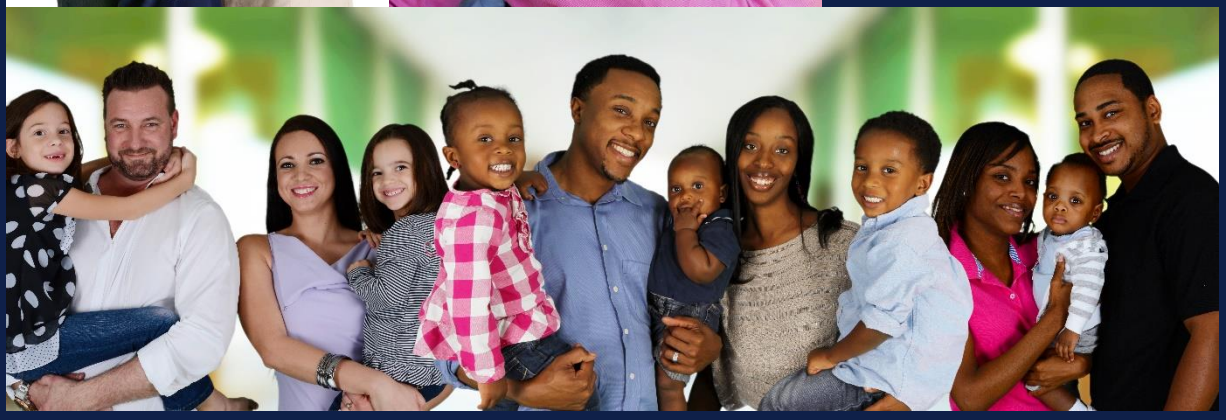

New York State Department of Health

2017 Quality Incentive for Medicaid Managed Care Plans

A Report on Quality Incentive Program in New York State

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Section 1 Background

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 to its current value. The QI Program continued to evolve over the years by including new components and measures as well as further refining 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 Prevention 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. Plans earn up to 150 points from the categories of Quality of Care, Consumer Satisfaction, and Preventive Quality Indicators. Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. A maximum of 20 points could be subtracted from the plan's total points for statements of deficiency associated with specific compliance areas. A plan can also earn up to 6 possible bonus points for an approved telehealth innovation plan. The plans total points out of the 150 points are 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**)	27 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**)	6 measures	Up to 20 points
Bonus for Telehealth Innovation (**Added to Total**)		Up to 6 points
Final Score		Final points/150

* The number of measures per component may vary 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. Plans must achieve or exceed the threshold for the respective tier to be eligible for their award. Plans achieving Tier 1-Tier 4 of the Quality Incentive award receive the quality preference in the auto-assignment algorithm. The financial incentive awards were impacted by enacted budget actions for SFY 18-19 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. Plans achieving Tier 1 - Tier 4 of the Quality Incentive award receive the quality preference in the auto-assignment algorithm. 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.

Section 1 Background

The 2017 Quality Incentive awards become effective for capitation rates and for auto-assignment preference on April 1, 2018. Final revised capitation rates for plans that received the 2017 Quality Incentive will be sent separately from the Division of Finance and Rate Setting. If you have questions regarding the incentive premium award, please contact the Bureau of Acute & Managed Care Reimbursement at (518) 473-8822.

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.

We welcome suggestions and comments on this publication. Please contact us at:

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Section 2 QI Components and Calculation Process – 2017 Methodology

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

The following five QI components were used to determine the 2017 QI results:

- Quality of Care: 2017 QARR results using 2016 data;
- Consumer Satisfaction: The most recent CAHPS® survey for children in Medicaid and Child Health Plus, which was administered in fall 2016 and results released in reports dated March 2017;
- Prevention Quality Indicators: Prevention Quality Overall Composite (PQI 90) and Pediatric Quality Overall Composite (PDI 90) using 2016 inpatient admissions; and
- Compliance: Regulatory compliance information from 2015 and 2016.
- Bonus Points: Telehealth Innovation Plan (TIP) request approved in 2017.

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 will be distributed evenly for all measure scores, and for measures with more than one indicator, each measure score will be counted as one measure. For example, if there are 27 measures in the quality section, each measure will be worth up to 3.70 points.

- If a measure has less than 30 members in the denominator, we consider it to be Small Sample Size (SS) and we will suppress those results. There will be no reweighting for Small Sample Size. If plan results are SS there will be overall reduction of quality points. For example, with 27 measures worth 3.70 points out of 100 possible points, if a plan only has 26 measures each will be worth 3.70 points but only out of 96.30 total points. The base will be reduced by the maximum value for that one measure.

- Plans will be 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 will be based on the same measurement year of the results. Therefore, only a certain number of plans will be able to achieve these percentiles for each measure. To determine the plans achieving the percentiles the results will be rounded to two decimal points prior to the percentile determination.

- Each plan's quality points are totaled and then divided by their base points. The resulting quality percentage points are normalized to 100. The percentage is normalized

using the highest plan quality percentage points. Since only a set number of plans can achieve points for each measure, this normalization of the quality percentage points to 100 allows this section of the Quality Incentive 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 2017 QI:

Quality Measure	Indicators	90th Percentile	75th Percentile	50th Percentile	Points Possible
Annual Dental Visit	Ages 2-18	69.08	66.98	62.09	3.70
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis					3.70
Breast Cancer Screening		73.10	70.80	68.04	3.70
Cervical Cancer Screening		77.87	75.99	71.63	3.70
Chlamydia Screening	16-20 years	79.99	76.92	71.71	3.70
	21-24 Years				
Childhood Immunization Status	Combination 3	83.21	81.86	77.13	3.70
Colorectal Cancer Screening		64.23	57.35	54.74	3.70
Comprehensive Diabetes Care	Received All Three Tests	62.04	59.95	57.31	3.70
Comprehensive Diabetes Care	HbA1C Control <8.0%	61.07	57.42	55.07	3.70
Controlling High Blood Pressure		70.80	65.21	62.84	3.70
Immunization for Adolescents	Combination 1	84.18	81.27	77.62	3.70
Medication Management for People with Asthma (Ages 5-64)	50% of Treatment Period Covered	50.88	48.51	46.25	3.70
	75% of Treatment Period Covered				
Use of Imaging Studies for Low Back Pain					3.70
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		55.20	54.44	45.32	3.70
Weight Assessment and Counseling for Children and Adolescents	Body Mass Index (BMI) Percentile Documentation	86.46	84.08	77.53	3.70
	Counseling for Nutrition				
	Counseling for Physical Activity				
Well Child Visits in the First 15 Months – Five or more visits		85.85	84.28	81.32	3.70
Well Child Visits in the 3rd, 4th, 5th and 6th Year		87.28	85.04	82.77	3.70
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		67.69	63.49	60.90	3.70
Antidepressant Medication Management	Effective Acute Phase Treatment	45.38	44.71	42.03	3.70
	Effective Continuation Phase Treatment				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Meds		83.26	82.54	80.93	3.70
Follow Up After Hospitalization for Mental Illness Within 7 Days	7 Days	70.29	66.74	60.61	3.70

Section 2 QI Components and Calculation Process – 2017 Methodology

Quality Measure	Indicators	90th Percentile	75th Percentile	50th Percentile	Points Possible
Follow Up for Children Newly Prescribed ADHD Medication	Initiation Phase	69.55	69.13	60.95	3.70
	Continuation and Maintenance (C&M) Phases				
Initiation and Engagement of Alcohol and other Drug Dependence Treatment	Initiation of AOD Treatment	41.18	40.12	35.20	3.70
	Engagement of AOD Treatment				
Metabolic Monitoring for Children and Adolescents on Antipsychotics		48.82	48.06	41.60	3.70
Timeliness of Prenatal Care		92.94	90.02	88.67	3.70
Postpartum Care		73.72	72.25	68.86	3.70
Viral Load Suppression		83.97	83.41	76.81	3.70
Total Points					100

Satisfaction Measures (30 points)

This year's QI incorporates satisfaction data from the state-sponsored CAHPS® survey for Children in Medicaid and Child Health Plus, which was administered in fall 2016, and results released in reports dated February 2017. 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 2017 Quality Incentive are listed below:

CAHPS Measure	Statewide Average	Satisfaction Points
Rating of Health Plan	85	10 points
Getting Care Needed	85	10 points
Customer Service and Information	86	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) are used in the 2017 Quality Incentive. To further align with the Agency for Healthcare Research and Quality (AHRQ), the prevention quality indicators will be 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 will be awarded points based on their risk adjusted rates. Plans will receive 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. Plans received no points for a measure above the 50th percentile.

PQI	10th Percentile	25 Percentile	50th Percentile	PQI Points
Pediatric Quality Overall Composite (PDI 90)	102.13	144.95	174.66	10 points
Adult Prevention Quality Overall Composite (PQI 90)	603.47	677.99	724.38	10 points
Total				20 points

Section 2 QI Components and Calculation Process – 2017 Methodology

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 2016 were used for this analysis. The patient had to be enrolled in the health plan for at least three 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 IDC-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)

The Compliance section includes six areas. Statements of deficiency for timely, complete, and/or accurate submissions of Encounter data, the Medicaid Managed Care Operating Report (MMCOR), Quality Assurance Reporting Requirements, plan network, provider directory, and member services. The Quality Reporting Requirement area for 2017 includes submission requirements for Care Management data, Performance Improvement Project reports, and performance matrices action plans. In the 2017 Quality Incentive, points from issues with Compliance will be subtracted from the total points prior to calculating the final percentage scores. The number of points subtracted is detailed below:

Category	Measure Description	Timeframe	Points
Encounter Data	Any statement of deficiency for timeliness or completeness of Encounter data submitted for the measurement year (2016).	Encounter data submitted for 2016	4 points for any statement of deficiency. No more than 4 points

Category	Measure Description	Timeframe	Points
			will be removed for this category.
Medicaid Managed Care Operating Report	Any statement of deficiency for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted for the measurement year (2016).	MMCOR reports submitted for 2016	4 points for any statement of deficiency for timeliness/ completeness/ accuracy or failure to meet reserves. No more than 4 points will be removed for this category.
	Any statement of deficiency for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted for the measurement year (2015).	MMCOR reports submitted for 2015	
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 (2016).	Quality Reporting Requirements for 2016 data	4 points for a statement of deficiency. No more than 4 points will be removed for this category.
	Any statement of deficiency related to the Performance Improvement Projects or the quality performance matrix process.	Quality reporting requirements for 2016.	
Plan Network	Any statement of deficiency issued for the measurement year (2016) 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 2016	2 points for any statement of deficiency. No more than 2 points will be removed for this item in the category.
Provider Directory	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 (2016).	Provider Directory Information and Participation results for 2016	2 points for any statement of deficiency for either directory information or for provider participation. No more than 2 points will be removed for this item in the category.

Category	Measure Description	Timeframe	Points
Member Services	Any statement of deficiency or statement of findings for member services during the measurement year (2016) for failure to: maintain a functional member services phone line; provide correct information to callers; provide specific information upon written request.	Member services for 2016	4 points for any statement of deficiency or statement of findings for any of the three-member service items. No more than 4 points will be removed for this category.
Total			20 points

Bonus Points: (Up to 6 points added)

Telehealth Innovation Plan

Medicaid managed care plans who submit a Telehealth Innovation Plan (TIP) and "in lieu of services" (ILS) and receive DOH approval of their TIP request submission will earn five (5) bonus points for their annual Quality Incentive (QI) award. An additional one (1) QI bonus point will be earned if the submission demonstrates enhanced access to services and seeks to improve outcomes for women with high risk pregnancies and/or children in their first 1000 days of life.

Section 3 QI Award Results

In 2017, the fifteen 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 2017 Quality Incentive awards become effective for capitation rates and for auto-assignment preference on April 1, 2018. Revised capitation rates for plans that received the 2017 Quality Incentive will be sent separately from the Division of Finance and Rate Settings. If you have questions regarding the incentive premium award, please contact the Bureau of Acute & Managed Care Reimbursement at (518) 473-8822.

2017 Quality Incentive Awards
Effective Period April 1, 2018 – March 30, 2019

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)	Bonus Points (6 points possible)	Total Points	Percent of Total Points (up to 100%)
Tier 1	Fidelis Care New York, Inc.	94.03	20	10	-2	6	128.03	85.35
Tier 2	MVP Health Care	82.09	20	12.5	-2	6	118.59	79.06
Tier 2	Healthfirst PHSP, Inc.	100.00	10	0	-2	6	114.00	76.00
Tier 2	MetroPlus Health Plan	98.51	10	0	-2	6	112.51	75.01
Tier 2	CDPHP	73.13	20	15	-2	6	112.13	74.76
Tier 3	Independent Health's MediSource	58.21	25	7.5	0	6	96.71	64.47
Tier 3	HIP (EmblemHealth)	68.66	15	0	-2	6	87.66	58.44
Tier 3	Empire BlueCross BlueShield HealthPlus	68.66	15	0	-2	6	87.66	58.44
Tier 3	HealthNow New York Inc.	52.70	20	10	-2	6	86.70	57.80
Tier 3	WellCare of New York	61.19	10	10	-2	6	85.19	56.80
Tier 3	UnitedHealthcare Community Plan	52.24	15	17.5	-6	6	84.74	56.49
Tier 3	Excellus BlueCross BlueShield	52.24	20	7.5	-2	6	83.74	55.83
Tier 3	Molina Healthcare	59.70	5	10	-4	6	76.70	51.13
Tier 4	Affinity Health Plan	43.28	15	0	-2	6	62.28	41.52
Tier 4	YourCare Health Plan	31.34	15	10	-2	6	60.34	40.23
Tier 5								

* Incentive premium awards were impacted by enacted budget actions for SFY 18-19 and may change to meet program fiscal targets