DRAFT

Quality Strategy for the New York State Medicaid Managed Care Program 2012

Prepared by The New York State Department of Health Office of Quality and Patient Safety Bureau of Quality Measurement and Improvement

November 30, 2012
Quality Strategy
for the
New York State Medicaid Managed Care Program
2012

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I. Introduction

In 1997 New York State received approval from the Center for Medicare and Medicaid Services (CMS) to implement a mandatory Medicaid managed care program. The goal of the New York State Department of Health’s (NYS DOH) 1115 Waiver Program, entitled The Partnership Plan, is to improve the health status of low-income New Yorkers by: increasing access to health care for the Medicaid population; improving the quality of health care services delivered; and expanding coverage to additional low-income New Yorkers with resources generated through managed care efficiencies.

Initially, the Partnership Plan enrolled the TANF and Safety Net Populations. In 2001, the Family Health Plus (FHP) Program was implemented providing comprehensive health coverage to low-income uninsured adults, with and without children. In 2006, New York State began mandatory enrollment of all aged and disabled adults and children (Supplemental Security Income eligible). In 2011, enrollees with HIV/AIDS were no longer exempt from the program and were mandatorily enrolled in both HIV/AIDS Special Needs plans (SNPs) and “mainstream” plans. Enrollment in the Medicaid managed care program now exceeds 3.5 million people.

The NYS DOH has operated a comprehensive Quality Strategy since 1997. The Strategy supports the goals of the program and has evolved over time as a result of programmatic changes, member health needs, clinical practice guidelines, federal and state law, lessons learned and best practices. The Strategy has been successful as we have seen an improvement in the quality of health care being provided to enrollees. The NYS DOH performs periodic reviews of the quality strategy to determine the need for revision and to assure managed care organizations (MCOs) are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement. Examples of results of analyses and evaluations are described throughout this document.

In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT) which consisted of provider, payer and consumer stakeholders. As result of their recommendations several additional plans and populations are now in managed care including approximately 60,000 enrollees in managed long-term care (MLTC) plans that provide community-based long-term care services to enrollees who may otherwise eligible to be in a nursing home and in need of more than 120 days of community based long term care services. The MRT has also expanded other models of managed care such as Behavior Health Organizations (BHOs).

Therefore, as a result of newly enrolled populations, this strategy encompasses the mainstream plans (including Child Health Plus and FHP populations), MLTC plans (including Medicaid Advantage Plus, PACE and Medicaid Advantage plans), HIV/AIDS Special Needs Plans, Behavior Health Organizations (BHOs), and a pending proposal with CMS referred to as the Fully-Integrated Duals Advantage (FIDA). Several of these plans are new and therefore their measurement systems and quality monitoring are not as established as those of the mainstream plans. As such, the goals of the Program, and therefore the activities related to the Quality Strategy, have expanded accordingly. The Quality Strategy will also be updated regularly to reflect the maturing of the quality measurement systems for these newer plan types, as well as new plans and populations that may be developed in the future.
A. Managed Care Program Objectives

Demonstrating success and identifying challenges in meeting the overall goals are based on data that reflects health plan quality performance, access to covered services extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care. Data for the measures used in this approach are derived from the Quality Assurance Reporting Requirements (QARR) - a set of measures based on The National Committee for Quality Assurance’s (NCQA) HEDIS measurement set, the Medicaid Encounter Data System (MEDS) and Semi-Annual Assessment of Members (SAAM) datasets, as well as, consumer satisfaction surveys including the Consumer Assessment Healthcare Provider Systems (CAHPS) survey. Other sources of data may include the NYS DOH’s Statewide Planning and Research Cooperative System (SPARCS), data reporting from New York Medicaid Choice, the contracted enrollment broker, and findings from The External Quality Review Technical Report and evaluation results of improvement initiatives.

Program Initiative Objectives:

The following lists some objectives of the program that seek to improve health care services, population health and reduce costs consistent with MRT and CMS’ Triple Aim objectives.

- Continue to expand on the measurement and improvement activities for the additional plan types such as HIV/SNPs, BHOs and MLTC.
- Demonstrate an increase of at least 5 percentage points in the statewide rate of diabetics who received all four required tests for the monitoring of diabetes.
- Decrease the prevalence of self-identified smokers on the biennial CAHPS survey.
- Increase the measurement, reporting and improvement initiatives associated with preventable events such as PQIs, readmissions (PPRs) and emergency department use for preventive care.
- Increase measurement in behavioral health by developing and implementing a more robust measurement set and incorporating expanded populations such as BHOs and Health Homes into QARR measurement.
- Continue to publish data by race and ethnicity, as well as aid category, age, gender and region in order to develop meaningful objectives for improvement in preventive and chronic care by engaging the plans in new ways to improve care by focusing on specific populations who whose rates of performance are below the statewide average.
- Decrease the disparity between Medicaid and commercial populations for the percentage of diabetics with HbA1c (blood sugar) levels in poor control. In 2011, the
percentage of Medicaid enrollees whose HbA1c level was in poor control was 33 percent versus 27 percent for commercial.

- Increase MLTC measurement with the implementation of HEDIS/QARR reporting and the development of additional measures using SAAM data.

- Decrease the percentage of MLTC enrollees who experienced daily pain from 52 percent to 45 percent.

- The statewide percentage of MLTC enrollees who have had one or more falls in a six-month period is 15 percent. However, several plans rates are above 15 percent. NYS DOH seeks to reduce the statewide average with no plan over 20 percent.

II. Assessment

As required by the Code of Federal Regulations (CFR) 438.202(d), the State assesses how well the managed care program is meeting the objectives outlined in the Introduction through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of MCOs/PIHPs and by monitoring MCO activities on an on-going or periodic basis.

A. Quality and Appropriateness of Care and Services

The NYS DOH assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources. The NYS DOH has developed many systems (QARR, SAAM, Encounter Data, Provider Network) to collect data from MCOs. MCOs are required to have information systems capable of collecting, analyzing and submitting the required data and reports. To ensure the accuracy and validity of the data submitted the State contracts with an External Quality Review Organization (EQRO) the Island Peer Review Organization. This section discusses the systems in place, the role of the EQRO and challenges and opportunities with data collection systems.

Quality Assurance Reporting Requirements (QARR)
NYS DOH staff developed the QARR in 1993 to monitor quality in managed care plans. QARR is based on the National Committee on Quality Assurance (NCQA) HEDIS measures, plus additional measures developed by the State to monitor the delivery of primary and chronic care services. QARR focuses on health outcome and process measures, and includes clinical data relating to prenatal care, preventive care, acute and chronic illnesses, mental health and substance abuse. QARR is submitted on an annual basis, in June of the year following the measurement year and published in hard copy and web-based formats.

To help ensure the integrity, reliability, and validity of the QARR data, the State contracts with the EQRO to audit and validate QARR data and to provide technical assistance to MCOs in collecting and submitting the requested information.

Semi-Annual Assessment of Members (SAAM)
In 2005, the Department developed and implemented a functional assessment tool for its growing managed long-term care (MLTC) program. Based on the national Outcome and Assessment Information Set (OASIS), the purpose of SAAM was to understand the functional, cognitive and healthcare profile and therefore needs of the population. The State’s EQRO conducted one audit of the data in 2009. The data are used in the calculation of the capitation rates and to evaluate the quality of care of the program.

The State will be requiring all MLTCs to begin use of Uniform Assessment System-New York (UAS-NY) beginning in 2013. The UAS-NY is an interRAI tool which replicates the data generated by SAAM and provides additional assessment information to allow comparisons across community-based programs.

**Encounter Data**
All MCOs are required to submit monthly encounters to MEDS. MEDS is consistent with national standards for a national uniform core data set. MEDS data provide a source of comparative information for MCOs and are used for purposes such as monitoring service utilization, evaluating access and continuity of service issues, monitoring and developing quality and performance indicators, studying special populations and priority areas, risk adjustment and setting capitation rates.

**Participating Provider Network Reports**
On a quarterly basis, MCOs must also submit updated information on their contracted provider network to NYS DOH. As part of the quarterly reports, MCOs provide information on the number of Medicaid enrollees empanelled to each network PCP. In addition, any material change in network composition must be reported to the State 45 days prior to the change. Provider network reports are used to monitor compliance with access standards, including travel time/distance requirements, network capacity, panel sized and provider turnover. MCOs also submit quarterly rosters for their network PCPs. The PCP is identified for every managed care enrollee, which allows new analyses such as quality of care for enrollees in patient-centered medical homes versus those who are not.

**Member Satisfaction Surveys**
The State, in conjunction with its external review agent, conducts a biennial CAHPS survey through its EQRO and a certified CAHPS vendor. Through IPRO, the Department has also conducted several surveys focused on specific populations such as diabetics or SSI enrollees who were being mandatorily enrolled for the first time. Enrollees of the MLTC plans have been surveyed in 2007 and 2011. A new survey will be in the field in late 2012. A new enrollee survey is also planned to determine the satisfaction levels of individuals who were enrolled mandatorily enrolled in MLTC.

These surveys allow the NYS DOH to evaluate the enrollees’ perceptions of quality, access and timeliness of health care services. Because the results are presented by plan, comparisons to the statewide average are possible and plans accountable for performance. Plans whose results are meaningfully and statistically below acceptable thresholds may be required to develop a corrective action plan that NYS DOH staff will review and monitor. The results of the surveys are made available to Medicaid beneficiaries to assist them in the process of selecting an appropriate MCO.
Focused Clinical Studies
Focused clinical studies, conducted by the EQRO, usually involve medical record review, surveys or focus groups. MCOs are required to participate in two or three focused clinical studies a year. Recommendations for improvement are offered for NYS DOH, plans and providers. For example, in our record review of testing for group A streptococcus test prior to prescribing an antibiotic for pharyngitis, it was determined that the poor rates of recommended testing were not entirely a result of an inability to capture data, but a lack of testing. NYS DOH coordinated efforts to improve performance by highlighting these results, sharing best practices which resulted in improved rates of testing. The graph below shows how Medicaid rates improved after NYS DOH began reporting the measure; and the disparity continues to decrease after a statewide focused clinical study that identified areas in need of improvement. 2011 QARR data show the disparity essentially eliminated with commercial and Medicaid rates of performance of 88 and 86 percent respectively. Studies concerning the reduction of falls, the provision of advanced directives and the administration of flu shots for the MLTC plans have been implemented as well.

Results: Children’s Health- Appropriate Testing for Pharyngitis

Data on Race, Ethnicity and Primary Language
New York Medicaid obtains race, ethnicity, and primary language spoken from several sources: the eligibility system; the enrollment form completed by the recipient, and the enrollee health assessment form mailed to new enrollees by both the social services district and the MCO. Completed enrollment forms are forwarded to the MCO. MCOs are now required to submit member-level QARR and CAHPS (satisfaction) data to the NYS DOH which enables the calculation of QARR rates by certain demographic characteristics which are available through enrollment information. Race/ethnicity is one of those characteristics. The most recent report is available here: http://www.health.ny.gov/health_care/managed_care/reports/docs/demographic_variation_2011.pdf
External Quality Review – Technical Report
As mentioned previously, the NYS DOH contracts with IPRO to serve as its EQRO. To comply with Federal regulations, the IPRO’s scope of work includes:

- validation of QARR, MEDS and SAAM submissions;
- technical assistance and validation of health plan Performance Improvement Projects (PIPs);
- development and implementation of focused studies of health service delivery issues such as coordination, continuity, access and availability of needed services;
- preparation of the EQRO Technical Report for each MCO including MLTC plans.

Every three years, IPRO prepares a full report summarizing plan-specific descriptive data incorporating CMS protocols for external review quality reports. Thus far the reports have been created for the mainstream and HIV/SNP plans with MLTC plans forthcoming. The report includes information on trends in plan enrollment, provider network characteristics, QARR performance measures, complaints and grievances, identification of special needs populations, trends in utilization using encounter data, statements of deficiencies and other on-site survey findings, focused clinical study findings and financial data. Every year, the reports are updated for a subset of this information focusing on strengths and weaknesses. The data are provided by NYSDOH to the EQRO which then compiles a profile for each plan including a summary of plan strengths and weaknesses. (For further information reference 42 CFR Part 438.364 External Quality Review Results.) The reports are distributed on CDs within the Department and to the New York City Department of Health and Mental Hygiene. As of 2006, each plan received its own technical report. These reports are available on the New York State Department of Health public website. [http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/](http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/)

Clinical Standards/Guidelines
The State requires MCOs to adopt clinical standards consistent with current standards of care, complying with recommendations of professional specialty groups or the guidelines of programs such as the American Academy of Pediatrics, the American Academy of Family Physicians, the US Task Force on Preventive Care, the New York State Child/Teen Health Program (C/THP) standards for provision of care to individuals under the age of twenty-one (21), the American Medical Association’s Guidelines for Adolescent and Preventive Services, the US Department of Health and Human Services Center for Substance Treatment, the American College of Obstetricians and Gynecologists, the American Diabetes Association.

Additionally, New York State has standards/guidelines for the following:

- adult, adolescent, and pediatric HIV care developed by the NYS DOH AIDS Institute.
- asthma care in New York State developed and updated through a collaboration with professional organizations, academicians and primary care providers and specialists.
**Health Information Technology**

The State has been successful in implementing systems to support the goals of the program. Systems are in place to collect encounter, provider network, complaint, quality, and satisfaction data. Plans are also required to submit financial reports. New data collection efforts include: annual case management data, semi-annual functional assessment data for the MLTC plans (SAAM) and a “roster” of assigned primary care physicians for each enrollee in managed care. New York’s MCOs have developed successful information systems that allow them to collect and submit required data and reports. The UAS-NY is a web-based system with robust data capture to create database in the State’s Medicaid data warehouse.

Many health plans have implemented electronic health records and established internal registries to assist them in disease management, such as diabetes, asthma and high risk prenatal care. Statewide and regional health registries such as the NYC Immunization registry have been useful to plans in measuring enrollee compliance with HEDIS immunization standards.

The US Department of Health and Human Services, parent agency of the Centers for Medicare and Medicaid Services (CMS), created the Office of the National Coordinator for Health Information Technology (ONCHIT) in 2004, to advance the President’s agenda of creating an electronic medical record for every American by 2014. New York State, in alignment with this agenda, enacted the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY), a grant program promoting adoption of the processes and interoperable Health Information Technologies that will improve population health and reduce healthcare costs. The total investment to date in New York's Health Information Infrastructure is over $840 million, nearly $440 million in funding through the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program, over $280 million in private sector matching funds and nearly $120 million in other state and federal programs.

**B. Level of Contract Compliance of MCOs/PIHPs and How New York State Determines Compliance**

As required by CFR 438.204(g) the State must establish standards for MCO/PIHP contracts regarding access to care, structure and operations and quality measurement and improvement. Table 1 in the Appendix outlines each required component of the federal regulations and identifies the section of the model contract and/or Operational Protocol where this requirement is addressed. (See Appendix 1)

New York ensures compliance with the quality strategy by requiring MCOs to have internal quality assurance programs and by monitoring MCO performance. To participate in the Medicaid managed care, MLTC and Family Health Plus programs, MCOs must have the structures and processes in place to assure quality performance. Minimum, required components of the MCO’s Quality Assurance Plan were originally described in Chapter 20 of the Operational Protocol and are listed in Table 2 in the Appendix of the Quality Strategy. MCO Quality Assurance Plans (QAP) are reviewed, along with documentation of the activities and studies undertaken as part of the QAP during both the certification process and pre-contract operational review. (See Appendix 2 and 2a)
C. MCO Monitoring

The NYS DOH has developed a comprehensive program to assess all aspects of MCO performance. The program involves routine analysis and monitoring of QARR data submitted by MCOs; comprehensive on-site operational reviews; other focused on-site reviews and surveys designed to monitor areas of particular concern, (such as, provider availability and other issues identified through routine monitoring activities); and analysis of functional assessment and consumer satisfaction data.

On-site operational reviews
Operational reviews are conducted on an annual basis. The review is a comprehensive examination of the operation of an MCO to ensure compliance with statutes, regulations and government program contract requirements. These reviews also supplement other State monitoring activities by focusing on those aspects of MCO performance that cannot be fully monitored from reported data or documentation. The review focuses on validating reports and data previously submitted by the MCO through a series of review techniques that include an assessment of supporting documentation, and conducting a more in-depth review of areas that have been identified as potential problem areas. One component of the operational survey is the in-depth review of each MCO’s quality assurance activities.

If any deficiencies are identified through the operational review, an MCO will be issued a Statement of Deficiency (SOD) which specifically identifies deficiencies. The MCO will be required to submit a Plan of Correction (POC) which addresses each deficiency specifically and provides a timeline by which corrective action will be completed. Follow-up visits may be conducted as appropriate to assess the MCO’s progress in implementing its POC.

In addition to the SODs and resulting POCs, findings from the operational reviews may be used in future qualification processes as indicators of the capacity to provide high-quality and cost-effective services and to identify priority areas for program improvement and refinement.

Ad Hoc Focused Reviews
Focused reviews, which may or may not be on-site, are conducted in response to suspected deficiencies that are identified through the routine monitoring processes. These studies will also provide more detailed information on areas of particular interest to the State such as emergency room visits, behavioral health, utilization management and problems with data systems.

Ongoing Focused Reviews
While particular studies or activities may be developed in response to unique situations, the following are examples of the kinds of focused studies that are conducted on an on-going basis.

• Appointment and Availability Studies - The purpose of these studies is to review provider availability/accessibility and to determine compliance with contractually defined performance standards. To conduct the study, undercover EQRO staff, on behalf of the NYS DOH, attempt to schedule appointments under defined scenarios, such as a pregnant woman requesting an initial prenatal appointment.
MCOs are required to conduct access and appointment availability studies and to follow-up when they identify providers who are not in compliance with 24-hour coverage and appointment availability requirements. MCOs that fall below the NYSDOH mandated access and availability thresholds are issued a Statement of Deficiency (SOD). MCOs are then required to submit a Plan of Correction. Results of the studies and recommended follow-up should be reported to the MCO’s QA committee. The State reviews the MCO follow-up efforts during subsequent onsite operational reviews and the NYSDOH conducts a re-audit of those MCOs that were issued SODs.

- Networks are reviewed on a quarterly basis to determine network adequacy and to see if providers are being listed as practicing in a plan’s network when they have been subjected to disciplinary action that would preclude them from participating in the provider network.

- **Facilitated Enrollment and Outreach/Advertising Studies** - The purpose of these studies is to determine adherence to State and local Facilitated Enrollment and Outreach/Advertising guidelines and restrictions. To conduct these studies, staff may visit sites where MCOs are permitted to do facilitated enrollment, to provide uninsured consumers with assistance with enrollment forms and educating them on New York State Sponsored Health Insurance Programs. The NYS DOH staff may pose as uninsured consumers or observe the activities of MCO facilitated enrollers to ensure that the facilitated enrollers are providing required information and are not engaging in any misleading facilitated enrollment practices.

As with the operational reviews, MCOs that are found to be out of compliance are issued an SOD and are required to develop a plan of correction. Follow-up studies are conducted for those MCOs that had a serious deficiency and for any MCO that fails to show improvement upon implementation of corrective action (as determined through review of indicators such as enrollment/disenrollment rates, complaints, etc.).

MCOs are also required by contract to submit all marketing materials, marketing plans and certain member notices to the NYS DOH for approval prior to use. This process ensures the accuracy of the information presented to members and potential members. In addition, New York Medicaid Choice the NYS DOH enrollment broker is required to track and report enrollment activity for MLTC including satisfaction with the process.

**Quarterly and Annual Financial Statements**
In order to monitor fiscal solvency, the NYS DOH requires MCOs to submit Quarterly and Annual Financial Statements of Operations pursuant to the MMC/FHPlus and MLTC contracts.

**Complaint Reports**
On a quarterly basis, MCOs must submit a summary of all complaints registered during that quarter, along with a more detailed record of all complaints that had been unresolved for more than forty-five (45) days. A uniform report format was developed to ensure that complaint data
is consistent and comparable. NYS DOH uses complaint data to identify developing trends that may indicate a problem in access or quality of care.

**Fraud and Abuse Reports**
The MCO must submit quarterly, via the HCS Complaint reporting format, the number of complaints of fraud or abuse that are made to the MCO that warrant preliminary investigation. The plan must also submit to the NYS DOH the following information on an ongoing basis for each confirmed case of fraud and abuse it identifies through complaints, organizational monitoring, contractors, subcontractors, providers, beneficiaries, enrollees, or any other source:

- The name of the individual or entity that committed the fraud or abuse;
- The individual or entity that identified the fraud or abuse;
- The type of provider, entity or organization that committed the fraud or abuse;
- A description of the fraud or abuse;
- The approximate dollar amount of the fraud or abuse;
- The legal and administrative disposition of the case, if available, including actions taken by law enforcement officials to whom the case has been referred; and,
- Other data/information as prescribed by NYS DOH.

**Enforcement**
The Office of Quality and Patient Safety, in collaboration with the Office Of Health Insurance Programs (OHIP) has an enforcement policy for data reporting which applies to reporting for quality and appropriateness of care, contract compliance and monitoring reports. If an MCO cannot meet a reporting deadline, a request for an extension must be submitted in writing to the NYS DOH. The NYS DOH will reply in writing as well, within one week of receiving the request. MCOS that have not submitted mandated data (or requested an extension) are notified within one week of non-receipt that they must: 1) contact the OQPS within 1 week with an acceptable extension plan; or 2) submit information by one week.

If the data are not submitted within one week of the deadline, enforcement options include:

- Face-to-face meeting with plan to discuss issues
- Issue Statement of Deficiency with required Plan of Correction
- Deny requests for an expansion
- Stop auto-assignment to the plan
- Freeze new enrollment
- Terminate contract

Upon determination of the appropriate enforcement option, the Bureau of Intergovernmental Affairs shall notify the counties and advise them of the actions to be taken.

**III. Improvement**

Based on the results of assessments of quality and appropriateness of care contract compliance and MCO monitoring activities, the NYS DOH targets improvement efforts through a number of interventions as described below.

**Cross-state Collaborations**
Following the successful asthma care collaborative study, the NYS DOH continues to encourage and oversee statewide and collaborative studies and performance improvement projects (PIPs). In an effort to improve quality of care for children and adolescents with ADHD, seven plans volunteered to work with NYS DOH, IPRO and an advisory panel of ADHD experts to implement interventions to improve diagnosis, and treatment and management of ADHD from 2007 - 2008.

**Performance Improvement Projects (PIP)**

Plans are required to conduct one Performance Improvement Project (PIP) annually using a report template that reflects the Centers for Medicaid and Medicare Services (CMS) requirements for a PIP. In the past, each plan has chosen a topic and with the technical assistance from the EQRO, developed a study methodology and conducted interventions to reach their improvement goals. Recently however, the NYS DOH has encouraged plans to participate in collaborative studies, such as childhood obesity and just recently, reducing readmissions through collaborations with network hospitals. A conference was held to discuss lessons learned from the childhood obesity study and plans are just now completing the readmission PIP. Study processes and results are presented in a final report due 18 months after the study begins. From 2009 – 2010 eighteen plans worked with NYS DOH and IPRO to improve the prevention of childhood obesity. Six plans are currently working to reduce the disparities in asthma care with partnering provider practices in Brooklyn. This collaborative effort began in 2011 and will conclude in 2012. The NYSDOH and IPRO have supported this collaborative effort.

**Quality Performance Matrix**

In order to monitor health plan performance on quality measures, a quality performance matrix was developed. The matrix approach provides a framework for benchmarking performance and helps plans prioritize quality improvement planning. The matrix gives a multi-dimensional view of plan performance by comparing rates for selected measures in two ways: 1) to the statewide average and 2) over two years. The result, as shown below, is a 3x3 table where measures are displayed in cells corresponding to a letter grade ranging from A (best performance) to F (worst performance). Plans are instructed to conduct root cause analyses and develop action plans for measures where there is poor performance based on the barriers identified. The action plans are reviewed and approved by OQPS staff and are monitored throughout the year to assure that they are being conducted and evaluated for effectiveness in improving performance.

![2000 Statewide Statistical Significance](image)

- **A** Performance is notable. No action plan required
- **B, C** No action plan required
- **D, F** Root cause analysis and action plan required
**Pay for Performance – Quality Incentive**

As of 2002, the NYS DOH has been rewarding plans that have superior performance by adding up to an additional 2.5 percent to plan premiums. The Quality Incentive (QI) algorithm awards points to health plans for high quality and satisfaction and deducts points for SODs related to reporting requirements. In 2009, the NYS DOH added measures of preventable hospitalizations (Prevention Quality Indicators – PQIs). Four plan-specific PQI measures are in the current algorithm: pediatric asthma, pediatric composite (all other PQIs), adult respiratory (COPD and Asthma) and an adult composite and risk-adjusted by enrollee demographic characteristics and severity. The QI algorithm is used for auto-assignment as well.

The following table provides a summary of the number of plans who received the maximum incentive percentage, a partial incentive and no incentive, as well as the expenditures associated with the awards.

<table>
<thead>
<tr>
<th>Number of Plans</th>
<th>QI 2007</th>
<th>QI 2008</th>
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<th>QI 2010</th>
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<td>Full Award (2.5% PMPM)</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Partial Award (any tier between full and none)</td>
<td>12</td>
<td>17</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>No Award (0% PMPM)</td>
<td>11</td>
<td>3</td>
<td>6</td>
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| Dollars (million)    | $62.3   | $76.7   | $49.5   | $99.3   |

**Quality Improvement Conferences and Trainings**

NYSDOH is committed to providing Medicaid managed care plans with tools to conduct successful quality improvement initiatives. One successful approach has been the sharing of other plan experiences in best practice forums. NYSDOH, in collaboration with its EQRO, has conducted conferences on immunization strategies, partnering for quality improvement, understanding CAHPS (consumer survey) results, adolescent preventive care, physician profiling, ADHD, childhood obesity and asthma, diabetes, and prenatal care. A conference for the latest PIP, Reducing Readmissions, is scheduled for early 2013. Evaluation feedback is always sought and comments are used when planning future events.
Plan Manager Technical Assistance
Each plan is assigned a plan manager in both the Offices of Health Insurance Programs and Quality and Patient Safety. The plan managers act as liaisons with the NYSDOH and the plan staff on all issues of quality performance and MCO monitoring. They provide technical assistance to plan staff as they develop their root cause analyses and action plans in response to the Quality Performance Matrix. They prepare a plan’s Quality Profile for the area office staff prior to their conducting an on-site operational survey. They also consult with plans concerning their Performance Improvement Projects.

Publication of Quality Performance Reports
In an effort to share results from our quality performance analyses, medical record reviews and surveys we have published findings in peer review journals, on the DOH website and distributed copies of External Quality Review reports to all health plans. Appendix 3 presents a bibliography of peer review journal articles published on health plan quality performance. Results from a recent dental survey of Medicaid managed care enrollees and copies of the EQR Technical Reports are available on the DOH website at:

IV. Review of Quality Strategy

A. Public Input
The Quality Strategy was placed on the NYS DOH web site providing stakeholders and the general public the ability to comment on the content and approach.

B. Strategy Assessment Timeline
Every three years, NYSDOH will assess the Quality Strategy objectives using QARR/HEDIS results, SAAM, case management, CAHPS and other consumer survey results, Access and Availability survey findings and the EQRO Technical Report Strengths and Opportunities for Improvement section.

<table>
<thead>
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<th>Activity</th>
<th>Date Completed</th>
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<tr>
<td>MEDS III data submitted (monthly)</td>
<td>January – December, 2013-2017</td>
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<tr>
<td>CAHPS survey conducted</td>
<td>November, 2013, 2015, 2017</td>
</tr>
<tr>
<td>Calculate Rates of Quality Performance</td>
<td>June, 2013-2017</td>
</tr>
</tbody>
</table>
V. Achievements and Opportunities

An assessment of achievements in quality improvement in New York State’s Medicaid managed care plans presented in this 2012 Quality Strategy is based on a quantifiable analysis of improvement in quality measures from measurement years 2009 - 2011.

**QARR Performance Rates**
Rates of performance in child health, chronic care, behavioral health and satisfaction with care have steadily increased over time and are frequently higher than national Medicaid benchmarks published in the National Committee for Quality Assurance’s (NCQA’s) *State of Healthcare Quality*. Additionally, New York’s Medicaid managed care plans have continued to close the gap between Medicaid and commercial performance.

Several initiatives implemented by NYS DOH are believed to have been effective in improving health care quality and service. The Quality Incentive has been an invaluable tool in improving performance. Plan collaborations, such as the ADHD, childhood obesity and the recent readmission collaborative where plans partnered with network hospitals and shared lessons learned during quarterly conference calls and in-person conferences and provide a useful mechanism for plans to focus on areas of concern to the Medicaid managed care population.

The table below identifies a list of measures where there was a 10 percent improvement in statewide rates of performance between 2010 and 2011. Significant improvement is defined as at least 10% of gap between last reported rate and 100%.

<table>
<thead>
<tr>
<th>Measures with Significant Improvement</th>
<th>Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Access to PCPs (12-24 months)</td>
<td>Getting Needed Mental Health Treatment (CAHPS)</td>
</tr>
<tr>
<td>Advising Smokers to Quit</td>
<td>Childhood Immunizations (IPV, Influenza and RV)</td>
</tr>
<tr>
<td>HIV/AIDS Comprehensive Care</td>
<td>Well Child Visits 15months and 3-6 Years</td>
</tr>
<tr>
<td>Adolescent Preventive Care</td>
<td>Weight Assessment &amp;Counseling - Nutrition and Exercise</td>
</tr>
<tr>
<td>Chlamydia Screening (16-24 years)</td>
<td></td>
</tr>
</tbody>
</table>

**HIV SNP**

<table>
<thead>
<tr>
<th>Measures with Significant Improvement</th>
<th>Medicaid Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Access to PCPs (25M-19 years)</td>
<td>Use of Imaging Studies for low Back Pain</td>
</tr>
<tr>
<td>Cholesterol Testing and Control for People with Cardiovascular Disease</td>
<td>Pharmacotherapy for COPD Exacerbation - Corticosteroid</td>
</tr>
</tbody>
</table>
The following graph shows the improvement in the percentage of two-year olds who are fully immunized from 2005-2011. (The measure is collected every other year; therefore years 2006, 2008 and 2010 are not available.) As shown, Medicaid’s rates of performance have improved each year and are now higher than the commercial statewide average.

**Childhood Immunization Rates**


*Fully Immunized* consists of 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, and 4 pneumococcal conjugate vaccines. For 2009, only 2 Hib vaccines were needed.

**Quality Performance Matrix**

Now in its eleventh year, the Quality Performance Matrix process has enabled plans to develop internal processes for conducting root cause analyses and implementing actions focused on the identified barriers. While early action plans may have included one or two activities, the overwhelming majority of responses are now multi-faceted, addressing improvement through member, provider, data and plan-level interventions.

**Opportunities for Improvement**

Rates of performance for NYS’ Medicaid managed care plans continue to be higher than national benchmarks for a large percentage of the measures. In many cases the performance gap between Medicaid and commercial has significantly narrowed. However, there are still areas in need of
improvement. Based on the most recent QARR data (2011), the rates for the following measures have not increased:

- Avoidance of Antibiotics for Adults w/Bronchitis
- Flu Shots for Adults
- Cessation Medications and Strategies
- Use of Spirometry Testing for COPD
- Diabetes HbA1c Control below 8.0%
- Diabetes BP Control
- HIV/AIDS – Viral Load and Syphilis Testing
- Annual Dental visits
- Antidepressant Medication Management
- Follow Up Care for Children Prescribed ADHD Medication

An upcoming PIP will focus on hypertension, diabetes and smoking cessation. As the MMC population has become older and more complex, hypertension and cardiac disease are more prevalent. Diabetes (including obesity) is prevalent and there is room for improvement in diabetes outcome measures. Smoking rates are rather high in the upstate population. In addition, as a result of the NYS DOH’s concerted effort to increase the suite of mental health measures, which is dovetailing with the new HEDIS measures related to mental health and medication management, the tools are available to enhance improvement activities for the mental health population. NYS DOH will also continue to work on improving behavioral health outcomes and access to care.
APPENDIX 1

Contract Compliance of MCOs/PIHPs

The following table itemizes the required components of CFR 438.204(g) and identifies where they are addressed in the Medicaid model contract.

<table>
<thead>
<tr>
<th>Required Component</th>
<th>“Mainstream” Contract Provision</th>
<th>Managed Long Term Care Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>438.204 - Elements of state quality strategy Standards at least as stringent as those in the Federal regulations, for access to care, structure and operation, and quality measurement and improvement.</td>
<td>Chapter 20 of the Op Prot and the Model Contract.</td>
<td>Model MLTC Contract Article V. Section F.</td>
</tr>
<tr>
<td>438.206 - Availability of services</td>
<td>Model Contract: 21.1, 15.1, 15.2, 15.3, 15.4, 15.5 and Appendix J (ADA Compliance Plan). 10.12 10.16 and App. K, K.1, 7. and K.2, 7. 21.2 21.4 10.1, 15.2, 15.3, 15.4, 15.5, 15.10, and 21.1</td>
<td>Model MLTC Contract Article V. Section A. Article VII. Section A. D. Appendix B – ADA Compliance Plan Not applicable to MLTC Not applicable to MLTC Article V. Section A. Article VII. Section C. Article V. Section E. F. Article VII. Section D.</td>
</tr>
<tr>
<td>438.207 - Assurances of adequate capacity and services</td>
<td>Model Contract 18.5 a) viii) and 21.1, Plan Qualification, Network requirements.</td>
<td>Certificate of Authority Process, Network Requirements. Model Contract Article VII. Section D.</td>
</tr>
<tr>
<td>Required Component</td>
<td>“Mainstream” Contract Provision</td>
<td>Managed Long Term Care Contract Provision</td>
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<tr>
<td>time there is a significant change.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.208 - Coordination and continuity of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees.</td>
<td>Model Contract: 10.30, 21.8, 21.11, 21.14, 13.6</td>
<td>MLTC Model Contract Article V. Section J.</td>
</tr>
<tr>
<td>▪ State must implement procedures to identify persons with special health care needs.</td>
<td>10.19 – 10.23</td>
<td></td>
</tr>
<tr>
<td>▪ MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions.</td>
<td>15.7</td>
<td></td>
</tr>
<tr>
<td>▪ State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.210 - Coverage and authorization of services</td>
<td>Model Contract: Section 14 &amp; Appendix F</td>
<td>MLTC Model Contract Article V. Section J. Appendix K</td>
</tr>
<tr>
<td>▪ Service authorization process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.214 - Provider selection</td>
<td>Model Contract: 21.6</td>
<td>MLTC Model Contract Article VII. Section C.</td>
</tr>
<tr>
<td>▪ Plans must implement written policies and procedures for selection and retention of providers.</td>
<td>21.4</td>
<td></td>
</tr>
<tr>
<td>▪ State must establish a uniform credentialing and recredentialing policy. Plan must follow a documented process for credentialing and recredentialing.</td>
<td>21.6 (b)</td>
<td></td>
</tr>
<tr>
<td>▪ Cannot discriminate against providers that serve high risk populations.</td>
<td>21.1 (b)</td>
<td></td>
</tr>
<tr>
<td>▪ Must exclude providers who have been excluded from participation in Federal health care programs.</td>
<td></td>
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<tr>
<td>▪ Plans must meet the requirements of 438.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.224 - Confidentiality</td>
<td>Model Contract: Section 20</td>
<td>MLTC Model Contract Article X. Section B. Appendix L</td>
</tr>
<tr>
<td>▪ Plans must comply with state and federal confidentiality rules.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.226 - Enrollment and disenrollment</td>
<td>Model Contract: Section 7.1, 7.2, 8.6, 8.7 and Appendix H</td>
<td>MLTC Model Contract Article V. Section B.,C.,D.</td>
</tr>
<tr>
<td>▪ Plans must comply with the enrollment and disenrollment standards in 438.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.228 - Grievance systems</td>
<td>Model Contract: Section 14 &amp; Appendix F</td>
<td>MLTC Model Contract Article V. Section E.</td>
</tr>
<tr>
<td>▪ Plans must comply with grievance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required Component</td>
<td>“Mainstream” Contract Provision</td>
<td>Managed Long Term Care Contract Provision</td>
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<td>-----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>system requirements in the Federal regulations.</td>
<td></td>
<td>Appendix K.</td>
</tr>
<tr>
<td>438.230 - Subcontractual relationships and delegation</td>
<td>Model Contract: 22.1(b), 22.3, and 22.5</td>
<td>MTLC Model Contract Article VII. Section B.,C.</td>
</tr>
<tr>
<td>▪ Plan is accountable for any functions or responsibilities that it delegates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ There is a written agreement that specifies the activities and report responsibilities that are delegated and specifies the revocation of the agreement if the subcontractor’s performance is inadequate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.236 - Practice guidelines</td>
<td>Model Contract: 16.2</td>
<td>MLTC Model Contract Article V. Section A. J. Appendix K.</td>
</tr>
<tr>
<td>▪ Plans must adopt practice guidelines that are based on valid and reliable evidence or a consensus of health care professionals in the field; consider the needs of the population, are adopted in consultation with health care professionals, and are reviewed and updated periodically</td>
<td>16.2(c) 14.2 , 16.2(b) and Appendix F, F.1, 2.</td>
<td></td>
</tr>
<tr>
<td>▪ Guidelines must be disseminated.</td>
<td></td>
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<tr>
<td>▪ Guidelines must be applied to coverage decisions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>438.240 - Quality assessment and performance improvement program</td>
<td>Model Contract: 16.1 , and 18.5 a) x) B) 16.1(b) &amp; 18.5 a) v) 18.5 a) x) B)</td>
<td>MLTC Model Contract Article V. Section F.</td>
</tr>
<tr>
<td>▪ Each MCO and PIHP must have an ongoing improvement program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ The State must require that each MCO conduct performance measurement, have in effect mechanisms to detect both underutilization and overutilization, have in effect a mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs.</td>
<td>18.5 a) x) B)</td>
<td></td>
</tr>
<tr>
<td>▪ Measure and report to the state its performance using standard performance measures required by the state. Submit data specified by the State to measure performance.</td>
<td>18.5 a) x) B)</td>
<td></td>
</tr>
<tr>
<td>▪ Performance improvement projects. Each plan must have an ongoing program of performance improvement</td>
<td>18.5 a) x) B)</td>
<td></td>
</tr>
<tr>
<td>Required Component</td>
<td>“Mainstream” Contract Provision</td>
<td>Managed Long Term Care Contract Provision</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
</tbody>
</table>
| projects that focus on clinical and nonclinical areas. Projects should be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects should include: Measurement of performance, implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the intervention, planning and initiation of activities for increasing or sustaining improvement. Each plan must report to the State the results of each project.  
  - The State must review at least annually, the impact and effectiveness of the each program. | 18.5 a) x) B)                                                                                      |                                          |
| 438.242 - Health information systems  
  - Each plan must have a system in place that collects, analyzes, integrates, and reports data and supports the plan’s compliance with the quality requirements.  
  - Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system.  
  - The plan should ensure that data from providers is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic and consistency, collecting service information in standardized formats, make all data available to the State and CMS. | Model Contract:  
  18.1(a)                                                                                          | MLTC Model Contract Article VIII. Section A., E.                                               |
Internal Quality Assurance Plan (QAP)

MCO Quality Assurance Plans are reviewed, along with documentation of the activities and studies undertaken as part of the QAP during both the certification process and the pre-contract operational review. QAPs must contain, at minimum, the following elements.

- **Description of Quality Assurance (QA) Committee structure** – The Medical Director must have responsibility for overseeing the QA committee’s activities. The committee must meet regularly, no less than quarterly. Membership must include MCO network providers.

- **Designation of individuals/departments responsible for QAP implementation** – MCOs must designate a high-level manager with appropriate authority and expertise (such as the Medical Director or the Director’s designee) to oversee QAP implementation.

- **Description of network provider participation in QAP** – MCOs must involve network providers in QAP activities. The mechanism for provider participation must be described in the written QAP, and providers must be informed of their right to provide input on MCO policies and procedures.

- **Credentialing/recredentialing procedures** – MCOs must institute a credentialing process for their providers that includes, at a minimum, obtaining and verifying information such as valid licenses; professional misconduct or malpractice actions; confirming that providers have not been sanctioned by Medicaid, Medicare or other state agencies; and the provider’s National Practitioner Data Bank profile. (See Appendix 20.2a.)

- **Standards of care** – MCOs must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional specialty groups pursuant to the requirements of the MMC/FHPlus Model Contract.

- **Standards for service accessibility** – MCOs must develop written standards for service accessibility, which at a minimum, meet the standards established by State and local districts as delineated in the MMC/FHPlus Model Contract.

- **Medical record standards** – The QAP must contain a description of the medical records standards adopted by the MCO as specified in the MMC/FHPlus Model Contract.

- **Utilization review procedures** – Utilization review policies and procedures must be in accordance with the requirements specified in State law Article 49 of the Public Health Law (PHL).

- **Quality indicator measures and clinical studies** – The State defines quality measures for MCOs in its Quality Assurance Reporting Requirements (QARR) document. The
QARR report is available on the NYS DOH website at http://www.health.state.ny.us/health_care/managed_care/reports/index.htm. MCOs are also required to conduct at least one Performance Improvement Project (PIP) each year in a priority topic area of their choosing. A description of PIPs must be included in the QAP.

- **QAP documentation methods** – The QAP must contain a description of the process by which all QAP activities will be documented, including Performance improvement studies, medical record audits, utilization reviews, etc.

- **Integration of quality assurance with other management functions** – To be effective, quality assurance must be integrated in all aspects of MCO management and operations. The QAP must describe the process by which this integration will be achieved.
APPENDIX 2a

CREDENTIALING CRITERIA - RECOMMENDED GUIDELINES

The following criteria reflect current observed standards of practice for the credentialing of physicians for participation in a managed care setting:

1. List of required licensure, certifications and registrations:
   a) a copy of a current New York State Medical License;
   b) a copy of current NYS registration (biennial registration as of 1995);
   c) a copy of current Drug Enforcement Agency (DEA) certificate;
   d) if the provider is Board Certified a copy of the Specialty Board Certification must be included and verified by written documentation from the Specialty Board.

2. The physician must also have:
   a) active hospital admitting privileges at an accredited hospital(s). This can be waived if the physician provides the following information:
      i. a description of the circumstances that merit consideration of a waiver;
      ii. either a copy of a letter of active hospital appointment other than admitting or evidence of an agreement between the applicant and a primary care physician who is licensed to practice in New York, has an active admitting privilege and will monitor and provide continuity of care to the applicant's patients who are hospitalized, and;
      iii. a Curriculum Vitae, proof of medical malpractice insurance, and two letters of reference from physicians who can attest to the applicant's qualifications as a practicing physician.
   b) a current Curriculum Vitae;
   c) graduation from Medical School as verified by one of these methods; written documentation from the Medical College or AMA Physician Master file;
   d) completion of a residency program as verified by written documentation from the program;
   e) evidence of satisfactory malpractice insurance.

3. The physician must submit the following information:
   a) a waiver by the physician of any confidentiality provisions concerning the information required for the credentialing process and reporting to the Department;
   b) a verification statement/attestation by the physician indicating that the information he/she is providing is true, accurate and complete;
   c) the names of any hospital, HMO, PHSP, IPA or medical group the physician was associated with for the purpose of providing/performing, his/her professional duties;
   d) reasons for discontinuing associations with any of the aforementioned entities;
   e) information regarding pending malpractice actions and/or professional misconduct proceedings in this state or any other state, the substance of these allegations and any other information concerning the proceedings/actions that the physician deems appropriate;
   f) history of any malpractice and/or professional misconduct judgments and/or settlements within the past 10 years;
g) a statement regarding his/her history of loss of professional license, limitation of privileges, disciplinary actions or felony convictions;

h) a statement indicating that the practitioner is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior;

i) a statement regarding the lack of present illegal drug use.

4. The Plan conducts the following:
   a) validation of all of the aforementioned requirements;
   b) search for medical sanctions by DSS and/or Medicaid;
   c) search of the National Practitioners Data Bank.

5. The credentialing process, as part of the total Quality Assurance/Quality Improvement program, must be directed by a peer review committee or a comparable designated committee.

6. The practitioner’s credentials must be reviewed at least every three years.
APPENDIX 3

Published Journal Articles – New York State Managed Care


