

**Quality Strategy  
For the  
New York State  
Medicaid Managed Care Program  
2007**

**Prepared by  
The New York State Department of Health  
Office of Health Insurance Programs  
Bureau of Program Quality, Information and Evaluation**

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## **I. Introduction**

In 1997 New York State received approval from the Center for Medicare and Medicaid Services, formerly the Health Care Financing Administration, to implement a mandatory Medicaid managed care program. The goal of the New York State Department of Health's 1115 Waiver Program, entitled The Partnership Plan, was 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 most Medicaid recipients (TANF and Safety Net Population). In 2001, the Family Health Plus Program was implemented providing comprehensive health coverage to low-income uninsured adults, with and without children. In 2006, the State began mandatory enrollment of all aged and disabled adults and children (Supplemental Security Income eligible). Enrollment in the Medicaid managed care program has now exceeded two million people.

The State has operated a comprehensive, multifaceted Quality Assurance Program (now Quality Strategy) since 1997. The Quality Strategy supports the goals of the program and has evolved over time based on member health needs, industry standards, federal and state law, lessons learned and best practices, and with input from the MCOs to establish objectives, priorities and achievable timelines. The Strategy has been successful; we have seen an improvement in the quality of health care being provided to enrollees. As the state of health care quality is continually changing (e.g. clinical practice and improved methods for quality measurement and monitoring accountability) the plan is amended.

The Department will perform periodic reviews of the quality strategy to determine the need for revision and to assure MCOs are in contract compliance and have committed adequate resources to perform internal monitoring and ongoing quality improvement.

### **A. Managed Care Program Objectives**

Quantifiable, performance-driven objectives for demonstrating success or challenges in meeting the overall goal have been set using data that reflects health plan quality performance, access to covered services and enrollee satisfaction with care. Data for the measures used in this approach are derived from HEDIS/QARR (Quality Assurance Reporting Requirements) or MEDS (Medicaid Encounter Data System) databases or are collected by New York State in the CAHPS (consumer satisfaction) survey. Other sources of data may include findings from The External Quality Review Technical Report and evaluation results of improvement initiatives.

#### *Program Initiative Objectives:*

- Demonstrate an increase in preventive care for children in Medicaid managed care through increases of at least 5 percentage points in the statewide rate for childhood

immunizations, lead screening, well child care visits (3 – 6 year olds) and adolescent well-care and preventive visits by 2010. Efforts to increase rates of preventive care for children in Medicaid managed care will also be evidenced by reducing the gap in rates of quality performance between Medicaid and commercial managed care product lines for these measures by 2010.

- Demonstrate an increase in services for the treatment and management of chronic diseases for adults and children in Medicaid managed care through increases of at least 5 percentage points in the statewide rate for controlling high blood pressure, diabetes HbA1c good control and diabetes lipid control by 2010.
- Decrease the detrimental effects of smoking on the health of Medicaid managed care enrollees and their families by increasing the statewide rate of smokers who are advised to quit by at least 3 percentage points in each CAHPS survey.
- Increase the frequency of on-going prenatal care for Medicaid managed care enrollees by increasing the statewide rate of ongoing prenatal care by at least 5 percentage points in the next 3 years.
- Demonstrate improvement in access to available primary care services by having every plan meet or exceed the 75% threshold for the Access and Availability Survey conducted annually by IPRO.
- Continue to review data on racial and ethnic disparities in order to develop meaningful objectives for improvement in preventive and chronic care.

## **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**

New York State assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through the collection and analyses of data from many sources. The State has developed many systems (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)*

The Department of Health 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.

### *Encounter Data*

All MCOs are required to submit encounters to the Medicaid Encounter Data System (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 and cost effectiveness analyses.

### *Participating Provider Network Reports*

On a quarterly basis, MCOs must also submit updated information on their contracted provider network to NYSDOH. 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 and to local districts as soon as possible but in no event more than 30 days after 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.

### *Member Satisfaction Surveys*

The State, in conjunction with its external review agent, conducts a statewide-standardized survey of patients' experience of care (satisfaction). This survey allows for MCO-to-MCO comparisons. Plans are required to participate, as appropriate, in the performance of such surveys. Plans whose results are meaningfully and statistically below acceptable thresholds may be required to develop a corrective action plan that the State will review and monitor. The results of the survey 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 External Quality Review Organization (EQRO), usually involve medical record review or surveys and focus groups. Plans are required to participate in up to four focused clinical studies a year. Recommendations for improvement are offered for NYSDOH, plans and providers. For example, in our record review of adolescent preventive care, it was recommended that plans develop and implement a quality improvement project or initiative that includes multi-faceted interventions to target both providers and enrollees such as: dissemination of intervention tools, interactive educational programs, academic profiling, provider incentives to increase screening rates and adolescent member outreach. NYSDOH coordinated efforts to improve performance by sharing best practices, continued adolescent preventive measurement and considered providing MCO incentives to improve screening rates.

### *Data on Race, Ethnicity and Primary Language*

The State obtains race, ethnicity, and primary language spoken from several sources: the eligibility system; the enrollment form completed by the recipient, and the new 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.

Race/ethnicity analysis is also conducted by NYSDOH from data collected in focused clinical studies and enrollee surveys. For example, in a focused clinical study on attention deficit hyperactivity disorder conducted by IPRO in 2006, non-white status was significantly associated with lower rates of documentation of a treatment plan and adherence to the plan compared to white members. The State shares results of the focused studies and enrollee surveys with plans by distributing reports and publishing reports on the department website.

### *External Quality Review – Technical Report*

The NYSDOH has contracted with the Island Peer Review Organization (IPRO) to serve as its external quality review organization. To comply with Federal regulations, the State expanded IPRO's scope of work to include:

- validate QARR and encounter data submissions;
- validate health plan Performance Improvement Projects (PIPs);
- conduct focused studies of health service delivery issues such as coordination, continuity, access and availability of needed services;
- prepare an EQRO Technical Report for each Medicaid managed care plan.

On an annual basis, the EQRO prepares a compendium of plan-specific descriptive data reflecting the CMS protocols for external review quality reports. This analysis 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. Each of the data files are provided by NYSDOH and the EQRO 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) This data is currently updated annually for each full-risk Medicaid managed care plan and is distributed on CDs within the Department and to the New York City

Department of Health and Mental Hygiene. In 2006, each plan received its own technical report. Beginning in 2007, these reports will be made available on the New York State Department of Health public website.

This report also provides a concise summary of critical quality performance data for each plan as well as the EQRO's assessment of plan strengths and opportunities for improvement. Each year, the state and the EQRO reassess each plan's progress in addressing and improving identified problem areas.

#### *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 developed standards/guidelines for the following:

- The New York State Department of Health AIDS Institute developed clinical standards for adult, adolescent, and HIV pediatric care.
- In 2003, the NYSDOH launched an effort to develop, disseminate and implement statewide guidelines for asthma care. An advisory group was formed to bring together professional organizations, academicians and primary care and specialty providers to develop consensus guidelines regarding clinical standards for asthma care in New York State.

#### *Health Information Technology*

The State has been successful in implementing systems to support the goals of the program. Systems were developed to collect Encounter Data, Provider Network Data, Complaint Data, Quality Data and Financial Reports. MCOs have developed Information Systems that allow them to collect and submit required data and reports.

However, challenges and opportunities with data collection systems are continually being identified. The NYSDOH has established a workgroup to further the development of Health Information Technology within the department as well as among our key stakeholders, namely the health plans and providers they contract with. Many health plans have established internal registries to assist them in disease management, such as diabetes, asthma and high risk prenatal care. Preventive 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, created 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. Over 100 New York exchange programs submitted applications for the first round of grants under this program. Most of these starting projects need Medicaid data at the point of care to be successful. This pilot program, to be conducted with the assistance of the New York City Department of Health and Mental Hygiene (NYCDOHMH), is intended to facilitate the exchange of medication history and formulary information between the Medicaid program and Regional clinical exchanges that have a high concentration of Medicaid recipients. The intent of the pilot is to show that viewing medication history and checking formulary at the point of care will improve healthcare outcomes for the pilot population and reduce their healthcare costs.

## **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 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 State has developed a comprehensive program to assess all aspects of MCO performance. The program involves routine analysis and monitoring of performance 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, MCO marketing activities, and other issues identified through routine monitoring activities); and analysis of consumer satisfaction data.

### *On-site operational reviews*

Operational reviews are conducted on a regular basis. The review is designed to 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 areas of non-compliance. 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 plans of correction, 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.

#### *On-Going 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 data collection problems. Another example of a focused review is an on-going review of plans' provider networks to determine if physicians are being listed as practicing in a plan's network when they have had their medical license suspended or revoked by the New York State Office of Professional Medical Conduct.

#### *Targeted Reviews*

While particular studies or activities may be developed in response to unique situations, the following are examples of the kinds of targeted studies that are conducted when appropriate.

- *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 NYSDOH and EQRO staff 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. Follow-up depends on the extent of the problem, and whether the provider has been previously notified of a problem. Generally, follow-up includes notifying the provider (in writing) of the findings, and requesting a plan of corrective action. MCOs may also assign a provider representative to work with the provider to address deficiencies. Results of the studies and recommended follow-up should be reported to the MCO's QA committee. The State and local districts review MCO follow-up efforts during subsequent onsite operational reviews.

- *Marketing and Enrollment Studies* - The purpose of these studies is to determine adherence to State and local marketing guidelines and restrictions. To conduct these

studies, staff may visit sites where MCOs are permitted to market and provide potential members with assistance with enrollment forms. The NYSDOH staff may pose as potential enrollees or observe the activities of MCO marketing representatives to ensure that the representatives are providing required information and are not engaging in any misleading marketing practices.

As with the operational reviews, MCOs that are found to be out of compliance are issued a Statement of Deficiency 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 State for approval prior to use. This process ensures the accuracy of the information presented to members and potential members.

#### *Quarterly and Annual Financial Statements*

In order to monitor fiscal solvency of plans, the NYSDOH requires MCOs to submit Quarterly and Annual Financial Statements of Operations pursuant to the MMC/FHPlus contract.

#### *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 have been unresolved for more than forty-five (45) days. A uniform report format has been developed to ensure that complaint data is consistent and comparable. NYSDOH uses complaint data to identify developing trends that may indicate a problem in access, quality of care and/or education.

#### *Fraud and Abuse Reports*

The MCO must submit quarterly, via the HPN 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 NYSDOH 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 source 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 NYSDOH.

#### *Enforcement*

The Division of Managed Care and Program Evaluation 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 Department. The Department 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 Department within 1 week with an acceptable extension plan; or 2) submit information by one week.

Enforcement options include:

- Conduct face-to-face meeting with plan to discuss issues
- Issue Statement of Deficiency with required Plan of Correction
- Deny requests for expansion
- Stop auto-assignment to the plan
- Freeze enrollment
- Mandate third party data collection reimbursed by plan
- 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.

#### **IV. Improvement**

Based on the results of assessments of quality and appropriateness of care, the level of contract compliance and MCO monitoring activities, New York State targets improvement efforts through a number of interventions.

##### *Cross-state Collaborations*

The NYSDOH has implemented one collaborative and is in the process of starting a second one. An asthma collaborative was implemented in 2003 to disseminate and implement state guidelines for asthma care. Following the development of a statewide asthma guideline, a learning collaborative sponsored by NYSDOH and the Center for Health Care Strategies was made available to NYS Medicaid managed care plans. Twelve plans participated. The collaborative had two major goals: 1) to implement the state's Asthma Care Guideline to establish practices that improve clinical quality and 2) to maximize resources by coordinating interventions and sharing information across stakeholder groups. With a similar approach, a collaborative to improve quality of care for children and adolescents with ADHD is currently being developed. Seven plans have volunteered to work with NYSDOH, IPRO and an advisory panel of ADHD experts to implement interventions to improve diagnosis and treatment and management of ADHD.

##### *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. For each PIP, the plan chooses a topic and with the technical assistance of the EQRO, develops a study methodology and conducts interventions to reach their improvement goals. Study processes and results are presented in a final report due 18 months

after the study begins. Selected projects are presented at state-sponsored, Health Plan Medical Director's meetings in an effort to share best practices.

#### *Quality Performance Matrix*

In an effort 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 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 of measures in the D and F categories and to develop action plans based on the barriers identified. The action plans are reviewed and approved by DMCPE staff and are monitored throughout the year to assure that they are being conducted and evaluated for effectiveness in improving performance.

#### *Pay for Performance*

An increasing number of health plans have been developing and implementing pay for performance programs to improve health care. A variety of programs are being offered by federal and state government as well as various private and public purchasers such as the Leapfrog Group, Integrated Healthcare Association and Bridges to Excellence. In May, 2006, a Request for Applications (RFA) was released to solicit applications for programs in NYS managed care plans. Four demonstration projects funded under this program began in mid-2007 and will run for two years.

#### *Financial Incentives for Quality*

New York State statute allows the NYSDOH to consider quality when distributing auto-assignees to health plans. Since 2000 the NYSDOH has used health plan quality scores to weight the auto-assignment algorithm.

In, 2002, the New York State Division of the Budget (DOB) allowed the NYSDOH to reward plans that did well on quality and consumer satisfaction by implementing an incentive payment of up to one percent of the premium. In 2005, DOB increased the maximum incentive payment to three percent. The measures used to reward plans are comprehensive, representing areas of performance for adults living with chronic illness, child preventive health, behavioral health, prenatal care and satisfaction. This program awards points to health plans for quality performance measures meeting or exceeding the 75<sup>th</sup> percentile from two years previous. Consumer satisfaction measures are compared to statewide average benchmarks from the previous collection year.

#### *Quality Improvement Projects (QIPs)*

The NYSDOH partners with IPRO to sponsor outpatient asthma and diabetes Quality Improvement Projects in Article 28 clinics and diagnostic centers. Currently there are 25 clinics/community health centers that voluntarily participate. The main objectives of the QIPs are to develop quality indicator measuring systems for asthma and diabetes, improve processes of care, promote patient self-management of their chronic disease and conduct provider education. Clinics participating in the Asthma QIP have had significant improvements in the

documentation of clinical asthma severity, the use of long-term anti-inflammatory controller agents, documentation of assessment of asthma triggers, evidence of patient education and the use of written asthma action plans. The Diabetes QIP has resulted in significant improvements in diabetes care such as documentation of hemoglobin A1c (HbA1c) testing, HbA1c control (less than 9), blood pressure control below 130/80, yearly lipid profile testing and LDL levels (less than 100 mg/dL), complete foot exams and referrals for eye exams.

#### *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 IPRO, has conducted conferences on immunization strategies, partnering for quality improvement, understanding CAHPS (consumer survey) results, adolescent preventive care, physician profiling, asthma and diabetes care, and prenatal care. Trainings have been held on development of Performance Improvement Projects (PIPs) and HEDIS/QARR preparation and auditing. Evaluation feedback is always sought and comments are used when planning future events.

#### *Plan Manager Technical Assistance*

In the Bureau of Program Quality, Information and Evaluation, Quality Improvement Unit, and in the Bureau of Certification and Surveillance, each managed care plan is assigned a Plan Manager. The Plan Manager acts as liaison 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:

[http://www.health.state.ny.us/health\\_care/managed\\_care/reports/index.htm](http://www.health.state.ny.us/health_care/managed_care/reports/index.htm).

## **IV. Review of Quality Strategy**

### **A. Public Input**

The quality strategy was designed during the development of the 1115 Waiver and the Operational Protocol. During this process, the State utilized an advisory committee composed of representatives of parties interested in managed care, including fee-for-service providers, the advocacy community, special care providers, and managed care providers for public input. The advisory committee provided a forum for stakeholders to raise issues and concerns and discuss possible solutions and provide advice and recommendations on a wide range of issues. A

subcommittee of the advisory committee comprised of Medical Directors from all MCOs was convened to serve as a forum for the discussion and clarification of quality issues related to Medicaid managed care, (e.g. reporting requirements, QARR and Encounter Data). In addition to input from these two committees, the waiver and all supporting documents were available for public review and comment before submission to CMS for approval in 1997 and again when the waiver was extended in 2002 and 2006. This Quality Strategy was also presented and discussed at the November 30, 2007 meeting of the Medicaid Managed Care Advisory Review Panel (MMCARP).

**B. Strategy Assessment Timeline**

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

Timeline for Quality Strategy – Assessment of Objectives 2007 - 2010

Activity	Date Completed
HEDIS/QARR data submitted (annually)	June, 2008, 2009, 2010
MEDS data submitted (monthly)	January – December, 2008, 2009, 2010
CAHPS survey conducted	June, 2008, 2010
Calculate Rates of Quality Performance	Sept., 2008, 2009, 2010
Report interim updates to CMS	Dec. 2008, 2009
Report changes to the Strategy	Dec. 2008, 2009
Report 2007 Quality Strategy Assessment	Dec. 2010

**V. Achievements and Opportunities**

An assessment of achievements in quality improvement in New York State’s Medicaid managed care plans presented in this 2007 Quality Strategy is based on a quantifiable analysis of improvement in quality measures from measurement years 2003 - 2005.

*QARR Performance Rates*

Increases in performance rates occurred between 2003 and 2005 for QARR measures in child health, chronic care, behavioral health and satisfaction with care.

Several activities conducted by NYSDOH are believed to have been effective in improving health care quality and service. Plan collaborations, such as the asthma collaborative with CHCS in 2004 - 2006, provided a useful mechanism for plans to work collectively on a problem and receive valuable input from experts in the field of asthma, quality improvement and outcomes measurement. Conferences and trainings provided through our external quality review contract offer plans an opportunity to hear from promising practices in New York State and throughout the country. During 2006, a managed care conference entitled, Beyond Managing Care: Striving for Excellence and an asthma collaborative conference were conducted. Trainings such as one conducted with the National Initiative for Children’s Healthcare Quality (NICHQ) based on their

Jump Start program have been very well received by the plans and have resulted in better designed PIPs.

#### *Quality Performance Matrix*

Now in its sixth 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*

While fourteen measures from the 2005 QARR showed improvement from 2003, statewide Medicaid rates for one measure, breast cancer screening, declined from 69% in 2003 to 66% in 2005. More study is also need to better target ways for decreasing racial and ethnic disparities in health care for Medicaid managed care enrollees.

The CAHPS survey results showed a high level of satisfaction statewide for Medicaid managed care plans with rates of Customer Service, Receiving Services Quickly and Overall Rating of Health Plan higher than the 2005 national averages. Medicaid managed care plans have an opportunity for improvement in the rate for Getting Care Needed which declined from 72% to 70% between 2003 and 2005 and remains below the 2005 national average of 74%.

**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.

<b>Required Component</b>	<b>Contract Provision</b>
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.	Chapter 20 of the Op Prot and the Model Contract.
438.206 - Availability of services <ul style="list-style-type: none"> <li>▪ Delivery network, maintain and monitor a network supported by written agreements and is sufficient to provide adequate access to services covered under the contract to the population to be enrolled.</li> <li>▪ Provide female enrollees direct access to women’s health specialists</li> <li>▪ Provide for a second opinion</li> <li>▪ Provide out of network services when not available in network</li> <li>▪ Demonstrate that providers are credentialed</li> <li>▪ Furnishing of services, timely access, cultural competence</li> </ul>	Model Contract: 21.1 15.5 and ADA Compliance Plan Appendix J.  10.12  10.16 21.2  21.4 15.10
438.207 - Assurances of adequate capacity and services <ul style="list-style-type: none"> <li>▪ MCO must provide documentation that demonstrates it has capacity to serve the expected enrollment. Submit the documentation in a format specified by the State at time of contracting and any time there is a significant change.</li> </ul>	Model Contract 21.1, Plan Qualification, Network requirements.
438.208 - Coordination and continuity of care <ul style="list-style-type: none"> <li>▪ Each MCO must implement procedures to deliver primary care to and coordinate health care services to enrollees.</li> <li>▪ State must implement procedures to identify persons with special health care needs.</li> <li>▪ MCOs must implement mechanisms for assessing enrollees identified as having special needs to identify ongoing special conditions.</li> <li>▪ State must have a mechanism to allow persons identified with special health care needs to access specialty care directly, (standing referral).</li> </ul>	Model Contract: 21.8  13.6  10.19 – 10.23  15.7
438.210 - Coverage and authorization of services <ul style="list-style-type: none"> <li>▪ Service authorization process.</li> </ul>	Model Contract: Section 14 & Appendix F
438.214 - Provider selection <ul style="list-style-type: none"> <li>▪ Plans must implement written policies and procedures for selection and retention of providers.</li> <li>▪ State must establish a uniform credentialing and</li> </ul>	Model Contract: 21.6  21.4

Required Component	Contract Provision
<p>recredentialing policy. Plan must follow a documented process for credentialing and recredentialing.</p> <ul style="list-style-type: none"> <li>▪ Cannot discriminate against providers that serve high risk populations.</li> <li>▪ Must exclude providers who have been excluded from participation in Federal health care programs.</li> </ul>	<p>21.6</p> <p>21.1 (b)</p>
<p>438.218 - Enrollee information</p> <ul style="list-style-type: none"> <li>▪ Plans must meet the requirements of 438.10</li> </ul>	<p>Model Contract: 11.1(c) &amp; 13.1 (a)</p>
<p>438.224 - Confidentiality</p> <ul style="list-style-type: none"> <li>▪ Plans must comply with state and federal confidentiality rules.</li> </ul>	<p>Model Contract: Section 20</p>
<p>438.226 - Enrollment and disenrollment</p> <ul style="list-style-type: none"> <li>▪ Plans must comply with the enrollment and disenrollment standards in 438.56</li> </ul>	<p>Model Contract: Section 7.8 &amp; 8.6</p>
<p>438.228 - Grievance systems</p> <ul style="list-style-type: none"> <li>▪ Plans must comply with grievance system requirements in the Federal regulations.</li> </ul>	<p>Model Contract: Section 14 &amp; Appendix F</p>
<p>438.230 - Subcontractual relationships and delegation</p> <ul style="list-style-type: none"> <li>▪ Plan is accountable for any functions or responsibilities that it delegates.</li> <li>▪ 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.</li> </ul>	<p>Model Contract: 22.1(b) &amp; 22.3</p>
<p>438.236 - Practice guidelines</p> <ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ Guidelines must be disseminated.</li> <li>▪ Guidelines must be applied to coverage decisions.</li> </ul>	<p>Model Contract: 16.2</p> <p>16.2(c)</p> <p>14.2 &amp; 16.2(b)</p>
<p>438.240 - Quality assessment and performance improvement program</p> <ul style="list-style-type: none"> <li>▪ Each MCO and PIHP must have an ongoing improvement program.</li> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ Performance improvement projects. Each plan must have</li> </ul>	<p>Model Contract: 16.1(a) &amp; (b)</p> <p>16.1(b)&amp; 18.6(x)(B)</p> <p>16.1(b) &amp; 18. 6(v)</p> <p>18.6(x)(B)</p> <p>18.6(x)(B)</p>

Required Component	Contract Provision
<p>an ongoing program of performance improvement 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.</p> <ul style="list-style-type: none"> <li>▪ The State must review at least annually, the impact and effectiveness of the each program.</li> </ul>	<p>18.6 (x)(B)</p>
<p>438.242 - Health information systems</p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system.</li> <li>▪ 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.</li> </ul>	<p>Model Contract: 18.1(a)  18.6(iv)  18.1(b)</p>

### 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](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.

## 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 Masterfile;
  - 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.

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