards of *Title 42 Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards* and the standards of *Title 42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Department of Health conducts a variety of oversight activities to ensure that the managed care plans are in compliance with federal and state Medicaid requirements and the standards of *Code of Federal Regulations Part 438 Managed Care Subpart D*, *Code of Federal Regulations 438.330*, the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*, *New York State Public Health Law Article 44* and *Article 49*, and *New York Codes, Rules, and Regulations Part 98-Managed Care Organizations*. These activities include the Managed Care Operational Survey, which is completed on a continuous timeline. This survey activity centers on the provision of Medicaid services and is conducted for the mainstream Medicaid managed care plans.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review, referenced in *Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii),* to determine managed care compliance with federal Medicaid standards. To meet this federal regulation, the Department of Health provided IPRO with the results of the Managed Care Operational Survey conducted for the mainstream Medicaid managed care plans in 2019, 2020, and 2021 for review.

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services granted New York State a Section 1135 (under the Social Security Act) Waiver to suspend the requirements of *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full onsite biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely. The granting of this waiver allowed the Department of Health to "pend" oversight activities that were scheduled for the remainder of 2020. Therefore, the Managed Care Operational Survey for 2020 was not conducted for some mainstream Medicaid managed care plans.

The results of the most recent compliance activities conducted for the mainstream Medicaid managed care plans by the Department of Health for 2019, 2020, and 2021 are presented in this report.

Technical Methods of Data Collection and Analysis

The Department of Health's primary method for managed care plan assessment and determination of compliance with federal and state Medicaid requirements is the Managed Care Operational Survey. The Managed Care Operational Survey is conducted by the Department of Health every 2 to 3 years based on a continuous timeline and is comprised of two parts: the Comprehensive Operational Survey and the Target Operational Survey.

The Comprehensive Operational Survey is a full review of state and federal Medicaid requirements which covers the following:

- Organization and Management
- Service Delivery
- Fraud, Waste, Abuse, and Program Integrity
- Management Information Systems
- Medicaid Contract
- Member Services

- Utilization Review Management
- Complaints and Grievances, Non-Utilization Review
- Behavioral Health Services
- Person Centered Care Management
- Quality Initiatives, Quality Assurance, Quality Improvement

The Target Operational Survey is a follow-up review to the Comprehensive Operational Survey and includes some standard reporting and review in addition to a follow-up of all areas and issues identified to be noncompliant during the Comprehensive Operational Survey. The Target Operational Survey includes, but is not limited to, the following:

- An evaluation of managed care plan changes related to the board of directors, officers, organizational changes, as well as modification to the managed care plan's utilization review and/or quality programs.
- An evaluation that the managed care plan has corrected the noncompliance identified during the Comprehensive Operational Survey and implemented a plan of correction.
- If the managed care plan was subject to complaints, was found to be deficient as a result of other Department of Health monitoring activities, or has undergone operational changes during the past year, a review of these areas is conducted.

Each 2019, 2020 and 2021 Comprehensive Operational Survey and Target Operational Survey was conducted over a 6-week period in three phases:

Phase 1 - Pre-onsite Visit
Each survey team lead, or facilitator, completed a review of the managed care plans previous operational survey results, as well as complaints history, external quality review activity results, and fair hearing data in preparation for the upcoming operational survey.

Each operational survey commenced with the issuance of an announcement letter to the managed care plan, along with a request for pertinent documents and data reports to serve as evidence of managed care plan compliance with the Medicaid standards under review. The requested documents included, but were not limited to, organization structure, policies and procedures, contracts and credentialing, utilization management and care management data, complaints, and grievances data.

Upon receipt of the requested documentation, the Department of Health survey staff reviewed the documentation for evidence of managed care plan compliance and to identify areas needing further review during the Department of Health's onsite visit to the managed care plan. The survey teams utilized Department of Health-developed tools throughout the survey process to ensure that standardization of the evaluation of evidence for compliance was maintained.

Phase 2 - Onsite Visit
During the onsite visit, the Department of Health survey staff continued its evaluation of documentation materials, reviewed quality assurance committee and board of directors meeting minutes, conducted staff and management interviews, and performed observations as needed.

Phase 3 - Post-onsite Visit
Six-to-eight weeks following the onsite visit, results were issued to the managed care plan. The survey results included written citations identifying the areas of the managed care plan's noncompliance with state and federal Medicaid standards. The written citations were issued to the managed care plan either as "deficiencies" for noncompliance with New York State *Public Health Law* and *New York Code, Rules, and Regulations* or as "findings" for noncompliance with the requirements of the *Medicaid Managed Care/HIV Special Needs Plan/Health and Recovery Plan Model Contract*. For areas of noncompliance, the managed care plan was required to submit a plan

of correction to the Department of Health for approval. Once the plan of correction was approved, the operational survey activity was considered closed.

Description of Data Received

To evaluate managed care plan compliance with federal and state Medicaid standards, IPRO reviewed the Department of Health-produced *Operational Deficiencies by Plan/Category Report* and the *Operational Plan Deficiencies Report*. The *Operational Deficiencies by Plan/Category Report* included a summary of noncompliance by review area for each managed care plan, while the *Operational Plan Deficiencies Report* included detailed information on the areas of noncompliance for each managed care plan. Both reports reflected the date of when the results were issued by the Department of Health to the managed care plan, the plan of correction submission date, and the plan of correction approval date.

Comparative Results

Managed care plan results for the operational survey activities conducted for 2019, 2020, and 2021 are presented by federal Medicaid standards in Table 19. In Table 19, a “C” indicates that the managed care plan was in compliance with all standard requirements and an “NC” indicates that the managed care plan was not in compliance with at least one standard requirement. The details for each “NC” designation are presented in the Managed Care Plan-Level Reporting section of this report.

Table 19: Managed Care Plan Operational Survey Results, 2019, 2020, and 2021

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
Affinity	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2021 Pended[1]											
CDPHP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	NC	C	C	C	C	C	NC	C	C	C	C
	2021 Pended[1]											
Empire BCBS HealthPlus	2019 Activity	C	C	C	C	NC	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	NC	C	C	NC	C
Excellus	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	NC	C	C	C	C
Fidelis	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	NC	C	NC	C	C	C	C
Healthfirst	2019 Activity	C	C	C	C	C	C	NC	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											
Highmark BCBS WNY	2019 Activity	NC	C	C	C	NC	C	NC	C	C	C	NC
	2020 Pended[1]											
	2021 Pended[1]											
HIP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	C	C	C	C	C	C	C	C	C	C	C
	2021 Activity	C	C	C	C	C	C	NC	C	C	C	C
IHA	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											
MetroPlus	2019 Activity	C	C	C	NC	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Activity	C	C	C	C	C	C	C	C	C	C	C
Molina	2019 Activity	C	C	C	NC	C	C	C	C	C	C	C
	2020 Pended[1]											
	2021 Pended[1]											

Managed Care Plan	Activity	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
MVP	2019 Activity	C	C	C	C	C	C	C	C	C	C	C
	2020 Activity	NC	C	C	C	NC	C	NC	C	C	C	C
	2021 Pended[1]											
UHCCP	2019 Activity	NC	C	C	NC	C	C	NC	C	C	C	NC
	2020 Pended[1]											
	2021 Activity	NC	C	C	C	NC	C	C	C	C	C	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.

C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Required	External Quality Review Activity 1. Validation of Performance Improvement Projects
Required	External Quality Review Activity 2. Validation of Performance Measures
Required	External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards
Optional	External Quality Review Activity 6. Administration of Quality-of-Care Surveys

Understanding the experiences that New Yorkers have with the Medicaid managed care program is a priority for the Department of Health. IPRO administers a survey on behalf of the Department of Health every year, alternating between adults and kids. The survey is sent to a group of New Yorkers that received care through one of the Medicaid managed care plans. IPRO asks these New Yorkers to rate their experiences with the mainstream Medicaid managed care plans, health care services, personal doctors, and specialists. This survey is called the Consumer Assessment of Healthcare Providers and Systems.

IPRO ensures that the survey is conducted properly and that the results are calculated correctly.

The Department of Health uses the survey results to monitor mainstream Medicaid managed care plan and provider performance. The mainstream Medicaid managed care plans use the survey results to understand the experience New Yorkers have with the Medicaid program.

In 2022, IPRO surveyed adult New Yorkers who received care in 2021 through a mainstream Medicaid managed care plan.

For more information about the 2021 survey, please read the rest of this section.

Technical Summary – Administration of Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality-of-care may be performed by using information derived during the preceding 12 months. Further, *Title 42 Code of Federal Regulations* 438*.358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

The Department of Health sponsors a member experience survey every other year for adults enrolled in a Medicaid managed care plan. The goal of the survey is to get feedback from these members about how they view the health care services they receive. The Department of Health uses results from the survey to determine variation in member satisfaction among the managed care plans.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the quality-of-care survey activity. To meet this federal regulation, the Department of Health contracted with IPRO to administer this survey. For measurement year 2021, IPRO subcontracted with DataStat, an NCQA-certified CAHPS vendor, to administer the *2022 CAHPS 5.1H Adult Medicaid Health Plan Survey* on behalf of all Medicaid managed care plans.

This external quality review report presents the 2022 CAHPS results for measurement year 2021.

Technical Methods for Data Collection and Analysis

The standardized survey instrument administered in 2021 was the *CAHPS 5.0H Adult Medicaid Health Plan Survey*. The majority of question items addressed members' experiences with their health care, such as getting care quickly, communication with doctors, and overall satisfaction with health care and with the health plan. The questionnaire was expanded to include 24 supplemental questions of particular interest to the Department of Health. Rounding out the instrument was a set of questions collecting demographic data. In total, the questionnaire consisted of 69 questions.

Table 20 provides more detail on how the 69 survey questions are categorized.

Table 20: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Customer Service	Never, Sometimes, Usually, Always *(Top-level performance is considered responses of "usually" or "always.")*
Global Rating Measures	
▪ Rating of All Health Care ▪ Rating of Personal Doctor ▪ Rating of Specialist Talked to Most Often ▪ Rating of Health Plan ▪ Rating of Treatment or Counseling	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

Adults who were current members of a New York State Medicaid managed care plan, ages 18 to 64 years, as of September 2021, and who had been enrolled for five out of the last six months were eligible to be randomly selected for the survey. A stratified random sample of 2,000 members was drawn for each managed care plan, resulting in a statewide sample size of 26,000 members.

Members were surveyed in English or Spanish. The survey was administered over a 13-week period using a mail-only three-wave protocol. The protocol consisted of a first questionnaire packet and reminder postcard to all selected members, followed by a second questionnaire packet and reminder postcard to individuals who had not responded to the initial mailings, concluding with a third questionnaire packet to individuals who had not responded to either the initial or secondary mailings.

Table 21 provides a summary of the technical methods of data collection.

Table 21: CAHPS Technical Methods of Data Collection Summary

Category	Data Collection Information
Survey Vendor	DataStat, Inc.
Survey Tool	5.1H Adult Medicaid Health Plan Survey
Number of Managed Care Plans	13
Type of Medicaid Managed Care Plan	Mainstream Plans
Survey Timeframe	10/14/21 to 1/13/22
Method of Collection	Mail only, three waves
Sample Size	26,000
Number of Completed Surveys	3,247
Response Rate	12.5%

DataStat, Inc. calculated the results in accordance with HEDIS specifications for survey measures.

Member responses to questionnaire items are summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion of responses qualifying as achievements. In general, somewhat positive responses are included with positive responses as achievements. For example, a response of "Usually" or "Always" to the question "How often did you get an appointment for health care at a doctor's office or clinic as soon as you needed?" is considered an achievement, as are responses of "8", "9", or "10" to rating questions with a scoring range of 0–10.

Achievement scores based on fewer than 30 responses were not considered reliable and were suppressed by DataStat.

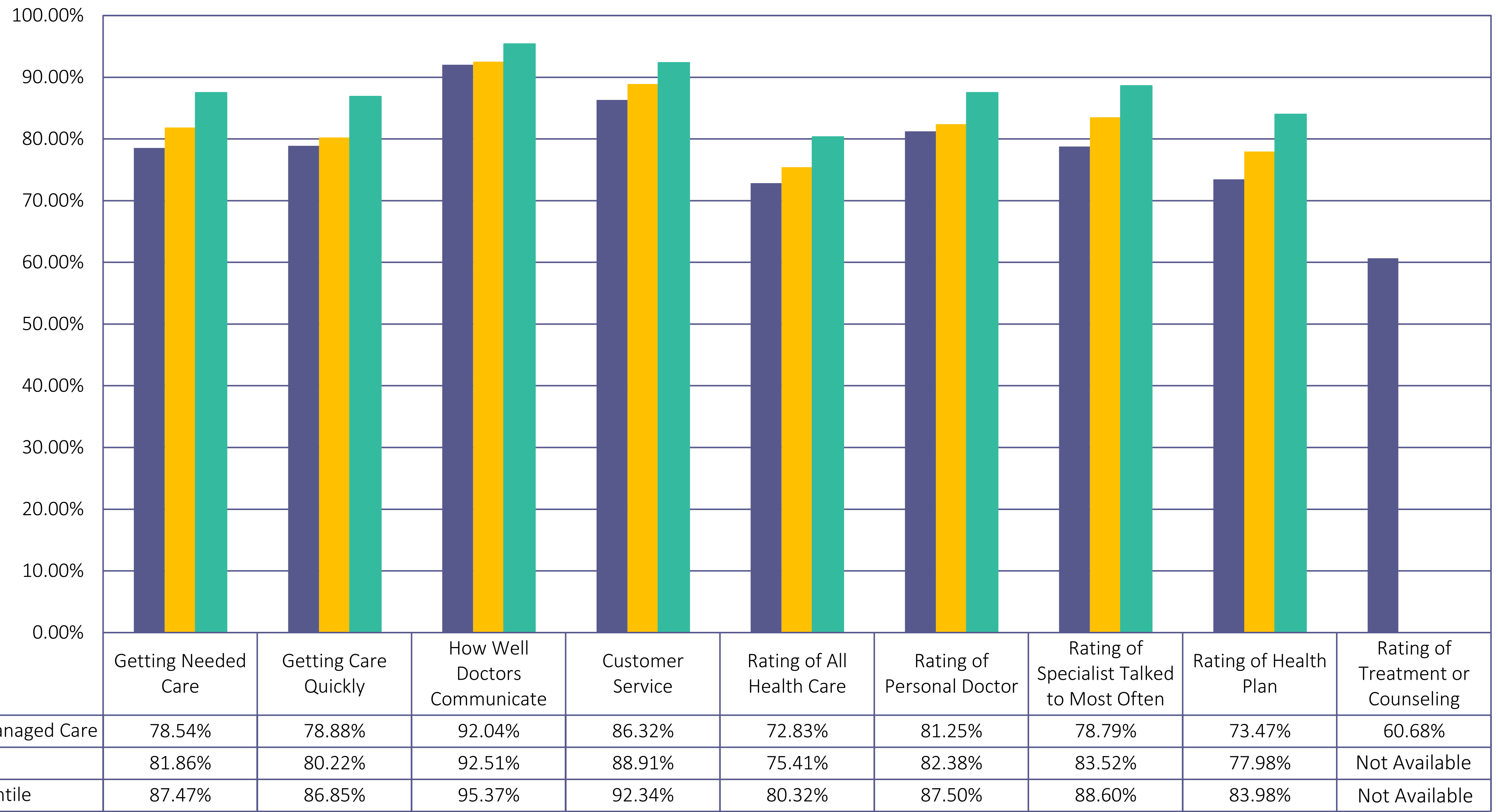
Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Description of Data Obtained

IPRO received a copy of the *New York State Medicaid Managed Care (MMC) CAHPS 5.1H Adult Medicaid Survey* that was produced by DataStat, Inc. in April 2022. The report included comprehensive descriptions of the project objectives, methodology, and data analysis, as well as results at the statewide, region (New York City and rest of state) and managed care plan levels.

Comparative Results

New York State achievement scores for the composite measures and global rating measures and national 2021 Medicaid benchmarks are presented in Figure 1. Achievement scores for the managed care plans are presented in Table 22.



	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Talked to Most Often	Rating of Health Plan	Rating of Treatment or Counseling
Statewide Mainstream Medicaid Managed Care	78.54%	78.88%	92.04%	86.32%	72.83%	81.25%	78.79%	73.47%	60.68%
National 2021 Medicaid Mean	81.86%	80.22%	92.51%	88.91%	75.41%	82.38%	83.52%	77.98%	Not Available
National 2021 Medicaid 90th Percentile	87.47%	86.85%	95.37%	92.34%	80.32%	87.50%	88.60%	83.98%	Not Available

Figure 1: 2021 Member Satisfaction Achievement Scores. Achievement scores for Medicaid managed care statewide (dark blue), National Medicaid Mean for (yellow) and National Medicaid 90th Percentile (green) for 2021.

Table 22: CAHPS Achievement Scores by Region and by Managed Care Plan, Measurement Year 2021

Region/Managed Care Plan	Getting Needed Care[1]	Getting Care Quickly[1]	How Well Doctors Communicate[1]	Customer Service[1]	Rating of All Health Care[2]	Rating of Personal Doctor[2]	Rating of Specialist Talked to Most Often[2]	Rating of Health Plan[2]	Rating of Treatment or Counseling[2]
Statewide Mainstream Medicaid Managed Care	78.54%	78.88%	92.04%	86.32%	72.83%	81.25%	78.79%	73.47%	60.68%
National 2021 Medicaid Mean	81.86%	80.22%	92.51%	88.91%	75.41%	82.38%	83.52%	77.98%	Not Available
National 2021 Medicaid 90th Percentile	87.47%	86.85%	95.37%	92.34%	80.32%	87.50%	88.60%	83.98%	Not Available
Affinity	76.04%	77.16%	93.12%	91.33%	68.08%	78.94%	74.64%	69.69%	Sample Size Too Small To Report
CDPHP	82.24%	82.39%	92.39%	83.72%	71.99%	84.71%	76.81%	77.71%	58.17%
Empire BCBS HealthPlus	81.73%	74.75%	91.89%	84.24%	78.09%	84.28%	83.45%	73.59%	Sample Size Too Small To Report
Excellus	77.70%	84.08%	92.24%	89.94%	73.91%	78.67%	82.69%	80.76%	59.20%
Fidelis Care	75.34%	81.59%	94.65%	84.97%	75.55%	85.95%	82.09%	74.19%	73.78%
Healthfirst	74.76%	73.93%	89.53%	81.38%	74.18%	80.40%	75.76%	73.26%	Sample Size Too Small To Report
Highmark BCBS WNY	85.03%	87.14%	94.69%	88.01%	74.43%	78.04%	77.98%	73.60%	66.10%
HIP	75.56%	70.45%	91.39%	82.54%	66.21%	80.82%	78.26%	69.60%	66.09%
IHA	84.29%	79.91%	94.17%	89.37%	76.08%	85.99%	81.43%	80.51%	67.95%
MetroPlus	77.46%	72.54%	88.28%	85.05%	69.12%	75.34%	69.70%	69.01%	Sample Size Too Small To Report
Molina	76.12%	79.44%	92.76%	81.69%	71.26%	80.66%	80.53%	69.38%	51.45%
MVP	79.68%	81.73%	91.10%	90.20%	74.52%	81.46%	80.88%	75.24%	61.37%
UHCCP	75.07%	80.37%	90.35%	89.66%	73.30%	81.03%	80.01%	68.63%	43.38%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's 2021 performance is statistically significantly better than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's 2021 performance is statistically significantly worse than the mainstream Medicaid managed care statewide 2021 performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Mainstream Medicaid Managed Care Plan-Level Reporting

To assess the impact of mainstream Medicaid managed care on the quality of, timeliness of, and access to health care services, IPRO considered managed care plan-level results from the external quality review activities. Specifically, IPRO considered the following elements during the 2021 external quality review:

- External Quality Review Mandatory Activity 1: Performance Improvement Projects
- External Quality Review Mandatory Activity 2: Performance Measures
- External Quality Review Mandatory Activity 3: Compliance with Medicaid and Children's Health Insurance Plan Standards
- External Quality Review Optional Activity 6: Quality of Care Survey, Member Satisfaction
- Managed Care Plan Follow-Up on 2020 External Quality Review Recommendations

Performance Improvement Project Summary and Results

This section displays the mainstream Medicaid managed care plan's 2021 performance improvement project topic, validation assessment, summary of interventions and results achieved. The corresponding tables display performance indicators, baseline rates, interim rates, final rates, and targets/goals.

Performance Measure Results

This section displays the mainstream Medicaid managed care plan-level HEDIS/Quality Assurance Report Requirements performance rates for measurement years 2019, 2020, and 2021, as well as the statewide average rates for measurement year 2021. The corresponding tables indicate whether the managed care plan's rate was statistically better than the statewide average rate (indicated by green shading) or whether the managed care plan's rate was statistically worse than the statewide average rate (indicated by red shading). A managed care plan statistically exceeding the statewide average rate for a measure was considered a strength during this evaluation, while a managed care plan rate reported statistically below the statewide average rate was considered an opportunity for improvement.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

This section displays mainstream Medicaid managed care plan results for the most recent Managed Care Operational Survey. A managed care plan being in compliance with federal Medicaid standards was considered a strength during this evaluation, while noncompliance with a requirement standard was considered an opportunity for improvement.

Quality-of-Care Survey Results – Member Experience

This section displays the mainstream Medicaid managed care plan-level Adult CAHPS performance for 2021. The corresponding tables display the satisfaction domains, individual supplemental questions, managed care plan scores, and the statewide average scores for measurement years 2017, 2019, and 2021. The table also indicates whether the managed care plan's score was significantly better than the statewide average score (indicated by green shading) or whether the managed care plan's score was significantly worse than the statewide average score (indicated by red shading). A managed care plan scoring statistically better than the statewide average score for a satisfaction domain was considered a strength during this evaluation, while a managed care plan scoring statistically worse than the statewide average score was considered an opportunity for improvement.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Title 42 Code of Federal Regulations 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCP, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each managed care plan describe how its organization addressed the recommendations from the 2020 External Quality Review Technical Report. Managed care plan responses are reported in this section of the report.

Table 23 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the 2020 external quality review recommendations.

Table 23: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed care plan's quality improvement response resulted in demonstrated improvement.
Partially Addressed
Managed care plan's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Strengths, Opportunities for Improvement, and Recommendations

The mainstream Medicaid managed care plan strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the quality of, timeliness of, and access to care are presented. These three elements are defined as:

- Quality is the extent to which a managed care plan increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- Timeliness is the extent to which care and services are provided within the periods required by the New York State model contract with managed care plans, federal regulations, and as recommended by professional organizations and other evidence-based guidelines.
- Access is the timely use of personal health services to achieve the best possible health outcomes.

Affinity

Performance Improvement Project Summary and Results

Table 24: Affinity's Performance Improvement Project Summary, Measurement Year 2021

Affinity's Performance Improvement Project Summary
Title: KIDS Quality Agenda Performance Improvement Project **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Affinity aimed to improve the incidences of screening and follow-up among its child members for three conditions of critical importance during infancy and childhood that require early intervention: 1) blood lead testing, 2) screening for hearing loss, and 3) screening for any developmental delays; and to improve health outcomes for the youngest of its member population. Member-Focused 2021 Interventions ▪ Educated parents/guardians via newsletter, member portal, and customer service centers on the importance of the newborn visit and meeting childhood development milestones. ▪ Encouraged parents/guardians of children identified as having elevated blood lead levels to see their provider for follow-up and management. ▪ Educated parents/guardians on the importance of hearing screens and follow-up care. Provider-Focused 2021 Interventions ▪ Outreached to high-volume provider groups with high well-child visit rates and low lead testing rates to identify potential billing issues and to develop corrective action plans. ▪ Outreached to provider groups with patients that had not had a capillary or venous blood test to facilitate root cause analysis discussions and to develop corrective action plans. ▪ Educated provider groups on clinical guidelines for follow-up testing for members with elevated blood lead levels and to discuss barriers to adherence to the guidelines. ▪ Educated providers via newsletter, fax blast and through the provider portal on screening requirements, appropriate coding, and the availability of a provider toolkit. ▪ Hosted an online seminar for provider groups on the submission of supplemental data. ▪ Produced monthly and bi-annual reports for providers with patients identified as missing screenings and or having lab results that required follow-up and monitoring. Managed Care Plan-Focused 2021 Interventions ▪ Established a bi-monthly data exchanges between Affinity and the New York State Information Immunization System and the New York City Citywide Immunization Registry.

Table 25: Affinity's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	42.05%	49.77%	48.09%	54.74%	51.00%
Blood Lead Test at Age 2 Years	68.01%	71.78%	70.51%	71.97%	74.00%
Blood Lead Test at Ages 1 and 2 Years	37.80%	40.09%	40.88%	53.29%	44.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	77.71%	87.17%	87.43%	84.95%	88.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	1.22%	1.24%	1.16%	1.30%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	77.30%	87.56%	86.74%	86.11%	88.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.37%	0.30%	0.30%	0.37%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	78.23%	88.54%	87.10%	79.05%	87.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	74.49%	80.55%	78.71%	76.96%	81.00%
Failed Screening by Age 1 Month	1.04%	1.70%	2.05%	1.48%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	31.58%	36.51%	44.44%	47.73%	50.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	33.33%	13.04%	13.89%	14.29%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	100.00%	100.00%	80.00%	100.00%	100.00%
Screening Before Age 3 Months	74.78%	80.55%	83.44%	83.77%	81.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	36.59%	35.85%	31.43%	32.76%	50.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	85.71%	100.00%	90.91%	92.86%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	58.54%	59.31%	62.51%	60.27%	65.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	78.29%	91.25%	84.14%	99.95%	84.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	36.78%	41.01%	41.29%	42.01%	43.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	57.70%	62.48%	59.99%	67.11%	64.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	4.87%	11.56%	11.61%	11.99%	11.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	3.12%	5.28%	7.26%	6.48%	10.00%

Performance Measure Results

Table 26: Affinity's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Affinity Measurement Year 2019	Affinity Measurement Year 2020	Affinity Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	47.69%	47.83%	52.39%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	32.86%	31.37%	35.31%	41.64%
Asthma Medication Ratio (5–64 Years)	57.65%	61.37%	61.38%	56.86%
Breast Cancer Screening	71.98%	70.50%	70.21%	64.75%
Cervical Cancer Screening	73.97%	73.97%	77.86%	69.19%
Chlamydia Screening in Women (16–20 Years)	80.40%	77.12%	78.57%	71.38%
Chlamydia Screening in Women (21–24 Years)	82.24%	75.31%	78.56%	74.13%
Colorectal Cancer Screening	65.45%	65.21%	70.32%	61.03%
Comprehensive Diabetes Care – Eye Exam	80.29%	67.88%	68.37%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	31.63%	30.90%	24.33%	34.74%
Controlling High Blood Pressure	75.43%	66.42%	72.75%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	68.35%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	64.32%	63.59%	62.68%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	47.58%	49.84%	49.41%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	78.03%	73.82%	69.14%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	81.27%	76.40%	72.51%	66.71%
Immunizations for Adolescents – Combination 2	43.55%	50.36%	52.07%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	87.83%	86.62%	93.19%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	85.40%	84.91%	92.46%	84.17%

Measure	Affinity Measurement Year 2019	Affinity Measurement Year 2020	Affinity Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	81.27%	82.00%	91.48%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	23.13%	23.57%	24.16%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62.97%	60.48%	53.04%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.48%	79.20%	78.98%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	65.08%	63.67%	62.60%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	67.72%	61.87%	65.26%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	67.20%	59.51%	62.73%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	80.49%	70.13%	65.08%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	47.92%	42.98%	42.53%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	38.66%	39.83%	40.04%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	14.45%	11.55%	11.58%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	65.84%	39.60%	52.17%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	24.89%	Not Available	25.24%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	Affinity Measurement Year 2019	Affinity Measurement Year 2020	Affinity Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	86.37%	91.00%	87.20%
Prenatal and Postpartum Care – Postpartum Care	74.70%	83.70%	88.32%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	77.34%	75.59%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	83.44%	85.11%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	71.66%	81.27%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 27: Affinity's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	C	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	C	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	NC	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Affinity failed to ensure the delegate DentaQuest issued initial adverse determination notices included the correct instructions on how to initiate an external appeal. Specifically, the phone number for which an enrollee may contact Affinity to request an external appeal application and instructions was not included. Affinity failed to provide the current external appeal instructions and application to the enrollee. Specifically, the address for Department of Financial Services was not correct, the applications did not include the placeholders for the enrollee's Date of Birth, and gender. *(Contract Article 4903. 5(b))*
- Affinity failed to submit and/or report an accurate 2nd quarter 2020 provider network. The network submission incorrectly reported seven of 20 providers who Affinity determined during the targeted operational survey were no longer participating. *(Contract Article 2005-98-1.16(j), 2005-98-1.16(i))*
- Affinity failed to ensure that delegates DentaQuest and EviCore included the correct information on how to file an appeal. Affinity failed to ensure that the delegate DentaQuest issued initial adverse determination notices that included the correct required timeframe to resolve an expedited appeal within 72 hours of receipt of request, in accordance with *42 Code of Federal Regulations Part 438.408(3)*. *Title 42 Code of Federal Regulations Part 438.402(b)* changes effective May 1st, 2018, a standard appeal after an upheld expedited appeal is no longer available for Medicaid, Child Health Plus, and individual insurance. *(Contract Article 4904. 2)*

Quality-of-Care Survey Results – Member Experience

Table 28: Affinity's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Affinity	Mainstream Medicaid Average	Affinity	Mainstream Medicaid Average	Affinity	Mainstream Medicaid Average
Getting Needed Care[1]	74.26%	78.71%	81.59%	81.33%	76.04%	78.54%
Getting Care Quickly[1]	73.22%	78.40%	76.55%	80.57%	77.16%	78.88%
How Well Doctors Communicate[1]	93.57%	90.95%	91.95%	92.00%	93.12%	92.04%
Customer Service[1]	84.89%	85.72%	86.38%	87.13%	91.33%	86.32%
Rating of All Health Care[2]	74.97%	76.50%	73.56%	75.33%	68.08%	72.83%
Rating of Personal Doctor[2]	83.00%	80.80%	78.22%	81.46%	78.94%	81.25%
Rating of Specialist Talked to Most Often[2]	76.96%	79.63%	85.54%	82.07%	74.64%	78.79%
Rating of Health Plan[2]	73.76%	75.93%	73.69%	75.90%	69.69%	73.47%
Rating of Treatment or Counseling[2]	72.14%	59.60%	Sample Size Too Small To Report	61.84%	Sample Size Too Small To Report	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 29: Affinity's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
Validation of Performance Improvement Projects					
The managed care plan should continue interventions implemented under the performance improvement project as these indicators have demonstrated performance improvement.	X			Even after the acquisition of Affinity by Molina effective November 1st, 2021, Affinity continues to educate parents and members on the importance of receiving required immunizations, lead screening, newborn hearing screening and follow-up, as well as timely developmental screenings through an educational brochure delivered to newly delivered moms. The brochure includes the Bright Futures/American Academy of Pediatrics recommendations for preventive pediatric health care. Additionally, the managed care plan will continue to host provider supplemental data webinars to address the need for the submission of lead results and hearing screening results data results to allow for a comprehensive and accurate view of members needing follow-up intervention. As provider education remains paramount to coding accurately, clinical documentation integrity documents have been produced and are being disseminated to providers as education resources for appropriate coding and documentation, including the coding of autism screening.	Partially Addressed
Validation of Performance Measures					
The managed care plan should continue interventions implemented to improve members accessing preventative screenings as the	X	X	X	In addition to previously implemented interventions, the managed care plan has also begun text and email campaigns focused on the annual well visit-especially for non-utilizing members to encourage them into care and to be assessed for other potential health care concerns. We continue to generate monthly gaps in care reports to attributed primary care providers and health homes when applicable. In 2023, a quarterly member gaps-in-care report card will be introduced to remind members of the outstanding health care goals that still need attention during the measurement year.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
majority of measures met or exceeded the statewide averages.				Since the availability of appointments become limited toward the end of the year, the health plan will use the latter part of the 3rd quarter and all of the 4th quarter to also encourage members to utilize telehealth or local CVS MinuteClinics®[14] as alternatives when delays in scheduling are encountered.	
The managed care plan should investigate opportunities to improve the health of members with cardiovascular disease and diabetes.	X			Affinity's main challenge to improving the health outcomes of members with cardiovascular and diabetic disease has been the ability to effectively identify members who are at-risk for gaps in medication adherence. As a solution, Affinity has collaborated with its pharmacy benefits manager, CVS Caremark, to report on members daily who are close missing or have missed a refill. From this report, the managed care plan initiates a text refill reminder for the first missed refill incidence. If a second missed refill incident occurs, Affinity's quality staff performs live outreach calls to remind and educate members on the importance of maintaining their medication regimen. The live call also affords us the opportunity to warm transfer members directly to CVS Caremark or connect them to the prescriber's office if the cause of their non-adherence is due to questions/concerns/side effects from their medication. Because the prescribing provider is not always the primary care provider and could be a specialist or out-of-network provider, our original, Affinity also developed medication gaps reports that are sent to prescribing providers of their at-risk members so they too can offer appropriate follow-up and outreach.	Partially Addressed
The managed care plan should investigate opportunities to	X			During the 2020 reporting year, Affinity delegated the administration of behavioral benefits to a vendor. The delegation arrangement experienced on-going challenges in that true integration of the behavioral health and physical health needs of	Partially Addressed

[14] MinuteClinic is a registered trademark of MinuteClinic, L.L.C.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
improve the health of members with depression and opioid abuse disorders.				members with cooccurring conditions was difficult to manage. As of January 1,2022, Affinity has transitioned all behavioral health care management in house to a fully integrated care management department that is staffed with clinicians who are trained and licensed to provide management of both behavioral health and physical health care. In this model, the care managers are offering comprehensive transitions of care services to get members connected to providers and resources in the community who can address their needs holistically. And because some diagnostic information around substance use is protected, the case managers are exploring the possibility of embedding staff in specific high-volume substance treatment facilities to allow engagement with members prior to discharge as well which could potentially increase the likelihood of connecting members to appropriate, ongoing outpatient services and medication assisted treatment while the members' location and whereabouts are is still known to the managed care plan (and reducing the potential for members getting lost to care).	
The managed care plan should investigate opportunities to improve members access to dental services, drug dependence treatments and postpartum care.	X		X	Since the previous measurement period, Affinity has introduced changes in resources, processes, and programs primarily because of its acquisition by Molina; nevertheless, the following interventions represent the steps taken by Affinity to improve outcomes. **Dental** Affinity has collaborated with DentaQuest—its dental benefits vendor—to perform live call campaigns to members in need of an annual dental visit. These calls serve to assist members with finding a dental provider and scheduling their next appointment. Also, after assessing the dental provider network and identifying dental practices with consistently high performance in the annual dental visit measure, members with 18 months of no dental utilization are either assigned or reassigned to a high-performing dental provider	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
				with a record of successful outreach and engagement. DentaQuest also offers their providers a quality incentive for achieving high performance standards. Additionally, Affinity expects to introduce a dental member incentive in 2023 for members of all ages who seek and complete preventive dental care during the measurement year. Alcohol/Other Drug Abuse The managed care plan is now receiving hospital admission/discharge/transfer alerts from three regional health information organizations within our catchment area, covering members across both upstate and downstate regions. These alerts are updated in the managed care plan's case management system and queued up for immediate action to be taken by the behavioral health case management team. The purpose of the frequent alerts updates is to facilitate timely identification of members diagnosed with substance use disorders so that timely initiation of treatment can be facilitated during the case manager's contact with the members. However, because some diagnostic information around substance use is protected, the behavioral health and Case Management Departments are exploring the possibility of embedding staff in specific high-volume substance treatment facilities to allow engagement with members prior to discharge to potentially increase the likelihood of connecting members to appropriate, ongoing outpatient services and medication assisted treatment while the members' location and whereabouts are is still known to the managed care plan (and reducing the potential for members getting lost to care). In 2023, the managed care plan will introduce a gift card reward to members who enroll in the case management program and complete their substance use disorder post-emergency department follow-up visit within seven days.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
				Prenatal and Postpartum Upon identification of pregnancy, the managed care plan's quality team initiates mailing of a maternity brochure to all qualifying members. The brochure is designed to deliver education on the importance of timely prenatal and postpartum care, what to expect at each stage of gestational development, and what to expect during the postpartum period. Also, throughout the year, the dedicated contact center staff of the Women's Health Line make outbound calls to pregnant members to (1) educate them on the importance of timely prenatal/postpartum care, and (2) assist with appointment scheduling. In addition to outbound calls, the Women's Health Line accepts inbound calls from members that may receive the toll free# from any of the member educational materials mailed, emailed, or texted to these members. The managed care plan is also working on a project to ensure maternity providers who are contracted at a global rate are submitting claims for all prenatal and postpartum care delivered to their members.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should investigate opportunities to ensure appeal policies and procedures are being followed by its' delegates DentaQuest and EviCore.	X	X	X	As part of its plan of correction submitted to the Department of Health following the 2020 Article 44 Comprehensive Plan Survey, Affinity reviewed a random sample of appeal notices prepared by DentaQuest and EviCore to ensure appeal policies and procedures are being adhered to. Any issues identified required a corrective action plan to be submitted by the delegates, where a follow-up review would be conducted to confirm the issues are resolved. This internal process of auditing delegated vendors' appeals policies has since been incorporated into the policies and procedures of Molina Healthcare of New York since the acquisition of Affinity effective November 1st, 2021.	Addressed
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should	X	X	X	There are three main interventions the managed care plan has engaged in to obtain more information and a better understanding	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Affinity's Response	IPRO's Assessment of Affinity's Response
evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.				about drivers of member dissatisfaction. First, a member satisfaction survey will be executed at the completion of a call that a contact center agent is already engaged in with the member. This survey will allow us to begin gathering and trending CAHPS-related member experience/satisfaction data around the ease of working with Affinity and the overall customer service experience during that contact. Secondly, the managed care plan has launched a program called "Care4Care" that deploys contact center staff to call members with more than one complaint against the managed care plan within a calendar quarter. The purpose of this contact is to ascertain if the member's complaint was handled timely, appropriately and to their satisfaction, as well as to elicit suggestions on how Affinity can prevent their issue from happening again. Thirdly, the managed care plan will be sending out post-doctor visit surveys—starting in early 2023—to members with a recent primary care visit to get feedback on key CAHPS questions around getting care needed and getting care quickly. Our goal is to use the feedback from all these sources to inform changes in company procedures, re-education of contact center staff, and performance improvement activities with our providers.	

Strengths, Opportunities for Improvement, and Recommendations

Table 30: Affinity's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Affinity's measurement year 2021 performance improvement project passed validation.	X	X	X
	Affinity exceeded target rates for two performance indicators related to blood lead screening.	X	X	X
	Affinity met or exceeded target rates for two performance indicators related to newborn hearing screening.	X	X	X
	Affinity exceeded target rates for three performance indicators related to developmental screening.	X	X	X
Performance Measures	Affinity met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Affinity performed significantly better than the mainstream Medicaid program on 19 measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Affinity performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Affinity performed significantly better than the mainstream Medicaid program on three measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, Affinity was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Affinity performed significantly better than the mainstream Medicaid program on one measure of member satisfaction.	X		
Opportunities for Improvement				
Performance Improvement Project	Affinity did not meet target rates for four performance indicators related to blood lead screening.	X	X	X
	Affinity did not meet target rates for four performance indicators related to newborn hearing screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Affinity did not meet target rates for three performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	Affinity performed significantly worse than the mainstream Medicaid program on five measures of effectiveness of care related to primary care, HIV care, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Affinity performed significantly worse than the mainstream Medicaid program on four measures of access/availability of care related to primary care, children's health, or substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, Affinity was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Performance Measures	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Compliance with Federal Managed Care Standards	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			
Quality-of-Care Survey	Affinity is no longer participating in the New York State Medicaid Managed Care program and therefore no recommendation was made.			

CDPHP

Performance Improvement Project Summary and Results

Table 31: CDPHP's Performance Improvement Project Summary, Measurement Year 2021

CDPHP's Performance Improvement Project Summary
Title: New York State Kids Quality Initiative Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim CDPHP aimed to address three priority areas for at-risk Medicaid members aged 3 years and younger for lead testing and follow-up, newborn hearing screening and follow-up, and developmental assessment monitoring for early intervention. Member-Focused 2021 Interventions ▪ Educated members on the availability of transportation services and how to access these services. ▪ Outreached to parents/guardians of members with gaps in care for lead testing and hearing screen. ▪ Collaborated with a federally qualified health center to schedule well-visit and lead testing appointments for members identified as having gaps in care. ▪ Incentivized members with a gift card for the completion of follow-up to a positive lead test. ▪ Empowered members with education and participation in the CDPHP Maternal Health Program. ▪ Coordinated and scheduled blood draw appointments for members as needed. ▪ Outreached to parents/guardians of members identified with a failed newborn hearing screen conducted at Albany Medical Center during birth admission. ▪ Initiated member case management following a newborn hearing screen birth admission post-discharge. ▪ Piloted the Focused Parenting Support Program in a primary care practice which included educational books and a support group. Provider-Focused 2021 Interventions ▪ Issued gaps in care reports to providers to support their patient outreach efforts. ▪ Outreached to high-volume, low performing practice sites with patients identified as having more than four gaps in care. ▪ Collaborated with practice sites to identify barriers to care coordination and to discuss the role of the provider in facilitating continuity of care. ▪ Facilitated an early intervention program coordinator meeting to identify barriers to timely referrals. ▪ Worked with practice sites to explore opportunities for extended appointment slots or screening events. Managed Care Plan-Focused 2021 Interventions ▪ Utilized New York State data to identify "at-risk" counties and identify practice sites for engagement activities. ▪ Assessed provider awareness of current lead screening and testing recommendations via questionnaire and provided follow-up education based on questionnaire results.

Table 32: CDPHP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	61.28%	68.92%	65.54%	66.68%	66.30%
Blood Lead Test at Age 2 Years	59.35%	63.28%	64.81%	62.22%	64.30%
Blood Lead Test at Ages 1 and 2 Years	43.35%	46.49%	49.72%	49.34%	48.30%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	53.65%	49.12%	63.64%	58.73%	58.60%
Confirmed Venous Blood Lead Level > 5 mcg/dl	10.35%	10.04%	10.18%	13.53%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	0.00%	24.53%	31.69%	31.07%	80.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	1.90%	1.72%	1.76%	4.36%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	0.00%	16.46%	16.95%	20.69%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	75.66%	81.73%	87.66%	82.24%	80.70%
Failed Screening by Age 1 Month	1.02%	1.56%	2.63%	1.91%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	9.52%	4.88%	1.32%	5.41%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	0.00%	50.00%	0.00%	50.00%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	Denominator=0	Denominator=0	100.00%	100.00%	80.00%
Screening Before Age 3 Months	61.02%	89.55%	91.15%	87.01%	66.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	28.57%	7.69%	8.86%	17.65%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	100.00%	Denominator=0	100.00%	100.00%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	8.67%%	10.42%	12.43%	12.80%	14.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	22.95%	28.64%	32.37%	37.52%	28.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	20.29%	21.35%	25.36%	30.53%	25.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	17.74%	20.56%	23.73%	27.38%	23.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.00%	7.47%	14.48%	5.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	2.00%	4.88%	5.00%

Performance Measure Results

Table 33: CDPHP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	CDPHP Measurement Year 2019	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	53.94%	58.81%	58.02%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.03%	42.68%	42.08%	41.64%
Asthma Medication Ratio (5–64 Years)	60.00%	66.03%	68.79%	56.86%
Breast Cancer Screening	64.62%	60.76%	57.82%	64.75%
Cervical Cancer Screening	73.39%	67.99%	64.75%	69.19%
Chlamydia Screening in Women (16–20 Years)	69.40%	65.21%	63.70%	71.38%
Chlamydia Screening in Women (21–24 Years)	76.72%	71.75%	68.95%	74.13%
Colorectal Cancer Screening	58.44%	57.61%	62.72%	61.03%
Comprehensive Diabetes Care – Eye Exam	68.37%	58.97%	54.68%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	28.99%	35.14%	30.96%	34.74%
Controlling High Blood Pressure	68.61%	71.78%	72.81%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	40.25%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	72.73%	73.97%	72.65%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	28.11%	30.80%	27.96%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	82.13%	78.66%	78.06%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	81.02%	82.48%	75.67%	66.71%
Immunizations for Adolescents – Combination 2	35.77%	34.91%	33.39%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	94.27%	88.40%	91.25%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	89.17%	84.00%	88.75%	84.17%

Measure	CDPHP Measurement Year 2019	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	85.35%	83.60%	85.00%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	24.91%	23.03%	16.38%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	61.82%	65.92%	63.96%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.48%	74.94%	77.24%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	44.89%	43.74%	47.68%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	67.00%	68.24%	64.81%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	50.63%	47.65%	41.02%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	61.90%	55.07%	51.42%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	42.41%	38.37%	39.19%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	42.25%	41.94%	42.62%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	17.94%	17.20%	17.02%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	64.59%	53.87%	58.98%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	40.10%	Not Available	49.35%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	CDPHP Measurement Year 2019	CDPHP Measurement Year 2020	CDPHP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	94.65%	93.46%	87.20%
Prenatal and Postpartum Care – Postpartum Care	81.51%	81.75%	79.23%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	74.57%	74.35%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	85.67%	81.58%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	67.51%	67.62%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 34: CDPHP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	NC	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	C	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	C	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Based on staff interview and review of the Child Health Plus initial adverse determination and final adverse determination notices, CDPHP failed to ensure its delegate, Delta Dental, provided clinical rationale explanations that included the term "not medically necessary" or enrollee-specific information in six of 10 Child Health Plus pre-authorization cases. *(Contract Article 98-2.9(e)(1))*
- Based on staff interview and review of the Child Health Plus final adverse determination notices, CDPHP and its delegate Delta Dental failed to ensure that the notices included the contact person for CDPHP. This was evident in five of 10 Child Health Plus standard appeal utilization review cases. *(Contract Article 98-2.9 (e)(3,4,5,6,7))*
- CDPHP failed to ensure that the written notices issued to the enrollees were factual and accurate in nature for three of 16, (#37, 38, and 40) Delta Dental Child Health Plus pre-authorization utilization review cases reviewed during the Comprehensive Operational Survey. Specifically, the Delta Dental Child Health Plus pre-authorization initial adverse determination notices did not include correct information to identify the dentist that completed the review and made the denial determination. *(Contract Article 98-1.13 (a))*
- CDPHP failed to provide evidence that two of 55 providers were sent an amendment to incorporate the 2017 New York State Department of Health Standard Clauses for Managed Care Provider/Independent Physician Association/Accountable Care Organization Contracts. *(Contract Article 98-1.13(a))*
- CDPHP failed to notify the Department of Health of three new board members and the resignation of three board members. *(Contract Article 2005-98-1.13(c)(2))*

Quality-of-Care Survey Results – Member Experience

Table 35: CDPHP's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	CDPHP	Mainstream Medicaid Average	CDPHP	Mainstream Medicaid Average	CDPHP	Mainstream Medicaid Average
Getting Needed Care[1]	85.73%	78.71%	84.85%	81.33%	82.24%	78.54%
Getting Care Quickly[1]	84.96%	78.40%	87.06%	80.57%	82.39%	78.88%
How Well Doctors Communicate[1]	92.82%	90.95%	94.02%	92.00%	92.39%	92.04%
Customer Service[1]	90.54%	85.72%	94.10%	87.13%	83.72%	86.32%
Rating of All Health Care[2]	83.26%	76.50%	82.37%	75.33%	71.99%	72.83%
Rating of Personal Doctor[2]	85.12%	80.80%	87.57%	81.46%	84.71%	81.25%
Rating of Specialist Talked to Most Often[2]	83.51%	79.63%	87.57%	82.07%	76.81%	78.79%
Rating of Health Plan[2]	86.88%	75.93%	84.85%	75.90%	77.71%	73.47%
Rating of Treatment or Counseling[2]	65.43%	59.60%	67.04%	61.84%	58.17%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's performance is statistically significantly better than the mainstream Medicaid managed care statewide performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 36: CDPHP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
Validation of Performance Improvement Projects					
The managed care plan should continue interventions implemented under the performance improvement project as these indicators have demonstrated performance improvement.	X			Ongoing actions: CDPHP continues with member and provider focused activities to further improve performance for blood lead testing, newborn hearing testing, and developmental screening. Member-focused: Activities include coordination of transportation for appointments. This is accomplished through member newsletter communication and targeted outreach to members with a gap in care for lead and hearing screening. Medical answering service transportation tip sheets with written guidance on how to use the medical answering service are available for members and through provider offices. Member-facing educational flyers has been updated to include the link to county lead programs. CDPHP continues to empower members through education and participation in the CDPHP Maternal Health Program. This proactive approach provided early education on the importance of Lead testing, newborn hearing testing and developmental screening. This initiative will continue in the future through a new platform called Ovia Health. Member outreach was broadened during the performance improvement project and will continue to include literature distributed in the Backpack Program. Information included the "How to Get Help for Your Child" flyer, as well as information on the Homeless and Travelers Aid Society Feed and Read Program which reaches 560 lower income households. Members will continue to assistance coordinating and scheduling blood draw appointments as needed. Additionally, case	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				management activities will include identification of all care gaps when engaging the member. CDPHP continues to financially support the Parenting Support Program in a designated primary care practice which includes educational books and a support group. Provider-focused: Interventions will continue to focus on education of coding to highest specificity to facilitate ongoing awareness of the use of CG 96110 or the International Classification of Diseases, 10th revision, or ICD-10, code Z13.41. To further educational support of lead exposure awareness, CDPHP updated the *Quality Metrics Reference Guidebook* for providers to include information and links to home lead assessment blood level information, the New York State Department of Health lead homepage, a nutrition flyer to reduce lead intake, and a link to county lead programs. The provider newsletter *Network in the Know* will continue to be the predominate communication strategy going forward. Improvement opportunities that are identified will be brought forth to the Quality Management Committee for provider input and action. Quality improvement nurse specialist engagement with provider practices will continue to identify and address barriers to care coordination. The Parenting Support Program pilot offered through a designated primary care provider practice will continue with hopes of expanding to more practices. The program is viewed as a tool for engaging parents of young patients. Managed care plan-focused: CDPHP continues to disseminate monthly gap reports to all enhanced primary care practices to assist provider practice outreach and gap closure. Provider	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				practices in "at-risk" counties are included in the provide gap sends. CDPHP sponsorship of designated programs will continue as an effective method for heightening community awareness of heath care gaps. The care management team reviews all gaps in care when engaging a member and will continue to monitor for lead, hearing, and developmental gaps. All initiatives identified above remain ongoing. The expected outcome include ongoing awareness on the importance of lead testing, newborn hearing screening follow up for failed initial testing and early intervention for developmental delays, gap closure, and improvement in overall performance. Enhanced primary care practices are monitored for performance annually. The above activities were noted to be effective during the performance improvement project and any barriers to ongoing implementation will be addressed.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve adolescents' access to immunizations and women's access to breast cancer and chlamydia screenings.	X	X	X	To address this, we have a two-pronged approach aimed at encouraging members to get preventive care and encouraging providers to ensure the patients they see get all of the appropriate preventive care. Encouraging preventive care, transportation, member outreach – phone and email campaigns, community events, member incentives (gift cards), provider action, value-based care, and provider communication. The goal is improved performance on the following HEDIS measures: *Immunizations for Adolescents*, *Breast Cancer Screening*, and *Chlamydia Screening in Women*. *What is the managed care plan's process for monitoring the actions to determine their effectiveness?*	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				▪ Monthly monitoring rates at the managed care plan and provider level.	
The managed care plan should investigate opportunities to improve the health of members with diabetes, chronic obstructive pulmonary disease, and lower back pain.	X			Diabetes *What has the managed care plan done or planned to do to address the recommendation?* ▪ Focus on Kidney Health Evaluation for patients with Diabetes along with the other measures that are available such as blood pressure control, eye exam and hemoglobin A1c Results for patients with diabetes. *When and how will this be accomplished?* ▪ Provider education ▪ Part of value-based programs both our Enhanced Primary Care (EPC) and specialty value-based programs have these key HEDIS measures built into them. ▪ Part of credentialing quality review ▪ Direct provider outreach Data Review: To ensure accuracy of data, review of medical records and Hixny[15], a health information network, in addition to claims information. *What are the expected outcomes or goals of the actions to be taken?* The goal is improved performance on the HEDIS measures listed above. *What is the managed care plan's process for monitoring the actions to determine their effectiveness?*	Partially Addressed

[15] Hixny Website: https://hixny.org/.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				Monthly monitoring rates at the managed care plan and provider level, and monthly review of data. Chronic Obstructive Pulmonary Disease/Spirometry *What has the managed care plan done or planned to do to address the recommendation?* ▪ Focus on the HEDIS *Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease* measure *When and how will this be accomplished?* ▪ Use of spirometry testing in the assessment and diagnosis of chronic obstructive pulmonary disease (planned for the fourth quarter of 2022) Data Review Analysis of current performance to plan for future actions member outreach *What are the expected outcomes or goals of the actions to be taken?* The goal is improved performance on the spirometry HEDIS measure (*Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease*). *What is the managed care plan's process for monitoring the actions to determine their effectiveness?* ▪ Monthly monitoring rates at the managed care plan and provider level ▪ Monthly review of data Lower Back Pain *What has the managed care plan done or planned to do to address the recommendation?* The LBP Drive to five team will identify opportunities to improve measured performance to meet the 90th percentile.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				Interventions will focus on avoidance of unnecessary radiology studies (X-rays). The goal is to reach the national 90th percentile performance. *When and how will this be accomplished?* ▪ Planned interventions ▪ Analyze data trends and prioritize high-volume performance outliers ▪ Engage low performers and monitor compliance. ▪ Conduct chart review specific to documentation and practices for targeted high-volume/low-performance providers. ▪ Identify educational opportunities specific to documentation practice and coding processes. ▪ Review previous quality-improvement activities and plans of corrections to evaluate the benefit of past process-improvement strategies. ▪ Review previously published educational articles for consideration in future communications. ▪ Review top-performing health plan websites to ascertain best-practice recommendations and member level education. ▪ Recommend CDPHP website redesign as needed to message: Use of Imaging Studies for Low Back Pain (LBP). Low back pain is caused by injury to a muscle (strain) or ligament (sprain). Common causes include improper lifting, poor posture, and lack of regular exercise, fracture, ruptured disk, or arthritis. Often, the only symptom is pain in the lower back. Most low back pain goes away on its own in two to four weeks. Physical therapy and pain relievers can help. A few cases may require surgery. ▪ Consider additional incentives. *What are the expected outcomes or goals of the actions to be taken?*	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				The goal is national 90th percentile performance. *What is the managed care plan's process for monitoring the actions to determine their effectiveness?* CDPHP's methodology to monitor use of imaging studies for low back pain is based on the HEDIS technical specifications for the *Low Back Pain* measure. HEDIS 2020 technical specifications and interim HEDIS 2020 reporting of *Low Back Pain* measure rates are used to monitor compliance. The *Low Back Pain* measure includes members aged 18 to 50 years with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, magnetic resonance imaging, computed tomography scan) within 28 days of the diagnosis. Prior years' data are assessed to determine performance trends by line of business. Interim performance goals are set and tracked throughout the year by interim HEDIS reports. CDPHP monitors and reports low back pain rates for commercial health maintenance organization, preferred provider organization, Health and Recovery Plan, Marketplace, and Medicaid line of business for both subsets of the measure.	
The managed care plan should investigate opportunities to improve emergency room follow-up, follow-up care for children on attention-deficit/hyperactivity disorder medication and opioid use.	X			*What has the managed care plan done or planned to do to address the recommendation?* Follow-Up After Emergency Department Visit for Mental Illness Partner with ApitHealth, Inc. and Valera Health virtual clinic to provide members with follow-up appointments via smartphone technology, bypassing the need to rely on a source of transportation. Expand access to the outpatient network by incentivizing collaboration with telehealth partners ApitHealth, Inc. and Valera Health using value-based payment contracts. Both vendors have their own virtual network of prescribing and non-prescribing behavioral health clinicians. Performance on the HEDIS *Follow Up After Emergency Department Visit for Mental*	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				Illness benchmarks determine the amount paid at the end of the contract. **Attention-deficit/hyperactivity disorder** CDPHP interviewed successful pediatric evidence-based practice center practices to learn about their best practices. Pharmacy data is also being collected daily. A value-based contract was arranged with the Children's Health Home of Upstate New York to dedicate resources that allow for care managers to devote time to ensuring teen patients are receiving follow-up visits. **Opioid Use** CDPHP has convened a multi-department opioid workgroup. This workgroup has executed a number of initiatives over the last five years to support core elements of the opioid strategy. These goals focused on the balance between judicious prescribing to ensure access to appropriate care, education, prevention, and access to treatment. While opioid prescribing and the use of prescription opioids have been the primary focus, the plan for 2023 is to pivot with a more concentrated effort toward treatment for opioid use disorder. Specific activities are yet to be determined but will involve education, provider engagement, use of peer support specialists, and improving access to treatment. *When and how will this be accomplished?* **Follow-Up After Emergency Department Visit for Mental Illness** Hospital Experience staff visited onsite at Albany Med and St. Peter's to raise awareness of telehealth app services and distributed flyers for members. CDPHP analytics and the telehealth partners created dashboards with member health insights. Various hospital emergency rooms have received presentations on the telehealth referral process for ApitHealth, Inc. and Valera Health. Both platforms signed a contract to provide follow up visits for *Follow Up After Emergency*	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				Department Visit for Mental Illness members and quarterly updates on their performance was shared, which was reviewed in the team meetings. Attention-deficit/hyperactivity disorder Interviews were performed in first quarter, 2022 and this information was shared with poorer performing offices throughout the year. As of the third quarter of 2021, practices who are prescribing new attention-deficit/hyperactivity disorder medications to children are being contacted to remind the prescriber that they need to see these children within at least two weeks. Opioid Use Throughout 2023, the workgroup will meet monthly to determine activities and timelines. *What are the expected outcomes or goals of the actions to be taken?* Follow-Up After Emergency Department Visit for Mental Illness The telehealth partnerships will allow more timely access to behavioral health clinicians after they discharge from the ER. This will reduce the likelihood of readmissions and provide additional support in a member's time of crisis. Attention-deficit/hyperactivity disorder Success is not only a workflow but making sure that the entire team (clerical and clinical) is aware that after a new attention-deficit/hyperactivity disorder/attention deficit disorder medication is started an appt is booked three weeks later. The medication requires careful monitoring and often dose adjustments. These providers will be able to track medication use and provide follow up care to observe symptoms and progress.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
				Opioid Use The goal of this work is to connect more members that present to the emergency room with opioid use disorder to treatment options. *What is the managed care plan 's process for monitoring the actions to determine their effectiveness?* **Follow-Up After Emergency Department Visit for Mental Illness** CDPHP created specific reports for ApitHealth, Inc. and Valera Health to monitor quarterly performance which include HEDIS data to give insight into benchmarks/goals. **Attention-deficit/hyperactivity disorder** Prescribing clinician offices are being monitored through their HEDIS data. **Opioid Use** Monitoring of emergency visits, subsequent office visits, buprenorphine prescribing and HEDIS data will all be used to determine effectiveness of programs.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should investigate opportunities to improve the areas in which noncompliance was identified and routinely monitor the effectiveness of the interventions to ensure full compliance	X	X	X	*What has the managed care plan done or planned to do to address the recommendation?* On a monthly basis rates are reviewed for all measures looking for trends and patterns. CDPHP has created a drive to five program that has it core mission to become a 5-star plan for all lines of business based on the current HEDIS/Quality Assurance Reporting Requirements measures that are being measured. *When and how will this be accomplished?* The drive to five teams in conjunction with our Enhanced Primary Care Program and Specialty Value Based Program allows us to focus on those measures that lag in performance based on the current 90th percentile results. Face to face meeting occur with these groups to discuss ways to improve quality and close gaps in	Addressed. (As CDPHP's submitted response did not address the recommendation, IPRO based its assessment of CDPHP's response to the 2020 recommendation on CDPHP's corrective action plan that was accepted by the

2020 External Quality Review Recommendation	Quality	Timeliness	Access	CDPHP's Response	IPRO's Assessment of CDPHP's Response
achieved during the next compliance review.				care. Monthly gap in care reports is also available for provider groups to utilize. *What are the expected outcomes or goals of the actions to be taken?* The goal is to maximize the opportunity of all HEDIS/Quality Assurance Reporting Requirements measures that are not at the current 90th percentile cut point. *What is the managed care plan's process for monitoring the actions to determine their effectiveness?* Monthly review of current rate reports on both the managed care plan and provider group reports.	Department of Health on 08/19/2021.

Strengths, Opportunities for Improvement, and Recommendations

Table 37: CDPHP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	CDPHP's measurement year 2021 performance improvement project passed validation.	X	X	X
	CDPHP exceeded target rates for three performance indicators related to blood lead screening.	X	X	X
	CDPHP met or exceeded target rates for four performance indicators related to newborn hearing screening.	X	X	X
	CDPHP exceeded target rates for four performance indicators related to developmental screening.	X	X	X
Performance Measures	CDPHP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	CDPHP performed significantly better than the mainstream Medicaid program on six measures of effectiveness of care related to primary care or children's health.	X	X	
Performance Measures – Access/Availability of Care	CDPHP performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to children's health or maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	CDPHP performed significantly better than the mainstream Medicaid program on two measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, CDPHP was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	CDPHP did not meet target rates for three performance indicators related to blood lead screening.	X	X	X
	CDPHP did not meet target rates for two performance indicators related to newborn hearing screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	CDPHP did not meet target rates for two performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	CDPHP performed significantly worse than the mainstream Medicaid program on nine measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	CDPHP performed significantly worse than the mainstream Medicaid program on one measure of access/availability of care related to primary care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	CDPHP performed significantly worse than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, CDPHP was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, CDPHP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	CDPHP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, CDPHP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	CDPHP should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2020 compliance	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	findings. CDPHP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.			
Quality-of-Care Survey	CDPHP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Empire BCBS HealthPlus

Performance Improvement Project Summary and Results

Table 38: Empire BCBS HealthPlus's Performance Improvement Project Summary, Measurement Year 2021

Empire BCBS HealthPlus's Performance Improvement Project Summary
Title: KIDS Quality Agenda Performance Improvement Project – Improving Long-Term Outcomes in the First 1000 Days Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Empire BCBS HealthPlus aimed to promote optimal physical health and to improve the developmental trajectory of its youngest and most vulnerable members by improving identification and access to services for at-risk children during the most crucial period of development, the first 1,000 days of life. Member-Focused 2021 Interventions ▪ Outreached via text messaging to parents/guardians of members aged 0 to 2 years, 0 to 3 months and 0 to 3 years prompting them to get lead screenings, hearing screenings and developmental screenings respectively and follow-up with their primary care provider. ▪ Educated parents/guardians of members with a blood lead level greater than 5 mcg/dl on the importance of primary care follow-up, additional testing, and referrals for needed services. ▪ Outreached to pregnant members who were in their prenatal phase and members with a live birth within two months postpartum and conducted education on the importance of lead and hearing screenings. ▪ Outreached to pregnant members and mothers of newborns to educate them on the importance of lead and hearing screenings. ▪ Conducted education on screenings during managed care plan baby shower events. Provider-Focused 2021 Interventions ▪ Issued monthly gaps in care reports to providers identifying members who may be in need of a lead screening. ▪ Conducted provider education visits to the largest 50 pediatric provider groups to discuss required follow-up care for lead, hearing, and developmental screenings including coding education and guidance.

Table 39: Empire BCBS HealthPlus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	82.57%	79.73%	73.02%	68.97%	87.57%
Blood Lead Test at Age 2 Years	82.94%	75.86%	78.87%	75.55%	87.94%
Blood Lead Test at Ages 1 and 2 Years	70.18%	63.31%	65.65%	19.31%	75.18%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	23.08%	19.09%	26.52%	43.33%	100.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	0.09%	0.11%	0.21%	0.06%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	36.00%	28.13%	35.77%	42.86%	100.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.10%	0.04%	0.03%	0.03%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	37.04%	22.73%	53.33%	38.46%	57.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	89.05%	82.90%	83.87%	87.01%	94.05%
Failed Screening by Age 1 Month	0.97%	2.80%	1.83%	1.69%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	16.67%	10.32%	7.52%	11.76%	100.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	44.44%	30.77%	40.00%	33.33%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	75.00%	100.00%	75.00%	75.00%	100.00%
Screening Before Age 3 Months	97.66%	89.97%	88.71%	88.82%	100.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	19.05%	18.75%	12.50%	15.75%	100.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	66.67%	100.00%	60.00%	91.67%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	15.89%	16.16%	20.14%	16.85%	20.89%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	27.00%	26.69%	32.41%	23.88%	32.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	27.87%	28.11%	32.43%	28.52%	32.87%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	23.84%	23.78%	28.25%	23.55%	28.84%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.06%	2.03%	6.39%	6.96%	15.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.48%	4.64%	2.41%	15.00%

Performance Measure Results

Table 40: Empire BCBS HealthPlus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Empire BCBS HealthPlus Measurement Year 2019	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	54.64%	51.29%	57.17%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.50%	36.02%	41.81%	41.64%
Asthma Medication Ratio (5–64 Years)	61.16%	65.11%	63.83%	56.86%
Breast Cancer Screening	71.88%	67.64%	65.42%	64.75%
Cervical Cancer Screening	76.89%	70.49%	71.78%	69.19%
Chlamydia Screening in Women (16–20 Years)	79.54%	77.10%	74.76%	71.38%
Chlamydia Screening in Women (21–24 Years)	80.36%	74.98%	75.51%	74.13%
Colorectal Cancer Screening	59.37%	55.72%	56.93%	61.03%
Comprehensive Diabetes Care – Eye Exam	65.21%	54.01%	58.88%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	30.66%	39.42%	36.25%	34.74%
Controlling High Blood Pressure	50.85%	51.09%	54.26%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	42.47%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	72.86%	67.11%	68.25%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	53.58%	47.92%	46.15%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	76.51%	71.64%	72.27%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	72.75%	64.48%	59.61%	66.71%
Immunizations for Adolescents – Combination 2	42.34%	41.61%	38.67%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	82.00%	85.40%	83.21%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for	80.78%	82.48%	81.27%	84.17%

Measure	Empire BCBS HealthPlus Measurement Year 2019	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Children/Adolescents – Counseling for Nutrition				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	71.53%	79.56%	78.59%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	13.49%	17.85%	17.47%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.31%	64.16%	61.77%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	84.82%	76.20%	79.79%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	67.04%	65.87%	61.98%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	61.20%	61.16%	60.41%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	63.03%	60.99%	53.75%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	75.94%	72.63%	66.67%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	54.93%	44.11%	49.74%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	44.94%	46.14%	45.23%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	17.32%	16.76%	15.05%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	62.54%	52.82%	58.08%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	39.24%	Not Available	38.46%	43.80%

Measure	Empire BCBS HealthPlus Measurement Year 2019	Empire BCBS HealthPlus Measurement Year 2020	Empire BCBS HealthPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Access/Availability of Care – Maternity Measures				
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	85.89%	80.29%	87.20%
Prenatal and Postpartum Care – Postpartum Care	79.32%	76.89%	79.56%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	63.21%	63.29%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	82.28%	78.07%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	67.92%	70.74%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 41: Empire BCBS HealthPlus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	NC	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	NC
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and review of final adverse determination notices Empire BCBS HealthPlus's delegate, Liberty, failed to ensure required enrollee information was included in the notices. *(Contract Article 98-2.9(e)(3))*
- Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus failed to ensure enrollees were provided the correct appeal documents. *(Contract Article 98-2.9(h)(1)(i))*
- Based on staff interview and review of initial adverse determination notices Empire BCBS HealthPlus and the delegates, AIM, American Specialty Health, Ingenio, Liberty, Evolent and Superior Vision failed to ensure the notices included the required appeal language. *(Contract Article 98-2.9(h)(1), 4904(2)(b) Appeal of adverse determinations by utilization review agents)*
- Based on staff interview and review of the prior authorization and approval case notes, Empire BCBS HealthPlus and its delegates, Ingenio, AIM, and SOMOS failed to ensure the enrollee, his or her designee and/or the health care provider were notified of the determination by telephone within three business days. Specifically, telephone notification was not provided to the member and/or provider. *(Contract Article 4903(2)(a) Utilization review determinations)*
- Based on staff interview and review of final adverse determination notices, Empire BCBS HealthPlus and its delegate, Liberty, failed to ensure members enrolled in individual insurance plans received the correct appeal rights. *(Contract Article 4903.2 § 4405 Health maintenance organizations)*
- Based on staff interview and review of case notes, Empire BCBS HealthPlus and its delegate, Liberty, failed to ensure requests for additional information were conducted by telephone and in writing to both the member and the provider. *(Contract Article 98-2.9(b))*

- Based on interviews with Empire BCBS HealthPlus network and claims staff on September 30th, 2021, review of claims denial documents, and follow up responses, Empire BCBS HealthPlus failed to appropriately process and pay claims. *(Contract Article 98-2.9(e)(4) Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1)*

Quality-of-Care Survey Results – Member Experience

Table 42: Empire BCBS HealthPlus's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Empire BCBS HealthPlus	Mainstream Medicaid Average	Empire BCBS HealthPlus	Mainstream Medicaid Average	Empire BCBS HealthPlus	Mainstream Medicaid Average
Getting Needed Care[1]	76.30%	78.71%	77.35%	81.33%	81.73%	78.54%
Getting Care Quickly[1]	75.01%	78.40%	76.62%	80.57%	74.75%	78.88%
How Well Doctors Communicate[1]	89.41%	90.95%	91.44%	92.00%	91.89%	92.04%
Customer Service[1]	86.35%	85.72%	88.25%	87.13%	84.24%	86.32%
Rating of All Health Care[2]	71.37%	76.50%	75.78%	75.33%	78.09%	72.83%
Rating of Personal Doctor[2]	78.02%	80.80%	78.55%	81.46%	84.28%	81.25%
Rating of Specialist Talked to Most Often[2]	73.50%	79.63%	86.18%	82.07%	83.45%	78.79%
Rating of Health Plan[2]	75.89%	75.93%	75.74%	75.90%	73.59%	73.47%
Rating of Treatment or Counseling[2]	36.76%	59.60%	Sample Size Too Small To Report	61.84%	Sample Size Too Small To Report	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 43: Empire BCBS HealthPlus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve blood lead testing, newborn hearing screenings, and developmental screenings.	X			Interventions in place for 2021 and ongoing: ▪ All providers are sent a monthly gap in care report with list of members who may need a lead screening and a monthly score card based on the compliance rate of lead screening and benchmark goal ▪ Provider education visits to provider groups with 50 largest pediatric member panels to discuss required follow-up for lead, hearing, and developmental delay screenings, includes coding education/guidance. ▪ Targeted text messaging to parent/guardian of all members aged zero to two years prompting them to get lead screenings and to follow up with primary care provider for result and any further care or referrals that may be needed. ▪ Targeted text messaging to parent/guardian of all members aged zero to three months prompting them to get hearing loss screenings completed by one month and follow up with primary care provider for result and any further care or referrals that may be needed. ▪ Targeted text messaging to parent/guardian of all members aged zero to three years prompting them to get developmental delay screenings and follow up with primary care provider for result and any further care or referrals that may be needed. ▪ Clinical case managers will call parent/guardian of members who had a blood lead screening at ages one and two and who have a blood lead level equal to or	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				greater than five to educate them on the need for follow up with primary care provider for further testing and referrals for services if needed (discontinued January 2022). ▪ Clinical case managers will call parent/guardian of newborn members who have failed hearing loss to educate them on the need for follow up with primary care provider for further testing and referrals for services if needed (discontinued January 2022). ▪ Maternity outreach team will conduct outreach calls to all members identified as pregnant during prenatal period and will include education on the importance of lead screenings at ages one and two years and hearing screenings for newborns (discontinued January 2022). ▪ Maternity outreach team will conduct outreach calls to all members with a live birth within two months post-partum and will include education on the importance of lead screenings at ages one and two years and hearing screenings for newborns. ▪ Maternity outreach team will include education on screenings for lead exposure, hearing loss, and developmental delays at baby shower events In 2022, the following interventions were developed and implemented: o Targeted text messaging to educate moms/ parents pre- and post-natal on the importance of screening baby for lead, hearing, and developmental delays.	
Validation of Performance Measures					
The managed care plan should	X	X		In-flight Interventions in 2021 and ongoing: Childhood Immunizations	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
investigate opportunities to improve childhood immunizations and colorectal cancer screenings.				▪ Text/interactive voice response campaigns to parents/guardians of children missing childhood immunizations ▪ Member gap in care reports to providers for missing childhood immunizations and report cards ▪ Healthy Rewards $25 incentive for completion of childhood immunizations ▪ Supplemental data file from New York City and New Jersey immunization registry ▪ Early and Periodic Screening, Diagnostic, and Treatment reminder annual birthday card and 90 overdue services reminder member mailings ▪ Early and Periodic Screening, Diagnostic, and Treatment provider mailing of members that are 90 overdue for services reminder ▪ Live telephonic outreach calls to parents/guardians of children missing childhood immunizations targeting specific anchor date of births; assistance with provider appointments, if needed ▪ Provider education regarding childhood immunizations ▪ Provider data exchange (secure file transfer protocol, chart collection, supplemental data) with health plan for missing childhood immunizations ▪ Customized provider reports with members detailing specific immunizations missing to complete series of shots ▪ Cross collaboration meetings with internal departments to share and discussion education and updates Colorectal Cancer Screenings ▪ Text/interactive voice response campaigns to members missing colorectal cancer screening	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Member gap in care reports to providers for missing colorectal cancer screenings and report cards ▪ Healthy Rewards $50 incentive for completion of colorectal cancer screening ▪ Provider data exchange with health plan for colorectal cancer screenings ▪ Live telephonic outreach calls to members missing colorectal cancer screenings; assistance with provider appointments, if needed ▪ Cross collaboration meetings with internal departments to share and discussion education and updates In 2022, the following interventions were developed and implemented: Childhood Immunizations ▪ Pay for performance provider incentive program for childhood immunizations ▪ *Pfizer Vaccine Adherence in Kids* program ▪ Social media campaign for childhood wellness including immunizations ▪ Colorectal cancer screenings ▪ Pay for performance provider incentive program for colorectal cancer screenings ▪ Proactive text campaign to members 45-49 in preparation for HEDIS colorectal cancer screening specification changes ▪ Provider education for completion of colorectal cancer screening for members 45-49 ▪ Orders on hold with quest labs for members missing colorectal cancer screening (pending)	
The managed care plan should investigate	X	X		In-flight Interventions in 2021 and ongoing: Diabetes	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
opportunities to improve the health of members with diabetes, cardiovascular disease, pharyngitis, and upper respiratory infections.				▪ Text/interactive voice response campaigns to members missing diabetic screenings ▪ Member gap in care reports to providers for missing diabetic screenings and report cards ▪ Healthy Rewards $50 incentive for completion of diabetic retinal eye screening ▪ Vendor home visits to members for completion of diabetic retinal eye screening ▪ Live telephonic outreach calls to members missing diabetic screenings; assistance with provider ▪ appointments, if needed ▪ Provider education and webinars regarding diabetic screenings ▪ Provider data exchange (secure file transfer protocol, chart collection, supplemental data) with health plan for diabetic screenings ▪ Case Management and Disease Management services to members with diabetic conditions; ▪ Community education and social media awareness regarding diabetes ▪ Assess social determinates of health and offer transportation to diabetic population, if needed ▪ Cross collaboration meetings with internal departments to share and discussion education and updates Cardiovascular Disease ▪ Member gap in care reports to providers for cardiovascular disease and report cards ▪ Pharmacy provider fax/mailing regarding cardiovascular disease ▪ Monthly pharmacy workgroup meetings regarding cardiovascular disease	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ Weekly pharmacy adherence calls to cardiovascular disease members ▪ Member mailings regarding importance of at least 80% statin medication adherence ▪ Live telephonic outreach calls to members missing cardiovascular disease screenings; assistance with ▪ provider appointments, if needed ▪ Text/interactive voice response campaigns to members missing cardiovascular disease screenings ▪ Healthy Rewards $10 quarterly incentive for blood pressure medication adherence ▪ Provider education regarding cardiovascular disease ▪ Provider data exchange (secure file transfer protocol, chart collection, supplemental data) with health plan for cardiovascular disease screenings ▪ Case management and disease management services to members with cardiovascular disease ▪ Community education and social media awareness regarding cardiovascular disease ▪ Cross collaboration meetings with internal departments to share and discussion education and updates Pharyngitis and upper respiratory infections ▪ Member gap in care reports to providers for pharyngitis and report cards ▪ Provider education regarding pharyngitis ▪ Member gap in care reports to providers for upper respiratory infections and report cards ▪ Provider education regarding upper respiratory infections In 2022, the following interventions were developed and implemented:	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				Diabetes ▪ Pay for performance provider incentive program for diabetic conditions ▪ Current Procedural Terminology (CPT®[16]) codes category II provider incentive program for diabetic conditions ▪ Provider webinars for diabetic conditions ▪ Home visits in targeted population health management zip codes for members diagnosed with diabetic conditions who are historically non-compliant ▪ Health tips distribution at community service centers for diabetes (English, Spanish, Chinese, Korean) ▪ Member health advisory committee meeting targeting members diagnosed with diabetic conditions for diabetes education by a licensed nurse ▪ CVS Health Tag program for diabetic members ▪ Community relations and marketing events for member screenings with diabetes ▪ AdhereHealth pilot vendor program for outreach to diabetic members ▪ Orders on hold with Quest Diagnostics®[17] labs for diabetic members (pending) Cardiovascular Disease ▪ Pay for performance provider incentive program for controlling blood pressure and statin therapy adherence	

[16] CPT® is a registered trademark of the American Medical Association.
[17] Quest Diagnostics® is a registered trademark of Quest Diagnostics Incorporated.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▪ CPT category II provider incentive program for controlling blood pressure ▪ Provider webinars for controlling blood pressure ▪ Telehealth kits in targeted population health management zip codes for members diagnosed with high blood pressure ▪ Home visits in targeted population health management zip codes for members diagnosed with high blood pressure who are historically non-compliant ▪ Healthy Rewards $10 quarterly incentive for statin therapy medication adherence (pending state approval) ▪ Provider bulletin for statin therapy education posted on health plan provider website; ▪ Provider bulletin for telehealth controlling blood pressure posted on health plan provider website ▪ Health tips distribution at community service centers for controlling high blood pressure (English, ▪ Spanish, Chinese, Korean) ▪ Member Health Advisory Committee meeting, targeting members diagnosed with high blood pressure for participation in member meetings ▪ Community Relations and Marketing events for member screenings with high blood pressure ▪ AdhereHealth pilot vendor program for outreach to members with high blood pressure	
The managed care plan should investigate opportunities to improve care for members with	X	X		In 2021, Empire BCBS HealthPlus held a monthly behavioral health workgroup that focused on behavioral health including substance use quality measures. Attendees were managers from behavioral health and Health and Recovery Plan along with medical directors. In 2022, Empire BCBS HealthPlus implemented a HEDIS domain workgroup	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
depression, mental illness, and substance abuse disorders.				entitled "Behavioral Health and HARP Domain Workgroup". This workgroup includes managers from behavioral health and Health and Recovery Plan along with medical directors and expanded to a cross functional collaboration across all departments, responsible for strategies development, execution, and closely monitoring rates and initiative outcomes. During the monthly workgroup, we review the HEDIS/Quality Assurance Reporting Requirements performance rates and evaluates measure performance throughout the measurement year. Collaboratively, we focus on interventions and strategies to address lower performing HEDIS/Quality Assurance Reporting Requirements measures. Upon analysis, we continue to implement strategically targeted interventions that would lead to improvements in the areas identified as consistently reporting below statewide averages and year over year decreases. In-flight interventions in 2021 and ongoing: ▪ *Antidepressant Medication Management* measure, *Metabolic Monitoring for Children and Adolescents on Antipsychotics*, and Diabetes Screening *for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* are on gaps in care reports and provider report cards. ▪ Dashboard with quality measures (*Antidepressant Medication Management*, Adherence to Antipsychotic Medications for Individuals With Schizophrenia, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, *Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Hospitalization for Mental Illness*, *Follow-Up Care for Children Prescribed ADHD Medication*, *Use of*	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				First-Line Psychosocial Care for Children and Adolescents on Antipsychotics) are shared with health homes for enrolled members monthly and quarterly calls held to review the quality dashboards with health homes. ▪ *Antidepressant Medication Management* measure- we have customized clinical messaging based on pharmacy ▪ claims that are delivered via fax to providers. Clinical messages are delivered with an explanation about what steps are recommended to address gaps in care. ▪ *Antidepressant Medication Management* measure- there are refill reminder message for those newly started members that are 2-14 days late to fill their medication. Member can also opt into future reminders via text. ▪ Utilize data in Healthix (a health information exchange) to identify members that went to the emergency room primarily for substance use or mental health. ▪ Utilize daily claims report to identify members that went to the emergency room primarily for substance use or mental health. ▪ Telephonic outreach to members identified on Healthix or claims report that went to the emergency room primarily for substance use or mental health. ▪ Utilization manager requests the facility inquire if the member is willing to sign a 1515 consent form for care coordination for all members that are inpatient for substance use. ▪ Telephonic outreach by case manager to all members that went inpatient for substance use or mental health to remind member of follow up appointment, assist with care coordination and linkage to outpatient providers, discuss any barriers to keeping the	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				appointment, and inquire if member consents to bridge referral. ▪ Dashboard with quality measures including denominator, numerator, and rate for *Follow-Up After Emergency Department for Substance Use*, *Follow-Up After High Intensity Care for Substance Use Disorder*, and *Pharmacotherapy for Alcohol and Opioids* are shared with health homes for enrolled members monthly and quarterly calls held to review the quality dashboards with health homes. ▪ Rounds with the physical team and medical directors to discuss members that are high utilizer of the emergency room. ▪ Crisis Psychiatric Emergency Program and emergency room reports are run to identify members that are high utilizers of the emergency room. Case managers conduct outreach to these identified members. ▪ Telephonic outreach to the parents of children that are prescribed antipsychotic medication to provide psychoeducation and discuss the importance of blood work. ▪ Telephonic outreach to adult members prescribed antipsychotic medication to provide psychoeducation and discuss the importance of blood work. ▪ Telephonic outreach to members that have a gap in refilling their medication to address any barriers to members refilling their medication (*Antidepressant Medication Management*, *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*, *Pharmacotherapy for Opioid Use Disorder*, *Use of Pharmacotherapy for Alcohol Abuse or Dependence*).	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				Discuss the importance of members keeping appointment with their prescribing provider. ▪ Case conferences with our health home providers for members that went inpatient. ▪ Provider outreach to members that have a gap in receiving their long-acting injectable medication. In 2022, the following interventions were developed and implemented: ▪ Hold discussions with facilities regarding their rates for follow-up care after emergency room or inpatient stay for mental health and substance use and discuss ways that we can partner with them to assist with discharge planning, outpatient appointments, and community supports for the member. ▪ Our case manager conducts telephonic outreach to the member and completes an assessment and assists member with scheduling appointment(s) with providers and discuss any barriers to keeping the appointment. ▪ Behavioral Health Emergency Department Incentive Program developed. Hospitals were identified to participate in this program if they had a high volume of emergency room visits for mental health and substance use. ▪ Training offered for all providers in our network specific to the substance use HEDIS quality measure and ▪ codes that can be billed. Some providers can receive continuing medical education credits and continuing education units. ▪ Two telehealth agencies were added to the network in 2022 that offer medication assisted treatment. medication assisted treatment Behavioral Health Operations Team is offering smoking cessation and	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				Screening, Brief Intervention & Referral to Treatment trainings with primary care providers discussing the importance of screening members for nicotine and substance use. High-volume primary care providers are offered an individual training and other primary care provider offices are offered a Webex®[18] training. ▪ Meetings with 29 providers to share utilization of services, gaps in care, and claims information. ▪ Discussion is held regarding partnering to share information timely with providers and assist providers with care coordination.	
The managed care plan should investigate opportunities to improve members access to psychosocial care and alcohol and other drug abuse treatments.	X	X	X	During the monthly "Behavioral Health and HARP HEDIS Domain Workgroup", we review the HEDIS/Quality Assurance Reporting Requirements performance rates and evaluates measure performance throughout the measurement year. Upon analysis, we continue to implement strategically targeted interventions that would lead to improvements in the areas identified as consistently reporting below statewide averages and year over year decreases. In-flight interventions in 2021 and ongoing: • Daily pharmacy report identifies children that are newly started on antipsychotic medication. • Telephonic outreach to member's caregiver when members newly started on an antipsychotic medication to discuss importance of follow-up appointment with provider and assist with care coordination such as	Partially Addressed

[18] Webex® is a registered trademark of Cisco Systems, Inc.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				linkage to outpatient mental health providers for psychosocial care. ▪ Telephonic outreach by case manager to all members that went inpatient for substance use to remind member of follow-up appointment, discuss any barriers to keeping the appointment, and inquire if member consents to bridge referral. ▪ Case managers when outreaching members assist with referrals to substance use providers as well as discuss importance of primary care provider visits. ▪ Telephonic outreach by case manager to all members that we are aware of that went to the emergency room for substance use to remind member of follow-up appointment, discuss any barriers to keeping the appointment and provide referrals to members. ▪ Every member new to the health plan completes a health risk assessment. Case manager conducts telephonic outreach to members that screen positive for alcohol and substance use and assists with referrals to providers. ▪ Utilization manager requests the facility inquire if the member is willing to sign a 1515 consent form for care coordination for all members that are inpatient. ▪ Care Coordination with hospital social workers regarding outpatient appointments for members. ▪ Case managers assist members with referrals to address social determinants of health. ▪ Peer support is offered to members. Peer support provides assistance with linkage to providers, navigating person centered recovery goals and providing other supports to members.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				In 2022, the following interventions were developed and implemented: ▪ Two telehealth agencies were added to the network in 2022 that offer medication assisted treatment) ▪ Training offered for all providers in our network specific to the substance use HEDIS quality measure and ▪ codes that can be billed. Some providers can receive continuing medical education credits and continuing education units. ▪ Behavioral Health Operations Team is offering smoking cessation and *Screening, Brief Intervention & Referral to Treatment* trainings with primary care providers discussing the importance of screening members for nicotine and substance use. High-volume primary care providers are offered an individual training and other primary care provider offices are offered a Webex training. ▪ Behavioral Health Emergency Department Incentive Program developed. Hospitals were identified to participate in this program if they had a high volume of emergency room visits for mental health and substance use. ▪ Hold discussions with facilities regarding their rates for follow up care after emergency room or inpatient stay for mental health and substance use and discuss ways that we can partner with them to assist with discharge planning, outpatient appointments with primary care provider and specialist and assist with community supports for the member.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its	X	X	X	The Department of Health conducted its 2019 Targeted Operational Survey of HealthPlus on October 2 – 4, 2019.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
compliance with Medicaid standards by addressing the noncompliance identified during the measurement year 2019 operational survey conducted by the Department of Health.				Only one deficiency was received: HealthPlus HP, LLC failed to provide the Department of Health with approval letters that correspond with 3 of the 27 contracts reviewed for compliance. Empire BCBS HealthPlus was unable to provide evidence that the three contracts were executed on a contract, or a contract template that had been reviewed and approved by the Department of Health. The plan of correction addressed this deficiency as follows: ▪ The three contracts were redrafted on the most current Department of Health-approved template and fully executed. ▪ An in-depth review of all Medicaid contracts was conducted in order to identify any others needing to be re-papered to the current Department of Health approved template. Monthly updates were provided to leadership throughout the review and re-papering process. ▪ All contract managers completed refresher training. The training covered multiple aspects of contracting, including the need to maintain accurate contract files and obtain all required Department of Health approvals for contract submission. The managed care plan's subsequent audit, the 2021 Operational Survey, confirmed the successful implementation of the above plan of correction: no provider contract-related deficiencies were identified	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member	X	X	X	Areas of opportunities based on results of the Department of Health measurement year 2021 Medicaid adult CAHPS survey; measurement year 2020 Medicaid child with chronic conditions CAHPS survey and measurement year 2021 HARP CAHPS Survey satisfaction measures: *Getting*	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
experience with the managed care plan.				*Needed Care*; *How Well Doctors Communicate*; *Customer Service*; and *Rating of Health Plan* In-flight interventions in 2021 and ongoing: ▪ CAHPS Strategy & Cross Functional CAHPS Workgroup to develop and execute a CAHPS improvement work plan ▪ Member education on health plan benefits, programs (quality improvement, care management, member services, renewal, social determinants of health) primary care provider assignments for new members, Healthy Rewards Program & Value Added-Benefits and assistance with connectivity to primary care provider-member engagement venues: member orientations; Member Health Advisory Committee; Empire mobile app; member website) ▪ Provider bulletin on CAHPS Survey awareness and importance; posted on provider website (Quarter 1) ▪ Provider Outreach and Engagement in free online Anthem webinars offering continuing medical education credits; topics include "What Matters Most: Improving the Patient Experience (CAHPS)", HEDIS/behavioral health topics and coding ▪ Provider Outreach & Engagement: the Department of Health's contractual requirement (October 2021- Notice from the state to the managed care plan)- to ensure the cultural competence of its provider network by requiring participating providers to certify, on an annual basis, completion of state-approved cultural competence training curriculum ▫ The managed care plan prioritized outreach to high volume and/or providers serving enrollees	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				or located in regions with known significant health disparities. ▫ Certification of training is being tracked and filed by the managed care plan. ▫ January 2022: Empire notification sent via email and fax blast to Medicaid participating providers(Included training link "Think Cultural Health," directions provided by the Department of Health) ▫ February 2022: Provider Solutions/Provider Experience Team Leads- created a Mailbox for Providers to submit certification of completed Training; Empire's Provider Solutions staff was trained in this process; participating providers required to provide certification to Empire per New York State regulatory compliance. ▫ March 1, 2022: Cultural Competency Training Provider Bulletin posted in the provider newsletter/network update. ▪ Outreach and Education to primary care providers and Specialists; discuss contractual obligation to meet appointment standards ▪ Telehealth services: educate members and promote utilization ▪ Voice of the Customer Improvement Initiative: ▫ Quarterly meetings between the managed care plan's operations, quality and marketing teams with the member services team to review and analyze Voice of the Customer Data Report, to identify reasons for member calls (i.e., Authorizations, Benefit Inquiries, find a Provider) and issue resolution opportunities	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Associate Awareness/CAHPS 101 Training- (third quarter/fourth quarter) ▫ Automated CAHPS 101 Training (video) offered via Anthem with incentive (giveaway) offered for course completion. ▫ Full staff e-blasts on CAHPS Awareness sent by the managed care plan's president ▪ Pharmacy– medication adherence program (asthma; diabetes, behavioral health): ▫ Pharmacy team communicates with providers to share that member is not taking prescription prescribed (prescription not filled) In 2022, the following interventions were developed and implemented: ▪ Member Engagement Strategy and Execution Cross Functional Workgroup ▪ Member survey- Post-primary care provider office visit survey: weekly text campaigns (3-5 questions) to members who have visited their primary care provider in the past 6 months (claims triggered); to assess member's experience with getting care from their primary care provider and specialist and overall health care; identify any trends, and implement process improvements and interventions to improve the member experience ▪ Quality Postcard/Annual Mailing (November 2022); Postcard directs members to the managed care plan's member website (Quality Standards Page) to view information and learn more about the managed care plan's quality improvement programs. ▪ Flu Shot Strategy (third quarter and fourth quarter)	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Provider fax blast and mailing on Flu Shot Reimbursement Policy (billing codes updates) ▫ Provider notice also posted on Provider Portal ▫ Flu shot article posted on member website (education and options for getting flu shot at the primary care provider site or pharmacy) ▫ Member outreach: interactive voice response calls and short message service/text campaigns; flu shot email campaign ▫ Social media campaigns ▫ Targeted members (diabetes, cardiovascular condition) who fill their prescriptions at CVS retail pharmacies receive a health tag "flu shot" message attached to the prescription bag (fourth quarter) ▪ Social Drivers of Health Strategy & Execution Cross Functional Workgroup ▪ Provider Bulletin on CAHPS Survey results (fourth quarter) - with summary of improvement opportunities and activities ▪ Post-emergency department visit – member outreach for Care Coordination and primary care provider linkage ▪ Member Call Connection Campaign: targeted outreach (text/mail/live calls) to members identified as having chronic condition in late 2020 and early to mid-2021, and zero claims experience in the last nine months; increase connectivity to primary care provider and the managed care plan's services ▪ During member engagement activities, disseminate multi-lingual educational materials to inform and empower members and parents/guardian to ask questions during doctor's visit.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Empire BCBS HealthPlus's Response	IPRO's Assessment of Empire BCBS HealthPlus's Response
				▫ Member flier "Ask me 3" – developed by the Institute for Healthcare Improvement ▪ Quarterly Joint Operating Committee – promote Anthem's free online provider trainings/webinars offering continuing medical education; Joint Operating Committees s are meetings with providers to share high-level operational updates and opportunities for focused collaborations.	

Strengths, Opportunities for Improvement, and Recommendations

Table 44: Empire BCBS HealthPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Empire BCBS HealthPlus's measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	Empire BCBS HealthPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Empire BCBS HealthPlus performed significantly better than the mainstream Medicaid program on six measures of effectiveness of care related to primary care or mental health.	X	X	
Performance Measures – Access/Availability of Care	Empire BCBS HealthPlus performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to children's health.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Empire BCBS HealthPlus performed significantly better than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, Empire HealthPlus was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Empire BCBS HealthPlus did not meet target rates for six performance indicators related to blood lead screening.	X	X	X
	Empire BCBS HealthPlus did not meet target rates for six performance indicators related to newborn hearing screening.	X	X	X
	Empire BCBS HealthPlus did not meet target rates for six performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	Empire BCBS HealthPlus performed significantly worse than the mainstream Medicaid program on four measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/Availability of Care	Empire BCBS HealthPlus performed significantly worse than the mainstream Medicaid program on three measures of access/availability of care related to primary care, substance use, or maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Empire BCBS HealthPlus performed significantly worse than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, Empire BCBS HealthPlus was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Empire BCBS HealthPlus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Empire BCBS HealthPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Empire BCBS HealthPlus should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Empire BCBS HealthPlus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Empire BCBS HealthPlus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Excellus

Performance Improvement Project Summary and Results

Table 45: Excellus's Performance Improvement Project Summary, Measurement Year 2021

Excellus's Performance Improvement Project Summary
Title: KIDS Health and Bright Futures Performance Improvement Project **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Excellus aimed to identify key barriers impacting childhood development including environmental issues, lead poisoning, newborn hearing loss, adequate treatment, and consistent developmental screening and parental survey of developmental milestones. Member-Focused 2021 Interventions ▪ Outreached via telephone to parents/guardians of members identified as needing a lead screening and/or follow-up to facilitate appointment scheduling. ▪ Mailed a letter to parents/guardians with tips on available community early intervention services. ▪ Outreached to parents/guardians of members identified as needing a diagnostic audiological evaluation or early intervention services. ▪ Assisted parents/guardians with transportation coordination transportation for parents or guardians and children needing early intervention services. Provider-Focused 2021 Interventions ▪ Issued monthly reports to providers of patients who were not treated in accordance with lead testing guidelines and or who had blood lead level test results that require follow-up. ▪ Partnered with University Health System to develop a process that supports timely development screenings and identifies barriers to screenings, and to develop interventions to improve the accuracy of global developmental data in electronic medical record systems.

Table 46: Exellus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	63.78%	87.07%	73.22%	81.21%	74.00%
Blood Lead Test at Age 2 Years	66.50%	74.24%	69.83%	71.94%	77.00%
Blood Lead Test at Ages 1 and 2 Years	48.41%	50.08%	47.00%	54.80%	56.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	60.84%	65.97%	47.83%	68.09%	65.40%
Confirmed Venous Blood Lead Level > 5 mcg/dl	2.07%	0.57%	0.27%	0.12%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	20.00%	21.26%	12.00%	11.54%	100.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.45%	0.22%	0.07%	0.05%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	0.00%	43.64%	57.14%	57.14%	100.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	71.89%	87.07%	92.82%	88.25%	83.22%
Failed Screening by Age 1 Month	0.96%	0.78%	1.10%	0.40%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	37.25%	6.06%	5.88%	0.00%	50.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	36.84%	0.00%	100.00%	Denominator=0	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	100.00%	0.00%	100.00%	100.00%	100.00%
Screening Before Age 3 Months	94.87%	91.03%	96.66%	94.48%	99.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	52.63%	0.00%	31.03%	4.44%	55.23%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	100.00%	0.00%	28.57%	0.00%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	16.16%	18.72%	21.71%	19.90%	25.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	33.68%	41.12%	39.59%	51.04%	54.45%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	29.46%	36.98%	34.72%	44.72%	49.60%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	26.63%	32.73%	32.25%	38.48%	42.35%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	1.06%	5.91%	9.27%	27.56%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.53%	0.45%	4.21%	27.56%

Performance Measure Results

Table 47: Excellus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Excellus Measurement Year 2019	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.64%	53.95%	56.29%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.15%	39.23%	42.29%	41.64%
Asthma Medication Ratio (5–64 Years)	53.46%	59.05%	57.33%	56.86%
Breast Cancer Screening	66.22%	64.45%	63.42%	64.75%
Cervical Cancer Screening	70.75%	70.98%	71.26%	69.19%
Chlamydia Screening in Women (16–20 Years)	53.74%	51.20%	52.00%	71.38%
Chlamydia Screening in Women (21–24 Years)	69.95%	65.73%	67.26%	74.13%
Colorectal Cancer Screening	59.17%	59.55%	56.53%	61.03%
Comprehensive Diabetes Care – Eye Exam	69.44%	58.27%	56.93%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	28.36%	39.26%	31.63%	34.74%
Controlling High Blood Pressure	65.69%	58.64%	61.10%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	42.00%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	74.86%	78.20%	78.88%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	43.69%	29.47%	27.94%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	83.64%	80.44%	78.80%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	85.54%	82.16%	75.06%	66.71%
Immunizations for Adolescents – Combination 2	40.15%	42.09%	40.15%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	89.26%	86.56%	80.56%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for	85.56%	81.64%	75.35%	84.17%

Measure	Excellus Measurement Year 2019	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Children/Adolescents – Counseling for Nutrition				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	76.67%	78.69%	72.57%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	22.17%	21.93%	21.75%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.11%	67.98%	64.29%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.76%	72.83%	73.97%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	48.00%	50.66%	54.37%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	61.15%	63.99%	65.40%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	45.20%	42.18%	39.78%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	52.97%	48.27%	44.57%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.71%	25.24%	28.04%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	41.59%	42.38%	43.83%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	19.53%	19.69%	19.23%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	63.38%	47.86%	49.72%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	40.07%	Not Available	52.32%	43.80%

Measure	Excellus Measurement Year 2019	Excellus Measurement Year 2020	Excellus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Access/Availability of Care – Maternity Measures				
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	92.21%	89.25%	87.20%
Prenatal and Postpartum Care – Postpartum Care	Not Reported	79.32%	79.57%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	74.00%	74.42%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	87.15%	83.10%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	66.73%	69.57%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 48: Excellus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	C	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	NC	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and review of the final adverse determination notices, Excellus failed to ensure the notices for the delegates EviCore and HealthPlex included the utilization review agent's contact person in four of 11 commercial standard appeal and two of 10 Commercial Expedited Appeal cases. *(Contract Article 2005-98-1.11(k))*
- Based on staff interview and review of the final adverse determination notices, the final adverse determination notices included incorrect information. The cases reviewed were expedited appeals, however, the subject line in the notice was labeled as "final adverse determination standard internal appeal." *(Contract Article 98-2.9(e)6)*

Quality-of-Care Survey Results – Member Experience

Table 49: Excellus's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Excellus	Mainstream Medicaid Average	Excellus	Mainstream Medicaid Average	Excellus	Mainstream Medicaid Average
Getting Needed Care	81.89%	78.71%	80.91%	81.33%	77.70%	78.54%
Getting Care Quickly	79.21%	78.40%	86.73%	80.57%	84.08%	78.88%
How Well Doctors Communicate	92.31%	90.95%	89.56%	92.00%	92.24%	92.04%
Customer Service	82.62%	85.72%	89.57%	87.13%	89.94%	86.32%
Rating of All Health Care	83.57%	76.50%	78.25%	75.33%	73.91%	72.83%
Rating of Personal Doctor	83.36%	80.80%	78.05%	81.46%	78.67%	81.25%
Rating of Specialist Talked to Most Often	79.02%	79.63%	82.84%	82.07%	82.69%	78.79%
Rating of Health Plan	79.72%	75.93%	83.71%	75.90%	80.76%	73.47%
Rating of Treatment or Counseling	65.87%	59.60%	59.40%	61.84%	59.20%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 50: Excellus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
Validation of Performance Improvement Project					
The managed care plan should investigate opportunities to improve blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		Excellus has implemented a performance improvement project focused on three key elements of the New York State 1000 Days in the life of a Medicaid member initiative. The three areas of focus from 2019-2021 include blood lead screening-infants, newborn hearing results and developmental screening. These areas of focus utilized HEDIS measure rates and data extractions for baseline rates and yearly remeasurements. The primary interventions for infant and child blood lead screening focused on telephonic outreach for promotion of screening at 12 and 24 months. The COVID-19 pandemic significantly impacted the overall rates in 2020 due to limited in office pediatric offices and reduced access to community laboratories for venous blood lead screenings. The fourth quarter 2020 also was impacted by the recall of lead screening reagents for office lead machines. Elevated blood level member rosters from the New York State Immunization Information System registry were provided to Excellus Health Plan. Excellus's case management staff in consultation with member's primary medical providers outreached to parents/caregivers to educate and assist parents to understand the implications of elevated blood lead levels on child development and long term social, medical, and educational needs. In addition, promotion of repeat testing was emphasized to parents/caregivers. This was successful in terms of parental trust and engagement	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				with both the managed care plan and medical providers. Long term continuation of this program is dependent upon the Department of Health forwarding of the member elevated lead level roster to the managed care plan. Newborn hearing screenings were reported to the managed care plan from the Department of Health. Excellus case management staff provided telephonic outreach to parents/caregivers for both missing screenings at delivery and abnormal findings. Education and linkages with available pediatric audiological specialists for additional diagnostic evaluations were provided by Excellus case managers. The yearly successful outreach rates ranged from 79-80% from 2019 to 2021. Referral information for early intervention services was a component of the telephonic outreach. This intervention stopped 12/31/21 after the referral rosters from the Department of Health ended. The managed care plan has no access to newborn hearing screenings findings beyond the rosters provided by the Department of Health. Information regarding newborn hearing screenings and blood lead screenings are provided in the annual member guidebook distributed to all Medicaid Managed Care adults. The addition of a modifier code to accompany the developmental screening code resulted in Excellus's capture of the prevalence of autism screening at age 24 months. The developmental screening medical record review also reported positive findings of the documentation of completion of autism screening at the recommended 24 months well child visit. Excellus's partnership with two community urban pediatric practices successfully identified key barriers impacting the	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				utilization and documentation of developmental screening at key milestones. The use of a standardized developmental screening tool within these practices required participation and completion by parent/caregiver. Frequent refusal by parents/caregivers to complete the parental survey component of the screening hampered the completion of a standardized screening form. Alternatives to use of a standardized form resulted in screening results documented in progress notes. The pandemic impacted parent/caregiver's access to initial in office visits for the second to fourth quarter of year 2. Additional practice issues affected in year 3 were internal staffing resources negatively impacted. The prevalence of a standard developmental screening tool was confirmed by the managed care plan staff following two medical record audits conducted 2020 and 2021. The medical record audit results indicated the use of a standard screening tool at key milestones 1, 2, and 3 years as well as progress notes of key findings. The Greater Rochester community has an initiative representing developmental services for children that has long term goals for promoting standardization of developmental screening via a uniform validated tool. It was validated that there is a tool utilized in pediatric private practice; measuring the presence of a standardized tool for routine developmental screening in most pediatric and family medicine practices across the regional network is beyond the scope of current auditing currently.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to	X	X		The managed care plan has aligned all women's health measures under one workgroup that focuses on all lines of business. Through the plan-do-study-act cycle interventions are focused on member communication, provider outreach,	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
improve breast cancer and chlamydia screenings.				and community partnerships. All interventions use data driven methodology to target gap closure initiatives. Key interventions include targeted chlamydia screening education in provider offices, health home education, and predictive analytics. During the 4th quarter of 2022 members aging into the breast cancer measure will be identified and outreach will occur. Expected outcomes of the interventions include increased measure compliance, visibility of priority measures, Member and provider education and optimal member health outcomes. Through mid-year and annual evaluations as well as year over year measure performance the managed care plan monitors these interventions to determine their effectiveness.	
The managed care plan should investigate opportunities to improve the health of members with asthma, diabetes, and chronic obstructive pulmonary disease.	X	X		The managed care plan's Disease Management program implemented opportunities within the Clinical Operations Department. Affected members are referred to Disease Management services from several sources: Utilization Management, Case Management, external providers, and of determining if the claim's diagnosis acuity CPT code coincides with the prescribed asthma, chronic obstructive pulmonary disease or diabetes medications. The outcomes of this workgroup will be utilized to determine provider interventions. The project aim is to build an efficient code-correcting process to improve claim accuracy, decrease duplicate work, and improve compliance rates for key measures. Work to automate this process is underway with a planned implementation date in the first quarter of 2023. Managed care plan member guidebooks are distributed annually to all Medicaid managed care members with	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				specific emphasis on education and related resources for these conditions. A Pediatric Asthmas Initiative workgroup was initiated July 2021 to identify members with gaps in asthma medication refills. Educational materials were developed and distributed by the Excellus's marketing team for internal and external events. This asthma educational flyer was translated in common languages within the managed care plan's pediatric population. An analysis of this intervention; telephonic outreach to close medication refills did not produce the outcomes anticipated. The team has changed outreach efforts to examine the subpopulation of members who have had current inpatient or emergency room admissions related to asthma. Following discharge telephonic outreach to caregivers with education and availability of support and resources will be the focus of the intervention. The managed care plan has also provided educational presentations to health homes focused on Asthma. Evaluation of these interventions are based on adult and child asthma medication ratio rates quarterly. The managed care plan-based case management program with specialized respiratory therapist case manager, has been an intervention aimed at health conditions of managed care plan members with respiratory issues/diagnosis. The primary focus of this program is telephonic outreach to identify health plan members with asthma. Key functions of this action is identification of member barriers impacting management of persistent asthma including member education, medication reconciliation, use of methods to improve effectiveness of	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				controllers for maintenance medications and assessment of other social determinants of care impacting treatment compliance.	
The managed care plan should investigate opportunities to improve care for children on attention-deficit/hyperactivity disorder and antipsychotic medications.	X	X		The managed care plan established the Psychotropic Medication Utilization Review Committee as a result of the 2019 Children's Health and Behavioral Carve-In. The committee is co-chaired by the children's medical director and the children's clinical director. In addition, the managed care plan expanded its pharmacy management program for behavioral health drug classifications to include children ages 0-21. A monthly psychotropic medication utilization review report was developed to track the drug classifications to include psychotropics, antidepressants, attention-deficit /hyperactivity disorder medications, anxiolytics/hypnotics, and mood stabilizers. Medical and clinical directors and managers meet on a monthly basis to review the psychotropic medication utilization review report. The report data is used to identify opportunities for psychotropic medication utilization and intervention referrals. The managed care plan monitors utilization data, claim data, and diagnosis data for behavioral health providers, primary care providers, and other specialty provider types. The Children's Clinical Team meets monthly to review the psychotropic medication utilization review report and determine appropriate interventions. The medical director monitors the report for high needs cases and determines interventions. The Behavioral Health Utilization Management Subcommittee reviews and analyzes psychotropic medication utilization review data as well as interprets the variances, reviews outcomes, and develops and/or approves interventions based on the findings.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				The primary goal is to monitor the use of psychotropic medication with children to identify opportunities for intervention to address safety, gaps in care, utilization, and cost stratified. There is also a goal specific to monitoring foster care children, children on attention-deficit/hyperactivity disorder medications and 0-5 years old to identify opportunities to improve care for children that fall into these categories.	
The managed care plan should investigate opportunities to improve members access to alcohol and other drug abuse treatments.	X	X	X	In 2020, the managed care plan established a Medication Assisted Treatment Workgroup with a focus on opioid addictions to address gaps in access to care, exploration of alternatives to traditional models of addiction care to close medication assisted treatment gaps and increase member centric medication assisted treatment strategies. By creating a collaborative workgroup of behavioral health and physical health clinical staff, physicians, quality, compliance, and pharmacy staff we aim improve member access and outcomes for substance abuse disorder treatment. The Medication Assisted Treatment Workgroup has implemented strategies to identify the most at-risk members in our communities, partner with providers and leverage resources in our services areas. Strategies implemented include utilization of a provider dashboard which provided data highlighting members with an opioid use disorder diagnosis without having received medications for opioid use disorder. The goals are to present this data to affected providers to investigate those members attributed to them while improving collaboration with the provider network. An additional opportunity is the Liberty Resources Peer Referral pilot program. Liberty Resources is a community provider in the managed care plan's network. This effort	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				revolves around connecting at risk Excellus members with certified peers. This provider is the recipient of a grant from OASAS that allows them to hire two full time certified peers. Liberty Resources and the managed care plan entered into a pilot agreement in June of 2020. The managed care plan refers members meeting the appropriate criteria to Liberty Resources. The managed care plan is very supportive of peer support as an alternative treatment approach to the opioid epidemic. The goal of the relationship between Liberty Resources and the managed care plan is to develop collaborative practices in the community by aligning the Recovery Oriented System of Care and the Continuing Care Guidance. The managed care plan has also made efforts to contact at risk members by working with data analytics to understand prevalence of substance use disorder diagnoses within specific zip codes in Monroe County (largest area of membership). The objective is to provide education, via postcard, to members on where to access providers that render addiction services within those zip codes. Educational post cards were mailed to all of the 40,000+ Safety Net members in those areas. The managed care plan reviews data on a monthly cadence that allows for a comparison of the different substance use disorder level of care admissions for four different service counties as well as understanding the facilities where members received treatment. This allows case management to understand where the outreach opportunities are as well as building collaborative relationships with high-volume providers. The managed care plan has also identified a high-volume substance use disorder rehabilitation facility that will allow managed care plan case managers to contact Excellus	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
				members in their care prior to discharge. This will establish an introductory relationship making transitions of care for the member an easier path to navigate. Using an internal Risk Stratification Report, members with a substance use disorder diagnosis were organized from high, medium, and low risk. Case Management trialed a program to support individuals struggling with an opioid use disorder diagnosis. The goal was to increase engagement of high-risk members with an opioid use disorder diagnosis. These efforts have been monitored to determine success rates. The overall results have demonstrated increased engagement in members seeking treatment. Barriers were difficulties sharing data with affected community providers due to shared staffing shortages in a post-covid environment. Members seeking treatment may be likely in the denial or pre-contemplation stages of recovery, which results in a lower volume of engagement. The managed care plan continues to modify existing strategies and redirect efforts to improve members access to alcohol and other drug abuse treatments.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the measurement year 2019 operational survey conducted by	X	X	X	Excellus did not receive a full operational survey in measurement year 2019. In 2019, the managed care plan was subject to a targeted survey based on the results of the 2018 operational survey. The findings from the 2018 operational survey were all corrected, and one new area of non-compliance associated with the Fair Hearing Form requirements were identified in 2019 for which there was an approved plan of correction that was remediated by way of system correction, training and education and continued monitoring ahead of the 2021 Operational	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Excellus's Response	IPRO's Assessment of Excellus's Response
the Department of Health.				Survey and by the date certain noted in the approved plan of correction.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	The managed care plan implemented a risk engagement strategy which runs annually for Medicaid managed care in 2021. It targets members for outreach based on common member questions/concerns and runs proactively with the annual Department of Health-sponsored survey. Additionally, a strategy refresh is planned for 2023. Outreach will align with other member communication and the strategy will be reviewed annually. In 2022 a value-based payment incentive program targeting provider based CAHPS measures began. Work will continue through 2024. Pulse surveys of Medicaid managed care members began in 2018 and a closed-loop feedback process started in 2019. Expected outcomes of the interventions include maintaining or increasing CAHPS scores. Ongoing monitoring through internal members pulse surveys (monthly) and reviewing value-based payment scores to evaluate improvement the managed care plan monitors the interventions to determine their effectiveness.	Partially Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 51: Excellus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Excellus's measurement year 2021 performance improvement project passed validation.	X	X	X
	Excellus exceeded target rates for two performance indicators related to blood lead screening.	X	X	X
	Excellus met or exceeded target rates for two performance indicators related to newborn hearing screening.	X	X	X
Performance Measures	Excellus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Excellus performed significantly better than the mainstream Medicaid program on two measures of effectiveness of care related to primary care or children's health.	X	X	
Performance Measures – Access/Availability of Care	Excellus performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to substance use.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Excellus performed significantly better than the mainstream Medicaid program on two measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, Excellus was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	Excellus performed significantly better than the mainstream Medicaid program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Excellus did not meet target rates for four performance indicators related to blood lead screening.	X	X	X
	Excellus did not meet target rates for four performance indicators related to newborn hearing screening.	X	X	X
	Excellus did not meet target rates for six performance indicators related to developmental screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Effectiveness of Care	Excellus performed significantly worse than the mainstream Medicaid program on nine measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Excellus performed significantly worse than the mainstream Medicaid program on two measures of access/availability of care related to primary care or children's health.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, Excellus was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Excellus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Excellus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Excellus should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Excellus should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Excellus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Fidelis Care

Performance Improvement Project Summary and Results

Table 52: Fidelis Care's Performance Improvement Project Summary, Measurement Year 2021

Fidelis Care's Performance Improvement Project Summary
Title: Optimizing Children's Health and Development to Improve Long-Term Outcomes Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Fidelis Care aimed to implement access to early intervention programs, screenings, and follow-up care for at-risk children within 36 months of life to improve pediatric preventative screenings for lead, hearing, and development from baseline to final measurement. Member-Focused 2021 Interventions ▪ Supplied parents/guardians with informational material on routine, age-appropriate tests covered by Medicaid. ▪ Facilitated appointment scheduling for members identified as needing a screening and or follow-up. ▪ Outreached to parents/guardians of members identified as needing a diagnostic audiological evaluation or early intervention services. ▪ Educated parents/guardians about the importance of follow-up visits via the member newsletter, targeted educational material, and member portal. ▪ Provided a resource list to parents/guardians to ensure providers refer infants diagnosed with permanent hearing loss to local EI programs. Provider-Focused 2021 Interventions ▪ Educated providers via the provider newsletter, provider portal and educational packages. ▪ Issued monthly reports to high-volume providers with patients who were not treated in accordance with lead testing guidelines and or who had blood lead level test results that require follow-up. ▪ Educated providers on proper claims coding.

Table 53: Fidelis Care's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	66.15%	62.85%	63.35%	64.21%	71.00%
Blood Lead Test at Age 2 Years	65.78%	65.06%	63.85%	64.54%	71.00%
Blood Lead Test at Ages 1 and 2 Years	41.37%	40.75%	41.73%	42.66%	45.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	19.01%	40.32%	37.54%	51.71%	24.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	0.71%	1.08%	0.85%	1.38%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	23.82%	41.80%	30.71%	51.24%	55.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.32%	0.46%	0.22%	0.30%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	7.08%	22.52%	20.88%	28.68%	42.50%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	30.91%	33.40%	30.15%	43.24%	36.00%
Failed Screening by Age 1 Month	0.80%	2.96%	2.67%	1.91%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	54.62%	80.00%	77.09%	65.57%	83.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	32.39%	22.92%	23.91%	37.50%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	91.18%	90.48%	85.00%	83.84%	94.00%
Screening Before Age 3 Months	77.91%	77.15%	77.74%	73.60%	83.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	64.36%	87.50%	83.66%	74.20%	90.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	92.35%	94.28%	89.74%	89.63%	95.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	21.56%	24.00%	20.15%	28.66%	25.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	29.46%	35.45%	34.23%	34.97%	35.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	13.19%	25.59%	18.49%	18.47%	18.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	21.46%	28.36%	24.11%	27.40%	25.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	2.28%	7.66%	13.70%	5.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.50%	2.77%	11.91%	2.00%

Performance Measure Results

Table 54: Fidelis Care's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Fidelis Care Measurement Year 2019	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	56.04%	56.83%	59.92%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.94%	41.12%	42.47%	41.64%
Asthma Medication Ratio (5–64 Years)	63.08%	58.08%	53.19%	56.86%
Breast Cancer Screening	69.55%	64.89%	62.68%	64.75%
Cervical Cancer Screening	73.72%	63.99%	65.69%	69.19%
Chlamydia Screening in Women (16–20 Years)	70.50%	66.42%	66.36%	71.38%
Chlamydia Screening in Women (21–24 Years)	73.62%	69.07%	70.26%	74.13%
Colorectal Cancer Screening	62.29%	59.61%	59.85%	61.03%
Comprehensive Diabetes Care – Eye Exam	64.80%	57.42%	58.15%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	25.06%	38.93%	36.50%	34.74%
Controlling High Blood Pressure	72.26%	58.88%	61.31%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	39.81%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	70.94%	72.31%	70.33%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	58.17%	49.02%	42.31%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	78.03%	72.79%	72.82%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	69.34%	66.91%	61.31%	66.71%
Immunizations for Adolescents – Combination 2	40.88%	35.77%	36.50%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	87.83%	81.02%	83.21%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	82.97%	81.75%	82.48%	84.17%

Measure	Fidelis Care Measurement Year 2019	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	71.78%	73.97%	77.86%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	24.48%	22.75%	21.30%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.81%	66.17%	63.37%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.09%	75.60%	78.00%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	62.73%	58.29%	58.14%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	66.98%	65.93%	65.11%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	58.18%	59.62%	54.65%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	68.18%	70.35%	66.03%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	41.65%	32.31%	38.11%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	53.76%	52.09%	50.52%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	24.76%	23.40%	21.87%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	63.83%	49.07%	54.30%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	40.10%	Not Available	46.55%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	Fidelis Care Measurement Year 2019	Fidelis Care Measurement Year 2020	Fidelis Care Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	86.86%	86.86%	87.20%
Prenatal and Postpartum Care – Postpartum Care	82.48%	81.51%	81.51%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	63.04%	62.93%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	80.50%	76.45%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	63.66%	66.30%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 55: Fidelis Care's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	C	Pended	C
438.214: Provider Selection	C	Pended	NC
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	NC
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and record review, Fidelis Care and the delegate NIA failed to issue adverse determination notices for administrative denials that were factual in nature *(Contract Article 4405.10 Health maintenance organizations).*
- Based on staff interview on August 17th, 2021, and review of initial adverse determination notices, Fidelis Care failed to ensure members enrolled in individual insurance plans received the correct appeal rights *(Contract Article 4405.10 Health maintenance organizations).*
- Based on staff interview on August 17th, 2021, and review of the initial adverse determination notices, Fidelis Care failed to ensure the delegate Turning Point issued notices that were factual in nature to Child Health Plus members *(Contract Article 4405.10 Health maintenance organizations).*
- Based on interviews with Fidelis Care staff and document review, Fidelis Care failed to include the correct Medicaid payment information in their contract. Specifically, five of 10 Behavioral Health contracts still included "lesser of" language *(Contract Article 4405.1 Chapter 57 of the Laws of 2017, Part P § 48-a.1 § 48-a.1).*
- Based on interview held on August 17th, 2021, and review of documents, Fidelis Care failed to ensure the required credentialing components were included for three out of 20 credentialing files *(New York Codes, Rules, and Regulations 98-1.12 (k)).*

Quality-of-Care Survey Results – Member Experience

Table 56: Fidelis Care's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Fidelis Care	Mainstream Medicaid Average	Fidelis Care	Mainstream Medicaid Average	Fidelis Care	Mainstream Medicaid Average
Getting Needed Care[1]	79.81%	78.71%	79.47%	81.33%	75.34%	78.54%
Getting Care Quickly[1]	80.30%	78.40%	78.73%	80.57%	81.59%	78.88%
How Well Doctors Communicate[1]	92.65%	90.95%	91.87%	92.00%	94.65%	92.04%
Customer Service[1]	85.54%	85.72%	92.50%	87.13%	84.97%	86.32%
Rating of All Health Care[2]	77.93%	76.50%	72.47%	75.33%	75.55%	72.83%
Rating of Personal Doctor[2]	81.12%	80.80%	81.14%	81.46%	85.95%	81.25%
Rating of Specialist Talked to Most Often[2]	80.34%	79.63%	87.12%	82.07%	82.09%	78.79%
Rating of Health Plan[2]	76.97%	75.93%	76.87%	75.90%	74.19%	73.47%
Rating of Treatment or Counseling[2]	57.09%	59.60%	Sample Size Too Small To Report	61.84%	73.78%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 57: Fidelis Care's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve its current interventions targeting blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		The Optimizing Children's Health and Development to Improve Long Term Outcomes project (Kids Quality Performance Improvement Project) started in January 2019 and originally was scheduled to end in 2020. As a result of the COVID-19 pandemic, the performance improvement project was extended until December 2021 due to the changes in health care delivery with many of the performance improvement project interventions needing to be paused. The performance improvement project intervention efforts aimed to follow up with parents/caretakers of children ages 0-3 years who had elevated blood lead levels, hearing loss, and/or positive developmental and autism screenings. Barriers identified for this performance improvement project included parents/caregivers were unaware of the importance of lead, hearing, and developmental testing and follow-up guidelines. There was a lack of understanding of the health risks associated with lead toxicity or the importance of testing and follow-up if blood lead levels ≥5 mcg/dL. In 2021, there was a decline in lead testing due to the recall of blood lead testing devices that providers used in the office compounded by decreased availability for laboratory testing. In addition, parents/caregivers were unaware that they needed to follow-up with a diagnostic audiological evaluation for children who did not pass the hearing screening or referred to Early Intervention services for children suspected of having a disability, including permanent hearing loss.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				2019-2021 performance improvement project results summary: ▪ Blood Lead testing and follow-up: The managed care plan increased in five of the eight focus area indicators when comparing final year rates to baseline rates (2 indicators declined and 1 remained the same). ▪ Hearing Screening and follow-up: The managed care plan increased in four of the eight focus indicators when comparing final year rates to baseline rates (four indicators declined). ▪ Developmental Screening: The managed care plan increased in all six focus indicators when comparing final year rates to baseline rates. Based on the performance improvement project analysis and noted barriers, Fidelis Care identified opportunities to improve interventions related to the three focus areas (blood lead testing, newborn hearing screenings, and developmental screenings). Examples of improved performance improvement project interventions include: 1) Fidelis Care successfully enhanced the workflow to include educational materials to parents/caregivers and providers of children who fell within the scope of the Kids Quality Performance Improvement Project. Materials included information surrounding the importance of preventative screenings for lead poisoning, hearing loss, and developmental delays by mail distribution and by providing access and reference to information on the Fidelis Care Website. 2) Fidelis Care stratified parents/caregivers of high-risk children to link them to the Case Management Team providing individualized education, support, and care coordination. 3) Enhancements that were made to the Clinical Care Advance system to successfully	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				support this performance improvement project will be incorporated into a new Care Management system that all markets can utilize within Centene Corporation. Fidelis Care shared successful best practices and findings from this project with other care management departments within the Centene family of health plans. 4) The managed care plan enhanced provider awareness/education outreach and materials by sending educational packages to high volume pediatricians, as well as updated provider newsletters and the provider portal with guidelines for age-appropriate well care visits, screenings, follow-up, and immunization schedule to outreach the overall provider network.	
Validation of Performance Measures					
Although the managed care plan has implemented interventions that include provider office site visits, provider report cards, and member notifications, the rates for adolescents and children's immunizations, breast cancer screening, and chlamydia screening continue to decline. The managed care plan should conduct a root cause analysis to	X	X		As part of the managed care plan's quality performance matrix activities, Fidelis Care conducted root cause analyses and implemented corrective action plans for each Effectiveness of Care domain indicator cited in the Opportunities for Improvement. Sub teams comprising of staff with subject matter knowledge were assembled to further support work activities and opportunities for improvement. Actions by indicator include: Childhood Immunization Status-Combo 3 ▪ Continued monthly postcard mailings to members 9 months prior to child's 2nd birthday. Postcard content emphasized child's well care visit schedule, required immunizations schedule, and tracking checklist. Postcard was further enhanced with messaging to encourage well visit/routine care. ▪ Based on best practices previously implemented by other Centene Plans, in 2021 Fidelis began a multimodal reminder to parents/caregivers with infant members of their 1-year well care visit and immunizations. This	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
identify additional barriers to members accessing these services.				multimodal approach begins with a postcard reminder, issued monthly for infants entering the reminder timeframe, followed by a Proactive Outreach Manager outreach call. ▪ Issued announcement mailing to parents/caregivers of members regarding member incentive statewide program. Deployed a Salesforce, Inc. health alert; when member calls in to Fidelis Care, the alert will inform the representative to discuss the importance of immunizations for the parent/caregiver of the child, as well as prompting the representative to assist in scheduling the appointment with the child's provider. Targeted email notification with link to a child wellness web page was issued to parent/caregiver of members. The email notification instills a reminder for parents/caregivers to complete their child's immunizations. Target focus: New York City and Hudson Valley regions, issued in English and Spanish translation. Immunizations for Adolescents ▪ Provider Relations staff received education/ training through the American Cancer Society related to exchanging dialog with providers and engaging parents with a child in conversation related to human papillomavirus, or HPV, awareness and HPV cancer prevention. ▪ Participated in the New York State HPV Health Plan Workgroup and American Cancer Society meetings in collaboration with other health plans in the state of New York to reduce the burden of cancer in New York and increase the HPV vaccination rates. Sent letters to providers with low compliance.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				Breast Cancer Screening ▪ Conducted monthly automated calls to members, provide monthly member list that have not had a mammogram in the last 2 years to providers, and member encouragement and education related to breast cancer screening. ▪ Other interventions currently included in our Health and Recovery Plan QPM may be rolled out to other lines of business if they show potential for improving breast cancer screening compliance. Chlamydia Screening in Women ▪ Re-established the member postcard mailings using updated design. ▪ Included an article in the Fidelis Care member newsletter to encouraging chlamydia screenings. ▪ Conducted chlamydia screening refresher training for case managers. ▪ Updated Provider Tip Sheet on chlamydia screenings on Fideliscare.org and wrote an article for providers that included a link to the tip sheet. ▪ Identified providers with high non-compliant membership and had Provider Services staff hold targeted discussions with these providers. In addition, the HEDIS/Quality Assurance Reporting Requirements monthly rate reports have been enhanced to provide compliance rate breakdowns by region, which allows for targeting of outreach to areas with the most need. The results of actions implemented in 2020 and 2021 will be more visible in the 2022 measurement year. However, we anticipate that there will be a lag to the impact on the compliance rate as a result of the COVID-19 pandemic, which	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				has appeared to lower the compliance rates for preventive care indicators overall.	
The managed care plan should investigate opportunities to improve medication management for members with asthma and diabetes.	X	X		Fidelis Care conducts Quality Assurance Reporting Requirements/HEDIS measure analysis annually with improvement opportunities identified for priority measures. The following actions are included to address the improvement opportunities for medication management for members with asthma and diabetes. Actions by indicator include: Asthma Medication Ratio ▪ Development and implementation of provider-based report with enhancements for provider outreach to support measure compliance. ▪ Established outreach /workflow process based on provider report output. ▪ Developed workflow process with Clinical Services Case Management for engaging members with asthma and talking points regarding medication management. ▪ Provide notice that Fidelis formulary currently covers a 90-day supply of asthma maintenance medication. ▪ Currently working on enhanced member and provider material with robust current information regarding asthma medication control (member and provider portal/newsletter). Medication Adherence for Diabetes Medications and Statin Therapy for Patients with Diabetes ▪ Review member medication list(s) to ensure current medication regimen and to determine history. ▪ Schedule/encourage appropriate follow-up with the members to evaluate if medication is taken as prescribed.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				▪ Work with providers to convert member's diabetes medication to a 90-day supply at mail order or retail pharmacy to improve adherence. ▪ Review missing pharmacy refills to ensure members are getting timely refills and make sure prescription instructions are up to date. ▪ Educate members on the importance of staying on the medication and benefits of adherence. ▪ Provider education for appropriate coding.	
The managed care plan should investigate opportunities to improve the care for children and adolescents on antipsychotics and to reduce members risk of the use of opioids.	X	X		Fidelis Care conducts HEDIS/Quality Assurance Reporting Requirements measure analysis annually with improvement opportunities identified for priority measures. The following actions are included to address the improvement opportunities for care for children and adolescents on antipsychotics and to reduce members risk of the use of opioids. Actions by indicator include: Metabolic Monitoring for Children and Adolescents on Antipsychotics ▪ Monthly member mailing to provide support and education to member's parent/guardian who have not met compliance. ▪ Monthly Proactive Outreach Manager calls to remind parents/guardians about the importance of obtaining metabolic testing. ▪ Quarterly prescriber mailing to provide education, support, and reminders for ordering the recommended metabolic testing. ▪ The managed care plan will potentially pilot a pediatric antipsychotic utilization program that will identify members younger than 10 years of age on potential antipsychotic related drug therapy issues. Targeted	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				medication communication with recommendations will be sent to the prescriber. Strategies to reduce members risk of the use of opioids ▪ Prior authorization is required for coverage of opiates in excess of 90 morphine milligram equivalents. ▪ Review of member medication history and current fills to assess for utilization of high-dose opiates in combination with benzodiazepines and/or skeletal muscle relaxers. ▪ Utilization of the above combinations will require provider acknowledgment of the potential dangers associated with combination use. ▪ Provider outreach is performed by the Fidelis Care medical directors for patients identified using high-dose opiates in combination with benzodiazepines and/or skeletal muscle relaxers for educational purposes.	
Quality-of-Care Survey – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	The following highlights the evaluation of the child CAHPS survey scores (most recent survey) with improvement opportunities identified to improve member experience with the managed care plan. The Fidelis Care child CAHPS survey scores compared favorably with the Medicaid Managed Care/Child Health Plus statewide average. The Fidelis Care rates for six of the eight survey scores were at or above the Medicaid Managed Care/Child Health Plus statewide average. The following scores were below the Medicaid Managed Care/Child Health Plus statewide average: ▪ Rating of child's personal doctor was 89 compared to the statewide average of 90 ▪ Rating of specialist child saw most often was 84 compared to the statewide average of 87	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Fidelis Care's Response	IPRO's Assessment of Fidelis Care's Response
				Fidelis Care implemented and/or is in the process of implementing the following interventions to improve CAHPS scores: Employee Awareness Campaign: A comprehensive communications campaign to make employees aware of when surveys are active, and important areas of focus, reinforcing key CAHPS principles to improve service over the entire organization. Member-Facing Teams Training: In process of developing an interactive training that will be used across the organization for member facing teams Key Driver Connection Employee education on positive member interactions which will drive higher CAHPS. Mock CAHPS Survey and Provider Scorecards: provider scorecards with mock survey results are distributed to providers; action plans and follow-up are scheduled with providers with low scores; use of knowledge of Key Drivers for actionable insights, communication of improvement opportunities and providing recommended resources to foster the member experiencee. The survey results are reviewed with the provider groups during the provider visits. Action plans for domain improvements are made and further discussed during follow up meetings. CAHPS Provider Summit: Plan and host a provider facing event focused on CAHPS education on a date to be determined.	

Strengths, Opportunities for Improvement, and Recommendations

Table 58: Fidelis Care's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Fidelis Care's measurement year 2021 performance improvement project passed validation.	X	X	X
	Fidelis Care exceeded the target rate for one performance indicator related to blood lead screening.	X	X	X
	Fidelis Care exceeded the target rate for one performance indicator related to newborn hearing screening.	X	X	X
	Fidelis Care exceeded target rates for five performance indicators related to developmental screening.	X	X	X
Performance Measures	Fidelis Care met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Fidelis Care performed significantly better than the mainstream Medicaid program on five measures of effectiveness of care related to primary care, substance use, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Fidelis Care performed significantly better than the mainstream Medicaid program on four measures of access/availability of care related to primary care, children's health, or substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, Fidelis Care was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Fidelis Care did not meet target rates for five performance indicators related to blood lead screening.	X	X	X
	Fidelis Care did not meet target rates for five performance indicators related to newborn hearing screening.	X	X	X
	Fidelis Care did not meet the target rate for one performance indicator related to developmental screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Effectiveness of Care	Fidelis Care performed significantly worse than the mainstream Medicaid program on seven measures of effectiveness of care related to primary care or children's health.	X	X	
Performance Measures – Utilization and Risk Adjusted Utilization	Fidelis Care performed significantly worse than the mainstream Medicaid program on three measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year, Fidelis Care was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Fidelis Care should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Fidelis Care should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Fidelis should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Fidelis Care should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	Fidelis Care should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Healthfirst

Performance Improvement Project Summary and Results

Table 59: Healthfirst's Performance Improvement Project Summary, Measurement Year 2021

Healthfirst's Performance Improvement Project Summary
Title: Improving the Health Outcomes of Our 0–3-Year-Old Population through the Early Identification and Management of Members At-Risk for Lead Exposure, Hearing Loss, and Developmental Delay Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Healthfirst aimed to improve the quality of life among its 0–3-year-old Medicaid and CHP members through the early identification and management of members at risk for lead exposure, hearing loss, and developmental delay. Member-Focused 2021 Interventions ▪ Conducted outreach calls to parents/guardians of members identified with gaps in care to reinforce the importance of preventive care and encourage the parents/guardians to schedule a well-child visit. ▪ Outreached to parents/guardians via mail, email, or automated call to promote the importance of timely well-child visits and lead screening tests. ▪ Posted educational information and available resources on the member website. ▪ Outreached to parents/guardians to reinforce the importance of completing a newborn hearing screen or a diagnostic evaluation, facilitate appointment scheduling, and arrange transportation. ▪ Mailed reminder letter to parents/guardians communicating the importance of completing a newborn hearing screening before the age of 1 month and completing a diagnostic audiological evaluation before the age of 3 months. Provider-Focused 2021 Interventions ▪ Issued a reminder via mail and email to primary care providers to comply with the lead screening requirements noted in the New York State Public Health Law along with a list of their patients identified as missing a well-child visit and or screening test and information on best coding practices. ▪ Posted lead screening guidelines, best practices, educational materials, and resources on the provider website and or provider newsletter. ▪ Outreached via mail and email to primary care providers with patients identified as needing a newborn hearing screen and follow-up. ▪ Distributed a provider toolkit including materials and resources on the Early Intervention Program, the New York City Department of Health and Mental Hygiene guidelines on the identification and referral of children with developmental delays or disabilities to the Early Intervention Program, and developmental and autism screening tools.

Table 60: Healthfirst's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	58.42%	64.72%	56.50%	55.99%	63.00%
Blood Lead Test at Age 2 Years	64.27%	71.96%	71.93%	63.11%	69.00%
Blood Lead Test at Ages 1 and 2 Years	51.19%	57.18%	57.39%	52.67%	56.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	24.82%	35.76%	32.77%	44.00%	30.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	0.29%	0.28%	0.22%	0.24%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	40.66%	46.34%	36.89%	44.61%	80.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.05%	0.05%	0.04%	0.06%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	35.06%	34.09%	31.09%	35.63%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	89.77%	88.08%	85.85%	95.35%	93.00%
Failed Screening by Age 1 Month	1.19%	2.42%	2.80%	3.28%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	21.56%	30.76%	31.60%	34.30%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	31.91%	16.57%	13.73%	10.17%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	46.67%	25.00%	23.21%	11.84%	80.00%
Screening Before Age 3 Months	91.70%	89.86%	90.03%	89.06%	95.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	32.03%	32.50%	37.44%	34.89%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	29.27%%	19.70%	20.63%	16.75%	80.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	9.88%	13.05%	19.87%	22.07%	13.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	17.02%	19.70%	25.58%	32.06%	20.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	11.15%	12.83%	16.91%	20.43%	14.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	12.71%	15.22%	20.67%	24.74%	16.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.03%	1.22%	6.88%	3.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	0.00%	2.76%	3.00%

Performance Measure Results

Table 61: Healthfirst's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Healthfirst Measurement Year 2019	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	52.08%	52.56%	57.76%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	35.33%	36.70%	40.81%	41.64%
Asthma Medication Ratio (5–64 Years)	63.43%	53.11%	54.34%	56.86%
Breast Cancer Screening	76.54%	70.34%	69.38%	64.75%
Cervical Cancer Screening	79.81%	71.68%	74.27%	69.19%
Chlamydia Screening in Women (16–20 Years)	83.47%	77.90%	80.59%	71.38%
Chlamydia Screening in Women (21–24 Years)	82.26%	75.99%	80.06%	74.13%
Colorectal Cancer Screening	73.05%	69.59%	69.34%	61.03%
Comprehensive Diabetes Care – Eye Exam	72.75%	65.69%	63.99%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	25.06%	46.47%	34.79%	34.74%
Controlling High Blood Pressure	65.21%	43.07%	72.02%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	44.97%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	66.08%	67.31%	67.16%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	54.16%	51.13%	45.02%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	78.14%	74.82%	74.42%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	79.08%	79.81%	73.72%	66.71%
Immunizations for Adolescents – Combination 2	56.20%	57.78%	53.60%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	87.36%	66.56%	86.37%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	82.24%	59.02%	88.56%	84.17%

Measure	Healthfirst Measurement Year 2019	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	77.01%	53.11%	82.97%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	15.77%	17.23%	17.30%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	62.91%	63.39%	61.87%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.35%	76.02%	80.32%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	45.12%	42.85%	45.03%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	70.25%	73.45%	75.43%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	63.14%	67.13%	62.73%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	79.85%	77.85%	76.00%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	47.92%	38.60%	46.46%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	41.48%	44.23%	42.17%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	14.95%	16.03%	14.53%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	62.23%	44.17%	49.68%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	26.19%	Not Available	30.98%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	Healthfirst Measurement Year 2019	Healthfirst Measurement Year 2020	Healthfirst Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	89.78%	90.88%	87.20%
Prenatal and Postpartum Care – Postpartum Care	87.59%	77.62%	83.11%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	67.45%	70.59%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	83.18%	80.53%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	68.55%	73.94%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 62: Healthfirst's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	C	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	NC	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2019 Results

- Based on staff interview and record review of the commercial/Child Health Plus standard utilization review appeals, Healthfirst and its delegate, DentaQuest, failed to send the member a written acknowledgment letter after filing for an appeal. This was evident in four of 10 commercial standard appeal cases reviewed. *(Contract Article 4904. 3)*
- Based on staff interview and record review, Healthfirst failed to ensure that acknowledgement notices for Medicaid complaints were sent to the members timely. This was evident in three of 22 cases. Healthfirst staff stated that they had staffing and computer systems issues. *(Contract Article 98-1.14(e), 4408.a 4)*
- Based on staff interview and record review, the Healthfirst failed to ensure that Medicaid Complaints resolution notices were sent to the members timely, according to regulatory guidance. This was evident in three of 22 cases. Healthfirst staff stated they had staffing and computer system issues. *(Contract Article 4408.a 4 (iii))*
- Based on staff interview and record review, Healthfirst failed to ensure that a DentaQuest commercial complaint appeal resolution notice was sent timely, in accordance with the regulatory guidance. Specifically, on July 27th, 2018, a complaint appeal was filed with the managed care plan. The "Child HealthPlus Appeal of Complaint Resolution Notice" was dated November 7th, 2018. This was evident in one of two cases. Healthfirst staff stated they had staffing and computer system issues. *(Contract Article 4408.a 11(ii))*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst failed to provide adequate oversight of delegated management functions (utilization review), by allowing an unregistered utilization review agent, Prest and Associates, to perform utilization review on behalf of Healthfirst. *(Contract Article 98-1.11(h))*

- Based on staff interview and record review of the final adverse determination notice, Healthfirst and its delegate, Orthonet, did not provide phone notice to the member and the provider, that additional information was needed to make a determination. This was evident in three out of 11 Medicaid expedited appeal cases. *(Contract Article 98-2.9(b))*
- Based on staff interview and record review of the Medicaid expedited appeals, Healthfirst did not issue the final adverse determination notice within 24 hours of the determination to the member. This was evident in three of 11 Medicaid expedited appeal cases. *(Contract Article 98-2.9(f))*
- Based on record review and staff interview, Healthfirst failed to ensure that a written acknowledgement notice was sent to a member. Specifically, on July 27th, 2018, a complaint was filed with the MCP. There was no evidence of an acknowledgement notice provided. This was evident in two of two DentaQuest commercial complaint appeal cases. *(Contract Article 4408.a 9)*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst delegated the utilization review activities for behavioral health benefits to an organization identified as Prest and Associates. This organization was not a registered utilization review agent approved by the Department of Health at the time of the determination. *(Contract Article 2005-98-1.11(k)(6), 98-1.11[j](4))*
- Based on staff interview and review of Concurrent initial adverse determination documents, Healthfirst delegated a management function (utilization review), to Prest and Associates without submitting a management services contract to the Department of Health for prior approval. This was discussed with Healthfirst during interview on May 16th, 2019, and May 17th, 2019. *(Contract Article 2005-98-1.11(j)(7))*
- Based on staff interview and review of concurrent initial adverse determination documents, Healthfirst delegated a management function (utilization review), to Prest and Associates without submitting a management services contract to the Department of Health for prior approval. *(Contract Article 98-1.11(k))*
- Based on staff interview and record review, the Healthfirst failed to ensure that commercial grievance resolution notices for denial of non-covered benefits were sent to the members timely, in accordance with the regulatory guidance. This was evident in five of 35 cases. *(Contract Article 4408.a 4 (iii))*

Quality-of-Care Survey Results – Member Experience

Table 63: Healthfirst's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Healthfirst	Mainstream Medicaid Average	Healthfirst	Mainstream Medicaid Average	Healthfirst	Mainstream Medicaid Average
Getting Needed Care[1]	73.40%	78.71%	83.79%	81.33%	74.76%	78.54%
Getting Care Quickly[1]	75.40%	78.40%	73.20%	80.57%	73.93%	78.88%
How Well Doctors Communicate[1]	90.03%	90.95%	91.25%	92.00%	89.53%	92.04%
Customer Service[1]	84.43%	85.72%	84.14%	87.13%	81.38%	86.32%
Rating of All Health Care[2]	75.10%	76.50%	76.77%	75.33%	74.18%	72.83%
Rating of Personal Doctor[2]	78.98%	80.80%	74.50%	81.46%	80.40%	81.25%
Rating of Specialist Talked to Most Often[2]	77.68%	79.63%	76.53%	82.07%	75.76%	78.79%
Rating of Health Plan[2]	78.52%	75.93%	78.91%	75.90%	73.26%	73.47%
Rating of Treatment or Counseling[2]	60.12%	59.60%	Sample Size Too Small To Report	61.84%	Sample Size Too Small To Report	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Healthfirst's response to all 2020 recommendations: The onset of COVID-19 significantly impacted Healthfirst members' access to primary and specialty care in 2020. New York State and New York City residents were advised to quarantine at home for most of the year. Many physician practices and community-based organizations were closed. Statewide staff shortages limited the ability to provide in-person health care services. Members were hesitant to seek medical care for their preventive health needs or to manage their chronic condition unless they required emergent attention. As a consequence of these COVID-19 barriers, there was an overall decrease in Healthfirst's rates for preventive screening, chronic disease management, behavioral health follow-up care, and timely prescription refill. Healthfirst will thus implement the quality initiatives noted below to ensure that our members receive the education, care coordination, and services they need to maintain their physical health and mental well-being in the community.

Table 64: Healthfirst's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve its current performance improvement project interventions targeting blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		One of the major lessons learned during this performance improvement project was that the decreased utilization of preventive services was attributed to our members' fear, lack of knowledge, and uncertainty of the unknown during a pandemic. Education on COVID-19 testing, COVID-19 vaccines, and community resources needed to be communicated through various modalities (i.e., outreach scripts, frequently asked questions, Healthfirst's intranet, website postings) and updated as necessary to ensure our members, providers, and Healthfirst staff were up to date with information about the pandemic that kept evolving. Workflows and interventions that supported the performance improvement project was also impeded by provider office staff shortages, the lack of access to in-office resources, closures, and the technical limitations of working virtually. The pandemic further exacerbated health care disparities and social determinants of health which poses a barrier to an individual's ability to access routine preventive care. Since our Medicaid population is comprised of low-income families who often lack health literacy and have	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				limited supports, Healthfirst developed an assessment tool that will routinely identify social determinants of health needs and established internal processes that will ensure social determinants of health -specific interventions/referrals are implemented with our most vulnerable members in a timely manner. As closures and limitations in the delivery system lifted, we also encouraged members to return to routine care and catch up as needed. Resources and education on the importance of routine screenings and follow-up care for lead exposure, newborn hearing, and developmental delay will continue to be promoted through provider webinars, trainings, and on Healthfirst's website.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve the weight assessment and counseling for nutrition and physical activity for children and adolescents	X	X		There was a decline in routine weight assessment and counseling for nutrition and physical activity among our pediatric population because the limitations imposed by COVID-19 resulted in a decreased utilization of preventive care services such as well-child visits. In an effort to improve our members' access to care, the availability of telehealth medicine is encouraged by our Care Managers and Member Services Representatives as an alternative to addressing our members' non-emergent health care needs, when appropriate. Education on weight management strategies, healthy lifestyle changes, and pediatric obesity provider toolkits is promoted on our website. In addition, primary care providers are eligible to receive a bonus payment from Healthfirst's Quality Incentive Program when their HEDIS rates for "Body Mass Index Percentile Documentation," "Counseling for Nutrition," and "Counseling for Physical Activity" meet or exceed the target rates established by Healthfirst.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
The managed care plan should investigate opportunities to improve the health of members with asthma, diabetes, hypertension, and pharyngitis.	X	X		To improve the health of our members with asthma, Healthfirst partnered with the American Lung Association and Asthma Educator Institute to offer continuing education unit trainings to our providers to promote adherence to the National Institute of Health, Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. Members aged 18+ receive a live outreach call by a vendor called Aspen RxHealth that has a team of pharmacists who reinforce the importance of taking long-term controller medications as directed by the health care provider and ensures members understand their asthma action plans to effectively manage their conditions. The parents/guardians of our members aged 5-18 years are outreached by Healthfirst's pediatric care managers who conduct asthma assessments, provide education regarding medications and proper spacer technique, connect members to community resources, update asthma action plans and care plans, as necessary, and help schedule Specialist appointments. Primary care providers have access to a list of their non-adherent members and their *Asthma Medication Ratio* rates on the Healthfirst Quality Application, which is a web-based tool that enables them to view their quality data in a single location and is refreshed monthly. Providers participating in Healthfirst's Quality Incentive Program are eligible to receive a bonus payment if their "Starting Controller Medication for Members with Only Rescue Inhaler Fills" rate meets or exceeds the target rate established by Healthfirst. In support of our members with diabetes, Healthfirst developed the "HF Cares Diabetes Program" which is a new initiative that focuses on the root causes of a member's health condition by addressing their social determinants of health needs and individual behaviors. It is designed to drive	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				better clinical outcomes and increase member engagement through innovative technologies; tailored touchpoints (e.g., live outreach, digital care management / coaching, telehealth); expanded care management support; enhanced assessment/care planning tools; and partnerships with vendors that can positively impact social determinants of health issues. Providers are also eligible to receive a Healthfirst Quality Incentive Program bonus payment when their performance with the HEDIS measure, Hemoglobin A1c Control for Patients with Diabetes, meets or exceeds Healthfirst's set targets. Education about the importance of medication adherence in blood pressure control, maintaining a healthy lifestyle, eating nutritious foods, and routinely having blood pressure readings done during medical visits is promoted on Healthfirst's website and through care management outreach activities. Similarly, member awareness about the inappropriate use of antibiotics for viral conditions (i.e., cold and flu) and the need for a rapid strep test or throat culture to confirm a diagnosis of pharyngitis prior to receiving an antibiotic prescription, continues to be reinforced on Healthfirst's website.	
The managed care plan should investigate opportunities to improve medication management and follow-up care for members with mental illness and	X	X		To improve the medication management of members with mental illness and substance abuse disorders, direct outreach is conducted to members who are within the denominator for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure to ensure members are adherent, and to prevent relapse and decompensation. During the outreach, the Healthfirst Pharmacist will conduct a barrier analysis and assess the member's symptoms, mood, and adherence. If active mental health symptoms are present, the member will be referred	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
substance abuse disorders.				to a behavioral health care manager for further support. Outreach is also conducted to the prescriber to let them know if a new prescription is needed or if a medication is not covered by the managed care plan. Similar outreach efforts are made for members that are within the denominator for the *Antidepressant Medication Management* measure and their prescriber. Outreach is made to members and their prescribers to ensure adherence to their prescribed antidepressant therapy and to address medication adverse events and other barriers. To support these efforts, in 2022, Healthfirst hired two behavioral health pharmacists to focus solely on member and provider outreach for these measures. There are various quality initiatives in place to improve follow-up care for members with mental illness and substance abuse disorders. Healthfirst utilizes the VNS Behavioral Health Community Transitions Program to conduct outreach and follow-up visits to members who have been recently discharged from an inpatient facility with mental health related diagnoses. The goal of the program is to provide a bridge visit between the discharge and the member's first appointment with their behavioral health community provider. This transitional visit can be provided via telehealth or face-to-face based on member preference. Additionally, the Healthfirst Behavioral Health Care Management team conducts outreach to members who recently visited the Emergency Department to resolve any barriers preventing the member from accessing follow-up care. These members are identified using the daily Health Information Exchange report that captures Emergency Department visits at participating hospitals. However, successful outreach efforts are often hindered due to	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				incomplete or out-of-date contact information. Therefore, the HIE report was enhanced in May 2021 to include alternate contact information for members when furnished by the discharging Emergency Department. To expand our member outreach efforts, Healthfirst launched a pilot in the 4th quarter of to use texting campaigns through the short message service/text platform. Members that were recently discharged from the Emergency Department were texted and asked to contact a Healthfirst Behavioral Health care manager through a toll-free number for assistance in scheduling an outpatient follow-up appointment for mental health and/or substance use treatment. Healthfirst has launched a Behavioral Health Provider Engagement Program in 2022 that is supported by financial incentives through the Healthfirst Quality Incentive Program. Participating providers are eligible to receive a bonus payment when their follow-up rates after an Emergency Department visit, as measured by the HEDIS *Follow-Up After Emergency Department Visit for Mental Illness 7-Day* or *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence 7-Day* rates, meet or exceed benchmarks established by Healthfirst. The Behavioral Health clinical leadership team uses the Provider Engagement Program to engage hospital sponsors in developing workgroups to improve care coordination, increase member engagement, share clinical best practices, and to identify effective resources that can address Social Determinants of Health concerns.	
The managed care plan should investigate opportunities to	X	X	X	Similar to other areas noted, COVID presented unique challenges to accessing dental care. To improve our members' access to dental care, Healthfirst collaborated with our delegated dental vendor to increase awareness	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
improve members access to dental care and alcohol and other drug abuse treatments.				about preventive dental care through live call campaigns that facilitate appointment scheduling and appointment reminder postcards / emails that reinforce the importance of making a routine dental appointment. Our dental vendor ensures that our non-adherent members have easier access to preventive dental services by assigning them to a dental home that is near their medical primary care provider. They engage our provider network through financial incentives and improved fee schedules to increase their delivery of preventive dental services. Our pediatric primary care providers are assisting our members with dental referrals and are offering dental screenings. We host community events that promote oral health through the distribution of educational materials/brochures and offers dental screenings in a mobile dental van. To improve members' access to alcohol and drug abuse treatment, Healthfirst prioritized network expansion efforts for additional telehealth providers that offer such services. Examples include Brave Health and WholeView Wellness, virtual providers that offer alcohol and drug abuse treatment services. Telehealth services give members the option of accessing outpatient addiction treatment services virtually with Behavioral Health providers in the privacy and comfort of their home and at their convenience. Healthfirst has also focused efforts on the development of clinical programs to support members access to alcohol and drug abuse treatment. The Walk with Me Program was developed and implemented in the 4th quarter of 2021 to engage members with opiate and alcohol dependence with wrap around services to promote recovery. The program provides an array of services that includes medication assisted treatment (medication assisted treatment),	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				psychiatric diagnostic evaluation, psychotherapy, medication administration, peer services, care coordination, linkages to resources to address social determinants of health, health education, and recovery-oriented socialization. Healthfirst also developed and implemented the S:US Behavioral Health Treatment Engagement Program in the 2nd quarter of 2022 with the goal of engaging Healthfirst members in ongoing behavioral health treatment who have a primary or co-occurring substance use disorder with a history of high Emergency Department utilization and nonadherence. This program aims to reduce avoidable Emergency Department and inpatient admissions by engaging members in outpatient behavioral health treatment by providing a combination of modalities including group and individual therapy and medication management.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the measurement year 2019 operational survey conducted by the Department of Health.	X	X	X	During the 2019 Operational Survey, the Department of Health cited three areas as deficient: Complaints and Grievances, Organization and Management, and Utilization Review. As part of Healthfirst's remediation of the noted deficiencies, we implemented an in-depth internal corrective action plan to address each citation. The Department of Health approved the corrective action plan on 12/19/2019. The corrective action model we employ follows key elements: Responsible Party, Date Certain (the date an operational area commits to an action), Monitoring and Auditing and Education and Training as applicable. To address and then promote sustained improvement, the steps outlined in every internal corrective action, are monitored by the Healthfirst Compliance team, led by the Healthfirst Chief Compliance Officer, with the goal to both mitigate issues and to prevent repeat occurrences. Progress	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst's Response	IPRO's Assessment of Healthfirst's Response
				on all corrective actions is reported out routinely to the Healthfirst Inc. Board of Directors via the Audit, Risk and Compliance Committee. In May 2021, the Department of Health conducted a Targeted Operational Survey of Healthfirst to determine compliance with the plan of correction from the 2019 Operational Survey and Healthfirst was found in compliance with the plan of correction with no further action required.	
Administration of Quality-of-Care Surveys – Member Experience					
Healthfirst should continue with its current interventions to improve members experience as CAHPS rates have improved. The managed care plan should continuously evaluate the CAHPS scores to identify additional opportunities to improve care.	X	X	X	To better understand specific areas of opportunity and improve our members' satisfaction with the CAHPS measures, Getting Care Quickly and Rating of Personal Doctor, Healthfirst conducted a telephonic member survey that was triggered after a provider visit was completed. The survey asked about how long the member waited to see the provider (under/over 15 minutes); how easy it was to schedule the appointment (scale of 1-5); and was the appointment convenient (yes/no). Data collected from these surveys is used to incent providers, through the Healthfirst Quality Incentive Program, to improve performance in these areas. Healthfirst's Clinical Quality, Delivery System Engagement and Partnerships for Medical Outcomes teams work together to improve our members' experience with our provider network. These teams share member experience and after visit survey data directly with the providers and offer their ongoing support to address our members' barriers at the practice level. If some members need extra help in navigating the healthcare system, Healthfirst's customer service center is available to provide them with a concierge level of support and assist them in scheduling a provider appointment at a time that is convenient for them. In addition, Healthfirst continues to	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Healthfirst’s Response	IPRO’s Assessment of Healthfirst’s Response
				maintain and monitor required network adequacy across all service regions as well as evaluates out of network providers who may be authorized for potential participation in the provider network	

Strengths, Opportunities for Improvement, and Recommendations

Table 65: Healthfirst's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Healthfirst's measurement year 2021 performance improvement project passed validation.	X	X	X
	Healthfirst exceeded the target rate for one performance indicator related to blood lead screening.	X	X	X
	Healthfirst exceeded the target rate for one performance indicator related to newborn hearing screening.	X	X	X
	Healthfirst exceeded target rates for five performance indicators related to developmental screening.	X	X	X
Performance Measures	Healthfirst met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Healthfirst performed significantly better than the mainstream Medicaid program on 16 measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Healthfirst performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Healthfirst performed significantly better than the mainstream Medicaid program on three measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Healthfirst was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*			
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Healthfirst did not meet target rates for five performance indicators related to blood lead screening.	X	X	X
	Healthfirst did not meet target rates for five performance indicators related to newborn hearing screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Healthfirst did not meet the target rate for one performance indicator related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	Healthfirst performed significantly worse than the mainstream Medicaid program on four measures of effectiveness of care related to primary care, substance use, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Healthfirst performed significantly worse than the mainstream Medicaid program on four measures of access/availability of care related to primary care, children's health, or substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Healthfirst was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Healthfirst should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Healthfirst should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Healthfirst should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Healthfirst should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019 compliance findings. Healthfirst should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey	Healthfirst should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Highmark BCBS WNY

Performance Improvement Project Summary and Results

Table 66: Highmark BCBS WNY's Performance Improvement Project Summary, Measurement Year 2021

Highmark BCBS WNY's Performance Improvement Project Summary
Title: Kids Quality Agenda Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Highmark BCBS WNY aimed to optimize children's health and development by improving screening, testing and linkage to services for lead exposure, newborn hearing loss and early identification of developmentally at-risk children. Member-Focused 2021 Interventions ▪ Established the Healthy Rewards program to incentivize parents/guardians to complete well-child visits. ▪ Educated parents/guardians via mail on the importance of lead testing, potential contaminants and how to access services. The mailing was timed to arrive 90 days prior to the member's birthday to support timely care. ▪ Outreached to parents/guardians of members identified as needing a diagnostic audiological evaluation or early intervention services. ▪ Developed member educational materials, highlighting common signs and symptoms of hearing loss and the importance of clinical follow-up. ▪ Utilized text messaging and interactive voice responses to enhance the member education strategy. ▪ Cosponsored a community event with the organization Every Person Influences where seminars on childhood development were facilitated. Provider-Focused 2021 Interventions ▪ Issued gaps in care reports to providers with patients identified as missing a lead screening and or not treated according to the guidelines for early detection and intervention. ▪ Disseminated the Centers for Disease Control and Prevention and the Department of Health guidelines for blood lead screening and follow-up to providers. ▪ Outreached to providers with members identified as having a blood lead level greater than 5 mcg/dl. ▪ Developed provider education segments on the early detection and intervention program, the availability of standardized development screening tools, and appropriate billing codes for lead, hearing, and developmental screenings.

Table 67: Highmark BCBS WNY's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	64.96%	71.96%	71.34%	52.11%	77.00%
Blood Lead Test at Age 2 Years	60.74%	70.56%	76.76%	63.58%	81.00%
Blood Lead Test at Ages 1 and 2 Years	42.46%	52.27%	61.23%	23.98%	66.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	30.93%	22.90%	26.52%	60.87%	36.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	2.21%	3.89%	1.41%	2.40%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	10.39%	6.88%	28.26%	50.35%	80.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.78%	1.12%	0.11%	2.08%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	11.11%	8.70%	18.18%	26.23%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	87.11%	93.95%	88.54%	98.52%	99.00%
Failed Screening by Age 1 Month	7.40%	4.37%	1.54%	4.24%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	6.67%	2.50%	25.00%	96.30%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	33.33%	100.00%	66.67%	7.69%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	100.00%	0.00%	100.00%	0.00%	100%
Screening Before Age 3 Months	87.66%	92.56%	91.58%	91.87%	98.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	50.00%	10.00%	42.86%	100.00%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	Denominator=0	0.00%	66.67%	11.11%	80.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	3.70%	6.22%	19.67%	29.36%	24.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	22.33%	33.91%	39.84%	33.24%	44.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	18.86%	30.67%	40.76%	27.68%	45.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	14.16%	22.71%	33.33%	30.00%	38.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	3.88%	19.05%	22.87%	24.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	1.00%	13.74%	9.59%	18.00%

Performance Measure Results

Table 68: Highmark BCBS WNY's BCBS Performance Measure Results, Measurement Years 2019 to 2021

Measure	Highmark BCBS WNY Measurement Year 2019	Highmark BCBS WNY Measurement Year 2020	Highmark BCBS WNY Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	56.50%	54.92%	56.62%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.60%	41.10%	42.80%	41.64%
Asthma Medication Ratio (5–64 Years)	62.68%	64.76%	63.90%	56.86%
Breast Cancer Screening	57.71%	54.36%	53.54%	64.75%
Cervical Cancer Screening	63.26%	62.29%	66.49%	69.19%
Chlamydia Screening in Women (16–20 Years)	59.21%	58.83%	58.43%	71.38%
Chlamydia Screening in Women (21–24 Years)	64.84%	64.65%	68.37%	74.13%
Colorectal Cancer Screening	56.45%	52.55%	49.88%	61.03%
Comprehensive Diabetes Care – Eye Exam	66.91%	58.64%	59.37%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	36.25%	48.18%	35.77%	34.74%
Controlling High Blood Pressure	61.07%	62.77%	63.02%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	35.81%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	71.88%	67.61%	64.51%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	38.67%	25.64%	30.43%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	82.09%	83.33%	80.66%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	84.91%	80.78%	81.27%	66.71%
Immunizations for Adolescents – Combination 2	35.28%	37.96%	41.85%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	84.67%	82.73%	85.64%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	86.13%	86.37%	86.13%	84.17%

Measure	Highmark BCBS WNY Measurement Year 2019	Highmark BCBS WNY Measurement Year 2020	Highmark BCBS WNY Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	80.54%	80.78%	82.24%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	23.95%	25.00%	29.92%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	73.62%	65.59%	60.00%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.92%	68.57%	72.82%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	77.08%	72.17%	72.99%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	51.40%	60.74%	59.00%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	50.00%	48.60%	55.73%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	61.22%	64.29%	66.67%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	25.00%	21.53%	27.23%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	43.57%	41.32%	43.37%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	19.41%	14.69%	16.19%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	66.42%	53.38%	55.39%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	42.86%	Not Available	55.77%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	Highmark BCBS WNY Measurement Year 2019	Highmark BCBS WNY Measurement Year 2020	Highmark BCBS WNY Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	88.81%	86.62%	87.20%
Prenatal and Postpartum Care – Postpartum Care	81.02%	77.13%	77.37%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	68.72%	68.77%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	89.44%	84.84%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	68.89%	70.52%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 69: Highmark BCBS WNY's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	NC	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	C	Pended	Pended
438.214: Provider Selection	NC	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	NC	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	NC	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2019 Results

- Based on staff interview and review of the final adverse determination notice, Highmark BCBS WNY failed to ensure its delegate, Amerigroup, included required information in the document. Specifically, the final adverse determination did not include the following information as required; utilization review agent (Amerigroup) address, contact person and phone number. This was evident in three of nine Child Health Plus standard appeal utilization review cases. *(Contract Article 98-2.9 (e)(5)(6))*
- Highmark BCBS WNY failed to have a sole contractor for vision benefits. Highmark BCBS WNY had two active Management Services Agreements for routine vision benefits management with two separate vendors – EyeMed Vision Care IPA, LLC and Davis Vision, Inc. This deficiency was discussed during the Organization and Management and Service Delivery Network interviews on September 26th, 2019. *(Contract Article 2005-98-1.11(k)(6))*
- Based on staff interview and review of the sampled provider contracts, Highmark BCBS WNY failed to provide evidence that four of 55 providers included in the sample were sent an amendment to incorporate the requirements set forth by the 21st Century Cures Act. *(Contract Article 2005-98-1.13(a))*
- Based on staff interview and review of the sampled provider contracts, Highmark BCBS WNY failed to provide the Department of Health approval letters that corresponded with the managed care plan unique identification numbers for 27 of 55 contracts included in the sample. *(Contract Article 98-1. 8(b), 2005-98-1.13(a))*
- Based on interview and review of behavioral health provider contracts, Highmark BCBS WNY failed to amend five of 10 contracts. Specifically, the contracts did not include the required language to ensure that providers will be paid at the government rate. *(Contract Article 2005-98-1.11(h), 2005-98-1.12(l))*

- Based on staff interview and review of credentialing files, it was identified that Highmark BCBS WNY failed to re-credential two of 20 providers from the contract sample, within the required time frame of every three years. *(Contract Article 2005-98-1.12(k))*
- Based on staff interview and review of the member notices, Highmark BCBS WNY failed to provide written notice to three of 11 members within the required 15 days from the date Highmark BCBS WNY became aware of a provider's change in status/termination. *(Contract Article 4408.4)*
- Based on interviews with plan staff and review of requested survey documentation, Highmark BCBS WNY failed to provide oversight to ensure the plan of correction developed in response to the 2018 deficiency (98-1.12 (k) Quality Management Program) issued for non-compliance with the required timeframe for credentialing review process was implemented. *(Contract Article 98-1.12(a))*
- Based on staff interview and review of the sampled provider contracts, Highmark BCBS WNY failed to provide evidence that three of 55 providers included in the contract sample were sent an amendment to incorporate the 2017 Department of Health Standard Clauses for Managed Care Provider/Independent Physician Association/Accountable Care Organization Contracts. *(Contract Article 2005-98-1.13(a))*
- Based on staff interview and review of the initial adverse determination notice, Highmark BCBS WNY failed to ensure its delegate, Amerigroup, provided clinical rationales that included: a clear statement for the denial, the reasons for the determination, the term "not medically necessary" and that were enrollee specific. This was evident in six of 18 Medicaid pre-authorization/concurrent utilization review cases. *(Contract Article 98-2.9(e)(1))*

Quality-of-Care Survey Results – Member Experience

Table 70: Highmark BCBS WNY's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Highmark BCBS WNY	Mainstream Medicaid Average	Highmark BCBS WNY	Mainstream Medicaid Average	Highmark BCBS WNY	Mainstream Medicaid Average
Getting Needed Care[1]	79.49%	78.71%	84.90%	81.33%	85.03%	78.54%
Getting Care Quickly[1]	84.83%	78.40%	88.24%	80.57%	87.14%	78.88%
How Well Doctors Communicate[1]	88.60%	90.95%	94.96%	92.00%	94.69%	92.04%
Customer Service[1]	83.14%	85.72%	85.83%	87.13%	88.01%	86.32%
Rating of All Health Care[2]	69.85%	76.50%	80.07%	75.33%	74.43%	72.83%
Rating of Personal Doctor[2]	75.41%	80.80%	89.38%	81.46%	78.04%	81.25%
Rating of Specialist Talked to Most Often[2]	81.08%	79.63%	79.31%	82.07%	77.98%	78.79%
Rating of Health Plan[2]	66.23%	75.93%	73.20%	75.90%	73.60%	73.47%
Rating of Treatment or Counseling[2]	55.97%	59.60%	68.29%	61.84%	66.10%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 71: Highmark BCBS WNY's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve the following performance improvement project indicators; blood lead testing and newborn hearing screenings.	X	X		The 2019-2021 Kids Quality Agenda Performance Improvement Program (Kids Performance Improvement Project) included a comprehensive range of interventions to improve the following performance improvement project indicators: blood lead testing and newborn hearing screenings. The goals of the Kids Performance Improvement Project were to decrease risks of developmental delays by improving screening, testing and linkage to services for lead exposure and newborn hearing loss. Baseline rates were established, and interventions were tracked each quarter with the goal of improving these performance improvement project indicators. The interventions for Lead Screening, testing and follow-up are noted below: ▪ Providers received quarterly gaps in care reports with members two years of age missing lead screening tests. ▪ Caregivers received telephonic outreach if the child did not have an annual well visit. Caregivers were also educated about the Healthy Rewards member incentive program if they completed the well visit. ▪ The updated Lead screening guidelines were posted to the provider website and faxed to providers. ▪ Providers received outreach if members had blood lead levels > 5 mcg/dL.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY’s Response	IPRO’s Assessment of Highmark BCBS WNY’s Response
				▪ Members 0-6 years received Early and Periodic Screening, Diagnostic, and Treatment educational mailers outlining the importance of lead testing. ▪ Members missing lead tests received short message service/text campaigns about the importance of getting tested for lead levels. The interventions for members in need for audiological evaluation to identify newborn hearing loss are noted below: ▪ Caregiver outreach was conducted for members in the New York State Department of Health report who needed an audiological evaluation. ▪ New members 0-9 months of age every quarter received an educational mailing about highlighting the common signs and symptoms of hearing loss and the appropriate action for follow up. ▪ Members missing newborn hearing screening received a short message service/text campaign about the importance of early detection and intervention. ▪ Every quarter, providers received faxed reports of their Medicaid and Child Health Plus members who failed hearing screening. The Department of Health provided specific member level files for lead testing and hearing evaluations which were used to identify members in need of testing and evaluation. The following indicators were tracked annually to determine the success of the interventions: ▪ The percentage of members who received blood lead tests at 1 and 2 years of age. ▪ The percentage of members with a capillary blood lead level of > 5mcg/dL who had a confirmatory venous blood lead test within 3 months.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				▪ The percentage of members with a capillary blood lead level of > 10 mcg/dL who had a confirmatory venous blood lead test within 1 month. ▪ The percentage of infant members who completed hearing screening by 1 month. ▪ The percentage of infants who failed hearing screening and had a subsequent diagnostic evaluation by 3 months of age. ▪ The percentage of members who were diagnosed with hearing loss who were referred to early intervention by 6 months of age. ▪ The percentage of members diagnosed with hearing loss who were referred to early intervention by 9 months of age. During the Kids Quality Agenda Performance Improvement Project, the interventions conducted, and the findings were made available to the managed care plan's regulatory committees including the Children's Advisory Committee, the Quality Assurance Committee, and the Medical Advisory Committee. Both, the Children's Advisory Committee, and the Medical Advisory Committee include external providers including pediatric providers, children's mental health psychiatric providers, pediatric specialists, and representatives from local behavioral health agencies. The annual findings and interventions were also documented annually as part of the annual quality management evaluation and reviewed and voted on by the managed care plan's Quality Assurance Committee voting members. The Kids Performance Improvement Project final report was approved by the Department of Health on 10/17/2022.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
Validation of Performance Measures					
In addition to the managed care plan's monthly monitoring of our current performance and gaps to goals, the managed care plan should investigate additional opportunities to improve cancer screenings, chlamydia screening, and adolescent immunizations as some of the rates declined from 2019 to 2020.	X	X		Highmark BCBS WNY developed a comprehensive workplan in 2022 to address preventive screening measures; this includes monthly monitoring of our current performance and gaps to goals for achieving HEDIS measure New York State benchmarks. The specific interventions developed have been closely tracked to determine outcomes and assess both utilization and intervention effectiveness. The workplan outlines both educational and care coordination approaches to engage members into care and attempt to reduce barriers to completion in screenings that include: ▪ Live calls and text messages to members in English and Spanish. These outreach campaigns offer a range of support including discussions of access, benefits, and education. A phone number is provided for members to outreach to the managed care plan for assistance in scheduling appointments and connecting members to care for (adult and children's health) preventative screening measures. All call campaigns remind members of the Healthy Rewards incentives available to close gaps in care. Member outreach and engagement reports are reviewed monthly for all short message service/text campaigns. ▪ Quality Improvement workgroups developed to monitor and track prevention and screening interventions. Workgroup meetings are held monthly with different business units to develop a comprehensive approach for member outreach, provider outreach and community events. The workgroups monitor monthly rates for measure	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				performance, effectiveness of short message service/text and outbound call campaigns, Healthy Rewards incentives redemption by measure, and community outreach events and engagement. ▪ Community Engagement team has participated in over 400 events including health fairs, exercise programs, maternal and child wellness, school-based health education, vaccine clinics and more. Well child events have included partnerships with local community-based organizations including Women Infants and Children, Doula organizations and Project Stork™. A health equity grant was awarded to Women Infants and Children to ensure ongoing support for childhood screenings and access to services. ▪ Healthy Rewards gift card incentives are offered through a vendor to encourage completion of preventive health screenings and chronic care management services. For this program effort, digital gift cards and messaging have been offered to members as an opportunity for use. Outreach calls and text messaging campaigns have also been implemented to educate members about specific gaps in screenings and inform them about the Healthy Rewards incentive program. Highmark BCBS WNY tracks utilization of incentives through redemption rates. In 2022, the managed are plan's members were eligible to earn $25 financial incentive for completed screenings for breast cancer, cervical cancer, chlamydia testing, colorectal cancer, adolescent immunizations and well-child visits.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				The workplan outlines provider-focused approaches to engage members into care and attempt to reduce barriers. The following interventions were implemented in 2022: ▪ Distributed quarterly gaps in care lists to primary care providers to identify members who have outstanding care gaps and requested information. Monthly gap in care reports were also distributed to independent physician associations. ▪ Held regular meetings with provider groups to review quality measure performance, discuss practice specific quality gaps in care report, share quality projects underway, information about the member incentive Healthy Rewards program, and resources available through the provider portal. ▪ Shared the 2022 Provider Webinar series with continuing medical education credits and education on HEDIS measures, telehealth, ICD-10 coding updates, Use of Category II codes, social determinants of health and health equity. Attendance is tracked for all webinars. ▪ A new Pay for Quality (P4Q) provider incentive program was also launched in the fourth quarter of 2022. Providers can earn $25-50 to close care gaps for every member identified as non-compliant to different prevention and screening measures. ▪ The managed care plan also conducts access and availability surveys of network providers to assess provider compliance with the Department of Health appointment availability standards. Additionally, Highmark BCBS WNY continues to: ▪ Track, monitor, and trend member complaints related to access to care through consumer surveys	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				administered to members after calls to the call center and after provider visits. ▪ Analyze Member complaints/grievances and appeals and services to identify negative trends, perform root cause/barrier analysis, and address member complaints/grievances related to quality of care and access to care. Highmark BCBS WNY has worked on further assessing and understanding of member barriers to care, especially during the COVID-19 pandemic and its impact. Highmark supports the use of telehealth to eliminate barriers through the pandemic. Highmark BCBS WNY will continue to address barriers and has workgroups established for 2022 to monitor outcomes, improve rates for all measures, and ensure members are aware of benefits and have opportunities to engage in care	
The managed care plan should re-evaluate its current interventions to improve the health of members with diabetes and COPD as rates have continued to decline. [Repeat recommendation.]	X	X		Highmark BCBS WNY has implemented a new chronic condition focused quality improvement workgroup, which meets quarterly and reviews quality measure performance trends for diabetes and COPD and implements interventions to improve testing, diagnosis, and medication adherence for those chronic conditions. Highmark BCBS WNY continues to maintain a comprehensive workplan for monitoring chronic condition management measures, to assess gap to goal performance and to track intervention outcomes and effectiveness. Highmark BCBS WNY conducts an educational and care coordination approach to engage members into care and attempt to reduce barriers to completion in screenings that include:	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				Disease management programming: Highmark BCBS WNY's disease management programs through 2020 and 2021 were designed and implemented, using an integrated and holistic care approach. Members are stratified into groups based on clinical risk using a predictive modeling tool. Members enrolled in Active management have complex, comorbid conditions, and work collaboratively with a nurse case manager using telephonic case management to develop a plan of care, and track progress towards meeting goals. Active management includes: ▪ Comprehensive Initial and Follow-Up Health Risk Assessments ▪ Provider notification upon active enrollment ▪ Collaborative care planning ▪ Monitoring and addressing identified HEDIS care gaps ▪ Ongoing provider collaboration as needed A higher percentage of eligible members considered to be at lower risk are enrolled in passive management and receive non-interactive interventions. Based on the monthly identification and stratification process, members may move between active and passive enrollment during the measure year. Passive management applies to a higher percentage of the eligible population and includes: ▪ A Passive Enrollment Package is mailed with our disease management contact information, an overview of the program, and condition-specific health information related to the member's condition and / or gap in care enclosed ▪ Members are offered the option to reach out and enroll in active management	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				▪ Motivational Interviewing techniques are incorporated in telephonic outreach, health risk assessments are offered, and care plans are developed. ▪ Engagement in programs changes throughout the year as members are lost due to eligibility requirements or contact, program completion or transfer to another internal or external program. In addition to disease management programming: ▪ Highmark continued to produce monthly live outbound calls to members and text messages in English and Spanish to discuss access, benefits, and education. A member services phone number is provided for members to outreach to the managed care plan for assistance in scheduling appointments, connecting members to care, and addressing needs such as transportation. ▪ Episodic case management is available to members with chronic care conditions issues requiring attention. ▪ The Healthy Rewards™ gift card incentive program is offered for members who get their diabetic services completed (HbA1c, retinal exam). ▪ The Network Relations and the Quality Management teams work collaboratively to close gaps in care by distributing gaps in care reports to individual provider groups with members within the eligible population for diabetes and high blood pressure and assisting in getting members services. ▪ Providers are encouraged to attend monthly educational webinars offering continuing medical education credits covering a range of topics including complete and accurate diagnosis coding, telehealth	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				services, addressing social determinants of health and improving patient experience. For members with chronic conditions, pharmacy programs have been in place since 2021 to optimize therapeutic outcomes and support adherence with medication management. The following interventions target members with diabetes and/or COPD through: ▪ Daily Late to Fill interactive voice response calls to members 2-14 days late in taking certain medications (including COPD and oral diabetes medications). ▪ Comprehensive medication review – Pharmacist will access medication profiles and contact prescribers for any safety and clinical care gaps. The goal is to improve adherence, address safety and identify care gaps in diabetics taking multiple medications. ▪ COPD Provider Fax-Daily faxes for members who were discharged from the emergency room but do not have evidence of a systemic corticosteroid prescribed within 14 days and a bronchodilator within 30 days following a hospitalization for COPD exacerbation. ▪ COPD Provider fax sent to provider to recommend testing for members with a new diagnosis of COPD who have not received spirometry testing to confirm the diagnosis. ▪ Diabetes Adherence and New Start Call- Outreach to members to discuss nonadherence to members on oral diabetes medications identified with < 80 percent adherence. The goal is to educate newly started members on the importance of taking medication as prescribed. New for 2022, a comprehensive population health workplan has been developed to address access to care	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				due to social barriers, analyze rates for chronic condition management of members with cardiovascular disease and disparities related to specific race/ethnicities and zip code analyses.	
The managed care plan should investigate opportunities to improve care for adolescents on antipsychotics.	X	X		Highmark BCBS WNY developed a behavioral health workplan in 2021 for monitoring our current performance and gap to goal for meeting HEDIS measures, including metabolic monitoring of adolescents using antipsychotic medication. Highmark BCBS WNY conducts an educational and care coordination approach to engage members into care and attempt to reduce barriers to completion in screenings that include: ▪ Members identified with a gap in pharmacy fills for antipsychotic medication receive an outreach call by the behavioral health case manager or outreach care specialist and if the member is enrolled in a health home, the health home case manager will be contacted. Members are educated about their current medications, importance of glucose and cholesterol testing, and availability of Healthy Rewards incentive for receiving lab tests. The Health Plan tracks the number of members who are eligible for the measure and those that were successfully outreached. ▪ Short message service/text campaigns will be deployed in the fourth quarter of 2022 to ensure that members receive a text reminder to complete metabolic monitoring and are made aware of the Healthy Reward incentive available to close the gap. As part of this effort, members who received outreach and those redeemed the incentive will be tracked.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				Provider-focused approaches to engage members into care and attempt to reduce barriers were implemented in 2022: ▪ Discharge Planning: the inpatient facility will receive an outreach call by the PH UM team to discuss discharge planning and notify them of the need for member follow up to discuss metabolic monitoring prior to discharge. ▪ Providers continue to receive gaps in care reports every quarter with the members who are non-compliant for the APM measure. The percent of provider groups receiving gaps in care reports will be tracked. ▪ A new Pay for Quality (P4Q) provider incentive program was also launched in the fourth quarter of 2022. Providers have the opportunity to earn $25 for every member that is non-compliant to antipsychotic measure receiving metabolic screening. ▪ Providers will receive a tip sheet listing all the behavioral health HEDIS measures via fax. The tip sheet will also be posted on the Provider-facing website. ▪ Providers continue to receive information about the Healthy Rewards incentives are available to members for metabolic testing if members are prescribed antipsychotic medication. ▪ The health plan believes that in some instances, the lab testing is bundled under a fee for service rate code. The managed care plan collects supplemental data including the lab testing measures to be uploaded to the Medical Record Database. The percentage of records received and requested are tracked.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				Highmark BCBS tracks intervention outcomes to assess effectiveness of the interventions outlined above.	
The managed care plan should investigate opportunities to improve members access to alcohol and other drug abuse treatments.	X	X	X	▪ Pharmacy programming is an important intervention for our members with substance use disorder including opioid use and alcohol use dependence. Clinical quality programs have been in place to optimize therapeutic outcomes for the managed care plan's members. Descriptions of the programs related to monitoring substance use disorder are as follows: CSUM or 'controlled substance utilization monitoring': This program includes provider alerts for members using multiple controlled substances or opioids, harmful combinations (opioids, benzodiazepines, and skeletal muscle relaxers), use of multiple claims from multiple prescribers using multiple pharmacies, and use of high doses >= 12 MME. Providers receive drug lists and emergency room/Urgent care visit information for high-risk members. ▪ Opioid medication management targeting members at high risk for opioid dependence and outlier prescribers. Providers receive monthly faxes identifying their high-risk members, pharmacists conduct telephonic outreach to prescribers. The managed care plan shares prescriber profiles showing aggregate quarterly prescribing patterns including an opioid prescription count and peer comparison profiles, % of new patients prescribed opioids, % of patients prescribed opioids for >30 days and opioid utilization summary for patients. ▪ Polypharmacy program to decrease the number of members with multiple psychotropics through monthly faxes with member utilization information and follow up calls to prescribers.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				The managed care plan also holds regular meetings with behavioral health agencies participating in the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program is designed for behavioral health providers, community mental health centers, and other high volume behavioral health providers participating in the managed care plan's network with membership attribution based on a 12-month retrospective active enrollment, with two behavioral health visits within 90 days with visits at least 15 days apart. ▪ The Behavioral Health Quality Improvement Program performance indicators include the quality measures for *Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* within seven days of discharge and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* within 14 days of diagnosis with a follow-up two or more additional services within 30 days of the initiation visit. ▪ Achievement of target rate for these measures includes points that are used to determine the maximum Behavioral Health Quality Improvement Program incentive payment. ▪ Providers receive a quarterly Behavioral Health Quality Improvement Program scorecard in 2021 and supporting member detail report. Highmark BCBS WNY developed a Behavioral Health Quality Improvement Workgroup in 2021 that continues into 2022.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				▪ Behavioral Health Quality Improvement Workgroup meetings are held quarterly with different business units to develop a comprehensive approach for member and provider outreach. ▪ The cross departmental workgroup monitors current performance and gap to goal for meeting HEDIS measures. These measures track care transitions after discharge from an acute setting and initiation of Medication Assisted Treatment for members newly identified with SUD. ▪ The workgroups also monitor monthly rates for measure performance, effectiveness of short message service/text and outbound call campaigns, Healthy Rewards incentives redemption, and community outreach events and engagement. A prevention-based approach has been implemented in which the managed care plan monitors the use the *Screening, Brief Intervention & Referral to Treatment* tool to identify members who need referrals for Alcohol and other substance use disorders. The following interventions are tracked monthly by the Population Health Management workgroup. ▪ Current *Screening, Brief Intervention & Referral to Treatment* claims are tracked and used to identify *Screening, Brief Intervention & Referral to Treatment* event volume by quarter, members receiving *Screening, Brief Intervention & Referral to Treatment* every quarter and percentage of members every quarter who had a subsequent follow up visit with an SUD diagnosis code on that follow up visit within 90-days of the *Screening, Brief Intervention & Referral to Treatment* screening.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				▪ A *Screening, Brief Intervention & Referral to Treatment* educational online seminar with continuing education credits was hosted in June 2022 and percentage of attendees was tracked. The online seminar included information on the billing codes available to administer a *Screening, Brief Intervention & Referral to Treatment* screening. ▪ An educational online seminar was held in March 2022 for Providers and Case Managers to learn about Project Teach™, a New York State Program to encourage consultation referrals from primary care clinicians for members with behavioral health conditions.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the measurement year 2019 operational survey conducted by the Department of Health.	X	X	X	As part of the measurement year 2019 operational survey, plans of correction were determined to be acceptable by the Department of Health on May 15, 2020. There is ongoing oversight of remediation plans by functional area sub-teams and compliance. Amerigroup provides monthly ongoing performance reports related to operational performance within its functional area sub-team. Results of those reports are reviewed and discussed monthly to ensure compliance with Medicaid standards. Ongoing and/or systemic issues are also escalated to the Amerigroup-Highmark Joint Operations Committee and to Compliance. Areas that are regularly monitored to ensure compliance include: Provider Credentialing monitoring: Education on credentialing is completed with the network team when a new associate is hired. Training on credentialing process and acceptable turnaround time is also presented at this time.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				New associate training also includes courses that are specific to credentialing policy, process, and systems. Following completion of those courses, the new associate is trained on specific task related responsibilities and will shadow an experienced associate for several weeks with oversight from a Credentialing Lead and Manager. New work is assigned along with 100% quality of all completed work for at least 6 months coupled with frequent meetings to address any questions or concerns. Ongoing training occurs in weekly Credentialing Lead meetings and monthly staff meetings. Annually, all policies and processes are reviewed with staff along with any state specific requirements. In addition, we have a team leads who help instruct the team in the event of any new criteria or regulation and are prepared to create any new documentation or training needs that then is relayed to the team. Turnaround time is reported on a quarterly cadence to the Medical Advisory Committee and the Quality Advisory Committee and is shared with the network relations team where a review of appropriate turnaround time is presented. Training on timeframes for processing grievances and appeals: New team members are educated on turnaround times and contractual operational standards prior to being assigned complaints. 100% of complaint resolution notices are reviewed daily, prior to mailing. Amerigroup's Grievance and Appeal managers, along with Vendor Oversight team, conducted education on contractual standards including turnaround times with its	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				delegated entities. Any ongoing performance reports or systemic issues are monitored monthly through the Amerigroup-Highmark Joint Operations Committee.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	▪ Highmark BCBS WNY established an inter-departmental member experience/CAHPS improvement workgroup to monitor the survey results and to strategize, implement and track interventions. This workgroup will continue to meet quarterly. ▪ A basic CAHPS training is offered annually to all managed care plan employees with the goal to ensure that all Highmark BCBS WNY associates understand what CAHPS is, why it is important and how they can impact the results. Reminders are delivered quarterly to complete the training. This intervention will continue into 2023 and a more in-depth training is being developed for all member-facing associates, expected to launch in Q1 2023. Highmark BCBS WNY tracks the names of associates who have completed the training and is implementing a process in the 4th quarter of 2022 to engage with those associates who have not taken the training to encourage timely completion. ▪ The Healthy Rewards Incentive program was launched in the 4th quarter of 2022. This program offers incentives to members for completing needed health services. The program was designed to improve member satisfaction and increase quality scores. In the 3rd quarter of 2021, an internal training around the Healthy Rewards program was developed and launched to the managed care plan's member facing associates. Highmark BCBS WNY expects that with more internal associates aware and familiar with the program and encouraging them to	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Highmark BCBS WNY's Response	IPRO's Assessment of Highmark BCBS WNY's Response
				discuss it with the members, the enrollment and engagement in the Healthy Rewards program will increase. Monthly activity reports for the Healthy Rewards program are available to Highmark BCBS WNY to track this intervention. This training continues to be offered as the need arises. Additionally, the Healthy Rewards program offerings are reviewed regularly to ensure that the maximum benefit is being offered to Highmark BCBS WNY members, and any program updates are shared and discussed with the team as they occur. ▪ In the second quarter of 2021, Highmark BCBS WNY launched a claim triggered post-visit text message survey for members who had a visit with either a primary care provider or a specialist within the last 60 days. The goal is to assess the member's experience with getting care, their rating of their provider and their overall health care. For 2022, Highmark BCBS WNY began extracting and analyzing the survey data to identify trends and define the specific criteria needed to begin implementing interventions at the provider level, if necessary. This intervention will continue through 2023. ▪ Providers are offered an annual CAHPS and improving the patient experience web-based live training. The invitation is distributed via email, provider portal, fax and it is posted on the public website. Highmark BCBS WNY has the ability to track registration, attendance, and feedback from attendees. The training is reviewed and updated annually by the managed care plan as needed and feedback from the providers is taken into consideration when scheduling.	

Strengths, Opportunities for Improvement, and Recommendations

Table 72: Highmark BCBS WNY's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Highmark BCBS WNY's measurement year 2021 performance improvement project passed validation.	X	X	X
	Highmark BCBS WNY exceeded the target rate for one performance indicator related to blood lead screening.	X	X	X
	Highmark BCBS WNY exceeded target rates for two performance indicators related to newborn hearing screening.	X	X	X
	Highmark BCBS WNY exceeded the target rate for one performance indicator related to developmental screening.	X	X	X
Performance Measures	Highmark BCBS WNY met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Highmark BCBS WNY performed significantly better than the mainstream Medicaid program on four measures of effectiveness of care related to primary care, children's health, substance use, or mental health.	X	X	
Performance Measures – Access/Availability of Care	Highmark BCBS WNY performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to children's health or substance use.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Highmark BCBS WNY performed significantly better than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Highmark BCBS WNY was in compliance with seven standards of *42 Code of Federal Regulations Part 438 Subpart D*.	X	X	X
Quality-of-Care Survey	Highmark BCBS WNY performed significantly better than the mainstream Medicaid program on two measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	Highmark BCBS WNY did not meet target rates for five performance indicators related to blood lead screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Highmark BCBS WNY did not meet target rates for four performance indicators related to newborn hearing screening.	X	X	X
	Highmark BCBS WNY did not meet target rates for five performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	Highmark BCBS WNY performed significantly worse than the mainstream Medicaid program on seven measures of effectiveness of care related to primary care or mental health.	X	X	
Performance Measures – Access/Availability of Care	Highmark BCBS WNY performed significantly worse than the mainstream Medicaid program on one measures of access/availability of care related to maternity care.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Highmark BCBS WNY was not in full compliance with four standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E* 438.330.	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Highmark BCBS WNY should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Highmark BCBS WNY should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Highmark BCBS WNY should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Highmark BCBS WNY should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	compliance findings. Highmark BCBS WNY should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.			
Quality-of-Care Survey	Highmark BCBS WNY should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

HIP

Performance Improvement Project Summary and Results

Table 73: HIP's Performance Improvement Project Summary, Measurement Year 2021

HIP's Performance Improvement Project Summary
Title: KIDS Quality Agenda Performance Improvement Project Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim HIP aimed to address the topics of blood lead testing and follow-up, newborn hearing screening and follow-up, and developmental screening.
Member-Focused 2021 Interventions ▪ Created an educational booklet for members containing information on requirements and recommendations for timely screening and follow-up related to blood lead testing, newborn hearing, and developmental delays. ▪ Executed a year-long communication strategy to engage members who recently delivered a baby and educate them on blood lead testing, newborn hearing screening, and screening for developmental delays. ▪ Encouraged members aged 15 to 45 years to utilize the Future Steps application to access information on lead screening and follow-up, newborn hearing, and developmental delays. ▪ Outreached via telephone to parents/guardians of members identified as having a blood lead level greater than 5 mcg/dl to facilitate the scheduling of follow-up appointments and to provide information as needed. ▪ Outreached via telephone to parents/guardians of members as failing a newborn hearing screening by 1 month of life and needing follow-up services for diagnostic audiological evaluation and early intervention.
Provider-Focused 2021 Interventions ▪ Created reference guides for providers containing information on specific recommendations and guidelines for lead screening and follow-up, newborn hearing screening and follow-up, developmental screening, and procedures for referring at-risk members to early intervention services. ▪ Collaborated with high-volume practice groups to encourage best practices for developmental screening and proper coding. ▪ Partnered with a group of providers to pilot an initiative aiming to improve documentation and coding for screenings. ▪ Partnered with Advantage Care Physicians of New York to leverage its point of care testing program, to improve the rate of lead screening.
Managed Care Plan-Focused 2021 Interventions ▪ Established the Neonatal Intensive Care Unit Care Management Program to monitor the progress of newborns during their neonatal intensive care unit stay and 1 year after discharge.

Table 74: HIP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	64.13%	61.11%	55.50%	55.08%	68.00%
Blood Lead Test at Age 2 Years	60.44%	60.80%	67.77%	60.22%	70.00%
Blood Lead Test at Ages 1 and 2 Years	44.95%	45.39%	44.92%	29.89%	50.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	22.73%	42.86%	30.00%	43.75%	50.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	1.07%	0.94%	0.80%	0.65%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	21.21%	42.86%	37.50%	38.46%	100.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.20%	0.21%	0.15%	0.17%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	37.50%	100.00%	33.33%	66.67%	100.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	82.18%	88.11%	86.90%	83.45%	95.00%
Failed Screening by Age 1 Month	0.98%	1.56%	2.40%	2.17%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	52.38%	32.35%	43.08%	38.89%	100.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	18.18%	18.18%	28.57%	9.52%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	21.74%	8.33%	9.18%	12.17%	80.00%
Screening Before Age 3 Months	65.80%	88.29%	89.75%	87.70%	95.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	75.86%	90.00%	92.96%	35.71%	95.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	23.08%	11.76%	28.00%	50.00%	80.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	10.54%	14.99%	18.21%	15.26%	25.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	16.24%	16.73%	19.23%	20.22%	25.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	6.17%	8.49%	7.70%	9.94%	25.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	10.90%	13.42%	15.24%	15.20%	20.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.00%	0.10%	1.01%	25.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	0.03%	1.01%	25.00%

Performance Measure Results

Table 75: HIP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	HIP Measurement Year 2019	HIP Measurement Year 2020	HIP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	56.85%	59.42%	60.07%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.04%	41.79%	42.15%	41.64%
Asthma Medication Ratio (5–64 Years)	56.65%	67.30%	64.06%	56.86%
Breast Cancer Screening	71.45%	69.06%	66.34%	64.75%
Cervical Cancer Screening	72.99%	67.46%	65.03%	69.19%
Chlamydia Screening in Women (16–20 Years)	76.16%	72.63%	74.10%	71.38%
Chlamydia Screening in Women (21–24 Years)	78.36%	71.72%	75.06%	74.13%
Colorectal Cancer Screening	64.29%	59.38%	61.79%	61.03%
Comprehensive Diabetes Care – Eye Exam	65.33%	58.05%	61.31%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	34.67%	45.12%	36.50%	34.74%
Controlling High Blood Pressure	62.09%	64.48%	66.58%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	37.70%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	78.12%	73.59%	72.41%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	50.28%	48.08%	45.22%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	78.48%	71.60%	71.78%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	70.32%	70.07%	66.91%	66.71%
Immunizations for Adolescents – Combination 2	39.17%	38.69%	35.52%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	84.67%	79.26%	84.45%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for	85.40%	76.30%	83.54%	84.17%

Measure	HIP Measurement Year 2019	HIP Measurement Year 2020	HIP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Children/Adolescents – Counseling for Nutrition				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	80.05%	73.70%	81.71%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	22.26%	17.11%	20.23%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.35%	70.95%	59.79%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.88%	72.78%	74.93%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	54.36%	48.53%	54.98%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	51.51%	57.37%	59.47%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	64.95%	54.64%	48.94%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	71.91%	72.31%	60.00%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	45.41%	36.31%	41.40%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	57.05%	50.02%	50.94%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	25.58%	20.06%	21.66%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	57.28%	40.63%	42.56%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	30.70%	Not Available	33.86%	43.80%

Measure	HIP Measurement Year 2019	HIP Measurement Year 2020	HIP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Access/Availability of Care – Maternity Measures				
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	79.64%	79.23%	87.20%
Prenatal and Postpartum Care – Postpartum Care	84.18%	75.77%	80.51%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	60.94%	62.12%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	75.72%	74.79%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	64.16%	69.68%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 76: HIP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021
438.206: Availability of Services	C	C	C
438.207: Assurances of Adequate Capacity and Services	C	C	C
438.208: Coordination and Continuity of Care	C	C	C
438.210: Coverage and Authorization of Services	C	C	C
438.214: Provider Selection	C	C	C
438.224: Confidentiality	C	C	C
438.228: Grievance and Appeal System	C	C	NC
438.230: Sub-contractual Relationships and Delegation	C	C	C
438.236: Practice Guidelines	C	C	C
438.242: Health Information Systems	C	C	C
438.330: Quality Assessment and Performance Improvement Program	C	C	C

C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- Based on staff interview and record reviews, HIP failed to issue final adverse determination notices that were factual in nature. *(Contract Article 4405 Health maintenance organization)*
- Based on staff interview and record review, of expedited appeals cases for commercial and Medicaid members, HIP failed to ensure that written and/or phone notice was provided to the member and/or provider when additional information was requested. *(Contract Article 4405(10), 98-2.9(b) Responsibilities of health care plans)*
- Based on staff interview and record review of the final adverse determination notices, HIP failed to ensure members enrolled in Medicaid received the correct appeal rights. *(Contract Article 98-2.9(b) § 4405 Health maintenance organizations)*

Quality-of-Care Survey Results – Member Experience

Table 77: HIP's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	HIP	Mainstream Medicaid Average	HIP	Mainstream Medicaid Average	HIP	Mainstream Medicaid Average
Getting Needed Care[1]	75.47%	78.71%	77.11%	81.33%	75.56%	78.54%
Getting Care Quickly[1]	75.67%	78.40%	78.80%	80.57%	70.45%	78.88%
How Well Doctors Communicate[1]	89.73%	90.95%	89.81%	92.00%	91.39%	92.04%
Customer Service[1]	89.02%	85.72%	82.13%	87.13%	82.54%	86.32%
Rating of All Health Care[2]	71.78%	76.50%	75.39%	75.33%	66.21%	72.83%
Rating of Personal Doctor[2]	77.55%	80.80%	84.57%	81.46%	80.82%	81.25%
Rating of Specialist Talked to Most Often[2]	76.35%	79.63%	80.40%	82.07%	78.26%	78.79%
Rating of Health Plan[2]	67.45%	75.93%	72.72%	75.90%	69.60%	73.47%
Rating of Treatment or Counseling[2]	58.14%	59.60%	63.28%	61.84%	66.09%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 78: HIP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		HIP implemented interventions during the project period 2019 – 2021 that impacted the results of the performance improvement project performance indicators. Three out of six lead screening performance indicator rates increased from baseline to the final measurement period. Three out of six hearing screening performance indicator rates increased from baseline to the final measurement period. All six of the developmental screening performance indicator rates increased from baseline to the final measurement period. Interventions developed during the project period, such as both member and provider booklets, focused on all performance improvement project indicators. These booklets which established a foundation of education for physicians and members were sent to physicians and members during the project and were made available on HIP's website. The booklets on the website remain a resource available to physicians and members. The Healthy Futures/NICU Care Management Program which was in place prior to the execution of the performance improvement project, monitored the progress of newborns throughout the duration of the performance improvement project. The program is still available to applicable members. Lead screening was recently added to the Care Management system as a potential measure gap for members being case managed by the Healthy Futures/NICU Care Management team.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				The Point of Care Lead testing pilot program that HIP partnered with AdvantageCare Physicians of New York on grew from one pilot site at the start of the program and performance improvement project to over forty-five sites by the completion of the project. The Point of Care Lead Testing program is still active and is successful. In addition to the interventions implemented during the duration of the performance improvement project, HIP took additional steps to further improve lead screening, hearing screening of newborns and developmental screening. The managed care plan published an article titled *Have You Heard About Universal Newborn Hearing Screening?* in the managed care plan's August 2022 *Office Visit* provider newsletter which highlighted the American Academy of Pediatrics's recommendations for newborn hearing screening and follow-up, helpful tips, a link American Academy of Pediatrics's Early Hearing Detection and Intervention webpage and information to include when referring the child to the early intervention program. In response to the Early Hearing Detection and Intervention/Newborn Hearing Screening and Early Intervention Program document distributed by the Department of Health, HIP developed a Hearing Screening workgroup to address the requirements as outlined in the document and to identify opportunities in which the managed care plan can help ensure that hearing screenings are being conducted. The workgroup developed a Monitoring Hearing Screening and Early Intervention Operational Process to monitor and ensure its participating practitioners are conducting newborn hearing screening and referring newborns diagnosed with	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				hearing loss for early intervention. The Quality Management Data Analytics and Reporting team developed a proxy measure so a report can be generated bi-annually for the Quality team to monitor and identify participating practitioners who are not meeting the identified targets. The measure developed by the Quality Management Data Analytics and Reporting team will be added to the monthly Quality Gap in Care report and monthly dashboard data, so practitioners are receiving actionable data throughout the year. Once the hearing measure is added to the monthly gap in care report, the measure including best practices and tips will be added to the Quality Measure Resource Guide that is distributed to practitioners. The Quality team will work with the Provider Network Population Health Department to determine appropriate interventions which could include but are not limited to emails, letters and/or meetings with the practitioners. Communications will include clinical practice guidance regarding the importance of screening and references to resources and best practices. Any significant issues uncovered will be reported to the designated Relationship Manager in the Provider Network Population Health Department to help drive performance improvement. For any issues that continue, reporting will be transferred to Credentialing to review and take corrective action if necessary. Additionally, the Hearing Screening report and data will be presented at least annually to the Quality Improvement Committee. Interventions, activities, and results will be tracked via the Quality Improvement Program Work Plan and included in the annual Quality Improvement Program Evaluation.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				HIP updated its Pediatric and Adolescent Preventive Services guidelines to include Hearing Loss Screening: Recommendations and Guidelines, available online for Practitioners to reference. Practitioners are notified of any changes or updates to Preventive Service Guidelines or Clinical Practice Guidelines in the monthly *Office Visit* newsletter. The Early Hearing Detection and Intervention (EHDI)/Newborn Hearing Screening (NHS) and Early Intervention Program (EIP) guidelines, workflow, best practices, and resource document provided by the Department of Health will also be added to HIP's website. HIP reviews and updates its Monitoring and Screening for TB, STDs, and Lead Poisoning operational process every two years unless a clinical guideline recommendation was implemented. Bi-annually a lead screening report is generated by the Quality Management Data Analytics and Reporting team and is reviewed by the Quality Improvement team to identify participating practitioners who are not meeting the identified targets. The Quality Improvement team will work with the Provider Network Population Health Department to determine appropriate interventions which could include but are not limited to emails, letters and/or meetings with the practitioner. Communications will include clinical practice guidance regarding the importance of screening and references to resources and best practices. Any significant issues uncovered will be reported to the designated Relationship Manager in the Provider Network Population Health Department to help drive performance improvement. Any issues that continue will be transferred to Credentialing to review and corrective action if necessary. Quality gap in care and dashboard data focused on preventive care are sent to practitioner groups/providers	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				monthly to ensure they are receiving actionable data throughout the year. The guidelines for the *Prevention, Identification, and Management of Lead Exposure in Children* and guidelines for *Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening* are reviewed, updated, and approved by the managed care plan's Medical Policy Committee every two years unless guidelines have changed. The guidelines are included in the Pediatric and Adolescent Preventive Services guidelines available on the managed care plan's website. Changes made to the guidelines are communicated to practitioners through the monthly *Office Visit* provider newsletter. Developmental Screening is a new HEDIS measure for measurement year 2022, therefore HIP will incorporate it into the Quality Resource Guide that is distributed to providers, as well as look at other opportunities to increase developmental screening and follow-up amongst its population.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve adolescent members receiving required immunizations.	X	X		HIP recognizes the importance of its members getting the appropriate care. HIP uses targeted processes and methodology for conducting and evaluating quality improvement activities that include baseline measurement, root cause-barrier analysis, development, and implementation of appropriate interventions to address the barriers, and re-measurement utilizing valid statistical analyses to determine the impact of interventions. HIP continues to monitor HEDIS® rates monthly to identify lower-than-anticipated performance against the goals and implement interventions as needed. Performance, goals, and	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				indicators are monitored through the quality committee structure and senior leadership steering committees. HEDIS reports are available to staff involved in specific performance improvement activities as well as those staff who oversee departments whose work impacts HEDIS measures. HIP continues its efforts to engage more members, providers, and employees in the quality process. HIP continues to implement interventions to improve its preventive care measures, including immunization measures for adolescents that perform below statewide average. Key interventions include but are not limited to partnering with provider groups and sharing educational tip sheets/guides as well as monthly gaps in care reports, collaboration with internal stakeholders, data exchange with providers and vendors, and improvements in data capture. Providers also receive a Quality Resource Guide with measure specifications, best practices, and helpful tips. Also, Adolescent Immunizations was included in the 2021 and 2022 Provider Quality Incentive Program. Immunizations for Adolescents was added to the Care Management system as a gap in care. Parents and/or guardians of adolescents are reminded of the importance of vaccines for adolescents which should be given at various stages in the adolescent's life to prevent infectious diseases and other illnesses. This is communicated to parents and/or guardians through digital Health Touch communications, directing them to applicable immunization schedules. HIP created a centralized member outreach team named the "Hub." The Hub telephones members with gaps in care to encourage them to receive needed services. Immunizations	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				for Adolescents is one of the many measures included in the gaps in care outreach.	
Although some rates for respiratory infections and diabetes have improved from 2019 to 2020, rates continue to remain significantly below the statewide averages. The managed care plan should investigate additional opportunities to improve these HEDIS measures.	X	X		HIP uses targeted processes and methodology for conducting and evaluating quality improvement activities that include baseline measurement, root cause-barrier analysis, development and implementation of appropriate interventions, and re-measurement utilizing valid statistical analyses to determine the impact of interventions. HIP continues to monitor HEDIS/Quality Assurance Reporting Requirements rates monthly to identify lower-than-anticipated performance against the goals and implements interventions as needed. Performance, goals, and indicators are monitored through the quality committee structure and senior leadership steering committees. Efforts continue to make HEDIS/Quality Assurance Reporting Requirements reports available to staff involved in specific performance improvement activities as well as those staff who oversee departments whose work impacts HEDIS/Quality Assurance Reporting Requirements measures. HIP continues its efforts to engage more members, providers, and employees in the quality process. Diabetes HIP encourages members diagnosed with diabetes to control their HbA1c levels and to get appropriate diabetic testing/screenings. Members are prompted to get screened through Health Touchpoint emails, member education, support, outreach, and access to resources for disease management. Members are encouraged to control their HbA1c levels as well as to get appropriate screenings across several Care Management programs. Furthermore, members have access to Neighborhood Care centers where members are provided in-person and virtual customer support, free	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				wellness classes, access to community resources, and programming to help the community learn more about managing diabetes. Diabetes measures are included in the provider quality incentive program to encourage providers to outreach their members with gaps in care in diabetes management and testing measures. Providers are expected to reach specific targets to receive the incentive. A Provider Incentive Tip Sheet is provided to eligible providers to highlight tips and best practices to improve care. A Quality Measure Resource Guide contains education on use of CPT II codes to capture A1c results. Some providers are beginning to change billing practices to submit claims with the CPT II codes. Additionally, diabetes blood sugar control continues to be an important metric built into value-based contracts. Engagement with eligible providers continues. Providers were set up to access gap in care reporting via a reporting tool (Tableau) in 2022. This allows providers to review their progress towards meeting goals and closing gaps in care. Providers exchange supplemental data with the managed care plan. Identification of improvement opportunities and collaboration on initiatives to close gaps in care continues. In addition, dedicated quality relationship managers work closely with large provider groups to improve member receipt of care. The Quality Improvement team has identified data gaps where claims were submitted with no A1c value. These targeted lists are shared with high volume providers to try and obtain the A1c reading through supplemental data. For much of 2020, members could not access physician offices due to COVID-19 pandemic restrictions, limited	

<table>
<tr><th>2020 External Quality Review Recommendation</th><th>Quality</th><th>Timeliness</th><th>Access</th><th>HIP’s Response</th><th>IPRO’s Assessment of HIP’s Response</th></tr>
<tr><td></td><td></td><td></td><td></td><td>physician availability, and changed member priority from receiving health services to self-preservation. In CY 2021, services continued to be limited resulting in limited services members could receive thereby impacting member receipt of care and services that inevitably impacted performance rates.

All diabetes measures improved from calendar year 2020 to calendar year 2021. The Diabetes HbA1c Testing rate increased by 6.36 percentage points calendar year 2020 to calendar year 2021. Diabetes HbA1c Poor Control improved because the rate decreased by 8.62 percentage points calendar year 2020 to calendar year 2021. Diabetes HbA1c Control (<8%) increased by 7.43 percentage points calendar year 2020 to calendar year 2021. Diabetic Eye Exam rate increased by 3.26 percentage points calendar year 2020 to calendar year 2021. Diabetes – Blood Pressure Control increased by 5.22 percentage points calendar year 2020 to calendar year 2021. The HbA1c Testing measure and Diabetic Eye Exam measure did not meet the Statewide Average in calendar year 2020. Both measures however exceeded the Statewide Average in calendar year 2021. See table below.

<table>
<tr><th rowspan="2">Diabetes Measure (Medicaid)</th><th colspan="2">Calendar Year 2020</th><th colspan="2">Calendar Year 2021</th></tr>
<tr><th>Plan Rate</th><th>State-wide Average*</th><th>Plan Rate</th><th>State-wide Average*</th></tr>
<tr><td>HbA1c Testing</td><td>82.93%</td><td>92.00%</td><td>89.29%</td><td>87.00%</td></tr>
<tr><td>HbA1c Poor Control (Lower rate is better)</td><td>45.12%</td><td>n/a</td><td>36.50%</td><td>n/a</td></tr>
</table>
</td><td></td></tr>
</table>

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response

HbA1c Control (<8%)	46.83%	n/a	54.26%	n/a
Diabetic Eye Exam	58.05%	63.00%	61.31%	57.00%
Diabetes – Blood Pressure Control (<140/90)	54.39%	n/a	59.61%	n/a

* Per eQuality Assurance Reporting Requirements

HIP continues to implement initiatives to improve Comprehensive Diabetes Care measures. A diabetes workgroup was formed in 2021 that continues to focus on health care disparities. HIP also holds Health Expos and collaborates with local community pantries and farmers markets in the diverse communities it serves to provide members with access to healthy foods.

Respiratory infections

HIP encourages members diagnosed with respiratory conditions on how to manage their conditions with appropriate medication management. For example, members diagnosed with asthma are educated on the important role of controller medications in managing symptoms. Members are encouraged to accomplish this through member newsletters, blog posts, and informational mailings. HIP continues to implement initiatives to help members manage their respiratory conditions.

HIP works closely with large provider groups exchanging monthly patient-level detailed reports.

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				Managing Respiratory Conditions for Adults measures as noted in eQuality Assurance Reporting Requirements 2021, such as *Asthma Medication Ratio* (Ages 19-64), *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, *Pharmacotherapy Management of COPD Exacerbation-Corticosteroid* and *Pharmacotherapy Management of COPD Exacerbation-Bronchodilator* are all included in the monthly gaps in care reports shared with provider groups. These measures are also included in the Quality Measure Resource Guide that is shared with providers. The guide provides details about each measure, best practices, and helpful tips.	
The managed care plan should continue with its current interventions to improve follow-up care for members with mental illness and substance use disorders as rates are trending upwards.	X	X		HIP continues to recognize the importance of members receiving appropriate follow-up care after being hospitalized for mental illness or substance use. HIP works closely with contracted behavioral health services to improve outpatient follow-up care after a mental health inpatient admission and to identify barriers to treatment. A root cause-barrier analysis was conducted, and member, provider and plan barriers were identified. To address barriers HIP identified, HIP educates hospitals on best practices for continuity of care, such as scheduling follow-up appointments, as well as share performance data and establishes action plans to improve performance. Additionally, hospital staff who habitually discharge patients with less-than-ideal discharge plans are educated on providing an actionable discharge plan. Inpatient social workers confirm the members phone number(s) on record so that members can be called following inpatient care to encourage keeping the appointments scheduled by the inpatient social worker and/or to reschedule the appointment. HIP Quality Management staff educate Case Management, Health Homes, and Care Management Agency staff on best	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				practices for following up with members post-hospital discharge to ensure they keep their appointments, help with resources and transportation needs. Monthly, HIP securely transmits patient level detail reports and accompanying dashboards for quality analysis and review to contracted behavioral health services which receives a data exchange of daily inpatient discharge reports from HIP to identify inpatient stay and needed follow-up care. Behavioral health services implemented weekly clinical/quality meetings to address quality measures and escalation for at-risk population. This meeting is attended by the contracted vendor's clinical, quality, and provider network teams. This transition of care collaboration happens twice weekly to explore a hands-on process to connect with members who are being discharged from inpatient care. Additionally, HIP monitors continuity and coordination of care between medical and behavioral health care by collaborating with behavioral healthcare practitioners and using information at its disposal to improve the coordination of care between medical and behavioral health care. This is critical to the well-being of members with co-morbid conditions. It is important that health care systems have comprehensive mechanisms in place to ensure systemic, multi-disciplinary care. The lack of such mechanisms results in poor continuity placing patients at risk for poor health outcomes. HIP's behavioral health vendor conducts an annual audit of high-volume behavioral health practitioners to assess the prevalence of information exchange with medical practitioners. This is accomplished through a random sample auditing records to see if medical records contain completed Release of Information authorization forms and if actual medical record information was received and reviewed.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				Overall coordination between medical and behavioral health improved from 2020 to 2021 as evidenced by the results meeting goals in the table below. Metric: Percent of records with signed authorizations for return on investment - Total Goal: 31% 2020: 43.2% (187/433) 2021: 47.1% (214/454) Goal Met in 2020: Yes Statistical Significance: No statistical significance Metric: Adult Goal: 31% 2020: 35.2% (116/330) 2021: 37.5% (138/370) Goal Met in 2020: Yes Statistical Significance: No statistical significance Metric: Child/Adolescent Goal: 31% 2020: 68.9% (71/103) 2021: 90.5% (76/84) Goal Met in 2020: Yes Statistical Significance: Statistically significant increase Metric: Percent of records where actual medical information was received and reviewed - Total Goal: 40% 2020: 44.8% (159/355) 2021: 45.4% (206/454) Goal Met in 2020: Yes	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				Statistical Significance: No statistical significance Metric: Adult Goal: 40% 2020: 41.5% (107/258) 2021: 40% (148/370) Goal Met in 2020: Yes Statistical Significance: No statistical significance Metric: Child/Adolescent Goal: 40% 2020: 53.6% (52/97) 2021: 69% (58/84) Goal Met in 2020: Yes Statistical Significance: Statistically significant increase A tip sheet highlighting when a provider can conduct telehealth visits to allow them more flexibility to provide quality of care for patients is shared with provider groups as well as posted to the Quality Provider website. Monthly, the HIP Quality team conducts clinical quality meetings to discuss quality improvement activities, member outreach engagement strategies, barriers to care, and opportunities to improve behavioral health quality care. HIP's Medicaid Care Management team and Member Outreach Hub will outreach members enrolled in a health home or in complex case management who had a hospital discharge visit for mental illness, using telephone calls to assist with scheduling, as an illustration of best practices for follow-up care post discharge. Also, to assist with social determinants of health needs such as transportation. HIP continues to improve performance in the follow-up care measures.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				(table below)	

Measure	CY 2019	CY 2020	CY 2021
Follow-Up after Hospitalization for Mental Illness: 7-Day	41.82%	55.08%	56.49%
Follow-Up after Hospitalization for Mental Illness: 30-Day	57.23%	71.69%	71.57%
Follow-Up After Emergency Department for Mental Illness: 7-Day	53.45%	47.80%	54.97%
Follow-Up After Emergency Department for Mental Illness: 30-Day	65.57%	62.22%	65.65%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day	22.26%	17.11%	20.23%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day	27.51%	22.71%	24.97%
Follow-Up After High-Intensity Care for	29.69%	32.45%	36.09%

<table>
<tr><th>2020 External Quality Review Recommendation</th><th>Quality</th><th>Timeliness</th><th>Access</th><th>HIP’s Response</th><th>IPRO’s Assessment of HIP’s Response</th></tr>
<tr><td></td><td></td><td></td><td></td><td><table><tr><td>Substance Use Disorder: 7-Day</td><td></td><td></td><td></td></tr><tr><td>Follow-Up After High-Intensity Care for Substance Use Disorder: 30-Day</td><td>49.78%</td><td>53.55%</td><td>56.66%</td></tr></table>
Barrier analysis will continue to be conducted to identify additional opportunities for improvement. HIP will continue to implement initiatives to improve the follow-up care measures.</td><td></td></tr>
<tr><td>The managed care plan should investigate opportunities to improve members access to dental and prenatal care.</td><td>X</td><td>X</td><td>X</td><td>Prenatal
HIP offers the Healthy Futures Pregnancy Program to its pregnant members. The program is a comprehensive and integrated care management model to address members prenatal care needs. A multidisciplinary team approach is taken to address the needs of eligible pregnant women and their newborn during and after pregnancy. HIP also offers the Neonatal Intensive Care Unit Care Management Program to address the needs of compromised newborns through one year of age. Newborns are monitored while confined to the neonatal intensive care unit. Care managers work collaboratively to address the needs of compromised newborns and monitor their progress while receiving care. Neonates are also monitored post-discharge until goals are met or up to one year of age. Neonatal follow-up provides supportive services for high-risk infants. Mothers are referred for care management for postpartum check in, care coordination and referral to community resources.</td><td>Partially Addressed</td></tr>
</table>

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				The Healthy Futures Pregnancy Program and Neonatal Intensive Care Unit Care Management programs offer comprehensive family-centered holistic, seamless, and clinically robust wraparound support to mother and child. These programs proactively focus on identifying pregnant women who are at high risk for pregnancy-related complications not limited to hypertension or diabetes. Members are supported and provided with a dedicated care management staff member. An initial risk assessment, appropriate prenatal education and ongoing assessment are completed to monitor those who may have become high risk during and after the course of pregnancy. Member outreach includes educational materials and blog posts to reinforce the importance of prenatal and postpartum care. HIP works with high volume provider groups to identify and engage pregnant member in timely prenatal and postpartum care. The percentage of cases identified in 2021 was 48 percentage points higher than those cases identified in 2020. This was attributed to the merging of the Neonatal Intensive Care Unit Care Management and the Healthy Futures programs as well as the implementation of a bi-weekly clinical rounds meeting with the medical directors where high-risk cases from both programs were presented and discussed. This combined approach program will continue. Currently, HIP becomes aware of a pregnancy based on receipt of a claim for an obstetric service. The claim for this service can be delayed by 30-60 days. Also, many members delay initiating prenatal care until the end of the first trimester. This late identification of a pregnancy hinders HIP's ability to encourage a pregnant member to initiate prenatal care before the end of the first trimester. HIP will conduct	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				additional analysis to identify opportunities to try to improve on receipt of notification of a pregnancy. HIP will continue to offer its Healthy Futures/ Neonatal Intensive Care Unit Care Management Program to eligible members. *Timeliness of Prenatal Care* and *Postpartum Care* rates will be monitored monthly. Additional interventions will be implemented as needed to further improve the rates. Prenatal care continues to be an important metric built into value-based contracts. Engagement with eligible providers continues. **Dental** HIP recognizes the importance of children going for regular dental visits. Regular dental visits help keep children's mouths healthy and helps identify issues before any serious problems arise which could impact the child's overall physical health. Members may lack the education and awareness regarding the importance of preventive dental care. Through data analysis HIP identified disparities in receipt of dental care for members 2 to 18 years of age. Compared to the white population, other races were more likely to not attend regular preventive dental visits and have trouble in finding a provider that speaks their languages. In 2022, HIP contracted with a new dental provider. The new dental provider provides screening for children at annual Health Expos and quarterly scheduled events for gap closure in neighborhoods where racial disparities exist. The new dental provider will outreach members to encourage receipt of dental care. Potential outreach may include:	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				National Children's Dental Health Month Flyer: Tips for a healthy smile/facts about teeth geared towards child audience. Dental School Note: A note will be sent to parents whose children have not had a dental visit in the past year; to encourage parents to schedule a dental visit for their child(ren) with a local dental provider. HealthPlex will partner with various schools as part of their outreach, and the school will distribute the letters to parents. "Healthy Mouth" annual Flyer: Tips for a healthy mouth and information for parents on how to protect their child(ren)'s teeth at every stage: infant, child, teen Medicaid Managed Care/Child Health Plus Benefits Flyer Automated calls to members in the HEDIS denominator who may have gaps in care as evidenced by no claim or encounter received. Gap in care closure. The annual dental visit measure is included in the provider quality incentive program to encourage providers to outreach their members with gaps in care. Providers are expected to reach specific targets to receive the incentive. A Provider Incentive Tip Sheet is provided to eligible providers to highlight tips and best practices to improve care. Additionally, the annual dental visit measure continues to be an important metric built into value-based contracts. Engagement with eligible providers continues. Providers are being reminded and encouraged to use telehealth services to help close gaps in services and to increase member compliance. Information on related policies and reimbursement is made available to providers. A telehealth tip sheet is sent to providers highlighting when a	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				provider can conduct telehealth visits to allow them more flexibility to provide quality of care for patients. It will be shared with provider groups as well as posted to the Quality Provider website.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	HIP conducts an analysis of member experience information to help identify member experience with services and to identify opportunities for improvement, set priorities, decide which opportunities to pursue and to initiate actions to improve performance. HIP monitors multiple aspects of member experience, including but not limited to member complaints, member appeals and member experience surveys using relevant CAHPS data. CAHPS is a survey designed to capture member experiences with their doctors and health plans. CAHPS question responses analyzed include *Customer Service*, *Getting Care Quickly*, *Getting Needed Care*, *How Well Doctors Communicate*, *Care Coordination*, *Rating of Doctor*, *Rating of Health Care*, *Rating of Health Plan* and *Rating of Specialist*. As a result of the analysis conducted on applicable CAHPS questions, HIP developed action plans to target improvements in key metrics. Activities implemented or scheduled to be implemented to improve member experience includes but is not limited to: ▪ Launched a new member portal for members to access benefit information, claims, and other health plan information. ▪ CAHPS Provider Tip Sheet; this tip sheet includes recommendations and helpful resources for improvement.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	HIP's Response	IPRO's Assessment of HIP's Response
				▪ New Member Survey which addresses member understanding and knowing how to access information about benefits and policies. ▪ Pilot survey of staff experience with language services for organizational functions in 2021. The 2022 survey was fielded in October. ▪ Pilot survey of member experience with language services during health care encounters to assess member satisfaction with verbal and written translations was fielded in October 2022. ▪ Pilot survey of member experience with translations was fielded in October 2022. ▪ Survey with Member Satisfaction with Providers resulting in physician receiving information about member satisfaction with their practice. ▪ Member satisfaction with the cultural diversity of the network, fielded yearly, provides information regarding member satisfaction with physician, specialists, and behavioral health practitioners. ▪ CAHPS metrics in value-based contracts and/or Provider Quality Incentive Program for 2023. ▪ Quality Leadership team reviews CAHPS results and data to determine next steps regarding barriers and prioritizing opportunities.	

Strengths, Opportunities for Improvement, and Recommendations

Table 79: HIP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	HIP's measurement year 2021 performance improvement project passed validation.	X	X	X
Performance Measures	HIP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	HIP performed significantly better than the mainstream Medicaid program on three measures of effectiveness of care related to primary care.	X	X	
Performance Measures – Access/Availability of Care	HIP performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to primary care.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, HIP was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	HIP did not meet target rates for six performance indicators related to blood lead screening.	X	X	X
	HIP did not meet target rates for six performance indicators related to newborn hearing screening.	X	X	X
	HIP did not meet target rates for six +performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	HIP performed significantly worse than the mainstream Medicaid program on three measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	HIP performed significantly worse than the mainstream Medicaid program on three measures of access/availability of care related to children's health, substance use, or maternity care.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Utilization and Risk Adjusted Utilization	HIP performed significantly worse than the mainstream Medicaid program on two measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, HIP was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	HIP performed significantly worse than the mainstream Medicaid program on two measures of member satisfaction.	X	X	X
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, HIP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	HIP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, HIP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	HIP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	HIP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

IHA

Performance Improvement Project Summary and Results

Table 80: IHA's Performance Improvement Project Summary, Measurement Year 2021

IHA's Performance Improvement Project Summary
Title: Optimizing Childhood Development in the First 1000 Days Through Early Intervention Initiatives Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim IHA aimed to increase lead screening rates and link children with elevated blood lead levels under age 5 years to critical treatment; to align with the Centers for Disease Control and Prevention's Early Hearing Detection and Intervention Program and the 1-3-6 recommendations that support universal newborn hearing screening and detection and follow-up treatment services for children identified with hearing loss; and to support community-level efforts for appropriate identification, and referral of young Medicaid-insured children in Erie County, New York, who are identified to be at risk for delays. Member-Focused 2021 Interventions ▪ Outreached via telephone followed by mailing to parents/guardians of children with high lead levels to schedule venous tests. ▪ Outreached and provided educational materials to parents/guardians reminding them to schedule second lead test. ▪ Outreached to parents/guardians of members who failed the newborn hearing screening with a reminder to complete the diagnostic audiological evaluation within 3 months. ▪ Utilized social media to increase member educational outreach on leading testing, hearing screening, and developmental milestones. Provider-Focused 2021 Interventions ▪ Conducted in-person and online training session for providers on guideline recommendations, available screening tools, management of patients, and appropriate coding. The Centers for Disease Control and Prevention guidelines, American Academy of Pediatrics recommendations, and information on accessing the New York Early Hearing Detection and Intervention Information System were presented. ▪ Tracked hospital pre-discharge newborn screenings and ensured results were made available to each member's primary care provider. ▪ Issued listings of members who did not complete the newborn hearing screen within 3 months of life. ▪ Informed providers of community initiatives that assist with service coordination, linkages to community agencies, and patient education.

Table 81: IHA's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	85.65%	87.72%	86.15%	93.20%	90.00%
Blood Lead Test at Age 2 Years	86.80%	90.07%	90.52%	84.98%	90.00%
Blood Lead Test at Ages 1 and 2 Years	72.47%	78.68%	82.43%	62.30%	80.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	22.07%	23.10%	37.04%	38.38%	30.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	5.18%	5.03%	4.52%	3.73%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	38.92%	37.81%	29.55%	22.97%	75.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	1.06%	0.97%	1.08%	0.84%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	27.17%	26.95%	16.67%	5.45%	50.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	89.85%	93.28%	93.65%	90.70%	99.00%
Failed Screening by Age 1 Month	0.94%	1.05%	0.90%	1.32%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	20.00%	23.08%	18.18%	37.50%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	50.00%	100.00%	100.00%	66.67%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	100.00%	100.00%	0.00%	100.00%	100.00%
Screening Before Age 3 Months	94.83%	95.54%	95.92%	96.13%	100.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	15.79%	15.79%	15.79%	25.00%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	100.00%	Denominator=0	66.67%	100.00%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	4.55%	7.59%	23.04%	39.78%	32.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	34.43%	37.00%	42.04%	52.20%	44.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	33.24%	34.18%	40.41%	50.13%	43.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	24.21%	26.25%	35.08%	47.56%	32.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.09%	4.75%	17.65%	28.76%	25.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.84%	3.30%	15.24%	25.00%

Performance Measure Results

Table 82: IHA's Performance Measure Results, Measurement Years 2019 to 2021

Measure	IHA Measurement Year 2019	IHA Measurement Year 2020	IHA Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.88%	54.38%	61.46%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	37.32%	39.21%	42.70%	41.64%
Asthma Medication Ratio (5–64 Years)	66.92%	66.56%	70.35%	56.86%
Breast Cancer Screening	70.32%	65.75%	61.27%	64.75%
Cervical Cancer Screening	75.72%	72.20%	69.85%	69.19%
Chlamydia Screening in Women (16–20 Years)	69.03%	65.85%	67.40%	71.38%
Chlamydia Screening in Women (21–24 Years)	74.35%	74.28%	73.26%	74.13%
Colorectal Cancer Screening	57.42%	60.64%	60.80%	61.03%
Comprehensive Diabetes Care – Eye Exam	65.21%	61.27%	65.19%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	25.82%	32.15%	26.42%	34.74%
Controlling High Blood Pressure	67.01%	66.42%	68.19%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	41.42%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	69.39%	73.44%	77.34%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	41.77%	42.47%	30.43%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	88.02%	81.97%	77.40%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	83.45%	76.37%	76.89%	66.71%
Immunizations for Adolescents – Combination 2	36.05%	43.31%	44.04%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	94.89%	94.69%	96.86%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	91.48%	92.75%	94.97%	84.17%

Measure	IHA Measurement Year 2019	IHA Measurement Year 2020	IHA Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	86.86%	90.82%	91.82%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	24.07%	28.57%	25.35%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	56.04%	55.34%	59.17%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.83%	73.86%	73.96%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	77.78%	78.29%	79.22%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	60.00%	68.53%	65.15%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	53.00%	55.95%	54.03%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	63.01%	64.29%	73.17%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.84%	34.58%	31.40%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	47.51%	47.43%	44.71%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	23.99%	20.63%	16.75%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	70.81%	52.00%	55.60%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	30.77%	Not Available	37.13%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	IHA Measurement Year 2019	IHA Measurement Year 2020	IHA Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	92.21%	92.96%	87.20%
Prenatal and Postpartum Care – Postpartum Care	77.86%	80.05%	81.85%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	72.96%	75.15%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	88.27%	82.75%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	72.28%	72.80%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 83: IHA's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	C	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	C	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements.

Quality-of-Care Survey Results – Member Experience

Table 84: IHA's Adult CAHPS Results, Measurement Years 2017, 2019 and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	IHA	Mainstream Medicaid Average	IHA	Mainstream Medicaid Average	IHA	Mainstream Medicaid Average
Getting Needed Care[1]	81.53%	78.71%	82.37%	81.33%	84.29%	78.54%
Getting Care Quickly[1]	81.51%	78.40%	90.29%	80.57%	79.91%	78.88%
How Well Doctors Communicate[1]	93.59%	90.95%	92.54%	92.00%	94.17%	92.04%
Customer Service[1]	85.67%	85.72%	93.16%	87.13%	89.37%	86.32%
Rating of All Health Care[2]	79.14%	76.50%	78.62%	75.33%	76.08%	72.83%
Rating of Personal Doctor[2]	85.68%	80.80%	79.90%	81.46%	85.99%	81.25%
Rating of Specialist Talked to Most Often[2]	87.64%	79.63%	77.47%	82.07%	81.43%	78.79%
Rating of Health Plan[2]	80.88%	75.93%	79.57%	75.90%	80.51%	73.47%
Rating of Treatment or Counseling[2]	59.83%	59.60%	64.81%	61.84%	67.95%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 85: IHA's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		Due to the overall success of the Kids Performance Improvement Project, many of the interventions described in the performance improvement project will continue. On the topic of lead screening, in the performance improvement project, two out of the seven performance indicator rates increased from baseline to final, and four of the indicators met the goal established for the lead indicators (two goal rates were not applicable). All eight of the performance indicators focused on hearing screening increased from baseline to final, and five of the eight indicators met the established goal (two goal rates were not applicable). Likewise, all six of the performance indicator rates focused on developmental screening increased from baseline to final measurement, and five of the six indicators met the goal. IHA implemented and tracked the performance of each intervention, and the measures for each of the three areas of focus. Independent Health implemented member, provider, and independent provider association-focused interventions to show success in the performance improvement project. Provider interventions for all three indicators were focused on pediatric practices and the independent provider associations those practices belong to. The independent provider association agreement included a process measure in which practices developed a standard operating procedure to conduct lead, hearing, and	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				developmental screenings for their members. Social media was used in lieu of live community events due to the COVID-19 pandemic to educate members about the importance of lead, hearing, and developmental screening. In addition, letters encouraging the completion of lead screening and follow-up or additional hearing screening as appropriate were mailed to parents or guardians. Telephonic outreach was conducted to encourage members to complete lead screening and follow-up. Finally, Independent Health developed a policy to ensure providers are following the accurate process for members that fail or do not pass the newborn hearing screening as provided by the Department of Health's EHDI Program guidance. Below are interventions we plan to continue to support the areas of focus in the Kids Performance Improvement Project (2019-2021). **Lead:** IHA will continue to educate parents/guardians, and primary care providers regarding the importance of lead screening, and the HEDIS lead screening measure will be tracked for quality performance. Education will occur via multiple channels for parents/guardians, such as letters, emails, or outreach calls. Education will be provided to providers either through our physician engagement team, "Office Matters" our provider informational sessions, or SCOPE, our provider newsletter. **Hearing:** IHA will work with facilities that are not reporting screening or not conducting newborn screening and monitor reporting rates for the facilities. Additionally, Independent Health will share the hearing policy with	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				practices through a policy process currently being drafted to ensure implementation. **Developmental:** IHA is including the completion of developmental screenings in our 2023 value-based payment program (Primary Value) program. With the continued tracking of performance rates and interventions, we expect to see continued improvement in the rates of blood lead testing, newborn hearing screenings, and developmental screenings. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve member's health outcomes to increase blood lead testing, newborn hearing screening, and developmental screening rates. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles, and interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly as applicable, looking at both process and outcome results, by IHA's Value Governance and quality committees as applicable.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve the health of members with low back pain.	X	X		IHA acknowledges the importance of reducing the use of imaging in members with low back pain. Independent Health has several interventions in process or completed and several additional interventions planned for members with low back pain. Our rates remained steady in 2020 and 2021 at 75.5% and 75.3%, respectively for the HEDIS measure *Use of Imaging Studies for Low Back Pain* (source: Independent Health's internal HEDIS performance monitoring).	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				Our current interventions include education about the prevention and treatment of back pain for members and providers. We have published a series of low back health on-demand workout videos. This series lets the viewer know that expensive equipment and time are unnecessary to build a healthy back routine. An on-demand online seminar titled "Ergonomics and Back Health" is also posted on the HealthHub portion of our website. This sixteen-minute online seminar discusses the prevalence of back pain in Americans and helps viewers understand how their back works and how to protect it from injury. We partnered with a local safety-net hospital to host a grand-rounds session with continuing medical education on October 11, 2022, to provide education about chronic low back pain. The presenter was a local interventional pain management doctor. The session provided treatment options for members with chronic low back pain, focusing on avoiding surgery and opiates. Our future interventions will also be focused on education about the prevention and treatment of low back pain for members and providers. We will reach out to members diagnosed with low back pain to provide education and resources related to treatment options for low back pain. Outreach may occur through multiple channels (i.e., emails, push notifications, letters, etc.). Additionally, we will work with a local pain management provider who specializes in using non-opioid techniques to treat pain and provide education to primary care providers about the treatment of low back pain. This education will be shared with providers through multiple channels, such as live or on-demand webinars and articles in our provider newsletter, SCOPE.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve members health outcomes with a goal of reducing unnecessary imaging for low back pain. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles and interventions found to be ineffective will be modified or abandoned and new interventions will be implemented. The effectiveness of the interventions is monitored on a monthly or quarterly basis as applicable, looking at both process and outcome results, by IHA's Value Governance and quality committees as applicable.	
The managed care plan should investigate opportunities to decrease members risk of continued opioid use.	X	X		IHA acknowledges that members with a new episode of opioid use are at risk for continued use. Independent Health is committed to reducing the risk of continued opioid use. Our rates for the HEDIS measure *Risk of Continued Opioid Use – 15 Days* improved when comparing 2020 (8.7%) to 2021 (8.1%). Additionally, our rates for *Risk of Continued Opioid Use* – 30 Days also improved when comparing 2020 (6.0%) to 2021 (5.6%) (source: IHA's internal HEDIS performance monitoring). Our current interventions include letters to members with a new opiate prescription with information about the risk of addiction, alternatives to alleviate pain (i.e., exercise, therapy, over-the-counter drugs), treatment for opiate overdoses, and safe disposal of opiate medications. We also send letters to members on high-dose opiates (50 morphine milligram equivalents or more per day) that includes tips on how to stay safe (i.e., talking with a provider about lowering the dosage of opioid medications, having naloxone on hand, how to get naloxone, and keeping medications safe and away from	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				loved ones). Providers that prescribe high-dose opiates (50 morphine milligram equivalents or more per day) also receive a letter encouraging the provider to incorporate the following methods into member treatment plans; tapering opiate doses, prescribing naloxone and medication assisted therapy (medication assisted treatment) for patients with substance use disorder. Recently, we collaborated with a local safety net hospital to host a grand-rounds session to provide education about chronic low back pain. The presenter was a local interventional pain management doctor. The session provided treatment options for members with chronic low back pain with a focus on avoiding surgical interventions and the use of opiates. IHA's pharmacy team has met with practices in which 4 or more providers have prescribed opiate medications for the same member to align with the Centers for Disease Control and Prevention Guidelines for Prescribing Opioids for Chronic Pain. In addition, several Independent Health associates participate in the Opiate Epidemic Task Force. IHA's pharmacy is working with the Western New York Opiate Epidemic Task Force to attend the Independent Health Foundation's Good for the Neighborhood Events. During these events, we hand out bags with information about stigmatizing conditions, including opioid use and additions treatment options, and services. Additionally, we will send email reminders to members about drug take-back days in April and October of 2023. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve member's health outcomes to decrease members risk of	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				continued opioid use. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles, and interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly, as applicable, looking at both process and outcome results, by Independent Health's Value Governance and Quality Committees as applicable.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	IHA is committed to providing positive member experiences, and we have monitored our CAHPS performance for many years. IHA has performed better than the statewide average in the measure year 2017 and 2018 adult surveys (2017 – IHA 80.88%, statewide average 75.93%, 2019 - IHA 79.57%, statewide average 75.9%) and in the measure year 2018 and 2020 child surveys (2018 – IHA 90.18%, statewide average 85.18%, 2020 – IHA 91.69%, statewide average 79.57%). All but the measurement year 2019 adult results are indicated as significantly better than the statewide average per New York State's Quality Assurance Reporting (Quality Assurance Reporting Requirements: Beginning 2008, State of New York (ny.gov)). CAHPS surveys are a focus area of the Independent Health RedShirt 2.0 program, which focuses on enhancing our member-centric approach to health insurance with a focus on digital experience and member awareness of health benefits and increasing member health engagement in preventive care and chronic health maintenance. IHA has implemented a CAHPS Success Team. This is a multidisciplinary team of IHA associates. The purpose of	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	IHA's Response	IPRO's Assessment of IHA's Response
				the team is to provide a forum to bring forward CAHPS experience measures and feedback on a regular, ongoing basis to identify the areas for the organization with the end goal of improved member experience and health. This team has several methods to monitor member experience data (i.e., annual CAHPS surveys, mock CAHPS surveys, voice of the customer poster interaction surveys, and patient post-primary care provider visits surveys). Additionally, CAHPS measures will be included in several independent provider association contracts for 2023. Including CAHPS measures in independent provider association contracts will provide increased focus in the primary care network providers on member experience. IHA will continue to evaluate performance measure rates, intervention effectiveness, and strategies to improve member experience. Performance measures and interventions will continue to be evaluated through plan-do-study-act cycles, and interventions found to be ineffective will be modified or abandoned, and new interventions will be implemented. The effectiveness of the interventions is monitored monthly or quarterly as applicable, looking at both process and outcome results, by IHA's Value Governance and Quality Committees as applicable.	

Strengths, Opportunities for Improvement, and Recommendations

Table 86: IHA's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	IHA's measurement year 2021 performance improvement project passed validation.	X	X	X
	IHA exceeded target rates for two performance indicators related to blood lead screening.	X	X	X
	IHA met target rates for two performance indicators related to newborn hearing screening.	X	X	X
	IHA exceeded target rates for five performance indicators related to developmental screening.	X	X	X
Performance Measures	IHA met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	IHA performed significantly better than the mainstream Medicaid program on eight measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	IHA performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to children's health or maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	IHA performed significantly better than the mainstream Medicaid program on three measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, IHA was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	IHA performed significantly better than the mainstream Medicaid program on three measures of member satisfaction.	X	X	X
Opportunities for Improvement				
Performance Improvement Project	IHA did not meet target rates for four performance indicators related to blood lead screening.	X	X	X
	IHA did not meet target rates for four performance indicators related to newborn hearing screening.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	IHA did not meet the target rate for one performance indicator related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	IHA performed significantly worse than the mainstream Medicaid program on two measures of effectiveness of care related to primary care.	X	X	
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, IHA should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	IHA should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, IHA should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	IHA should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	IHA should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

MetroPlus

Performance Improvement Project Summary and Results

Table 87: MetroPlus's Performance Improvement Project Summary, Measurement Year 2021

MetroPlus's Performance Improvement Project Summary
Title: Kids Performance Improvement Project; Improving Lead, Hearing and Developmental Screenings Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim MetroPlus aimed to improve the health and lives of its youngest members to ensure that they have a head start by increasing the rate of necessary tests such as blood lead testing, hearing screening, and developmental screening. Member-Focused 2021 Interventions ▪ Educated parents/guardians via the member newsletters and online library on the importance of blood lead testing and associated health risks, as well as the associated risks of unidentified developmental, behavioral, and social delays. ▪ Sent text messages to parents/guardians of members on the importance of blood lead level testing and sources of lead, the importance of well-child visits and the incentives for completing the visit. ▪ Conducted targeted outreach via mail and telephone to parents/guardians of members with high lead levels and members who did not pass a diagnostic evaluation and need early intervention services. ▪ Informed parents/providers via mail of diagnostic audiological testing locations. Provider-Focused 2021 Interventions ▪ Conducted site visits for low performing practices and educated providers on the benefits of early screening and intervention for young patients. ▪ Published provider newsletter articles on the importance of childhood screenings. ▪ Conducted targeted outreach for providers with patients identified as having high blood lead levels, and patients who did not pass the initial hearing screening and require a follow-up screening. ▪ Posted updated clinical guidelines and diagnostic testing locations on the provider portal. ▪ Developed a provider quick reference guide for lead screening. ▪ Issued hearing screen results via mail to providers to ensure provider access to accurate results. ▪ Conducted site visits for New York City Health & Hospital locations and large community provider locations to provide clinical guidelines.

Table 88: MetroPlus's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	66.20%	70.40%	57.31%	60.04%	71.20%
Blood Lead Test at Age 2 Years	64.93%	69.59%	60.88%	49.04%	69.90%
Blood Lead Test at Ages 1 and 2 Years	50.97%	56.07%	52.31%	40.97%	56.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	62.50%	64.00%	50.00%	58.82%	65.50%
Confirmed Venous Blood Lead Level > 5 mcg/dl	0.48%	0.43%	0.22%	0.20%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	46.49%	53.26%	46.02%	47.52%	80.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.06%	0.08%	0.04%	0.04%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	41.46%	43.24%	43.75%	32.56%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	87.09%	86.21%	85.56%	81.53%	92.10%
Failed Screening by Age 1 Month	1.38%	8.16%	11.99%	13.42%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	29.08%	26.23%	20.70%	18.31%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	14.63%	14.06%	11.32%	17.46%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	66.67%	44.44%	66.67%	36.36%	80.00%
Screening Before Age 3 Months	88.22%	87.10%	88.80%	86.07%	93.20%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	43.10%	31.00%	22.33%	26.05%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	38.46%	0.00%	Denominator=0	Denominator=0	80.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	3.89%	5.30%	9.63%	20.08%	8.90%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	7.88%	9.46%	15.94%	26.15%	12.90%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	8.60%	10.07%	12.89%	23.57%	13.60%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	6.73%	8.24%	12.72%	23.32%	11.70%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.00%	0.94%	1.76%	3.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	0.22%	1.01%	3.00%

Performance Measure Results

Table 89: MetroPlus's Performance Measure Results, Measurement Years 2019 to 2021

Measure	MetroPlus Measurement Year 2019	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	55.67%	54.65%	58.65%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	38.52%	39.36%	41.49%	41.64%
Asthma Medication Ratio (5–64 Years)	60.24%	57.41%	54.60%	56.86%
Breast Cancer Screening	72.63%	68.41%	66.89%	64.75%
Cervical Cancer Screening	74.94%	72.02%	64.72%	69.19%
Chlamydia Screening in Women (16–20 Years)	79.13%	80.03%	81.07%	71.38%
Chlamydia Screening in Women (21–24 Years)	81.27%	77.43%	79.34%	74.13%
Colorectal Cancer Screening	66.67%	58.15%	54.50%	61.03%
Comprehensive Diabetes Care – Eye Exam	69.34%	59.85%	65.69%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	23.60%	37.23%	27.98%	34.74%
Controlling High Blood Pressure	75.91%	68.37%	67.15%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	34.13%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	74.12%	75.65%	73.09%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	46.25%	38.93%	35.73%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	76.30%	71.06%	72.32%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	82.97%	81.27%	69.34%	66.71%
Immunizations for Adolescents – Combination 2	61.56%	58.88%	55.72%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	94.16%	92.21%	89.29%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	92.70%	89.54%	89.78%	84.17%

Measure	MetroPlus Measurement Year 2019	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	85.64%	84.91%	87.59%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	27.35%	30.42%	21.35%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	61.97%	67.72%	60.87%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.92%	79.30%	81.24%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	50.13%	53.00%	53.48%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	56.07%	57.05%	56.32%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	61.07%	58.17%	59.75%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	80.71%	62.70%	71.13%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	47.59%	44.95%	51.55%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	49.08%	61.67%	55.73%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	17.02%	21.82%	17.47%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	64.93%	44.93%	50.88%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	40.94%	Not Available	42.29%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	MetroPlus Measurement Year 2019	MetroPlus Measurement Year 2020	MetroPlus Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	92.94%	86.62%	87.20%
Prenatal and Postpartum Care – Postpartum Care	84.43%	85.89%	85.16%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	66.00%	67.50%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	82.36%	75.86%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	65.58%	71.15%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 90: MetroPlus's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	C	Pended	C
438.207: Assurances of Adequate Capacity and Services	C	Pended	C
438.208: Coordination and Continuity of Care	C	Pended	C
438.210: Coverage and Authorization of Services	NC	Pended	C
438.214: Provider Selection	C	Pended	C
438.224: Confidentiality	C	Pended	C
438.228: Grievance and Appeal System	C	Pended	C
438.230: Sub-contractual Relationships and Delegation	C	Pended	C
438.236: Practice Guidelines	C	Pended	C
438.242: Health Information Systems	C	Pended	C
438.330: Quality Assessment and Performance Improvement Program	C	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements.

Summary of 2019 Results

- Based on interview and demonstration of the online provider manual functions, MetroPlus failed to ensure the provider links to utilization review policies for all delegates were in place and functioning. This issue was identified during the comprehensive operational survey and the plan of correction did not include auditing or monitoring. The issue was not identified until demonstrating to the surveyor on April 9th, 2019. The delegates whose links were not functioning were HealthPlex and Integra. *(Contract Article 98-1.12(o))*
- Based on review and interview, MetroPlus failed to make a utilization review determination, provide written and phone notice with in three business days of receipt of the necessary information, to the enrollee and the provider in four of 7 Medicaid standard prior authorization cases. Specifically, the MCP was late in its determination process. The written notices and phone notices to the member and the provider in the above cases were late. *(Contract Article 4903.2)*

Quality-of-Care Survey Results – Member Experience

Table 91: MetroPlus's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	MetroPlus	Mainstream Medicaid Average	MetroPlus	Mainstream Medicaid Average	MetroPlus	Mainstream Medicaid Average
Getting Needed Care[1]	70.58%	78.71%	76.13%	81.33%	77.46%	78.54%
Getting Care Quickly[1]	70.97%	78.40%	76.71%	80.57%	72.54%	78.88%
How Well Doctors Communicate[1]	89.96%	90.95%	91.89%	92.00%	88.28%	92.04%
Customer Service[1]	88.38%	85.72%	83.35%	87.13%	85.05%	86.32%
Rating of All Health Care[2]	74.38%	76.50%	68.00%	75.33%	69.12%	72.83%
Rating of Personal Doctor[2]	78.38%	80.80%	77.09%	81.46%	75.34%	81.25%
Rating of Specialist Talked to Most Often[2]	77.11%	79.63%	72.50%	82.07%	69.70%	78.79%
Rating of Health Plan[2]	79.11%	75.93%	74.64%	75.90%	69.01%	73.47%
Rating of Treatment or Counseling[2]	52.20%	59.60%	Sample Size Too Small To Report	61.84%	Sample Size Too Small To Report	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 92: MetroPlus's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		A Kids Performance Improvement Project was implemented from 2019-2021 with the objective of increasing blood lead testing, newborn hearing screenings, and developmental screenings. MetroPlus Health Medicaid/Child Health Plus children ages 0 to 6 years old were included in the study. The following interventions were conducted during the project: ▪ Educate caregivers on the importance of blood lead testing and health risks associated with lead toxicity in children through member newsletters and member website library. ▪ Text messages to caregivers about the importance of blood lead level testing and sources of lead. ▪ Educate providers with low compliance rates during site visits on the benefits of early screening and intervention for young children. ▪ Post articles in provider newsletter on the importance of testing for children. ▪ Develop lead screening quick reference guide for doctors. ▪ Mailings to parents/caregivers of members with high blood lead levels. ▪ Outreach calls to parents/caregivers of members with high blood lead levels. ▪ Provider outreach via mailing for accurate hearing screenings results.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Update providers with clinical guidelines through provider portal. ▪ Promote member rewards program for a well child visit through member website and text messages. ▪ Update New York City Health + Hospitals and large community providers with clinical guidelines, importance of full developmental screening, early intervention referrals, proper documentation, and use of CPT code 96110 through provider visits. ▪ Chart review was completed for two targeted New York City Health + Hospital facilities to monitor the use of CPT code 96110 to report developmental screening with a standardized tool and use of CPT 96110 with either CG modifier or ICD-10 code Z13.41 to report use of a standardized autism screening tool. After the conclusion of the performance improvement project, various interventions continue. A postcard with a first-year birthday checklist and information on the value of well-child visits is mailed. The new Quality Assurance Reporting Requirements Developmental Screening measure will be embedded in gaps in care reports and Provider Report Cards and will be monitored as a part of the managed care plan's Quality Improvement program. Additional education will be provided to members to explain what a developmental screening is and why it is important and what to do if developmental delays are identified. Lastly, effective April 1, 2022, the managed care plan reimburses for developmental and autism screening for Medicaid. Reimbursement rules allow for billing of up to two autism screenings beginning at 18 months of age and for billing of developmental screening for global developmental delay once annually up to 3	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				years of age. Providers are educated about using these codes and the associated reimbursement. The COVID-19 pandemic severely affected children's engagement in primary and preventive care. As a result of the COVID-19 crisis, parents delayed healthcare visits due to fear of possible COVID exposure. At the height of the pandemic, provider offices were closed or had reduced hours. Staffing shortages and staff turnover are still plaguing some provider sites. The COVID-19 pandemic has highlighted how closely household poverty, education/literacy levels, and environmental factors influence access to healthcare and health outcomes. *Lead Screening in Children* rates are monitored through a monthly dashboard. Annual rates are: ▪ calendar year 2019 91.97% ▪ calendar year 2020 90.86% ▪ calendar year 2021 81.26% The interventions listed above were monitored and evaluated through the performance improvement project quarterly progress summary report to IPRO. The results were reported to the Department of Health. Results were monitored internally by the quarterly Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership.	
Validation of Performance Measures					
The managed care plan should investigate additional opportunities to improve the health of	X	X		**Asthma Medication Ratio** MetroPlus continues interventions to address nonadherence to asthma controller medications. Primary barriers include members lack of understanding about their asthma condition and lack of asthma controller	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
members with acute and chronic conditions such as asthma, HIV, diabetes, chronic obstructive pulmonary disease, and pharyngitis, as rates have continued to decline.				medication prescriptions, and providers not prescribing asthma controller medications. The following interventions were conducted in 2019 and are ongoing: ▪ Member text campaigns with education about managing asthma and reminders to refill controller medications. ▪ MetroPlus Health Member Rewards Program provides rewards for members who adhere to controller medications as prescribed by their doctor. ▪ *Asthma Medication Ratio* measure is incentivized in the MetroPlus Provider Pay for Performance Program. ▪ Primary care providers are supported with monthly gap in care reports which alert the provider of members who are not maintaining adherence to controller medications. ▪ Pharmacy data is used to identify members filling a 30-day-supply of controller medications, and providers are asked to consider converting these members to a 90 day-supply. ▪ MetroPlus Health's Integrated Case Management partners with Bridges to Health Equity program which works directly with network providers of qualifying pediatric members. The program pairs members with community health workers who provide coaching to members on asthma self-management. ▪ MetroPlus Health's Integrated Case Management partners with Medicaid Together Improving Asthma, a project developed by the New York City Department of Health and Mental Hygiene. The aim is to deploy Integrated Pest Management with Allergen Reduction to the homes of pediatric members who have been	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				admitted to a hospital with an asthma diagnosis and have an allergy to cockroaches or mice or have pests at home. Integrated Pest Management with Allergen Reduction primarily involves the removal of existing pest allergens from the home and improving sanitary and structural conditions to deny pests food, water, harborage, and movement. Interventions that are new include: ▪ Follow-up with members who have consistently not been adherent in the *Asthma Medication Ratio* measure by the MetroPlus Health Pharmacy Department to assist with filling asthma controller medications, redirect members back to their providers to get a controller prescription and troubleshoot any pharmacy issues. ▪ MetroPlus Health Pharmacy Department is calling providers of noncompliant members to encourage the provider to prescribe controllers. ▪ Member barrier text survey to determine what member barriers hinder controller medication adherence. ▪ Text with information regarding the New York City Health Neighborhood Program which provides free home assessments for people diagnosed with persistent asthma to mitigate environmental triggers. ▪ Post the 2022 GINA Clinical Practice Guidelines Pocket Guide to the Provider Portal. MetroPlus Health's Integrated Case Management partnership with The Bridges to Health Equity program has ended. This program worked directly with network providers of qualifying pediatric members. The program paired members with community health workers who	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				provided coaching to members on asthma self-management. Rates are monitored through a monthly dashboard. Rates for *Asthma Medication Ratio >50%* for ages 5 to 64 years: ▪ calendar year 2019 60% ▪ calendar year 2020 57% ▪ calendar year 2021 55% *Asthma Medication Ratio* interventions and rates are reported and monitored at the Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership. HIV Viral load suppression performed below the statewide average in 2020. Viral load suppression was selected as an area for improvement with an action plan in place for 2022. The goal of the plan is to increase the rate of viral load suppression for our Medicaid and HARP members living with HIV to the statewide average: 71% to 74% for Medicaid and 55% to 66% for HARP. Barriers to improving viral load suppression include the lack of viral load test result data from community providers, difficulty outreaching and engaging members who are lost to care, member's difficulty adhering to HIV care and treatment, and member's lack of knowledge about HIV/medication adherence/services. Several interventions are being implemented and monitored to address these barriers: ▪ Partnership in Care leadership is meeting with community providers and lab vendors to explore solutions to enhance data collection of viral load test results.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Members who are out of care for over 12 months are outreached by our Ending the Epidemic staff using a focused return to care intervention with the goal of addressing the member's barriers to engaging in HIV primary care. If unsuccessful, out of care members are referred to a vendor for street outreach. ▪ Members with poor adherence or unsuppressed viral loads are outreached by Health and Wellness Advisors using an adherence coaching intervention to help identify and overcome barriers to adherence. ▪ Members with HIV are enrolled into several text message campaigns as needed or by member preference: HIV medication refill reminders if they are >14 days late picking up medications, adherence education for members with unsuppressed viral loads, and daily medication reminders for members who opt in. The interventions outlined above are monitored and evaluated through the action plan. Results are reported to the Department of Health. A proxy of viral load suppression performance is also reported quarterly at the Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership. Appropriate Test for Pharyngitis The *Appropriate Testing for Children with Pharyngitis* measure specification changed in 2020 to include adults. Barriers include a lack of member understanding about the appropriate use of antibiotics and providers who are not testing for pharyngitis before prescribing antibiotics.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				The managed care plan continues the following ongoing interventions to address these barriers: ▪ Member newsletter article educating members on the proper use of antibiotics, difference between viral and bacterial infections, tips on how to manage viral infections like over-the-counter medication, and the development of "super bugs" caused by antibiotic resistance from overuse of antibiotics. ▪ Provider newsletter articles which remind providers about the need for appropriate testing for pharyngitis to avoid the unnecessary use of antibiotics. ▪ Provider Report Card distribution to assist providers in monitoring their rates of testing for pharyngitis. Due to the specification changes, trending for *Appropriate Testing for Children with Pharyngitis* measure is not currently feasible. The *Appropriate Testing for Children with Pharyngitis* rate is reported to managed care plan leadership via the Quality Management and the Quality Assurance Performance Committees. Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation Multiple barriers exist to managing chronic obstructive pulmonary disease effectively. Members lack awareness of the importance of follow-up post inpatient/emergency room visit for chronic obstructive pulmonary disease. Providers are not aware of members' new diagnosis of chronic obstructive pulmonary disease; lack of proper coding and documentation of spirometry testing; no pulmonary function testing available in providers' offices;	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				and spirometry testing occurring outside of measure timeframe. In 2020, during the COVID-19 pandemic, pulmonary function testing was recommended to be limited to tests that were only essential for immediate treatment decisions, that the type of pulmonary function testing be limited to the most essential tests when possible, and that measures to protect both the staff and individuals being tested should be put in place such as personal protective equipment (PPE) that limits aerosolized droplet acquisition for staff and enhanced cleaning of the testing space such as wiping down surfaces with appropriate cleaners. Interventions do continue include: ▪ Providers educated about *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* measure with Provider Report Cards and Gaps in Care reports. ▪ The clinical practice guidelines, "Global Initiative for Chronic Obstructive Lung Disease (GOLD): Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease," posted on the provider portal. ▪ *Use of Spirometry Testing in Assessing and Diagnosing Chronic Obstructive Pulmonary Disease* measure information included in Member and Provider Newsletter articles. ▪ Text message campaign to members with chronic obstructive pulmonary disease with education on how to manage chronic obstructive pulmonary disease. ▪ Text message campaign to members recently discharged from inpatient or emergency room to remind members to attend follow-up care.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease and *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation* rates are monitored via a monthly dashboard. Rates are reported to managed care plan leadership via the Quality Management and Quality Assurance Performance Improvement Committees. *Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease* rates are: ▪ calendar year 2019 46% ▪ calendar year 2020 39% ▪ calendar year 2021 36% *Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease Exacerbation - Corticosteroids* rates are: ▪ calendar year 2019 68% ▪ calendar year 2020 62% ▪ calendar year 2021 62% Comprehensive Diabetes Care For diabetes care, the rates for HbA1c testing, HbA1c control, and diabetic eye exams aligned with the statewide average in 2020; however, the rates did drop from the previous year for *Kidney Health Evaluation for Patients with Diabetes* measure, 2020 was the first year this rate was reported, and the managed care plan's rate was 30% which was significantly lower than the statewide average of 39%. The rates in 2020 were substantially impacted by the COVID-19 pandemic and additionally by difficulties encountered with obtaining medical records for hybrid review during a COVID surge. Members were not attending routine care due to the disruption in	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				healthcare, and lifestyle choices (i.e., poor diet; lack of exercise) were also affected by the emotional and financial hardship caused by the pandemic. Ongoing interventions to address diabetes care include: ▪ Monthly Provider Report Cards and gap in care reports are shared monthly with large community providers. ▪ Pay for Performance Provider Incentive program incentivizes providers HbA1c control and diabetic eye exam in 2020; HbA1c control in 2021; diabetic eye exam and kidney health screening in 2022. ▪ Letter/panel report to eye care providers of members needing diabetic eye exams. ▪ Kidney Health Screening Provider Alert Bulletin was e-faxed to community providers in 2020. ▪ Kidney Health Screening Postcard to members informing them of the importance of kidney health screening. ▪ Member Rewards Program incentivizing members to complete diabetic eye exam. ▪ Text/interactive voice response campaign to members to provide education and resources on how to manage diabetes. ▪ Diabetes Community Resources guide developed to link members to free exercise, nutrition, and diabetes educational programs in New York City. ▪ Online seminar for members with diabetes and care management staff by a certified diabetes educator and registered dietician regarding plant-based diet and intuitive eating in 2021. Measures related to diabetes care are monitored through monthly dashboards and are reported quarterly to the	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				Quality Management and Quality Assurance Performance Improvement Committees attended by managed care plan leadership. HbA1c Test rates are: ▪ calendar year 2019 93% ▪ calendar year 2020 86% ▪ calendar year 2021 92% HbA1c Control rates are: ▪ calendar year 2019 64% ▪ calendar year 2020 54% ▪ calendar year 2021 59% Diabetic Eye Exam rates are: ▪ calendar year 2019 69% ▪ calendar year 2020 60% ▪ calendar year 2021 66% Kidney Health Screening rates are: ▪ calendar year 2020 30% ▪ calendar year 2021 34%	
Although rates for follow-up care for members with mental illness have improved from 2019 to 2020, rates remain significantly below the statewide averages. Additionally, the managed care plan's rates for the risk of continued opioid use	X	X		Follow-up After Hospitalization for Mental Illness Follow-up After Emergency Room Visit for Mental Illness MetroPlus recognizes the importance of follow up care post inpatient mental health care. In response to 2020 performance the managed care plan conducted an in-depth barrier analysis to identify member barriers to aftercare and implemented the following interventions to support members in their recovery journey. ▪ MetroPlus attempts to outreach every member discharged from an Inpatient stay/emergency room visit for mental health by telephone to confirm that the member has and understands their aftercare plan.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
have remained significantly worse than the statewide average for two consecutive years. The managed care plan should continuously investigate opportunities to improve these measures.				We also assist members with making doctor appointments as needed. This outreach is continued from June of 2021. The managed care plan uses advanced methods to locate the best phone number to reach the member. ▪ MetroPlus recently placed Field Based Case Managers in high volume facilities to assist members in securing aftercare services. ▪ Members with multiple admissions are offered case management services and assistance with social determinants of health. ▪ MetroPlus makes use of peers to better engage members in aftercare services. ▪ MetroPlus engaged one large Inpatient provider in a value-based performance arrangement to support members in obtaining aftercare services post discharge. MetroPlus has observed a little change in year-over-year performance in the *Follow-Up After Hospitalization for Mental Illness 7-Day* measure and significant decline in the *Follow-Up After Emergency Department Visit for Mental Illness 7-Day* and *30-Day* measures for Medicaid. Rates are noted below: *Follow-Up After Hospitalization for Mental Illness* ▪ *7-Day Measure*: calendar year 2019 52% calendar year 2020 53% calendar year 2021 52% ▪ *30-Day Measure:* calendar year 2019 64.81% calendar year 2020 65.02%	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				calendar year 2021 69% *Follow-Up After Emergency Department Visit for Mental Illness* ▪ *7-Day Measure:* calendar year 2019 50% calendar year 2020 53% calendar year 2021 41% ▪ *30-Day Measure* calendar year 2019 64% calendar year 2020 65% calendar year 2021 56% Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence MetroPlus recognizes the importance of medication assisted treatment for members diagnosed with an opioid use disorder. In response to 2020 performance the managed care plan conducted an in-depth barrier analysis to identify member barriers to medication assisted treatment and implemented the following interventions to support members in their recovery journey. ▪ On a weekly basis the managed care plan runs data on members who were diagnosed with opioid use disorder in the preceding seven days. The managed care plan outreaches these members to support their recovery and assist them in securing medication assisted therapy. ▪ Members with opioid diagnosis who were seen and discharged from emergency room/inpatient substance use care are outreached telephonically to support engagement in medication assisted treatment.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Quarterly meetings are held with high-volume inpatient substance treatment facilities to discuss better identification of members appropriate for medication assisted treatment as well as monitoring of facility performance in this measure. ▪ MetroPlus makes use of weekly collaboration meetings with our internal Behavioral Health Department to address member and provider barriers to medication assisted treatment. ▪ MetroPlus has developed a provider assessment to support annual screening for substance use disorders as well as resources for treatment and referral for these disorders. MetroPlus has observed a decrease in year-over-year performance in the *Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence* measure for Medicaid. Rates are noted below: ▪ calendar year 2019 40% ▪ calendar year 2020 46% ▪ calendar year 2021 42% MetroPlus uses member demographics to determine if disparities exist based on gender, age, race and ethnicity, language spoken, and geography. If poor performance is noted, the managed care plan will alter actions or implement new interventions to prioritize members as needed to address and reduce these disparities. The managed care plan's process for monitoring actions is to: ▪ Track measure rate performance by utilizing internal monthly dashboards and year over year trend reports. ▪ Monitor process data and the effectiveness of each intervention on Quality Improvement Activity tools.	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Report outcomes to the Quality Management Committee and Quality Assurance Performance Improvement Committee.	
The managed care plan should investigate opportunities to improve members access to dental care.	X	X	X	Annual Dental Visit The following interventions to improve members' access to dental care and understanding of the importance of dental care were implemented in 2020. ▪ An annual dental school letter mailing targets members ages 2-20 year with no visit in the current year to inform them that they should have a visit before school begins. ▪ COVID-19 postcard mailing was created for outreach purposes to encourage members to seek needed dental treatment while educating members on the precautions dental offices take to ensure their safety. ▪ Live outreach calls are made annually to members who have not yet had a dental visit. The objective of the calls is to assist them in scheduling a routine dental appointment. ▪ A virtual training event was held in 2021 consisting of oral health education for members; a local dental provider list was sent via email for print and distribution. ▪ Provider dental incentive exclusively for New York City Health + Hospitals primary care providers. The eligible population for the dental incentive included all children in the annual dental visit denominator attributed to an New York City Health + Hospitals primary care provider in the Medicaid and Child Health Plus lines of businesses.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				▪ Member text campaign with education highlighting the importance of regular dental visits and dental benefits. ▪ Member text campaign targeting households with multiple siblings and who had not had an annual dental visit in the past two years. Annual dental visit rates are monitored via a monthly dashboard. Rates are reported to managed care plan leadership via the Quality Management and Quality Assurance Performance Improvement Committees. The HEDIS *Annual Dental Visit* rates are calendar year 2019 63%/ calendar year 2020 44%/ calendar year 2021 49%. The COVID-19 pandemic caused significant disruption in MetroPlus members' access and availability to healthcare as dental offices were temporarily closed during the height of the pandemic which significantly decreased the managed care plan's annual dental visit rate. Additionally, many dental offices reported that they had difficulty maintaining staffing during the pandemic even as COVID levels were decreasing throughout 2020 and 2021.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the measurement year 2019 operational survey conducted by	X	X	X	MetroPlus underwent a full operational survey from November 29 through December 7, 2021. The survey reviewed key areas and the managed care plan received one deficiency related to a contracted vendors utilization review initial adverse determination notice for three Child Health Plus cases in which the vendor failed to ensure the notice included a complete statement of clinical rationale. Upon investigation, the vendor discovered this was an error made by a staff nurse. The template was updated to ensure that this error does not occur again. The managed care plan continues to monitor compliance with Medicaid	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
the Department of Health.				standards by addressing the noncompliance identified during the survey and by conducting quarterly random samples of cases to ensure that this error has been resolved and is not re-occurring. To date, no issues have been identified.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	Our core areas of focus have been on addressing the areas of low performance that most affect the member's experience starting with: Access to care Getting care quickly and getting needed care MetroPlus has focused on elevating appointment availability for constant monitoring and evaluation with our network. MetroPlus is monitoring this through appointment availability data and will share this with our providers when we notice issues. This was done throughout 2020 and is expected to continue through 2021. Additionally, we have expanded the awareness of our telehealth services to our members so that they are able to access appointments in as many ways as possible. In 2020, MetroPlus partnered with Amwell to offer 24/7 telehealth services to our members and monitored utilization and member satisfaction around the service. MetroPlus trained our customer facing staff to help our members to be able to make appointments on their behalf when they struggle to make appointments. MetroPlus monitor appointment availability and as needed hand them over to the customer experience escalation unit to support with any complex cases. When members call in with issues with accessing appointments	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				their calls are routed to a unit that supports them with issues around accessing care MetroPlus tracked retention of members and had over a 70% retention rate of members who were initially dissatisfied. MetroPlus expanded the use of text messaging to support our members with awareness around the alternatives they have. MetroPlus were able to expand our outreach to improve awareness of different opportunities for our members and had very low opt out rates on the messages. MetroPlus also focused efforts on network evaluation and expansion while ensuring that there is continuous support to members for scheduling critical member appointments with specialists. MetroPlus also followed up with post appointment surveys to gain insight into the appointments and understand any issues around access that could be fixed. When post appointment surveys identified issues, members of the MetroPlus customer experience team help members resolve their issues and support any coordination of care that is needed. Customer Service The Customer Experience team designed and implemented a training focusing on Listening and Empathy and problem resolution for member facing teams. This was done with the intention of elevating the experience of our members. This was rolled out through several customer facing parts of the organization such as Customer Experience, Partnership in Care and Customer Service. These trainings	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MetroPlus's Response	IPRO's Assessment of MetroPlus's Response
				were also incorporated in the call quality assessment that allowed us to rate the representative's performance. The Customer Service team focused on improving service levels so that members were able to be served in under 30 seconds. Performance against that measure was tracked with monthly stats presented to leadership. The Customer Experience team evaluated net promoter sore and customer satisfaction opportunities to establish a continuous listening program to understand key drivers of member dissatisfaction. Evaluation was completed in 2020 and expected to be implemented in 2021/2022.	

Strengths, Opportunities for Improvement, and Recommendations

Table 93: MetroPlus's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MetroPlus's measurement year 2021 performance improvement project passed validation.	X	X	X
	MetroPlus exceeded target rates for four performance indicators related to developmental screening.	X	X	X
Performance Measures	MetroPlus met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	MetroPlus performed significantly better than the mainstream Medicaid program on 12 measures of effectiveness of care related to primary care, children's health, or mental health.	X	X	
Performance Measures – Access/Availability of Care	MetroPlus performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to primary care.		X	
Performance Measures – Utilization and Risk Adjusted Utilization	MetroPlus performed significantly better than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, MetroPlus was compliant with the standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	MetroPlus did not meet target rates for six performance indicators related to blood lead screening.	X	X	X
	MetroPlus did not meet target rates for five performance indicators related to newborn hearing screening.	X	X	X
	MetroPlus did not meet target rates for two performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	MetroPlus performed significantly worse than the mainstream Medicaid program on four	X	X	

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	measures of effectiveness of care related to primary care or mental health.			
Performance Measures – Access/Availability of Care	MetroPlus performed significantly worse than the mainstream Medicaid program on one measure of access/availability of care related to children's health.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	MetroPlus performed significantly worse than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	None.			
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, MetroPlus should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	MetroPlus should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MetroPlus should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	MetroPlus should ensure its continued compliance with federal and state Medicaid standards by conducting internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	MetroPlus should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Molina

Performance Improvement Project Summary and Results

Table 94: Molina's Performance Improvement Project Summary, Measurement Year 2021

Molina's Performance Improvement Project Summary
Title: KIDS Quality Agenda Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Molina aimed to improve member health outcomes by increasing the early assessments that lead to early intervention. Member-Focused 2021 Interventions ▪ Mailed educational materials to members identified as needing blood level testing, hearing screen, and/or a well-child visit/developmental screening. Outreach via telephone was conducted for members who received materials on developmental screenings. ▪ Conducted targeted outreach via telephone to parents/guardians of members identified as having an elevated blood level and a gap for lead screening; members who did not pass a hearing screening; and members diagnosed with hearing loss. ▪ Conducted targeted outreach to members in their postpartum phase to reinforce the important of newborn well-child visits. ▪ Utilized social media platforms to education members on the importance of lead screenings. Provider-Focused 2021 Interventions ▪ Educated providers on proper coding for blood lead level testing, developmental screenings, and the importance of early intervention. ▪ Conducted educational outreach to birthing facilities to ensure awareness of coding practices and documentation of services rendered. ▪ Conducted outreach to health homes and community-based organizations on the importance of lead screening, hearing testing and developmental screening. ▪ Established a reporting process for practice sites using SharePoint to improve documentation and reporting. Managed Care Plan-Focused 2021 Interventions ▪ Participated in a community Lead Coalition to learn of potential new education, data or activities that could be used to implement new interventions.

Table 95: Molina's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	57.72%	45.23%	17.10%	64.64%	47.00%
Blood Lead Test at Age 2 Years	67.61%	62.48%	47.06%	46.74%	70.00%
Blood Lead Test at Ages 1 and 2 Years	43.88%	44.75%	39.60%	15.25%	60.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	54.84%	50.00%	62.50%	50.00%	65.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	5.13%	5.70%	4.28%	3.13%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	35.14%	35.71%	41.41%	50.00%	80.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	1.69%	2.04%	0.37%	0.13%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	46.43%	56.00%	42.86%	58.33%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	86.93%	91.48%	89.37%	81.34%	95.00%
Failed Screening by Age 1 Month	6.02%	3.72%	2.90%	2.51%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	No Data Reported	32.36%	6.90%	6.67%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	No Data Reported	20.00%	50.00%	33.33%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	No Data Reported	100.00%	0.00%	0.00%	100.00%
Screening Before Age 3 Months	No Data Reported	91.83%	92.94%	88.02%	95.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	No Data Reported	40.00%	19.57%	16.33%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	No Data Reported	100.00%	0.00%	0.00%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	9.75%	31.95%	10.24%	19.24%	14.10%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	13.65%	31.24%	9.18%	20.24%	16.33%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	6.24%	23.56%	6.13%	14.66%	20.06%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	9.85%	28.93%	8.54%	18.10%	15.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.00%	3.57%	16.96%	30.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	1.48%	8.09%	15.00%

Performance Measure Results

Table 96: Molina's Performance Measure Results, Measurement Years 2019 to 2021

Measure	Molina Measurement Year 2019	Molina Measurement Year 2020	Molina Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	45.30%	57.86%	48.30%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	32.05%	42.56%	33.26%	41.64%
Asthma Medication Ratio (5–64 Years)	57.30%	66.59%	58.26%	56.86%
Breast Cancer Screening	70.14%	62.62%	57.96%	64.75%
Cervical Cancer Screening	72.02%	63.33%	63.75%	69.19%
Chlamydia Screening in Women (16–20 Years)	75.20%	66.14%	68.55%	71.38%
Chlamydia Screening in Women (21–24 Years)	76.92%	67.76%	71.72%	74.13%
Colorectal Cancer Screening	57.42%	54.26%	48.80%	61.03%
Comprehensive Diabetes Care – Eye Exam	71.78%	59.85%	56.69%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	28.47%	47.20%	41.12%	34.74%
Controlling High Blood Pressure	66.91%	57.66%	62.29%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	37.75%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	61.54%	80.83%	64.20%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	33.64%	36.12%	28.65%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	80.36%	80.65%	79.88%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	75.43%	74.70%	73.48%	66.71%
Immunizations for Adolescents – Combination 2	44.28%	42.82%	37.71%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	94.40%	82.24%	82.73%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	88.56%	85.40%	80.78%	84.17%

Measure	Molina Measurement Year 2019	Molina Measurement Year 2020	Molina Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	84.18%	78.83%	76.40%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	13.46%	20.00%	15.98%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	48.00%	63.36%	54.07%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	72.39%	70.89%	73.16%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	35.32%	43.83%	40.83%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	52.70%	54.77%	58.11%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	98.60%	75.85%	90.16%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	69.77%	70.21%	61.11%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	33.33%	23.31%	28.29%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	39.71%	35.91%	38.31%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	17.30%	12.90%	13.70%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	54.44%	45.77%	69.72%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	60.30%	Not Available	55.82%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	Molina Measurement Year 2019	Molina Measurement Year 2020	Molina Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	81.27%	82.00%	87.20%
Prenatal and Postpartum Care – Postpartum Care	79.56%	71.78%	69.34%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	67.45%	67.33%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	79.01%	75.37%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	62.50%	65.81%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 97: Molina's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021[1]
438.206: Availability of Services	C	Pended	Pended
438.207: Assurances of Adequate Capacity and Services	C	Pended	Pended
438.208: Coordination and Continuity of Care	C	Pended	Pended
438.210: Coverage and Authorization of Services	NC	Pended	Pended
438.214: Provider Selection	C	Pended	Pended
438.224: Confidentiality	C	Pended	Pended
438.228: Grievance and Appeal System	C	Pended	Pended
438.230: Sub-contractual Relationships and Delegation	C	Pended	Pended
438.236: Practice Guidelines	C	Pended	Pended
438.242: Health Information Systems	C	Pended	Pended
438.330: Quality Assessment and Performance Improvement Program	C	Pended	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2019 Results

- Based on staff interview and review of the Molina provider manual and associated materials, Molina failed to update the provider manual and associated materials to include/communicate required information to the managed care plan's providers. *(Contract Article 98-1.12(o))*
- Based on staff interview and review of the provider network submission, Molina failed to submit and/or report an accurate 2nd quarter 2019 provider network. *(Contract Article 98-1.16 (i)(j))*
- Based on staff interview and review of approval notices, Molina failed to ensure its delegate, HealthPlex, made the determination and issued the written and the phone notice within three business days of receipt of the necessary information. This was evident in two of 10 Medicaid approval utilization review cases. *(Contract Article 4903(2)(a))*

Quality-of-Care Survey Results – Member Experience

Table 98: Molina's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	Molina	Mainstream Medicaid Average	Molina	Mainstream Medicaid Average	Molina	Mainstream Medicaid Average
Getting Needed Care[1]	82.87%	78.71%	80.25%	81.33%	76.12%	78.54%
Getting Care Quickly[1]	78.28%	78.40%	78.50%	80.57%	79.44%	78.88%
How Well Doctors Communicate[1]	87.91%	90.95%	92.22%	92.00%	92.76%	92.04%
Customer Service[1]	81.94%	85.72%	82.99%	87.13%	81.69%	86.32%
Rating of All Health Care[2]	78.05%	76.50%	66.54%	75.33%	71.26%	72.83%
Rating of Personal Doctor[2]	84.83%	80.80%	84.32%	81.46%	80.66%	81.25%
Rating of Specialist Talked to Most Often[2]	85.76%	79.63%	83.84%	82.07%	80.53%	78.79%
Rating of Health Plan[2]	72.45%	75.93%	72.00%	75.90%	69.38%	73.47%
Rating of Treatment or Counseling[2]	57.63%	59.60%	45.03%	61.84%	51.45%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 99: Molina's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		Since the conclusion of the KIDS Performance Improvement Project, the Molina Quality team has maintained education for providers around coding and continues to promote care through member outreach, including but not limited to follow-up phone calls to members with gaps-in-care, prenatal mailings, post-partum mailings detailing importance of lead, hearing, and developmental screenings. The Molina Quality team also continues to encourage proper care for mothers throughout prenatal and postpartum periods. Because of the hesitancy of members to answer calls from unknown numbers, we are planning to implement different text messaging campaigns for both prenatal and postpartum members, highlighting the importance of care throughout pregnancy and subsequent early childhood care.	Partially Addressed
Validation of Performance Measures					
The managed care plan should investigate additional opportunities to improve cancer screenings and chlamydia screening as rates have declined from 2019 to 2020.	X	X		The Molina Quality team has partnered with the corporate Women's Health Line which is a service offered through a dedicated member contact center. Throughout the year, contact center staff will make outbound calls to members who show no evidence of a cervical cancer screening and/or chlamydia screening within the recommended timeframe to (1) educate them on the importance of screening, (2) assist with identifying a provider within the network who can meet their healthcare needs, and (3) assist with making a connection between the member and provider for appointment scheduling. In addition to outbound calls, the Women's Health Line accepts inbound calls from members that may receive the	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				toll-free telephone from any of the member educational materials mailed, emailed, or texted to these members. Members calling into the Women's Health Line are offered the same level of service and assistance. Additionally, monthly reports of members who are still in need of cervical cancer screening and/or chlamydia screening are provided to their attributed primary care provider to facilitate provider-specific outreach. For those members who are enrolled in a health home, their attributed health homes also receive a monthly report of their healthcare gaps to facilitate outreach especially for harder-to-reach members or members with co-occurring health issues that might sometimes take priority.	
The managed care plan should investigate opportunities to improve the health of members with chronic conditions such as diabetes and chronic obstructive pulmonary disease.	X	X		Molina's root causes and resulting interventions for improving the health of members with chronic conditions such as diabetes and chronic obstructive pulmonary disease are indicated below. Diabetes Obtaining lab results data and knowing if diabatic members require intervention to maintain A1c control has been the main obstacle for ensuring appropriate levels of care and care management is delivered. In addition to generating monthly reports of members requiring A1c tests and sharing with the members' attributed primary care providers and assigned health homes when applicable, we have engaged with several large standalone lab vendors to receive monthly data feeds of lab results. Also, we are receiving lab results data as part of supplemental data feeds from two regional health information exchanges. These data feeds have resulted in a more complete and accurate view of our diabetic members needs and numbers, so we can target the right members are the right time. Additionally, the managed care plan expects to engage a national lab vendor in an in-home lab testing program to	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				address potential provider capacity/access/availability issues and to meet the members "where they are" if they experience challenges/barriers in keeping up with office visits. **Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease** Through data analysis, the Molina NY Quality team has been able to identify the greatest opportunity for impact to *the Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease* measure is to notify primary care providers of index episode events arising from acute inpatient stays for which the primary care provider may not have been aware. As a solution, we are sending reports of members identified through this method to their attributed providers for appropriate follow-up diagnostic confirmation. To support the providers' outreach efforts, we are also sending text message campaigns to all members in the population with a gap in care to educate them and encourage them into care.	
The managed care plan should investigate opportunities to improve follow-up care for members with mental illness and reduce members risk to continued opioid use.	X	X		The Molina Quality team, in collaboration with our Case Management and Behavioral Health Departments, have implemented several interventions that facilitate the timely identification of and follow-up for members experiencing acute mental health episodes of care. Additionally, for members identified as opioid users, a comprehensive care management program now exists to ensure continued treatment assistance. **Mental Health and Opioid Use** Molina is now receiving hospital admission/discharge/transfer alerts from three regional health information organizations within our catchment area, covering members across both upstate and downstate regions. These alerts are received throughout the business day, updated in the Molina's case management system every 15 minutes, and queued up for	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				immediate action to be taken by the behavioral health case management team. The case managers, in turn, make several attempts to successfully contact the members for coordination of medical, behavioral health, and social services required to safely transition and stabilize the member in the community. The alerts are also being shared with the attributed health homes for the members identified for additional follow-up assistance—specially for the harder-to-reach members. Currently, the managed care plan is developing a mechanism to load the alerts directly into the electronic medical records of the members' attributed primary care providers. Also triggered by the alerts and daily utilization management census are robocall reminders to recently discharged members to remind and educate them of the importance of maintaining visits with their primary provider in the community. In 2023, the managed care plan will introduce a gift card reward to members who complete their follow-up visit within seven days. Also, the Behavioral Health and Case Management Departments are exploring the possibility of embedding staff in specific high-volume facilities that will allow engagement with members prior to discharge.	
The managed care plan should investigate opportunities to improve members access to dental care, alcohol and other drug abuse treatments, prenatal and postpartum care.	X	X	X	Since the previous measurement period, Molina has realized improvements in the measures. Equally as important are the changes in resources, processes and programs that have been implemented as indicated below. **Dental** During measurement year 2021, Molina identified an opportunity to acquire additional dental utilization data for services rendered in dental teaching facilities, namely the University of Buffalo which sees a large volume of Molina members in the Upstate region. Acquisition of this additional data alone significantly improved Molina's reported rate. Also,	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				in late 2021, Molina transitioned to a new dental benefits vendor, DentaQuest. Through this new vendor relationship, the Molina New York Quality team has collaborated with DentaQuest to perform live call campaigns to members in need of an annual dental visit. These calls serve to assist members with finding a dental provider and scheduling their next appointment. Also, after assessing the dental provider network and identifying dental practices with consistently high performance in the annual dental visit measure, members with aged 18 months on no dental utilization are either assigned or reassigned to a high-performing dental provider with a record of successful outreach and engagement. DentaQuest also offers their providers a quality incentive for achieving high performance standards. Alcohol and Other Drug Abuse Molina is now receiving hospital admission/discharge/transfer alerts from three regional health information organizations within our catchment area, covering members across both upstate and downstate regions. These alerts are updated in the managed care plan's case management system and queued up for immediate action to be taken by the behavioral health case management team. The purpose of the frequent alerts updates is to facilitate timely identification of members diagnosed with substance use disorders so that timely initiation of treatment can be facilitated during the case manager's contact with the members. The behavioral health and Case Management Departments also are exploring the possibility of embedding staff in specific high-volume facilities that will allow engagement with members prior to discharge. Prenatal and Postpartum Women's Health Line: upon identification of pregnancy, the Molina Quality team initiates the mailing of a maternity	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
				brochure to the member which is designed to deliver education on the importance of timely of prenatal and postpartum care, what to expect at each stage of gestational development, and what to expect during the postpartum period. Also, throughout the year, the dedicated contact center staff of the Women' Health Line make outbound calls to pregnant members to (1) educate them on the importance of timely prenatal/postpartum care, and (2) assist with appointment scheduling. In addition to outbound calls, the Women's Health Line accepts inbound calls from members that may receive the toll free# from any of the member educational materials mailed, emailed, or texted to these members. Molina is also working on a project to ensure maternity providers who are contracted at a global rate are submitting claims for all prenatal and postpartum care delivered to their members.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the compliance review conducted by the Department of Health.	X	X	X	Molina submitted a plan of correction to address identified deficiencies on January 31, 2020, and received Department of Health approval on July 22, 2020. The plan of correction included immediate updates to the provider directory to accurately reflect primary care physicians, updates to the managed care plan's provider manual along with quarterly audits to ensure compliance with regulatory requirements, immediate action by the dental benefit manager to correct processes to respond to prior authorization requests in a timely fashion. All corrective actions and future monitoring activities are monitored by the managed care plan's Compliance Committee on a quarterly basis. Molina was reaudited in December 2020 for the previously identified areas and found to be fully compliant as of January 15, 2021.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	Molina's Response	IPRO's Assessment of Molina's Response
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	There are three main interventions Molina has engaged in to obtain more information and a better understanding about drivers of member dissatisfaction. First, a member satisfaction survey will be executed at the completion of a call that a contact center agent is already engaged in with the member. This survey will allow us to begin gathering and trending CAHPS-related member experience/satisfaction data around the ease of working with Molina and the overall customer service experience during that contact. Secondly, we have launched a program called "Care4Care" that deploys contact center staff to call members with >1 complaint against the Plan within a calendar quarter. The purpose of this contact is to ascertain if the member's complaint was handled timely, appropriately and to their satisfaction, as well as to elicit suggestions on how the managed care plan can prevent their issue from happening again. Thirdly, the Plan will be sending out post-doctor visit surveys—starting in early 2023—to members with a recent primary care visit to get feedback on key CAHPS questions around *Getting Needed Care* and *Getting Care Quickly*. Our goal is to use the feedback from all these sources to inform changes in company procedures, re-education of contact center staff, and performance improvement activities with our providers.	Partially Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 100: Molina's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	Molina's measurement year 2021 performance improvement project passed validation.	X	X	X
	Molina exceeded the target rate for one performance indicator related to blood lead screening.	X	X	X
	Molina exceeded target rates for three performance indicators related to developmental screening.	X	X	X
Performance Measures	Molina met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	Molina performed significantly better than the mainstream Medicaid program on two measures of effectiveness of care related to children's health or mental health.	X	X	
Performance Measures – Access/Availability of Care	Molina performed significantly better than the mainstream Medicaid program on two measures of access/availability of care related to children's health or substance use.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Molina was in compliance with 10 standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	Molina did not meet target rates for five performance indicators related to blood lead screening.	X	X	X
	Molina did not meet target rates for six performance indicators related to newborn hearing screening.	X	X	X
	Molina did not meet target rates for three performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	Molina performed significantly worse than the mainstream Medicaid program on 11 measures of effectiveness of care related to primary care or mental health.	X	X	

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/Availability of Care	Molina performed significantly worse than the mainstream Medicaid program on four measures of access/availability of care related to primary care or maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	Molina performed significantly worse than the mainstream Medicaid program on one measure of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2019, Molina was not in full compliance with one standard of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, Molina should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	Molina should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Molina should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	Molina should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2019 compliance findings. Molina should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	Molina should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

MVP

Performance Improvement Project Summary and Results

Table 101: MVP's Performance Improvement Project Summary, Measurement Year 2021

MVP's Performance Improvement Project Summary
Title: KIDS Quality Agenda Validation Summary: There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim MVP aimed to improve the rates blood lead level testing, newborn hearing screens, developmental and autism evaluations for MVP members enrolled in Medicaid MMC and CHP and to ensure follow-up or referral services for children with abnormal screening results is provided.
Member-Focused 2021 Interventions ▪ Outreached via telephone and mail to parents/guidelines with educational material and assistance with the coordination of care. ▪ Mailed reminders to parents/guidelines of members identified as needing a blood lead test, follow-up care, and/or a confirmatory test. ▪ Sent annual mailing to parents/guidelines of all children in the eligible population outlining the importance of newborn hearing screening and follow-up. ▪ Sent educational mailing for members with information on the importance of developmental screening and the recommended screening schedule. ▪ Sent letters to parents/guidelines of children who are due for one or more developmental screenings.
Provider-Focused 2021 Interventions ▪ Provided educational materials to network primary care providers, provider-office laboratories and laboratories that are Clinical Laboratories Improvement Amendments of 1988-certified to perform blood lead level testing on how to navigate the New York State Immunization Information System including utilization of the point of care device tool. ▪ Conducted targeted outreach to providers with patients identified as having a recent a blood lead level between 5 mcg/dl and 10 mcg/dl to notify of the result and advise on the need for a follow-up confirmatory venous blood draw. ▪ Published newsletters articles on newborn hearing screening requirements and referral services for audiology and Early Detection and Intervention program services. ▪ Conducted targeted outreach to providers with patients identified as failing the initial hearing screen and did not have a follow-up audiological exam on file or were diagnosed with hearing loss and not referred to early intervention services. ▪ Provided tools and resources to all network providers via newsletters, fast faxes and mailings on developmental screening tools, coding guidelines and follow-up documentation. ▪ Issued discharge logs, Public Health Law reporting obligations and follow-up requirements to birthing facilities with the highest number of missing results in the Ealy Hearing Detection and Intervention system.
Managed Care Plan-Focused 2021 Interventions ▪ Observed high-volume, high performing practices to capture best practices for developmental screenings. Best practices were shared with high-volume, low performing practices.

Table 102: MVP’s Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	44.17%	70.42%	68.19%	67.65%	74.00%
Blood Lead Test at Age 2 Years	42.40%	68.46%	72.04%	63.08%	82.00%
Blood Lead Test at Ages 1 and 2 Years	30.77%	47.32%	52.99%	42.73%	56.00%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	66.18%	31.91%	30.00%	25.00%	76.00%
Confirmed Venous Blood Lead Level > 5 mcg/dl	1.68%	0.63%	0.66%	0.00%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	25.52%	28.71%	28.69%	31.58%	65.00%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.51%	0.08%	0.09%	0.00%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	22.22%	13.16%	10.87%	3.85%	65.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	98.58%	89.01%	90.02%	4.32%	99.00%
Failed Screening by Age 1 Month	1.81%	1.60%	1.42%	0.89%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	59.52%	53.95%	38.46%	33.33%	75.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	18.00%	21.95%	24.00%	0.00%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	23.08%	33.33%	30.00%	0.00%	100.00%
Screening Before Age 3 Months	91.33%	89.68%	92.74%	5.62%	95.00%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	62.26%	50.00%	53.00%	0.00%	77.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	5.66%	10.53%	26.32%	0.00%	100.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	9.94%	10.70%	16.44%	25.36%	20.00%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	13.44%	34.37%	36.60%	42.90%	43.00%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	19.07%	27.16%	32.46%	38.72%	34.00%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	14.52%	24.32%	28.42%	35.89%	30.00%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.53%	6.03%	10.35%	10.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.06%	1.56%	4.64%	10.00%

Performance Measure Results

Table 103: MVP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	MVP Measurement Year 2019	MVP Measurement Year 2020	MVP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	51.33%	53.51%	54.88%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	35.52%	38.72%	39.27%	41.64%
Asthma Medication Ratio (5–64 Years)	64.58%	64.02%	62.55%	56.86%
Breast Cancer Screening	66.57%	63.05%	60.07%	64.75%
Cervical Cancer Screening	71.05%	67.88%	67.40%	69.19%
Chlamydia Screening in Women (16–20 Years)	68.64%	62.62%	61.66%	71.38%
Chlamydia Screening in Women (21–24 Years)	74.25%	71.08%	70.57%	74.13%
Colorectal Cancer Screening	57.66%	56.45%	55.72%	61.03%
Comprehensive Diabetes Care – Eye Exam	64.96%	53.77%	55.47%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	32.85%	59.12%	51.09%	34.74%
Controlling High Blood Pressure	63.02%	45.74%	57.91%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	35.81%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	68.22%	69.55%	65.44%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	43.96%	38.03%	37.65%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	87.38%	80.43%	79.85%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	81.51%	71.53%	70.32%	66.71%
Immunizations for Adolescents – Combination 2	46.47%	42.34%	42.82%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	87.59%	67.88%	83.21%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	82.48%	66.18%	76.89%	84.17%

Measure	MVP Measurement Year 2019	MVP Measurement Year 2020	MVP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	73.97%	57.91%	74.70%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	25.93%	17.36%	13.22%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.10%	59.62%	58.37%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.64%	75.88%	75.06%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	83.79%	52.87%	48.87%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	56.40%	63.60%	63.73%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	47.71%	46.43%	38.30%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	52.11%	54.19%	42.18%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.69%	31.01%	38.43%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	46.72%	46.00%	43.97%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	22.87%	21.77%	19.25%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	69.32%	52.33%	58.02%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	40.56%	Not Available	47.11%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	MVP Measurement Year 2019	MVP Measurement Year 2020	MVP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	82.97%	87.59%	87.20%
Prenatal and Postpartum Care – Postpartum Care	79.56%	77.13%	76.89%	81.63%
Utilization and Risk Adjusted Utilization – Children's Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	73.80%	72.57%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	85.25%	80.60%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	67.57%	70.22%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan's performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 104: MVP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020	2021[1]
438.206: Availability of Services	C	NC	Pended
438.207: Assurances of Adequate Capacity and Services	C	C	Pended
438.208: Coordination and Continuity of Care	C	C	Pended
438.210: Coverage and Authorization of Services	C	C	Pended
438.214: Provider Selection	C	NC	Pended
438.224: Confidentiality	C	C	Pended
438.228: Grievance and Appeal System	C	NC	Pended
438.230: Sub-contractual Relationships and Delegation	C	C	Pended
438.236: Practice Guidelines	C	C	Pended
438.242: Health Information Systems	C	C	Pended
438.330: Quality Assessment and Performance Improvement Program	C	C	Pended

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2020 Results

- Based on staff interview and review of sampled hospital contracts, MVP failed to notify the Department of Health 45 days in advance of three of 65 contracts that were set to expire. *(Contract Article 2005-98-1.13(c)(2))*
- Based on staff interview and review of the external appeal instructions and application, MVP failed to issue current external appeal instructions and application forms to enrollees in four of 16 Medicaid standard and expedited appeals, and four of 15 commercial/Child Health Plus standard and expedited appeals. *(Contract Article 98-2.9(h)(1))*
- Based on staff interview and review of the final adverse determination notices, MVP failed to ensure its delegate, EviCore, issued notices to enrollees that included the utilization review agent's contact person or department name in two of eight Medicaid expedited appeal utilization review cases. *(Contract Article 98-2.9(e)(1), 4904. (3)(a))*
- Based on staff interview and review of the Adverse Determination Notices, MVP failed to ensure its delegate, HealthPlex, issued written notices that were factual and accurate in nature for three of 13 Child Health Plus pre-authorizations and for two of eight Child Health Plus standard appeal utilization review cases. *(Contract Article 4405(10))*
- Based on staff interview and review of the sampled provider credentialing files, MVP failed to credential two of 16 providers every three years as required. *(Contract Article 2005-98-1.12(k))*
- Based on staff interview and review of the sampled provider contracts, MVP failed to provide evidence that 15 of 65 providers were sent an amendment that included the 2017 New York State Department of Health Standard Clauses for Managed Care Provider/Independent Physician Association/Accountable Care Organization Contracts Incorporation Language. *(Contract Article 2005-98-1.13(a))*

Quality-of-Care Survey Results – Member Experience

Table 105: MVP's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	MVP	Mainstream Medicaid Average	MVP	Mainstream Medicaid Average	MVP	Mainstream Medicaid Average
Getting Needed Care[1]	82.99%	78.71%	83.57%	81.33%	79.68%	78.54%
Getting Care Quickly[1]	76.87%	78.40%	80.62%	80.57%	81.73%	78.88%
How Well Doctors Communicate[1]	92.91%	90.95%	93.24%	92.00%	91.10%	92.04%
Customer Service[1]	91.62%	85.72%	94.15%	87.13%	90.20%	86.32%
Rating of All Health Care[2]	80.81%	76.50%	75.86%	75.33%	74.52%	72.83%
Rating of Personal Doctor[2]	85.19%	80.80%	81.63%	81.46%	81.46%	81.25%
Rating of Specialist Talked to Most Often[2]	81.36%	79.63%	81.04%	82.07%	80.88%	78.79%
Rating of Health Plan[2]	85.06%	75.93%	81.17%	75.90%	75.24%	73.47%
Rating of Treatment or Counseling[2]	76.20%	59.60%	81.61%	61.84%	61.37%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Green shading indicates managed care plan's measurement year performance is statistically significantly better than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 106: MVP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate additional opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings as no rates met the target goals.	X	X		MVP's Kids' Quality Agenda Performance Improvement Project occurred during the COVID-19 Pandemic and a substantial portion of MVP's pediatric Medicaid population reside in and around the mid-Hudson NY area, one of the natation's first hotspots for COVID-19. MVP feels that many of the disruptions in preventive care (providers' offices closing or switching to virtual care, and caregivers' hesitancy to bring their children for appointments for fear of exposing them to the virus) were beyond the managed care plan's control. When the performance improvement project was extended to 2021, MVP extended the intervention end dates and as the initial waves of the pandemic subsided, many rates rebounded. By the end of the final measurement period, four of six lead screening indicators demonstrated improvement from baseline, and six of six developmental screening indicators met or exceeded target goals. To continue to improve MVP will continue to mail reminder letters to caregivers of children who are due for a blood-lead screening, newborn hearing screening, developmental screening, and/or autism screenings. The caregivers will be notified of the test required and will be encouraged to follow-up with their child's pediatrician to schedule an appointment. To determine if this targeted approach is effective, MVP will continue to monitor blood lead testing, newborn hearing screening and developmental screening rates.	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
				Member education on the importance of blood lead screening, blood lead prevention, newborn hearing screening and follow-up, and developmental and autism screening will continue to be a focus for MVP. Educational information is communicated through member newsletters, and via the MVP member website. Additionally, MVP will continue to educate providers on the updated screening and coding guidelines via Provider Newsletters, Fast-Faxes, MVP Provider Website, and verbally from our Professional Relations and Health Management teams.	
Validation of Performance Measures					
The managed care plan should investigate opportunities to improve women's and children's access to preventative screenings as rates have declined from 2019 to 2020.	X	X		MVP feels that many of the disruptions in preventive care (providers' offices closing or switching to virtual care, and members hesitancy to go to medical office for in-person appointments) due to the COVID-19 Pandemic were beyond the managed care plan's control, and while rates declined from 2019 to 2020, many rates have rebounded as the initial waves of the pandemic have subsided. To improve women's and children's access to preventive screenings, MVP has contracted with a vendor that can perform in-home lab services and expanded the access to telehealth visits through MVP's app, Gia where members can be connected to primary and specialty care through a virtual care delivery provider.	Partially Addressed
In addition to the managed care plan's current interventions, the managed care plan should conduct a root cause analysis	X	X		MVP recognizes that diabetes and COPD are both chronic conditions that need special attention. In 2020 and in 2021 MVP offered a four-part educational online seminar series entitled Navigating Diabetes which was available to all members. This series provided information on diabetes prevention, early diagnosis, living with and managing diabetes	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
to identify additional barriers to members effectively managing their diabetes and chronic obstructive pulmonary disease.				symptoms, nutrition, and exercise to help member effectively manage their diabetes. To provide additional ongoing support to members with diabetes and or chronic obstructive pulmonary disease, MVP offers both a Diabetes Care Management program and a Chronic Obstructive Pulmonary disease Condition Health Coaching program, and condition specific newsletters for diabetes, and chronic obstructive pulmonary disease. The MVP Quality team is currently collaborating with the MVP Case Management team to improve the effectiveness of gap closure through daily case management activities and member work plans.	
In addition to the managed care plan provider bridge programs, the managed care plan should investigate additional opportunities to improve follow-up care for members with substance abuse disorders and for children on attention-deficit/hyperactivity disorder medication, as these rates declined in measurement year	X	X		In addition to the bridge providers MVP partners with to provide MVP members with access to immediate community-based outreach and support from licensed practitioners when members are discharged from inpatient psychiatric, and substance use units. MVP also has an active Opioid Taskforce that meets regularly to discuss decreasing opioid use, substance use disorder readmission rates and improve member access to medication assisted treatment. The Opioid Task Force has raised awareness within the health plan about the support, treatment, and access needs of members with substance use disorder/opioid use disorder and incorporated MVP's response to these needs into the routine operational work of the health plan. MVP temporarily suspended many member communications regarding routine visits and screenings at the onset of the COVID -19 pandemic to focus messaging on COVID-19 testing, treatment, resources, and the promotion of telehealth services. Unfortunately, attention deficit rates fell during this time. As the initial waves of the pandemic subsided, MVP has restarted attention deficit-initiation and attention deficit-	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
2020. Additionally, the managed care plan should investigate opportunities to reduce members use of opioids at high dosages.				continuation call campaigns and completed additional reminder and education initiatives for caregivers of children on attention-deficit/hyperactivity disorder medication.	
The managed care plan should investigate opportunities to improve members access to prenatal care.	X	X	X	MVP is investigating opportunities to improve member access to prenatal care and is currently assessing the feasibility of an ongoing outreach program to pregnant members and members who have recently given birth to inform them about the importance of prenatal and postnatal care appointments. For members who are identified as having high risk pregnancies, MVP offers a prenatal education program. Medicaid members who have recently given birth also receive a Baby Care Kit which includes a thermometer, a copy of the book "Goodnight Moon" in English or Spanish, a blanket, a bib, a onesie, a teething ring, and educational information for parents.	Addressed
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during measurement year 2020 operational survey conducted	X	X	X	MVP recognizes that complying with Medicaid standards is an integral part of providing a high-quality health plan and creating a positive experience for MVP's customers. Compliance with these standards is an enterprise-wide effort, and MVP teams remain committed to improving our internal collaboration and communication to ensure compliance with Medicaid standards.	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	MVP's Response	IPRO's Assessment of MVP's Response
by the Department of Health.					
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	MVP continues to monitor CAHPS scores, evaluate results and identify opportunities to enhance member experience with MVP.	Addressed

Strengths, Opportunities for Improvement, and Recommendations

Table 107: MVP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	MVP's measurement year 2021 performance improvement project passed validation.	X	X	X
	MVP exceeded target rates for four performance indicators related to developmental screening.	X	X	X
Performance Measures	MVP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	MVP performed significantly better than the mainstream Medicaid program on two measures of effectiveness of care related to primary care or HIV care.	X	X	
Performance Measures – Access/Availability of Care	MVP performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to children's health.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	MVP performed significantly better than the mainstream Medicaid program on two measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, MVP was in compliance with eight standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	MVP did not meet target rates for six performance indicators related to blood lead screening.	X	X	X
	MVP did not meet target rates for six performance indicators related to newborn hearing screening.	X	X	X
	MVP did not meet target rates for two performance indicators related to developmental screening.	X	X	X
Performance Measures – Effectiveness of Care	MVP performed significantly worse than the mainstream Medicaid program on 16 measures of effectiveness of care related to primary care, children's health, substance use, or mental health.	X	X	

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Access/Availability of Care	MVP performed significantly worse than the mainstream Medicaid program on two measures of access/availability of care related to primary care or maternity.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2020, MVP was not in full compliance with three standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	None.			
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, MVP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	MVP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, MVP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	MVP should ensure its compliance with federal and state Medicaid standards by continuing the initiatives put in place to address the measurement year 2020 compliance findings. MVP should conduct internal reviews as it prepares for the compliance review conducted by the Department of Health.	X	X	X
Quality-of-Care Survey	MVP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

UHCCP

Performance Improvement Project Summary and Results

Table 108: UHCCP's Performance Improvement Project Summary, Measurement Year 2021

UHCCP's Performance Improvement Project Summary
Title: Optimizing Developmental Trajectory of Children: Risk Identification and Linkage to Services **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP aimed to identify and stratify eligible Medicaid and CHP members who are required to receive blood lead testing, newborn hearing screening and/or standardized developmental screening, and implemented interventions aimed at improving screening rates and necessary follow-up within appropriate timeframes. Member-Focused 2021 Interventions ▪ Issued automated interactive voice responses to parents/guardians educating them on the importance of blood lead level testing and linkages to appropriate services. ▪ Conducted outreach calls to parents/guardians of members identified as not having a blood lead level test to educate them on the importance of blood lead level testing and linkages to appropriate services; to members identified as having elevated blood lead levels and no follow-up; to members who require a follow-up hearing screen; and to members with no developmental screenings to educate them on appropriate linkages to services and encouraging them to schedule follow-up appointments. ▪ Published articles in the member newsletter with information on where lead is found in homes and the effects of blood lead poisoning, and newborn hearing screenings and linkages to appropriate services. ▪ Established the LetsGetChecked program where participating members receive home blood lead level testing kits and a follow-up call. ▪ Sent annual mailer to members with information about the importance of developmental screenings and linkages to appropriate services. Provider-Focused 2021 Interventions ▪ Provided high-volume provider groups a dashboard with a complete with measure requirements, helpful links to provider resources and a list of patients identified needing a blood level test and or follow-up, newborn hearing screening and or follow-up, or developmental screening and or follow-up. ▪ Outreached to providers with patients identified as having elevated blood lead levels and did not receive timely follow-up. Providers were encouraged to follow-up with these patients and retest. ▪ Distributed updated member demographic information to providers for patients categorized as "potentially lost to follow-up." ▪ Posted clinical guidelines for blood lead level testing, newborn hearing screening, developmental screening, reporting guidelines, and the management of associated risks even with low blood lead levels on the provider website. ▪ Published newsletter article on blood lead level testing and follow-up requirements.

Table 109: UHCCP's Performance Improvement Project Indicators, Measurement Years 2018 – 2021

Indicator	Baseline Measurement Year 2018	Interim Measurement Year 2019	Interim Measurement Year 2020	Final Measurement Year 2021	Target/ Goal
Blood Lead Screening Measures					
Blood Lead Test at Age 1 Year	69.62%	63.82%	45.02%	44.77%	72.91%
Blood Lead Test at Age 2 Years	69.01%	64.91%	60.49%	53.01%	72.01%
Blood Lead Test at Ages 1 and 2 Years	48.67%	45.60%	48.01%	40.27%	51.67%
Blood Lead Level > 5 mcg/dl With a Confirmatory Venous Blood Lead Level Test Within 3 Months	32.68%	54.49%	56.29%	42.80%	39.68%
Confirmed Venous Blood Lead Level > 5 mcg/dl	0.45%	1.48%	1.31%	1.28%	No Target
Confirmed Venous Blood Lead Level > 5 mcg/dl Follow-Up Test Within 3 Months	81.88%	100.00%	100.00%	100.00%	96.88%
Confirmed Venous Blood Lead Level > 10 mcg/dl	0.07%	0.52%	0.52%	0.57%	No Target
Confirmed Venous Blood Lead Level > 10 mcg/dl Follow-Up Test Within 1 Month	32.13%	100.00%	100.00%	100.00%	80.00%
Newborn Hearing Screening Measures					
Screening by Age 1 Month	76.00%	82.40%	88.25%	89.05%	83.01%
Failed Screening by Age 1 Month	1.53%	1.73%	2.91%	1.56%	No Target
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months	35.82%	22.60%	39.39%	41.61%	80.00%
Failed Screening by Age 1 Month with a Diagnostic Audiological Evaluation by Age 3 Months and Diagnosed with Hearing Loss by Age 3 Months	25.00%	12.50%	16.48%	17.54%	No Target
Failed Screening by Age 1 Month and Diagnosed with Hearing Loss by Age 3 Months and Referred to Early Intervention by Age 6 Months	37.50%	50.00%	27.27%	20.00%	80.00%
Screening Before Age 3 Months	64.79%	87.92%	89.81%	88.44%	88.79%
Failed Screening with a Diagnostic Audiological Evaluation by Age 6 Months	62.71%	35.71%	46.36%	45.36%	80.00%
Hearing Loss Diagnosis and Referred to Early Intervention Services Before Age 9 Months	2.52%	14.93%	16.92%	18.97%	80.00%
Developmental Screening Measures					
Screening for Developmental, Behavioral, and Social Delays by Age 1 Year	18.67%	21.91%	26.79%	28.14%	23.67%
Screening for Developmental, Behavioral, and Social Delays by Age 2 Years	29.64%	35.01%	41.49%	41.47%	36.64%
Screening for Developmental, Behavioral, and Social Delays by Age 3 Years	24.70%	27.54%	34.51%	36.66%	29.70%
Screening for Developmental, Behavioral, and Social Delays Using American Academy of Pediatrics Well-Child Visit Guidelines	24.06%	27.81%	33.75%	35.91%	29.06%
Screening for Autism by Age 30 Months: 1 Screening Claim	0.00%	0.00%	4.19%	8.15%	3.00%
Screening for Autism by Age 30 Months: 2 Screening Claims	0.00%	0.00%	0.97%	3.33%	3.00%

Performance Measure Results

Table 110: UHCCP's Performance Measure Results, Measurement Years 2019 to 2021

Measure	UHCCP Measurement Year 2019	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Effectiveness of Care – Primary Care Measures				
Antidepressant Medication Management – Effective Acute Phase Treatment	54.60%	58.66%	61.33%	58.36%
Antidepressant Medication Management – Effective Continuation Phase Treatment	39.87%	43.41%	44.28%	41.64%
Asthma Medication Ratio (5–64 Years)	61.63%	63.69%	60.50%	56.86%
Breast Cancer Screening	65.13%	61.14%	59.03%	64.75%
Cervical Cancer Screening	70.32%	64.07%	68.37%	69.19%
Chlamydia Screening in Women (16–20 Years)	69.29%	66.15%	66.11%	71.38%
Chlamydia Screening in Women (21–24 Years)	73.99%	69.12%	71.30%	74.13%
Colorectal Cancer Screening	56.93%	56.45%	53.53%	61.03%
Comprehensive Diabetes Care – Eye Exam	64.72%	57.66%	64.23%	61.32%
Comprehensive Diabetes Care – HbA1c Poor Control (>9%)[1]	30.41%	36.98%	36.01%	34.74%
Controlling High Blood Pressure	58.15%	60.10%	63.26%	64.97%
Kidney Health Evaluation for Patients with Diabetes (Total)	New Measure in 2020	First Year Measure[2]	33.88%	41.36%
Statin Therapy for Patients with Cardiovascular Disease – Adherence 80%	70.82%	75.35%	70.38%	69.64%
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	53.43%	46.74%	33.30%	40.16%
Effectiveness of Care – HIV Measure				
Viral Load Suppression	75.35%	68.71%	70.48%	73.38%
Effectiveness of Care – Children's Health Measures				
Childhood Immunization Status – Combination 3	55.96%	61.80%	55.96%	66.71%
Immunizations for Adolescents – Combination 2	24.82%	27.74%	26.03%	42.37%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Percentile Documentation	82.24%	82.48%	84.43%	85.12%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	76.89%	77.37%	79.81%	84.17%

Measure	UHCCP Measurement Year 2019	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity	69.83%	74.70%	76.40%	80.25%
Effectiveness of Care – Substance Use Measure				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days	14.86%	16.61%	14.60%	19.43%
Effectiveness of Care – Mental Health Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	60.29%	62.59%	61.87%	61.63%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.90%	75.18%	78.50%	78.10%
Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	45.39%	43.31%	43.10%	53.37%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	62.03%	65.54%	67.47%	66.00%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Initiation Phase	57.27%	63.57%	54.46%	53.28%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication – Continuation and Maintenance Phase	66.23%	70.45%	60.68%	61.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics	40.08%	35.34%	38.27%	39.35%
Access/Availability of Care – Primary Care Measures				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation of Treatment (Total)	46.25%	45.83%	42.87%	46.67%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement of Treatment (Total)	20.06%	19.13%	16.23%	18.24%
Access/Availability of Care – Children's Health Measure				
Annual Dental Visit (2–18 Years)	63.05%	50.68%	54.75%	53.29%
Access/Availability of Care – Substance Use Measure				
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	39.52%	Not Available	45.94%	43.80%
Access/Availability of Care – Maternity Measures				

Measure	UHCCP Measurement Year 2019	UHCCP Measurement Year 2020	UHCCP Measurement Year 2021	Mainstream Medicaid Measurement Year 2021
Prenatal and Postpartum Care – Timeliness of Prenatal Care	Not Required	80.54%	81.02%	87.20%
Prenatal and Postpartum Care – Postpartum Care	82.48%	77.86%	79.81%	81.63%
Utilization and Risk Adjusted Utilization – Children’s Health Measures				
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure[2]	60.14%	58.04%	66.69%
Well-Child Visits in the First 30 Months of Life – Age 15 Months–30 Months	First Year Measure[2]	78.22%	73.31%	78.24%
Child and Adolescent Well-Care Visits (Total)	First Year Measure[2]	60.78%	63.87%	69.73%

[1] Lower rate indicates better performance.

[2] First year measures are not publicly reported.

Green shading indicates managed care plan’s performance for the measurement year is statistically significantly better than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Red shading indicates managed care plan's performance for the measurement year is statistically significantly worse than the mainstream Medicaid statewide performance for the corresponding measurement year. (Statewide performance for measurement years 2020 and 2019 are not shown.) Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Compliance with Medicaid and Children's Health Insurance Program Standards Results

Table 111: UHCCP's Compliance with Federal Medicaid Standards Findings

Part 438 Subpart D Quality Assurance and Performance Improvement Program Standards	2019	2020[1]	2021
438.206: Availability of Services	NC	Pended	NC
438.207: Assurances of adequate capacity and services	C	Pended	C
438.208: Coordination and continuity of care	C	Pended	C
438.210: Coverage and authorization of services	NC	Pended	C
438.214: Provider selection	C	Pended	NC
438.224: Confidentiality	C	Pended	C
438.228: Grievance and appeal system	NC	Pended	C
438.230: Sub-contractual relationships and delegation	C	Pended	C
438.236: Practice guidelines	C	Pended	C
438.242: Health information systems	C	Pended	C
438.330: Quality assessment and performance improvement program	NC	Pended	C

[1] Activity pended due to COVID-19. The Centers for Medicare & Medicaid Services granted New York State a Section 1135 Waiver that suspended the requirements under *Title 42 Code of Federal Regulations 438.66 State monitoring requirements* for full on-site biannual operational, targeted, focused managed care surveys and readiness reviews, and allowing partial completion of essential survey and readiness activities remotely.
C: Mainstream Medicaid managed care plan is in compliance with all standard requirements; NC: Mainstream Medicaid managed care plan is not in compliance with at least one standard requirement.

Summary of 2021 Results

- UHCCP failed to ensure that four of the 27 contracts reviewed included required components. Specifically, the contracts did not include the 21st Century Cures Act Amendment and/or the 2017 Standard Clause incorporation language or attachment. *(New York Codes, Rules, and Regulations 98-1.13(a))*
- Based on an interview held on June 16th, 2021, and a review of documents, UHCCP failed to ensure that credential files included the required components for four of 16 credential files reviewed. *(Contract Article 2005-98-1.13(a))*
- Based on an interview held on June 16th, 2021, and a review of documents, UHCCP failed to notify the New York State Department of Health, of the departure of former board member. *(Contract Article 2005-98-1.12(k))*

Quality-of-Care Survey Results – Member Experience

Table 112: UHCCP's Adult CAHPS Results, Measurement Years 2017, 2019, and 2021

Measure	Measurement Year 2017		Measurement Year 2019		Measurement Year 2021	
	UHCCP	Mainstream Medicaid Average	UHCCP	Mainstream Medicaid Average	UHCCP	Mainstream Medicaid Average
Getting Needed Care[1]	76.01%	78.71%	82.43%	81.33%	75.07%	78.54%
Getting Care Quickly[1]	80.32%	78.40%	77.65%	80.57%	80.37%	78.88%
How Well Doctors Communicate[1]	89.96%	90.95%	92.73%	92.00%	90.35%	92.04%
Customer Service[1]	80.59%	85.72%	82.24%	87.13%	89.66%	86.32%
Rating of All Health Care[2]	74.14%	76.50%	74.09%	75.33%	73.30%	72.83%
Rating of Personal Doctor[2]	77.57%	80.80%	84.44%	81.46%	81.03%	81.25%
Rating of Specialist Talked to Most Often[2]	78.59%	79.63%	84.67%	82.07%	80.01%	78.79%
Rating of Health Plan[2]	69.73%	75.93%	68.66%	75.90%	68.93%	73.47%
Rating of Treatment or Counseling[2]	52.02%	59.60%	Sample Size Too Small To Report	61.84%	43.38%	60.68%

[1] Measure represents the percent of members who responded "usually" or "always."

[2] Ratings range from 0 to 10. This measure represents the percent of members who responded "8" or "9" or "10."

Red shading indicates managed care plan's measurement year performance is statistically significantly worse than the corresponding mainstream Medicaid statewide measurement year performance. Statistically significant differences between scores were determined using t-tests. A significance level of 0.05 or less was considered statistically significant.

Sample size too small to report means that the denominator is less than 30 members

Assessment of Managed Care Plan Follow-up on the 2020 External Quality Review Recommendations

Table 113: UHCCP's Response to the Previous Year's Recommendations

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
Validation of Performance Improvement Projects					
The managed care plan should investigate additional opportunities to improve the following performance improvement project indicators; blood lead testing, newborn hearing screenings, and developmental screenings.	X	X		From 2019-2021, parents and caregivers received live outreach calls of identified of eligible plan members to educate and encourage scheduling appointments with providers for blood lead level testing, newborn hearing, and developmental screenings. UHCCP continued to outreach parents and caregivers via the interactive voice response to educate and promote timely testing and screenings. Providers were provided dashboards which included screening tools and developmental screening links, a CPT Code Glossary. The quarterly dashboard also included lists of members with overdue screening and/or testing as well as lists of members who were lost to follow-up. Providers were notified of pediatric preventative screening guidelines and claims processing via the provider portal. All process measures were reviewed quarterly and measured against the progress of the performance improvement project indicators of three focus areas: blood lead level testing, newborn hearing screenings and developmental screenings. This performance improvement project objectives for the three focus areas were mostly met with thirteen out of the eighteen performance indicator measures improving from baseline. Nine measures exceeded goal. Three out of the six blood lead level testing performance Indicators increased from the 2018 baseline to the 2021 final rate. Blood lead levels 6 and 8 significantly improved to 100% from 2019 through 2021. Four out of six newborn hearing	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				performance indicators rates improved from baseline. Six out of six of the developmental and autism screening indicators steadily improved year over year. Three out of six blood lead level measures exceeded goal. Hearing measure #1 exceeded goal. The two autism measures significantly improved year of year and exceeded goal. Initial parameters for blood lead level data did not include all opportunities for compliant numerator and denominators affecting baseline results. After meeting with state in fall 2020 blood lead levels requirements for CPT and claims/lab codes were clarified. The rate difference from 2018 baseline to the 2019 and 2020 interim rates for blood level measure compliance is due to revised measure specifications. Improvement rate for blood lead level measures 4-8 was due to inclusion of claims/lab data. This impacted compliance by increasing numerator compliance more accurate performance for the measures. The lead test CPT codes 83655 without specification of blood lead testing codes 36415 or 36416 resulted in a drop numerator compliance for the first three blood level measures. Due to the inability to retrieve historical 2018 baseline data the plan was unable to update the measure data with the new methodology modifications to these measures. With this change, UHCCP was unable to compare the baseline rates to the final rates. UHCCP will continue to evaluate health disparities which might influence compliance with developmental, autism and hearing screening and blood lead level testing. Clinical practice consultants working with providers to disseminate information to support new and on-going initiatives. Expansion of the clinical practice consultants team will facilitate this effort. Actions that will be taken to sustain	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				improvement include continued use of claims/lab codes in addition to claims data, clinical practice consultants will continue to support providers, annual review of clinical practice guidelines will be posted on the company portal. The performance improvement project requirements continue to be posted on the provider portal.	
Validation of Performance Measures					
The managed care plan should investigate additional opportunities to improve members' access to preventative screenings and immunizations.	X	X		Preventative health and vaccinations are the starting point for an optimal trajectory beginning in childhood and throughout adulthood. UHCCP analyzed opportunities to improve members' access to preventative screenings and immunizations and launched the direct member and provider-based initiatives. The health plan will continue to analyze opportunities to improve preventative and vaccination rates to care. UHCCP is looking closely at how health disparities might affect member compliance with these rates. The following programs which components related to prevention and immunization are new and on-going programs: Member direct outreach is facilitated use of the auto-dialer by which the plan outreach coordinators call members to help close gaps in care. This includes educating members on screening and helping schedule appointments. In 2021, there were almost 77,000 interactive voice response calls on colorectal cancer screenings, breast cancer screenings, cervical cancer screenings, blood lead level testing, developmental and newborn hearing screenings. Data is monitored monthly by the managed care plan's member outreach manager. Members who attended preventative care appointments received a gift card after UHCCP received a signed form by their doctor confirming an appointment took place for a	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				particular preventive service. Additional follow-up is conducted by comparing claims received for each measure. The managed care plan has implemented programs which provide home testing kits for colorectal cancer screening via iFOBT. Results are reported to the member and primary care provider. The ongoing Flu Season Campaigns provides the member with information regarding the flu vaccine and encourages members to obtain the vaccine at no cost. The healthtalkexam.myuhc.com will help members find location for flu shots on the myuhc.com/findflushot page. The Woman Email Campaign encourages members ages 18 years and older to go to their annual wellness exam. This campaign also includes language around breast and cervical cancer screenings and resources. Member newsletters include prevention and screening topics such as vaccines, blood lead level, earing and development screenings, well-child visits, breast and cervical cancer screenings, adolescent well visits and vaccines as well as annual dental visits. Education on getting the appropriate care and how to prevent chronic conditions help members understand the importance of preventative care. There are articles that focus on where and when to go for treatment such as your primary care provider, urgent care, or emergency room. Getting appropriate care and now who to see and where to go. Information regarding smoking cessation, Flu vaccines and ways to prepare to see your providers. UHCCP has a program that focuses on the members preferred way to be contacted. We use text, email and	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				interactive voice response calling based on their preference to educate them on preventative care. Families receive postcard reminders for missed dose vaccines targeting parents or guardians of children at ages 6 months, 8 months, and 16 months. Ten-month postcards are sent as reminders for to schedule 1 year well visit doctor appointment. The same program offices post care reminders for missed dose vaccines. These monthly postcards target parents and guardians or young adult members at ages 16-17 years and 18-19 years. Postcards for 18-19 years will run throughout the summer to help young adults catch up with immunizations before going back to school/college. UHCCP has also launched provider facing opportunities to improve compliance with member preventative and screening measures. The *Patient Care Opportunity Report* is a comprehensive report which allows providers to get details about preventive care opportunities for their UnitedHealthcare patients. Providers will receive monthly *Patient Care Opportunity Report* lists with member level details. On a monthly basis, clinical practice consultants will reinforce the *Patient Care Opportunity Reports* by engaging with providers and communicating the importance of educating their patients regarding scheduling preventative care appointments. In addition, the Community Plan Primary Care Professional Incentive Program is an ancillary incentive program to the *Patient Care Opportunity Report* designed to reward specific physician groups for improving their quality of care and controlling medical costs. This supports provider engagement quality monitoring of providers. The program rewards qualifying physician practices for performance tied to addressing patient care	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				opportunities to close gaps in care with components of preventative care.	
The managed care plan should investigate opportunities to improve the health of members with HIV.	X	X		UHCCP identified opportunities to improve the health of members with HIV. Possible barriers preventing members from accessing case management support may be due to maybe due to member's disclosure of their HIV status Members before case managers can work with members on an HIV-specific care plan. The following actions were implemented to improve the health of members with HIV: Monthly report received by Medical Management team: Members with an HIV diagnosis, no claim with a viral load testing code in the last 12 months, and not engaged in a case/care management program (UHCCP case management or Health Home). Members with any emergency room or inpatient visits or high cost not related to pharmacy are referred to UHCCP case management for engagement. Actions are monitored and evaluated by review of the number of members who were referred to the program to those who were contacted. (April 2021-on-going) Monthly Medical Management Reports: Utilize medical management monthly report to refer members without inpatient or emergency room visits to non-clinical outreach for engagement. Outreach calls will be made to members in the denominator to remind the member to keep their appointments with their provider and to adhere to their medication regimen. (August 2022) Provider Newsletters: Article on clinical practice guidelines for HIV treatment/testing and definitions based on New York State Department of Health AIDS Institute. (Spring 2021, Summer 2022)	Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				Member Newsletters: Article on understanding HIV and getting tested and includes the link to the New York State Department of Health AIDS Institute. (Spring 2021 and Summer 2022)	
The managed care plan should investigate additional opportunities to improve follow-up care after an emergency department visit for mental illness or substance abuse as all rates remain significantly below the statewide averages.	X	X		Access to regional health information organization emergency department service reports within one to two days of the episode of care is the most efficient method to engage the managed care plan with members who were recently discharged from the emergency room for mental health illness or substance abuse reasons. The regional health information organization emergency room episode report was used to inform case managers, health homes, and assertive community treatment teams of the member's emergency room visit to intervene and support a member's transition of care. Although difficult it was difficult to *Follow-Up After Emergency Department Visit for Mental Illness 7-Day* and *30-Day* to reach members, the managed care plan secured a data feed from Healthix, a health information exchange, to obtain emergency department discharge data of recently discharged members. The managed care plan also established a successful process for recording member alternate phone numbers in our system upon a utilization management or case management encounter but that has not resulted in an increase in successful post emergency department member contacts as we had hoped. Going forward we are planning to add an emergency department navigator position. The emergency department navigator will focus on emergency department follow-up with aftercare providers as well as with members. *Follow-up After Emergency Dept Visit for Alcohol & Other Drug Dependence* the goal was met. Improvement was	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				attributed to case management outreach. The intervention shall continue. The managed care plan is continuing to evaluate additional opportunities to improve follow-up care after an emergency department visit for mental illness or substance abuse.	
The managed care plan should investigate opportunities to improve members access to substance abuse treatments and prenatal care.	X	X		Prenatal Care Improving access to prenatal care begins with promoting the importance and benefits of prenatal care. Opportunities encompass interactive voice response recording designed to encourage and engage members to schedule prenatal appointments. One of the most successful programs is the Upstate Summer Program supporting the large Hasidic community population living in Brooklyn, New York. For several years, the managed care plan as supported an obstetrics/gynecology office set up in the Catskills where families vacation every summer from mid-June to mid-August. On a yearly average between 500 and 700 pregnant women are seen there for prenatal visits. Engaging providers in routine prenatal visits was another important factor in engaging our members in prenatal care. Providers can notify UHCCP immediately of a member's confirmed pregnancy to help ensure appropriate follow-up and coordination by the Healthy First Steps program. Provider can call Health first steps program directly or complete the digital "Obstetrical Risk Assessment Form" and submit within five days of a woman's first prenatal care visit. Participating providers will receive an incentive bonus which is paid on a quarterly basis. Substance Abuse Promoting member access to substance abuse treatment can be challenging but an important effort towards long term sobriety. NCQA measures *Follow-Up After Emergency*	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				Department Visit for Alcohol and Other Drug Abuse or Dependence Assesses emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence, who had a follow-up visit for alcohol or other drug abuse. From 2019-2021 the managed care plan participated in a performance improvement project to improve access to care for members who followed up after emergency room visits for alcohol and other drug abuse treatment. Improvement was attributed to case management outreach ad this opportunity shall continue. Case managers and peers are embedded at high volume inpatient substance use treatment facilities to support engagement in follow-up care. A COVID related suspension of onsite services did interfere in 2020-2021. However, the "in field" case manager and peer assignments have resumed in the second quarter of 2022 and shall continue. Measurement of success is the Quality Assurance Reporting Requirements *Follow-Up After High Intensity Care for Substance Use Disorder* data and a reduction in the against medical advice discharges from the facilities where UHCCP has embedded staff.	
Review of Compliance with Medicaid and Children's Health Insurance Program Standards					
The managed care plan should ensure its compliance with Medicaid standards by addressing the noncompliance identified during the compliance review conducted by the	X	X	X	1. Based on record review and staff interview, UHCCP and its delegate, United Behavioral Health, failed to provide a written notice to the enrollee within one business day. The initial adverse determination notice to the member was issued late. This was evident in 3 of 9 Medicaid concurrent cases. On January 14, 2020, a reminder was sent to staff on the importance of meeting compliance of state required turnaround time. On January 16, 2020, Optum/United	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
Department of Health				Behavioral Health provided additional staff- coaching via email to the team. A daily dashboard is currently in use on a manual basis and will be automated to optimize performance tracking of Optum/United Behavioral Health inventory. This reporting will allow the inventory to be reviewed daily by leadership. The report will be used to manage and identify cases that require immediate review to ensure turnaround time compliance at least twice a day by leadership. This is in addition to the individual coordinators running their own inventory report to review cases that have been assigned to them. Leadership holds a daily inventory call to review overall turnaround time compliance for all types of denials. Regulatory Adherence Advisory will be issued to reinforce expectations as to New York State requirements regarding turnaround times including the issuing of the notice of verbal and written notification by the end of April 2020. New York State Department of Health Division of Health Plan Contracting and Oversight accepted plan of correction March 9, 2020. 2. Based on record review and staff interview, UHCCP failed to include required components in contract files. UHCCP completed a review of all contracts to ensure that both the 2017 Standard Clause incorporation language as well as the 21st Century Cures Act Amendment are included. A Provider amendment via mailing went out to the entire Provider network with an amendment replacing the New York Regulatory Appendix and New York State Standard Clauses with an updated version as required by the state in October 2021. This version addresses previous concerns with discrepancies with language as well as addressing Cures Act requirements. To ensure the submission and management of any business segment	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				contractual changes to include regulatory or managed care plan changes are appropriately submitted, a Health Plan Contract Change Management Policy & Procedure has been created and implemented. Education was provided to all applicable submitters by March 2022. The Associate Director of Network Programs and Associate Director of Provider Operations maintain oversight of this process. Once a quarter, a statistical sample of new Provider contracts will be pulled across all functional areas to be reconciled utilizing quarterly quality checks of all contractual requirements. Contracts not containing the correct language will be corrected and resubmitted to the Provider. Monitoring results, remediation, and process improvements will be reviewed and discussed at the appropriate monthly or quarterly Joint Operating Committees. New York State Department of Health Division of Health Plan Contracting and Oversight accepted Plan of Correction May 14, 2020. 3. Based on record review and staff interview, UHCCP failed to include required credential components for 2 of 20 files. UnitedHealthcare worked with the National Credentialing Center team to complete an entire audit of our Provider Network credentialing files to ensure all applicable components to include Office of Professional Medical Conduct verifications were completed by March 2022. The National Credentialing Center utilized their Internal Audit Process for Credentialing Policy &Procedure, to ensure that an audit includes verification that credentialing findings are based on criteria as specified by the current UnitedHealthcare Credentialing and Recredentialing Plan and are conducted in a non-discriminatory manner. Quality	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				analysts selected random records, for audit from daily inventory across functional areas. If during the audit process errors were identified, they were submitted for remediation. Moving forward, once a quarter, the Associate Director of Provider Operations will utilize the Credentialing and Recredentialing File Preparation Guidelines Submission process which specifies the process and procedures in which the National Credentialing Center shall accept requests from health plans for file preparation for the purpose of regulatory and accreditation audits. This will be utilized to review credentialing/recredentialing files to determine whether the Provider record needs to be updated and/or terminated based on a list of reasons through the National Credentialing Center checklist. The credentialing analyst will work with the network data analyst of the Provider Network Data System submission file to continuously monitor and reconcile any Provider Changes prior to the next quarterly Provider Network Data System submission. New York State Department of Health Division of Health Plan Contracting and Oversight accepted plan of correction May 14, 2020. 4. Based on record review and staff interview, UHCCP failed to ensure that its delegate, United Behavioral Health, included member specific information in its denial of services letter. Specifically, the initial adverse determination notices did not include enrollee-specific clinical/social detail to show how the enrollee did not meet the criteria. This was evident in 8 of 20 Medicaid prior-authorization and concurrent cases reviewed. In October 2019, the denial letter template was updated to include member specific rationale. Additionally, all New York medical directors were educated on the internal	

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				guidance relating to the updated denial letter template. Lastly, denial letter reviews were added to the monthly internal audits to monitor, ensure compliance, and identify any additional training needed, if necessary. A regulatory adherence validation audit was be conducted in the 2nd quarter of 2020 to determine commitments were met and efforts for regulatory adherence were sustained post the commitment date. Monthly auditing is being conducted of denial letters, specifically that the initial adverse determination notices include enrollee specific clinical/social detail to show how the enrollee did not meet criteria. New York State Department of Health Division of Health Plan Contracting and Oversight accepted plan of correction accepted May 12, 2020.	
Administration of Quality-of-Care Surveys – Member Experience					
The managed care plan should evaluate the CAHPS scores to identify opportunities to improve member experience with the managed care plan.	X	X	X	The measurement year 2020 CAHPS results indicated members were satisfied with *Getting Needed Care* and *Getting Care Quickly* and improved by at least 4 percentage points from the prior year and statewide average for measurement year 2020. Access to routine, urgent, after-hours care, or specialty appointments. The managed care plan identified opportunities to increase member satisfaction with the UHCCP. CAHPS measurements are reflective of prior year services and the COVID-19 pandemic negatively impacted members' ability to access appointments across the healthcare spectrum as practitioners were impacted by staffing shortages and closures. UHCCP New York identified opportunities relating to billing/financial (appeals) and noted *Getting Needed Care/Getting Care Quickly* relate directly to *Rating of Healthcare/Rating of Health Plan*, as members are less likely to be satisfied with their health	Partially Addressed

2020 External Quality Review Recommendation	Quality	Timeliness	Access	UHCCP's Response	IPRO's Assessment of UHCCP's Response
				plan or health system in general if they are unable to access the care they need when they need it. Additionally, *Rating of Personal Doctor* and *Rating of Specialist* play a part in member engagement with health services and were chosen as high priority opportunities due to the ongoing public health emergency. Members require flexibility in how they access care, when they can see their provider, and that they feel comfortable with providers to achieve the most optimal health outcomes. As such, the following interventions were implemented: health literacy program and enhanced dental provider portal for benefit clarity, provider data improvement for access/getting needed care, telehealth, provider directory indicators for getting appointment for routine care/getting care quickly. Interventions to improve member satisfaction include UHCCP.com Live Chat, myuhc.com enhancements and mobile app upgrades.	

Strengths, Opportunities for Improvement, and Recommendations

Table 114: UHCCP's Strengths, Opportunities, and Recommendations

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
Performance Improvement Project	UHCCP's measurement year 2021 performance improvement project passed validation.	X	X	X
	UHCCP exceeded target rates for three performance indicators related to blood lead screening.	X	X	X
	UHCCP exceeded the target rate for one performance indicator related to newborn hearing screening.	X	X	X
	UHCCP exceeded target rates for six performance indicators related to developmental screening.	X	X	X
Performance Measures	UHCCP met all the requirements to successfully report HEDIS data to NCQA and Quality Assurance Reporting Requirements data to the Department of Health.	X	X	X
Performance Measures – Effectiveness of Care	UHCCP performed significantly better than the mainstream Medicaid program on three measures of effectiveness of care related to primary care.	X	X	
Performance Measures – Access/Availability of Care	UHCCP performed significantly better than the mainstream Medicaid program on one measure of access/availability of care related to children's health.		X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, UHCCP was in compliance with nine standards of *42 Code of Federal Regulations Part 438 Subpart D and Part 438 Subpart E 438.330.*	X	X	X
Quality-of-Care Survey	None.			
Opportunities for Improvement				
Performance Improvement Project	UHCCP did not meet target rates for three performance indicators related to blood lead screening.	X	X	X
	UHCCP did not meet target rates for five performance indicators related to newborn hearing screening.	X	X	X
Performance Measures – Effectiveness of Care	UHCCP performed significantly worse than the mainstream Medicaid program on 11 measures of effectiveness of care related to primary care,	X	X	

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	children's health, substance use, or mental health.			
Performance Measures – Access/Availability of Care	UHCCP performed significantly worse than the mainstream Medicaid program on three measures of access/availability of care related to primary care or maternity care.		X	X
Performance Measures – Utilization and Risk Adjusted Utilization	UHCCP performed significantly worse than the mainstream Medicaid program on three measures of utilization related to children's health.	X	X	X
Compliance with Federal Managed Care Standards	During measurement year 2021, UHCCP was not in full compliance with two standards of *42 Code of Federal Regulations Part 438 Subpart D.*	X	X	X
Quality-of-Care Survey	UHCCP performed significantly worse than the mainstream Medicaid program on one measure of member satisfaction.	X		
Recommendations				
Performance Improvement Project	Although the state's requirement to continue a performance improvement project on the topic of the kids' quality agenda ended with the 2021 measurement period, UHCCP should continue to address the improvement of incidences of screening and subsequent follow-up among its child members to improve the health outcomes for the youngest of its member population.	X	X	X
Performance Measures	UHCCP should continue to utilize the results of the HEDIS/Quality Assurance Reporting Requirements in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP should focus on the areas of care in which its rates did not meet mainstream Medicaid performance.	X	X	
Compliance with Federal Managed Care Standards	UHCCP should execute the approved corrective action plan and conduct routine monitoring to ensure compliance is achieved and maintained.	X	X	X
Quality-of-Care Survey	UHCCP should work to improve its performance on measures of member satisfaction for which it did not meet the mainstream Medicaid average.	X	X	X

Appendix A – Quality Assurance Reporting Requirements for Measurement Year 2021

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Administrative	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	SAA	Required	Required	Required	HEDIS 2020-2021
Administrative	Antidepressant Medication Management	AMM	Required	Required	Required	HEDIS 2020-2021
Administrative	Appropriate Testing for Pharyngitis	CWP	Required	Required	Required	HEDIS 2020-2021
Administrative	Appropriate Treatment for Upper Respiratory Infection	URI	Required	Required	Required	HEDIS 2020-2021
Administrative	Asthma Medication Ratio	AMR	Required	Required	Required	HEDIS 2020-2021
Administrative	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	AAB	Required	Not Required	Required	HEDIS 2020-2021
Administrative	Breast Cancer Screening	BCS	Required	Required	Required	HEDIS 2020-2021
Administrative	Cardiac Rehabilitation	CRE	Required	Required	Required	HEDIS 2020-2021
Administrative	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	SMC	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Cervical Cancer Screening	CCS	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Childhood Immunization Status	CIS	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Chlamydia Screening in Women	CHL	Required	Required	Required	HEDIS 2020-2021
Administrative/	Colorectal Cancer Screening	COL	Required	Required	Required	HEDIS

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Hybrid						2020-2021
Administrative/ Hybrid	Comprehensive Diabetes Care	CDC	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Controlling High Blood Pressure	CBP	Required	Required	Required	HEDIS 2020-2021
Administrative	Diabetes Monitoring for People With Diabetes and Schizophrenia	SMD	Required	Required	Required	HEDIS 2020-2021
Administrative	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Required	Required	Required	HEDIS 2020-2021
Survey	Flu Vaccinations for Adults Ages 18 - 64	FVA	Required	Required	Required	CAHPS 5.0H
Administrative	Follow-Up After High Intensity Care for Substance Use Disorder	FUI	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Emergency Department Visit for Mental Illness	FUM	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up After Hospitalization for Mental Illness	FUH	Required	Required	Required	HEDIS 2020-2021
Administrative	Follow-Up Care for Children Prescribed ADHD Medication	ADD	Required	Required	Not Required	HEDIS 2020-2021
Administrative/ Hybrid	Immunizations for Adolescents	IMA	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Kidney Health Evaluation for Patients With Diabetes	KED	Required	Required	Required	HEDIS 2020-2021
Administrative/ Hybrid	Lead Screening in Children	LSC	Required	Required	Not Required	HEDIS 2020-2021
Survey	Medical Assistance With Smoking and Tobacco Use Cessation	MSC	Required	Required	Required	CAHPS 5.0H

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Administrative	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Non-Recommended Cervical Cancer Screening in Adolescent Females	NCS	Required	Not Required	Not Required	HEDIS 2020-2021
Administrative	Persistence of Beta-Blocker Treatment After a Heart Attack	PBH	Required	Required	Required	HEDIS 2020-2021
Administrative	Pharmacotherapy for Opioid Use Disorder	POD	Required	Required	Required	HEDIS 2020-2021
Administrative	Pharmacotherapy Management of COPD Exacerbation	PCE	Required	Required	Required	HEDIS 2020-2021
Administrative	Risk of Continued Opioid Use	COU	Required	Required	Required	HEDIS 2020-2021
Administrative	Statin Therapy for Patients With Cardiovascular Disease	SPC	Required	Required	Required	HEDIS 2020-2021
Administrative	Statin Therapy for Patients With Diabetes	SPD	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Imaging Studies for Low Back Pain	LBP	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Opioids at High Dosage	HDO	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Opioids from Multiple Providers	UOP	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	Required	Required	Required	HEDIS 2020-2021
Administrative	Viral Load Suppression	VLS	Required	Required	Required	NYS 2020-2021
Administrative/ Hybrid	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	WCC	Required	Required	Not Required	HEDIS 2020-2021

Data Collection Method	Measure	Measure Abbreviation	Medicaid Managed Care Plan Types			Technical Specifications
			Mainstream	HIV Special Needs	Health And Recovery Plan	
Administrative	Adults' Access to Preventive/Ambulatory Health Services	AAP	Required	Required	Required	HEDIS 2020-2021
Administrative	Annual Dental Visit	ADV	Required	Not Required	Not Required	HEDIS 2020-2021
Administrative	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET	Required	Required	Required	HEDIS 2020-2021
Administrative	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	POD-N	Required	Required	Required	New York State 2020-2021
Administrative/ Hybrid	Prenatal and Postpartum Care	PPC	Required	Required	Required	HEDIS 2020-2021
Administrative	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	APP	Required	Required	Not Required	HEDIS 2020-2021
Administrative	Use of Pharmacotherapy for Alcohol Abuse or Dependence	POA	Required	Required	Required	New York State 2020-2021