

New York State Department of Health



2016 Quality Incentive for Medicaid Managed Care Plans



A Report on Quality Incentive
Program in New York State

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New York's Medicaid Managed Care Quality Incentive (QI) Program began in early 2001. In 2002, the program was expanded to provide increased incentives for improvement. Plans became eligible to receive bonuses added to the premium based upon composite scores from quality measures and satisfaction measures. The bonus was later increased in 2005; it currently remains at this amount. The QI Program continued to evolve over the years by including new components and measures as well as further refinement of the methodology to calculate current performance relative to peers.

The data sources used in the Quality incentive have included quality measures from New York's Quality Assurance Reporting Requirements (QARR), which is largely comprised of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and state-specific performance measures; measures using a national satisfaction survey methodology called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and Preventions Quality Indicators using the Agency for Healthcare Research and Quality (AHRQ).

Rates of performance in Medicaid managed care have been increasing steadily over the last decade. New York State Medicaid plans have demonstrated a high level of care compared to national averages, and for many domains of care, the gap in performance between commercial and Medicaid managed care has been decreasing since the QI Program was implemented. The use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources to promote high quality care. Incorporating financial incentives that tie payment directly to quality is an important approach to improving the quality of care and holds health plans accountable for the care they provide and rewards those who invest in processes that improve care. State Medicaid programs have steadily increased the use of financial incentives or pay-for-performance (P4P) mechanisms in their payment systems. A report published by the Commonwealth Fund in April 2007 shows that more than half of state Medicaid programs were operating one or more P4P programs by mid-year 2006, with more than 50 percent in existence for more than five years.¹ Seventy percent of the existing P4P programs were operating in managed care or primary care case management systems and focused on children, adolescent, and women's health services. Among the programs in place, the authors identified six types of incentive: bonuses, differential reimbursement for rates or fees, penalties, auto-assignment of beneficiaries to a plan or provider, withholds, and grants. Results of this independent, external evaluation and frequent communication with Medicaid managed care plan staff indicate that the QI Program is a valuable tool with which to incentivize health plans and their providers to improve the measurement and delivery of health care to Medicaid managed care enrollees.

¹ The Commonwealth Fund. Pay-For-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs. 2007.
http://www.commonwealthfund.org/usr_doc/Kuhmerker_P4PstateMedicaidprogs_1018.pdf

Section 1 Background

Currently, the QI Program has a defined methodology to determine the percentage of the potential financial incentive that a plan receives, based on results from the four components of Quality of Care, Consumer Satisfaction, Prevention Quality Indicators (PQIs) and Compliance. Compliance points are deducted for any Statements of Deficiency (SOD) issued for failure to fulfil managed care requirements. Assessments of quality satisfaction and efficiency are derived from QARR measures, satisfaction data from CAHPS®, and AHRQ’s PQIs.

Plans earn up to 150 points from the components of Quality, Satisfaction, and PQIs. Points are subtracted from the plan’s total points if the plan had statements of deficiency in the Compliance category. The plans’ total points out of the 150 points are then normalized to a 100-point scale. A summary of the current QI structure components and possible points is listed below:

Component	Measures *	Points
Quality – QARR (HEDIS® and NYS-specific)	33 measures	100 points
Satisfaction – CAHPS® Health Plan Survey	3 measures	30 points
Prevention Quality Indicators	2 measures	20 points
Total points		150 points
Compliance (Subtracted from Total)	5 measures	Up to 20 points
Final Score		Final points/150

* The number of measures per component has varied from year to year.

The awards include financial incentive and auto-assignment preference. Plans are grouped into tiers to determine the financial incentive award (such as full award, one or more levels of partial award and no award, which is added to the monthly member premium). The tiers are based on the percentage of points earned by the plans. The number of tiers has varied from year to year. Plans must achieve or exceed the threshold for the respective tier to be eligible for an award. The financial Incentive awards were impacted by enacted budget actions for SFY 17-18 and may change to meet program fiscal targets. The amount of the incentive award is determined by the Division of Finance and Rate Setting and subject to final approval from Division of Budget and the Center for Medicare and Medicaid Services (CMS).

Plans’ tiers affect the auto-assignment preference. The quality preference in the algorithm directs a proportion of auto-assignees only to plans that qualified for the incentive. The quality preference for auto-assignment is not adjusted by the tier of the QI award; rather all tiers other than Tier 5 receive the same quality preference and share in the distribution of auto-assignees equally.

The QI methodology aligns with the Department's efforts to reward comprehensive quality care. The improvement in results for Medicaid managed care has been impressive over the past ten years. The objective with the incentive methodology is to expand the scope of accountability and provide continued encouragement for improvement.

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In this section, a detailed description of the four QI components and the calculation process are presented to explain how the points are assigned to each measure within each component.

The following four QI components were used to determine the 2016 QI results:

- Quality of Care: 2016 QARR results using 2015 data;
- Consumer Satisfaction: The most recent CAHPS® survey for adults in Medicaid, which was administered in fall 2015 and results released in reports dated February 2016;
- Prevention Quality Indicators: Prevention Quality Overall Composite (PQI 90) and Pediatric Quality Overall Composite (PDI 90) using 2015 inpatient admissions; and
- Compliance: Regulatory compliance information from 2014 and 2015.

Quality of Care Measures (100 points possible)

Quality performance points were earned based on percentiles of the current year performance for Medicaid plans.

- The allotted 100 points for quality was distributed evenly for all measures. For example, if there were 33 measures in the quality section, each measure was worth up to 3.03 points.
- If a measure had less than 30 members in the denominator, we considered it to be Small Sample Size (SS), and suppressed those results. There was no reweighting for Small Sample Size. The base points were reduced by the maximum value for that one measure. The plan's total points were then converted to a percentage to control for differences in base points. For example, with 33 measures worth 3.03 points each for a total of 100 possible points, if a plan only had 32 measures each was worth 3.03 points but only out of 96.97 total points.
- Plans were awarded 50 percent of possible points for a measure result at or above the 50th percentile, but less than the 75th percentile; 75 percent of possible points for a measure result at or above the 75th percentile, but less than the 90th percentile; and 100 percent of possible points for the measure at or above the 90th percentile. Plans were given no points if they scored below the 50th percentile.
- The determination of the 50th, 75th and 90th percentiles were based on the same measurement year of the results. Therefore, only a certain number of plans could achieve these percentiles for each measure. To determine the plans achieving the percentiles, the results were not rounded prior to the percentile determination. For example, two plans with the same rate after rounding, may have achieved different points for the measure.
- The total quality points were aggregated and converted to a normalized quality percentage points of 100. The percentage is normalized using the highest plan quality percentage points. Since only a set number of plans could achieve points for each

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measure, the normalization of the percentage allows this section of the QI to continue to retain a similar weight in the makeup of the overall scores.

Benchmarks for the 90th, 75th and 50th percentiles for the Quality measures in the 2016 QI:

Quality Measure	90 th Percentile	75 th Percentile	50 th Percentile	Points Possible
Adult BMI Assessment	95.28	92.35	87.10	3.03
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.99	63.25	60.68	3.03
Antidepressant Medication Management	48.37	45.24	43.10	3.03
Annual Monitoring for Patients on Persistent Medications	93.01	91.99	90.36	3.03
Appropriate Testing for Pharyngitis	90.90	88.94	85.71	3.03
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	34.74	32.18	28.10	3.03
Breast Cancer Screening	73.33	71.65	68.04	3.03
Cervical Cancer Screening	75.81	73.06	70.49	3.03
Chlamydia Screening	78.49	76.15	70.24	3.03
Childhood Immunization Status (Combo 3)	82.97	79.60	76.64	3.03
Colorectal Cancer Screening	67.25	60.87	54.38	3.03
Comprehensive Care for People Living with HIV/AIDS - Engaged in Care	89.73	86.18	82.99	3.03
Comprehensive Diabetes Care - Received All Tests	60.22	58.94	55.38	3.03
Comprehensive Diabetes Care - HbA1C Control <8.0%	59.85	57.40	55.84	3.03
Controlling High Blood Pressure	71.78	70.07	62.06	3.03
Diabetes Monitoring for People with Diabetes and Schizophrenia	83.57	80.84	75.33	3.03
Flu Shot for Adults (CAHPS)	47.20	44.24	40.49	3.03
Follow Up After Hospitalization for Mental Illness Within 7 Days	75.27	70.63	62.92	3.03
Follow Up for Children Newly Prescribed ADHD Medication	63.56	62.81	56.98	3.03
Human Papillomavirus Vaccination for Female Adolescents	39.42	36.01	26.33	3.03
Immunization for Adolescents	79.55	77.26	74.26	3.03
Medical Assistance with Tobacco Cessation (CAHPS)	66.83	65.09	63.49	3.03
Medication Management for People with Asthma (Ages 5-64)	51.47	48.72	46.73	3.03
Persistence of Beta-Blocker Treatment After a Heart Attack	90.00	88.89	85.94	3.03
Use of Imaging Studies for Low Back Pain	81.96	79.14	74.73	3.03
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	59.85	54.70	49.79	3.03
Weight Assessment and Counseling for Children and Adolescents	83.19	81.99	78.59	3.03
Annual Dental Visit (Ages 2-18)	68.32	63.89	60.47	3.03
Frequency of Ongoing Prenatal Care (81% and more)	73.48	72.75	67.64	3.03
Timeliness of Prenatal Care	90.55	89.03	87.38	3.03
Postpartum Care	75.18	71.05	67.64	3.03
Well Child Visits in the First 15 Months – Five or more visits	86.17	83.19	80.71	3.03
Well Child Visits in the 3rd, 4th, 5th and 6th Year	86.11	82.93	81.83	3.03
Total Points				100

Satisfaction Measures (30 points)

This year’s QI incorporates satisfaction data from the state-sponsored CAHPS® survey for Adults in Medicaid, which was administered in fall 2015, and results released in reports dated February 2016. Thirty points (of the total 150) were assigned to the CAHPS® measures. To achieve 10 points for a measure, the plan’s result for the measure must be significantly higher than the statewide average. Plan results that were not significantly different than the statewide average earn 5 points, and plan results that were significantly below the statewide average did not receive any points (zero points).

The CAHPS® measures included in the 2016 Quality Incentive are listed below:

CAHPS Measure	Statewide Average	Satisfaction Points
Rating of Health Plan	76	10 points
Getting Care Needed	79	10 points
Customer Service and Information	84	10 points
Total		30 points

Prevention Quality Indicator (PQI) Measures (20 points)

The Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) quantify hospital admissions that most likely could have been avoided through high-quality outpatient care. To align with the Delivery System Reform Incentive Payment program (DSRIP), the PQI Composite measure (PQI 90) and the PDI Composite measure (PDI 90) were used in the 2016 Quality Incentive. To further align with the Agency for Healthcare Research and Quality (AHRQ), the prevention quality indicators were calculated as the number of admissions that met one of the prevention quality or pediatric quality indicators over the total number of people in your health plan. Plans were awarded points based on their risk adjusted rates. Plans received 50 percent of possible points for a measure at or below the 50th percentile, but greater than the 25th percentile; 75 percent of possible points for a measure at or below the 25th percentile, but greater than the 10th percentile; and 100 percent of possible points for the measure at or below the 10th percentile.

PQI	PQI Points
Adult Prevention Quality Overall Composite (PQI 90)	10 points
Pediatric Quality Overall Composite (PDI 90)	10 points
Total	20 points

A more detailed explanation of the methodology used in calculating the PQIs follows:

Data Source

Encounter data submitted by the managed care plans to the Medicaid Encounter Data System (MEDSII) for inpatient hospitalizations where the patient was discharged in calendar year 2015 were used for this analysis. The patient had to be enrolled in the health plan for at least three

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months before the hospital admission. AHRQ PQI version 6.0 logic was used to assign PQI indicators to the hospitalizations. For hospitalizations prior to October 1, 2015 ICD-9 version 6.0 was used and post October 1, 2015 ICD-10 version 6.0 was used to account for changes to ICD-10 coding. AHRQ PDI version 5.0 logic was used to assign PDI indicators to the hospitalizations prior to October 1, 2015 and AHRQ PDI 6.0 logic was used to assign PDI indicators to the hospitalizations post October 1, 2015. AHRQ did not release a version 6.0 ICD-9 compliant version of the PDI software at the time of the analysis. Members who were dually enrolled in Medicaid and Medicare at any time in the measurement year were removed.

Population

Health plan enrollment was determined as four months of continuous enrollment in a health plan. If a person was enrolled for more than four months in more than one health plan during the year, the member was counted in each health plan. The members enrolled in the plan were used to create the denominator for the PQI and PDI measures. Members who were dually enrolled in Medicaid and Medicare were removed.

Rate Calculation

Observed and risk adjusted rates per 100,000 enrollees were calculated for each plan for each of the two measures. The measures were risk adjusted by the patient's age group, gender, race/ethnicity, Medicaid aid category and the enrollee's Clinical Risk Group (CRG) status from the previous year.

Compliance Measures (up to 20 points subtracted)

Compliance points are related to plans meeting regulatory requirements in five areas. Plans not meeting requirements as evidenced by Statements of Deficiencies lose points from their total. Each compliance measure and scoring criteria are as follows:

Category	Measure Description	Timeframe	Points
Medicaid Encounter Data System II	Any statement of deficiency for timeliness or completeness of MEDS II data submitted for the measurement year (2015).	MEDS data submitted for 2015	4 points for any statement of deficiency. No more than 4 points were removed for this category.
Medicaid Managed Care Operating Report	Any statement of deficiency for timeliness or completeness of MMCOR reports submitted for the measurement year (2015).	MMCOR reports submitted for 2015	4 points for any statement of deficiency for timeliness/ completeness or for accuracy. No more than 4 points were removed for this category
	Any statement of deficiency issued for accuracy of MMCOR reports submitted the year prior to the measurement year (2014).	MMCOR reports submitted for 2014	

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Category	Measure Description	Timeframe	Points
Quality Reporting Requirements	Any statement of deficiency for failure to submit required complete quality data for Care Management (CMART) data and QARR data (includes the required member-level file and the birth file) by the established deadlines for the measurement year (2015).	Quality Reporting Requirements for 2015 data	4 points for a statement of deficiency. No more than 4 points were removed for this category.
	Any statement of deficiency related to the Performance Improvement Projects or the quality performance matrix process.	Quality reporting requirements for 2015.	
Plan Network	Any statement of deficiency issued for the measurement year (2015) for failure to manage access to care to maintain network with at least 75% compliance with required appointment timeframes based on the Access and Appointment Availability survey conducted for the department.	Access and Availability survey results for 2015	2 points for any statement of deficiency. No more than 2 points were removed for this item in the category.
	Any statement of deficiency for incomplete or inaccurate provider listings and/or failure to maintain at least 75% provider participation rate for the measurement year (2015).	Provider Directory Information and Participation results for 2015	2 points for any statement of deficiency for either directory information or for provider participation. No more than 2 points were removed for this item in the category.
Member Services	Any statement of deficiency or statement of findings for member services during the measurement year (2015) for failure to: maintain a functional member services phone line; provide correct information to callers; provide specific information upon written request.	Member services for 2015	4 points for any statement of deficiency or statement of findings for any of the three member service items. No more than 4 points were removed for this category.
Total			20 points

Section 3

QI Award Results

In 2016, the sixteen NYS Medicaid Managed Care plans were grouped into five tiers based on their QI scores. The table below shows the tier assigned to each plan. The 2016 Quality Incentive awards become effective for capitation rates and for auto-assignment preference on April 1, 2017. Revised capitation rates for plans that received the 2016 Quality Incentive will be sent from the Division of Finance and Rate Settings.

2016 Quality Incentive Awards Effective Period April 1, 2017 – March 30, 2018							
Incentive Tier	Plan Name	Normalized Quality Points = Quality Points/Highest Score (100 points possible)	Satisfaction Points (30 points possible)	PQI/PDI Points (20 points possible)	Compliance Points (20 points possibly subtracted)	Total Points	Percent of Total Points (up to 100%)
Tier 1	CDPHP	71.19	30	10	-2	109.19	72.80
Tier 1	Healthfirst PHSP, Inc.	99.43	15	0	-6	108.43	72.28
Tier 1	MetroPlus Health Plan	100.00	10	0	-6	104.00	69.33
Tier 2	Fidelis Care New York, Inc.	84.70	10	5	-6	93.70	62.46
Tier 2	Hudson Health Plan	54.01	20	12.5	0	86.51	57.67
Tier 2	Excellus BlueCross BlueShield	47.87	25	12.5	-2	83.37	55.58
Tier 3	Empire BlueCross BlueShield HealthPlus	71.19	10	0	-2	79.19	52.80
Tier 3	UnitedHealthcare Community Plan	65.06	5	12.5	-6	76.56	51.04
Tier 3	HealthNow New York Inc.	44.30	15	15	0	74.30	49.54
Tier 3	MVP Health Care	35.28	25	15	-2	73.28	48.85
Tier 4	WellCare of New York	50.33	10	0	-2	58.33	38.88
Tier 4	Affinity Health Plan	46.64	20	0	-10	56.64	37.76
Tier 4	Independent Health's MediSource	33.14	20	5	-2	56.14	37.43
Tier 5	Total Care, a Today's Options of New York Health Plan	37.98	15	7.5	-8	52.48	34.98
Tier 5	YourCare Health Plan	20.87	15	15	-2	48.87	32.58
Tier 5	HIP (EmblemHealth)	34.37	10	0	-2	42.37	28.25

* Incentive premium awards were impacted by enacted budget actions for SFY 17-18 and may change to meet program fiscal targets