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

2015

Health Plan

Care Management Report

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Introduction

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

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

The Department is committed to sharing information about care management services with the public, plans, and stakeholders. Therefore, this report provides a summary of each plan's most recent care management data submission. This submission included data about member and program characteristics for all members who received care management services administered by health plans during measurement year 2015. The goal of this annual report is 1) to provide information about plan care management programs, the members identified for care management, and the efficiency of their programs, 2) to describe utilization patterns for emergency department visits, inpatient stays, and outpatient services for members in care management, and 3) to describe quality results for members in care management.

Data/Methodology

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

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

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

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

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

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

- Birthweight

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

Limitations

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

Measures

This report represents the health plan population during 2015 and contains the following four sections:

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

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

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

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

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

- **Complex Chronic:** CRG numbers 6 (Pairs – significant chronic disease in multiple organ systems) and 7 (Triples – dominant chronic disease in three or more organ systems)
    - **CRG #6:** Diabetes and Congestive Heart Failure (CHF)
    - **CRG #7:** Diabetes and CHF and Chronic Obstructive Pulmonary Disorder
- **Critical/HIV:** CRG numbers 8 (Malignancies – dominant, metastatic, and complicated) and 9 (Catastrophic conditions/HIV)
    - **CRG #8:** Metastatic Colon Malignancy, under active treatment
    - **CRG #9:** History of Major Organ Transplant

Outreach

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

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

Table 1 shows the number of care management triggers, stratified by CRG. Members in the Complex Chronic CRG, significant chronic disease in multiple organ systems, account for just over 50 percent of triggered Statewide.

Table 1: Triggered by CRG

	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/ HIV	
	N	%	N	%	N	%	N	%	N	%
Affinity	33	1.5	89	3.9	253	11.2	1,062	46.9	829	36.6
CDPHP	75	3.1	93	3.8	346	14.1	1,711	69.9	223	9.1
Excellus	182	3.8	146	3.1	690	14.5	3,255	68.6	475	10.0
Fidelis Care	583	3.6	532	3.3	2,071	12.9	9,622	59.9	3,248	20.2
Health Plus	220	1.8	437	3.7	1,682	14.1	8,073	67.5	1,542	12.9
HealthFirst	1,206	4.0	772	2.6	3,674	12.3	16,775	56.3	7,393	24.8
HealthNow	11	1.6	29	4.3	79	11.6	502	73.8	59	8.7
HIP	369	4.7	434	5.5	1,407	17.8	4,824	61.1	859	10.9
Hudson	590	14.5	742	18.2	670	16.4	1,779	43.6	299	7.3
Independent Health	21	1.2	41	2.3	149	8.5	1,140	65.0	403	23.0
MetroPlus	110	2.0	247	4.5	656	11.9	3,267	59.2	1,239	22.4
MVP	261	9.9	225	8.5	466	17.6	1,525	57.6	170	6.4
Total Care	41	6.8	33	5.5	93	15.4	377	62.3	61	10.1
UnitedHealthCare	5,300	15.4	6,052	17.5	5,458	15.8	14,598	42.3	3,108	9.0
WellCare	51	3.5	25	1.7	172	11.7	1,109	75.3	115	7.8
YourCare	31	2.2	39	2.7	144	10.1	1,020	71.8	187	13.2
Statewide	9,084	7.1	9,936	7.8	18,010	14.1	70,639	55.2	20,210	15.8

Once the member is triggered, the plan's care management program will attempt to contact the member and offer care management services. This is the outreach phase. Outreach is usually conducted by phone, but there are examples when it is conducted in-person. Table 2 shows the percentage of triggered members which were contacted.

The percentage contacted is the number of members successfully contacted by the plan divided by the number triggered during the calendar year. The percentage of members contacted varies across plans because of differences in eligibility criteria, outreach strategies, and other factors. Statewide, a little more than half of outreach efforts end in a successful contact. Most successful contacts occur the same day the member is triggered.

Table 2: Triggered Members Contacted

	Triggered	Contacted Same Day		Contacted 1-30 Days		Contacted 31+ Days		Contacted Total	
		N	%	N	%	N	%	N	%
Affinity	2,266	910	60	526	35	71	5	1,507	67
CDPHP	2,448	958	58	664	40	40	2	1,662	68
Excellus	4,748	1,138	34	1,828	54	409	12	3,375	71
Fidelis Care	16,056	13,875	98	159	1	63	0	14,097	88
Health Plus	11,954	2,453	43	2,607	46	656	11	5,716	48
HealthFirst	29,820	1,449	16	3,200	35	4,493	49	9,142	31
HealthNow	680	166	51	154	47	7	2	327	48
HIP	7,893	1,134	16	1,620	23	4,366	61	7,120	90
Hudson	4,080	1,031	55	516	28	323	17	1,870	46
Independent Health	1,754	178	19	535	58	202	22	915	52
MetroPlus	5,519	1,061	35	1,353	45	585	20	2,999	54
MVP	2,647	791	49	814	50	25	2	1,630	62
Total Care	605	118	30	252	63	28	7	398	66
UnitedHealthCare	34,516	2,525	17	8,663	58	3,809	25	14,997	43
WellCare	1,472	248	17	370	25	854	58	1,472	100
YourCare	1,421	453	38	544	45	200	17	1,197	84
Statewide	127,879	28,488	42	23,805	35	16,131	24	68,424	54

Once the plan contacts the member, the member may choose to engage in care management or decline the offer. Table 3 shows the percentage of contacted members who enroll in plan-led care management services. Statewide, over half of the number of members who participate in plan-led care management enroll within a month of their trigger date.

Table 3: Contacted Members Enrolled

	Contacted	Enrolled Same Day		Enrolled 1-30 Days		Enrolled 31+ Days		Enrolled Total	
		N	%	N	%	N	%	N	%
Affinity	1,507	430	46	355	38	158	17	943	63
CDPHP	1,662	925	61	569	37	28	2	1,522	92
Excellus	3,375	478	20	1,468	63	398	17	2,344	69
Fidelis Care	14,097	2,750	41	3,672	55	235	4	6,657	47
Health Plus	5,716	1,224	33	2,369	64	125	3	3,718	65
HealthFirst	9,142	1,374	16	2,854	34	4,193	50	8,421	92
HealthNow	327	73	38	113	59	7	4	193	59
HIP	7,120	359	7	1,079	22	3,393	70	4,831	68
Hudson Health	1,870	803	90	77	9	13	1	893	48
Independent Health	915	173	20	495	57	202	23	870	95
MetroPlus	2,999	493	22	1,092	49	660	29	2,245	75
MVP	1,630	530	53	446	44	29	3	1,005	62
Total Care	398	77	35	126	57	20	9	223	56
UnitedHealthCare	14,997	1,334	19	4,486	64	1,212	17	7,032	47
WellCare	1,472	802	55	450	31	214	15	1,466	100
YourCare	1,197	360	35	475	47	183	18	1,018	85
Statewide	68,424	12,185	28	20,126	46	11,070	26	43,381	63

Enrollment

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

Table 4 shows the number of care management enrolled episodes, stratified by CRG. An episode is a distinct unit of care management with a begin date and an end date. A member may trigger for and enroll in care management more than one time during the measurement year, and therefore have more than one episode during the measurement year. As in Table 1 Triggered by CRG, the Complex Chronic CRG is the largest group.

Table 4: Enrolled by CRG

	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/ HIV	
	N	%	N	%	N	%	N	%	N	%
Affinity	10	1.1	47	5.0	97	10.3	500	53.0	289	30.6
CDPHP	59	3.9	67	4.4	185	12.2	1,086	71.4	125	8.2
Excellus	34	1.5	30	1.3	231	9.9	1,778	75.9	271	11.6
Fidelis Care	75	1.1	60	0.9	645	9.7	5,080	76.3	797	12.0
Health Plus	30	0.8	136	3.7	378	10.2	2,318	62.3	856	23.0
HealthFirst	23	0.3	46	0.5	566	6.6	5,920	69.3	1,986	23.3
HealthNow	7	3.6	4	2.1	14	7.3	137	71.0	31	16.1
HIP	204	4.2	202	4.2	862	17.8	3,185	65.9	378	7.8
Hudson Health	55	6.2	136	15.2	104	11.6	486	54.4	112	12.5
Independent Health	5	0.6	8	0.9	54	6.2	656	75.4	147	16.9
MetroPlus	46	2.0	118	5.2	230	10.2	1,099	48.5	771	34.1
MVP	42	4.2	43	4.3	103	10.2	717	71.3	100	10.0
Total Care	7	3.1	9	4.0	26	11.7	159	71.3	22	9.9
UnitedHealthCare	555	7.9	834	11.9	1,006	14.3	3,691	52.5	946	13.5
WellCare	51	3.5	25	1.7	171	11.7	1,106	75.4	114	7.8
YourCare	15	1.5	19	1.9	72	7.1	792	77.8	120	11.8
Statewide	1,218	2.8	1,784	4.1	4,744	10.9	28,710	66.0	7,065	16.2

Services offered to members within care management programs will differ by plan and by member needs. These differences impact the duration of enrollment and the number of interventions provided to enrolled members. Table 5 shows the mean number of days enrolled in care management and mean number of interventions, stratified by the number of days to closure per each episode.

Table 5: Mean Number of Days and Interventions by Episode Duration

	Same Day		1-30 Days		31+ Days	
	Mean days	Mean Interventions	Mean days	Mean Interventions	Mean days	Mean Interventions
Affinity	0.0	4.4	20.4	6.8	103.5	8.4
CDPHP	0.0	N/A	22.3	3.8	82.6	6.3
Excellus	0.0	1.0	18.9	2.7	134.0	4.4
Fidelis Care	0.0	N/A	18.2	6.0	167.5	8.4
Health Plus	0.0	N/A	19.6	0.1	100.4	0.1
HealthFirst	0.0	1.5	15.5	2.3	95.9	4.9
HealthNow	0.0	2.0	13.4	5.7	97.5	9.6
HIP	0.0	1.6	19.5	3.6	123.4	7.0
Hudson Health	0.0	3.1	15.2	5.1	99.6	9.2
Independent Health	0.0	2.1	16.3	3.0	170.6	4.7
MetroPlus	0.0	1.8	15.6	3.2	105.2	7.8
MVP	0.0	5.4	17.7	9.5	80.3	15.2
Total Care	0.0	N/A	18.7	2.4	97.2	5.1
UnitedHealthCare	0.0	N/A	14.7	1.9	100.6	3.1
WellCare	0.0	6.4	21.1	11.3	334.0	14.5
YourCare	0.0	0.5	19.8	3.9	149.8	6.7
Statewide	0.0	1.7	16.6	3.1	111.9	5.1

N/A: no enrolled segments closed in one day.

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

Table 6 shows the number of closed episodes by reason for closure for the measurement year.

Table 6: Reasons for Closure

	N	%
Met program goals	12,783	52.7
Lost to follow up	6,645	27.4
Disenrolled from plan	2,731	11.3
Refused to continue	1,059	4.4
Missing	705	2.9
Transitioned to non-plan Care Management	321	1.3

An episode that met program goals is considered a success. Table 7 shows the percentage of episodes which closed with program goals met, stratified by CRG. Statewide, members in the stable CRG group were most likely to end their care management episode because they met program goals (42%). Please note, this does not include episodes that are not closed within the measurement year. There may be episodes which successfully meet goals and close in the subsequent year.

Table 7: Met Program Goals by CRG

	Healthy		Stable		Simple Chronic		Complex Chronic		Critical/ HIV	
	N	%	N	%	N	%	N	%	N	%
Affinity	7	4	27	14	34	18	98	51	27	14
CDPHP	24	4	24	4	86	14	445	72	42	7
Excellus	10	2	12	2	78	13	454	74	56	9
Fidelis Care	10	1	20	3	71	10	442	63	164	23
Health Plus	12	1	70	6	155	12	778	61	253	20
HealthFirst	6	0	10	1	111	8	886	63	401	28
HealthNow	2	2	1	1	6	5	84	75	19	17
HIP	12	3	36	10	65	18	203	57	41	11
Hudson Health	15	4	35	8	48	12	262	63	56	13
Independent Health	2	1	6	3	24	11	163	72	30	13
MetroPlus	12	1	68	7	119	13	611	66	118	13
MVP	37	5	36	5	82	10	572	72	68	9
Total Care	1	1	4	6	12	17	45	63	9	13
UnitedHealthCare	300	7	454	10	564	13	2,444	55	660	15
WellCare	12	6	6	3	24	12	134	67	25	12
YourCare	13	3	15	3	32	7	338	76	45	10
Statewide	475	4	824	6	1,511	12	7,959	62	2,014	16

SS: Small sample size.

Quality Measures

Quality measures and PQIs used to measure performance across health plans in New York State can be used to identify problems, opportunities for improvement, and obtain a baseline assessment of current practices. They are used as a first step to establishing performance benchmarks for the care management group. Table 8 shows the performance by enrolled care management members for each of the quality measures by CRG. The measures in Table 8 are expressed as the percentage of members meeting the criteria for the quality measures.

Table 8: Quality Measures by CRG

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Adult BMI Assessment (ABA)	SS	SS	SS	90	SS
Breast Cancer Screening (BCS)	SS	SS	55	70	65
Cervical Cancer Screening (CCS)	74	83	80	67	67
Chlamydia Screening (CHL)	75	83	78	74	59
Colorectal Cancer Screening (COL)	23	31	36	55	55
Comprehensive Diabetes Care - HbA1c Test (CDC)	SS	SS	77	86	81
HIV/AIDS Comprehensive Care - Syphilis Screening	SS	SS	SS	33	71
HIV/AIDS Comprehensive Care - Viral Load Monitoring	SS	SS	SS	SS	69
HIV/AIDS Comprehensive Care - Engaged in Care	SS	SS	SS	95	91
Medication Management for People with Asthma - 50% Days covered (MMA)	SS	SS	48	67	80
Medication Management for People with Asthma - 75% Days covered (MMA)	SS	SS	19	42	50
Antidepressant Medication Management - Acute Phase (84 days) (AMM)	SS	41	37	57	55
Antidepressant Medication Management - Continuation Phase (180 days) (AMM)	SS	19	26	45	40
Follow Up After Hospitalization for Mental Illness - 7 days (FUH)	SS	SS	63	57	48
Follow Up After Hospitalization for Mental Illness - 30 days (FUH)	SS	SS	77	71	59
Initiation of Alcohol and Other Drug Dependence Treatment (IET)	SS	SS	60	59	57
Engagement of Alcohol and Other Drug Dependence Treatment (IET)	SS	SS	17	13	10

SS: Small Sample Size

The measures in Table 9 are rates of potentially preventable hospitalizations for specific chronic conditions. These chronic conditions are prevalent for many of the members enrolled in care management. The measures are expressed as the rate of events per 100,000 members.

Table 9: Prevention Quality Indicators Rates per 100,000 Enrollees by CRG

	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Diabetes Short-Term Complications Admission Rate (PQI #1)	SS	SS	370	2,148	1,487
Diabetes Long-Term Complications Admission Rate (PQI #3)	SS	SS	59	2,650	3,269
COPD or Asthma in Older Adults Admission Rate (PQI #5)	SS	SS	716	8,275	8,884
Hypertension Admission Rate (PQI #7)	SS	SS	74	589	785
Heart Failure Admission Rate (PQI #8)	SS	SS	104	3,138	5,427
Dehydration Admission Rate (PQI #10)	SS	SS	44	629	1,602
Bacterial Pneumonia Admissions Rate (PQI #11)	SS	141	59	1,247	2,059
Urinary Tract Infection Admission Rate (PQI #12)	SS	113	59	640	1,275
Uncontrolled Diabetes Admission Rate (PQI #14)	SS	SS	30	372	507
Asthma in Younger Adults Admission Rate (PQI #15)	SS	SS	237	2,342	3,275
Lower-Extremity Amputation among Patients with Diabetes Rate (PQI #16)	SS	SS	15	268	425

SS: Small Sample Size

Utilization

Utilization of medical services is a major component of the total cost of health care. One of the goals of care management is to lower utilization cost by decreasing emergency department and inpatient use, while simultaneously increasing outpatient use. The utilization shift is expected to cost less and improve member outcomes. Tables 10 - 12 show the utilization rates of emergency department, inpatient care, and outpatient care for anytime during the calendar year that the care management episode occurred.

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

Table 10: Emergency Department Rates per 1,000 member years by CRG

Plan	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity	607	1,444	1,407	2,983	1,884
CDPHP	592	1,539	1,119	2,353	3,226
Excellus	612	1,109	1,101	1,818	1,958
Fidelis	270	824	813	1,527	1,959
HIP	316	1,033	719	901	1,750
Health First	771	1,618	1,210	1,893	2,135
Health Plus	771	1,311	1,394	1,757	1,670
HealthNow	889	2,125	1,446	2,615	3,568
Hudson Health	518	1,029	1,202	2,197	2,431
Independent Health	500	891	1,163	2,264	2,282
MVP	400	1,510	1,467	2,907	2,797
Metro Plus	1,402	1,971	1,721	2,043	1,456
Today's Choice	373	1,325	1,853	3,527	5,101
UnitedHealthCare	464	756	829	1,600	1,387
WellCare	435	397	471	864	1,636
Your Care	686	813	991	1,542	2,421
Statewide	550	1,182	1,081	1,730	1,896

Table 11: Inpatient Rates per 1,000 member years by CRG

Plan	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity	607	807	908	1,665	2,200
CDPHP	331	596	625	1,118	3,305
Excellus	316	431	415	754	1,905
Fidelis	SS	151	88	487	1,772
HIP	206	569	295	667	2,572
Health First	601	869	551	1,123	2,663
Health Plus	554	875	821	1,596	2,930
HealthNow	111	250	434	1,435	4,176
Hudson Health	667	697	851	1,370	2,725
Independent Health	564	707	713	969	1,602
MVP	387	497	460	857	2,676
Metro Plus	668	1,107	996	1,485	1,248
Today's Choice	373	519	493	823	2,623
UnitedHealthCare	812	891	832	1,372	2,548
WellCare	29	SS	76	396	1,493
Your Care	707	748	451	782	2,457
Statewide	543	773	581	995	2,320

Table 12: Outpatient Rates per 1,000 member years by CRG

Plan	Healthy	Stable	Simple Chronic	Complex Chronic	Critical/ HIV
Affinity	12,508	15,406	14,403	16,060	18,523
CDPHP	4,698	7,211	7,552	14,334	18,432
Excellus	4,532	7,554	7,397	15,409	17,627
Fidelis	995	4,975	3,704	13,142	20,091
HIP	4,061	8,429	7,584	15,927	26,475
Health First	11,780	15,664	10,640	17,872	21,892
Health Plus	9,036	11,755	9,847	16,189	22,541
HealthNow	3,111	5,125	7,952	13,435	18,365
Hudson Health	11,632	14,453	14,428	17,734	26,420
Independent Health	3,054	4,131	4,829	11,605	14,600
MVP	3,922	6,943	6,914	13,624	19,114
Metro Plus	9,208	11,322	11,716	14,661	15,071
Today's Choice	4,845	13,922	10,504	16,209	31,919
UnitedHealthCare	7,799	9,267	9,710	16,285	20,182
WellCare	1,913	4,413	5,997	13,688	19,619
Your Care	2,953	4,797	4,698	14,218	19,598
Statewide	7,021	10,565	8,880	15,499	20,396

High-Risk Obstetrics (HROB)

The Health Plan CMART has a total of ten program type choices. Not all plans have all ten programs; however, all plans offer the HROB program. This section describes the HROB population served by the plans and the population's health outcomes. The HROB care management program is different from the other program types, because there is a definitive closure day to each person's time in the program (either the birth of the child or two weeks after the birth). In this section, measures are based on women who were referred to an HROB care management group and numbers and percentages are based on a rolling three years. For this report, 2012-2014 data is included.

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

Table 13 shows the distribution of HROB mothers across the plans by enrollment.

Table 13: High-Risk Pregnancies

	Triggered Mothers	Enrolled	
		N	%
Affinity	3,700	299	8
CDPHP	640	307	48
Excellus	2,237	595	27
Fidelis Care	1,630	323	20
Health Plus	3,096	998	32
HealthFirst	30,810	10,986	36
HealthNow	692	686	99
HIP	2,824	931	33
Hudson Health	464	459	99
Independent Health	2,593	1,902	73
MetroPlus	1,172	1,144	98
MVP	1,439	435	30
Total Care	12	6	50
UnitedHealthCare	3,415	2,283	67
WellCare	257	253	98
YourCare	525	387	74
Statewide	55,506	21,994	40

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

Table 14 shows the maternal demographics and other characteristics for members who triggered only compared to those who enrolled in HROB care management services during the measurement year.

Table 14: HROB Maternal Demographics and Characteristics

Demographic	Triggered		Enrolled Only	
	N	%*	N	%*
Place of Birth				
USA	27,323	49	10,983	50
Other	27,410	49	10,683	49
Region of NYS				
Central	1,006	2	433	2
Hudson Valley	1,893	3	760	3
Long Island	5,612	10	1,917	9
Northeast	700	1	268	1
NYC	38,927	70	14,663	67
Western	6,478	12	3,440	16
Aid Category				
FHP	3,835	7	1,538	7
SSI	1,188	2	517	2
TANF	50,483	91	19,939	91
Education Level				
Not HS Graduate	17,653	32	6,716	31
HS Graduate	17,224	31	6,907	31
College	20,355	37	8,273	38
Age				
< 18 Years	1,127	2	890	4
18 - 19 Years	2,582	5	11,421	52
20 - 29 Years	30,614	55	8,696	40
> 29 Years	21,183	38	987	4
Race				
White	11,744	21	5,101	23
Black	10,424	19	4,336	20
Hispanic	15,584	28	5,822	26
Asian/Pacific Islander	6,964	13	2,786	13
Other	10,790	19	3,949	18

Table 14 (Cont.): HROB Maternal Demographics and Characteristics

Demographic	Triggered		Enrolled Only	
	N	%*	N	%*
CRG Group				
Healthy	16,063	29	5,851	27
Stable	14,658	26	5,701	26
Simple Chronic	14,830	27	5,925	27
Complex Chronic	9,331	17	4,239	19
Critical/HIV	624	1	278	1
Risks				
Diabetes	718	1	386	2
Gestational Diabetes	4,089	7	1,874	9
Hypertension	1,158	2	553	3
Gestational Hypertension	1,942	3	827	4
Characteristics				
High-Risk Referral	3,735	7	1,503	7
Hospitalized during Pregnancy	2,684	5	1,179	5
Number Previous Pregnancies				
0	15,231	27	5,751	26
1 - 2	24,379	44	9,660	44
3 - 4	10,310	19	4,241	19
5 +	5,586	10	2,342	11

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

Table 15 reports demographic data for infants born to the women triggering and enrolling in HROB care management.

Table 15: Infant Demographics and Characteristics

Demographic	Triggered		Enrolled Only	
	N	%	N	%
Sex				
Female	27,650	49	10,952	49
Male	28,988	51	11,482	51
Gestational Age				
< 33 weeks	1,400	2	636	3
33 - 35 weeks	2,317	4	1,013	5
36 - 38 weeks	16,272	29	6,721	30
39 + weeks	36,651	65	14,065	63
NICU Use	6,926	12	2,865	13
Birthweight				
Very Low Birthweight	947	2	425	2
Low Birthweight	4,240	7	1,786	8
Large for Gestational Age	3,292	6	1,353	6
Macrosomia	3,722	7	1,493	7
Modified Kessner Index*				
Intensive	5,885	11	2,532	12
Adequate	29,330	53	11,965	54
Intermediate	14,764	27	5,653	26
Inadequate	3,926	7	1,259	6
No Care	212	0	67	0
Missing	1,207	2	455	2

(Triggered: 56,640; Enrolled Only: 22,435)

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

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

Table 16 shows the number and percentage of time women enrolled in the HROB program prior to delivery. The large percentage of mothers who were triggered and enrolled after the infant was born, were most likely members of a mom and infant oriented care management program that occurs during the first two weeks of the infants' lives.

Table 16: Time in Care Management to Delivery

	Enrolled Only	
	N	**%**
Length of Time Before Delivery		
More than 8 Months	46	0
8 Months	770	4
7 Months	2,082	9
6 Months	2,546	12
5 Months	2,875	13
4 Months	2,694	12
3 Months	2,829	13
2 Months	2,323	11
1 Month	1,683	8
Same Day Delivery	398	2
After Delivery	3,748	17
	Mean	
Mean Number of Days	92.7	

Appendix

Definitions/Descriptions

Medicaid Managed Care (MMC): A Medicaid health insurance plan that coordinates the provision, quality, and cost of care for its membership.

Care Management Episode: The time from enrollment in a care management program to closure. One member may have multiple episodes in the same measurement year.

Triggered: A care management episode members that was identified by the plan or referred to the plan as needing care management meeting plan criteria

Contacted: A care management episode that was contacted by a plan-administered care management program.

Enrolled: A triggered and contacted care management episode for members that enrolled in a plan-administered care management program.

Triggered Enrollment Rate: Number of episodes that enrolled during the measurement year divided by the number of episodes triggered.

Contacted Same Day Rate: Number of episodes contacted on the same day they triggered for care management divided by the total number of episodes contacted.

Days to Contact Rate: Number of episodes contacted in days divided by the total number of episodes contacted.

Enrolled Same Day Rate: Number of episodes enrolled on the same day they triggered for care management divided by the total number of episodes enrolled.

Days to Enrollment: Number of episodes enrolled in days divided by the total number of episodes enrolled.

CRG: 3M® Clinical Risk Groups (CRGs) provide a way to consider illness and resource utilization of a full range of patient types, including low income, elderly, commercial beneficiaries and those with disabilities. 3M® CRGs use standard claims data and, when available, additional data—such as pharmaceutical data and functional health status—collected longitudinally to assign an individual to a single, mutually exclusive risk group. The Standard Model was used which does not use the four groups based upon pregnancy/delivery (pregnancy/delivery was not the focus of medical care during the calendar year).

Quality Measures

Improving Preventive Care

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

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

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

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

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

Improving Disease-related Care for Chronic Conditions

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

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

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

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

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

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

Improving Outcomes for Persons with Mental Illness

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

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

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

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

Improving Outcomes for Persons with Substance Use Disorders

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

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

Prevention Quality Indicators; Reducing Avoidable Hospitalizations

Diabetes Short-Term Complications Admission Rate (PQI #1): Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis,

hyperosmolarity, or coma) per 100,000 population; excludes obstetric admissions.

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

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

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

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

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

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

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

Uncontrolled Diabetes Admission Rate (PQI #14): Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or

other unspecified) complications per 100,000 population; excludes obstetric admissions.

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

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

Reducing Utilization Associated with Avoidable IP stays and ED visits

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

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

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