POLICY BRIEF
May 2009

Promoting Equity & Quality in New York's Public Insurance Programs

First in a Two-Part Series on Racial and Ethnic Disparities in Health

Community Service Society | Fighting Poverty Strengthening New York

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PROMOTING EQUITY & QUALITY IN NEW YORK'S PUBLIC INSURANCE PROGRAMS

By Elisabeth Ryden Benjamin, MSPH, JD & Arianne Garza, MPA

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The Community Service Society of New York (CSS) is an informed, independent, and unwavering voice for positive action that serves the needs of our constituents: the 2 in 5 New Yorkers who live on poverty's front line. CSS draws on a 160-year history of excellence in using research, advocacy, litigation, and innovative program models to shape actionable policy solutions that strengthen and benefit all New Yorkers.

David R. Jones, President & CEO

Steven L. Krause, Executive Vice President & COO

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At the end of the day, this report was written by Elisabeth Ryden Benjamin and Arianne Garza and all errors or omissions are ours alone.

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I. Introduction

Despite significant overall health spending and extensive public health insurance coverage, New York State experiences challenges in achieving a high-performing health care system. These challenges are particularly acute for underserved communities, which are disproportionately made up of low-income people and racial and ethnic minorities. New York has a sophisticated quality assurance and monitoring program that tracks health outcomes in our public insurance and commercial insurance plans. However, to date, New York has not harnessed these systems with an eye to promoting health equity and addressing racial and ethnic disparities. The purpose of this Policy Brief is to describe health outcomes for racial and ethnic minorities in New York's public health insurance programs and to recommend how New York can better leverage existing resources to improve health outcomes and reduce disparities.

The Policy Brief begins by describing New York State's public health insurance programs and quality surveillance system. It then presents findings from an analysis of health outcomes for racial and ethnic minorities in New York State's public insurance programs conducted by the Community Service Society (CSS); and concludes with a series of concrete recommendations aimed at leveraging the State's public insurance programs to promote health equity and reduce racial and ethnic disparities in health outcomes.

Methodology

The findings in this brief are based on an original analysis of state quality data; interviews with state officials, representatives from health plans, and experts on disparities and quality improvement programs; and a national review of literature on racial and ethnic disparities in health outcomes and pay-for-performance programs. On February 27, 2009, CSS hosted a roundtable with health care providers, state and city officials, health plan representatives, elected officials, and health advocates to present this work and gather feedback.

II. New York's Health System and Racial Disparities in Health Outcomes

New York spends $126 billion annually on health care, nearly the highest per capita expenditure in the nation.[1] Yet, despite this significant public and private financial investment, New York's health system continues to underperform by almost every measure: a significant proportion of adults (18%) are uninsured;[2] the State rarely achieves top health outcomes and statistics;[3] and New York ranks 22nd in a national study assessing health system performance.[4]

New York's Public Insurance Programs

Of the State's overall health spending, $45 billion is spent per year on Medicaid, comprising nearly 40 percent of New York State's budget. The program has grown by 2 million beneficiaries over the past decade and now covers nearly 4.5 million New Yorkers. Today, public insurance is an important source of coverage for low-income working families in New York.

The majority of Medicaid enrollees in New York State are racial and ethnic minorities: 21 percent are African American,[5] 28 percent are Latino, 9 percent are Asian, and 11 percent are "other," while 31 percent of enrollees are White.[6]

While it is widely recognized that health insurance can help narrow the gap in health outcomes between racial and ethnic groups,[7] disparities in health measures persist in New York State. Racial and ethnic minorities make up a large portion

Public Insurance & Managed Care

In 1997, New York State began to require most Medicaid beneficiaries to enroll in managed care plans in an effort to reduce costs and improve quality. At present, all Family Health Plus and Child Health Plus enrollees and the majority (62%) of Medicaid enrollees are enrolled in plans. Currently, 2.3 million New Yorkers are enrolled in Medicaid Managed Care; 467,000 are enrolled in Family Health Plus; and 372,000 are enrolled in Child Health Plus, for a total annual cost of $7.5 billion.

of the State's uninsured population.[8] Even among those with insurance, racial minorities tend to fare worse on both treatments received and subsequent health outcomes.[9]

Quality Efforts to Date

New York has invested significant resources to develop a sophisticated system, called Quality Assurance Reporting Requirement (QARR), for measuring and monitoring health plan quality.[10] Managed care plans serving both publicly and commercially insured individuals participate.[11]

In 2002, the State implemented a pay-for-performance program, called the Quality Incentive (QI), to rank and reward plans participating in Medicaid Managed Care and Family Health Plus.[12] The QI program uses QARR scores as well as patient-reported experience with plans[13] and plan compliance data. High-performing plans that meet or exceed QI benchmarks are rewarded annually.[14] In most years, two thirds of plans qualify for some level of incentive payment; in 2007 these payments totaled $62.3 million.[15]

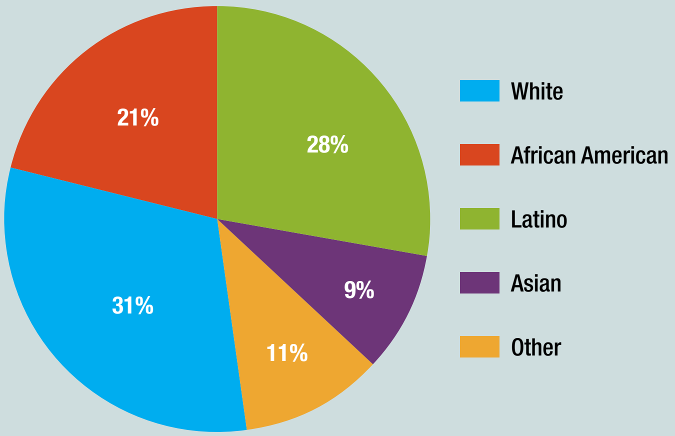
The implementation of this pay-for-performance system coincides with significant quality gains in the State's public insurance programs. For example, between 2002 and 2007:

- Complete immunizations rose from 64 percent to 73 percent;
- Well-child visits:
  - Between 0-15 months rate rose from 58 percent to 65 percent;
  - Between 3-6 years rate rose from 71 percent to 76 percent;
  - Adolescents (12-21 years) rate rose from 45 percent to 49 percent;
- Diabetes in poor control decreased from 42 percent to 35 percent.[16]

The State's quality efforts have helped identify four historically lower-performing plans, which left the program over the past five years.[17] Finally, while commercial plans have historically outperformed public insurance plans, public insurance programs have begun to approach commercial performance for certain measures, including mental health, diabetes, postpartum, HIV testing of pregnant women, lead testing for children, and patient satisfaction.[18]

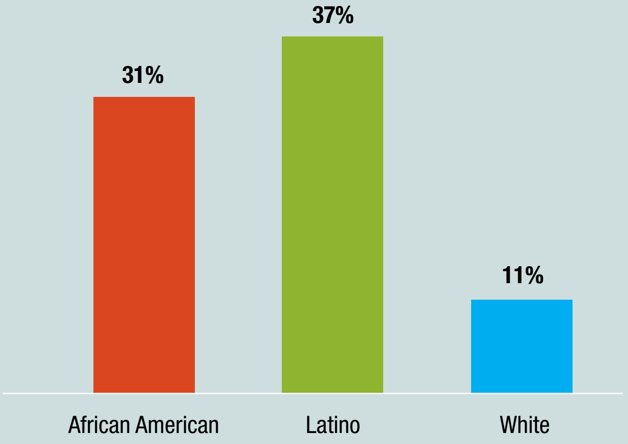
While these overall quality efforts bring value to all public insurance enrollees, the State has yet to report or monitor health outcomes in the QARR and QI systems that target health equity and reducing racial and ethnic disparities.

Figure 1
Race & Ethnicity of New York's Medicaid Enrollees



Source: Adapted from P. J. Roohan, "Race/Ethnicity Differences in the Quality of Care for Medicaid Managed Care Enrollees in New York State," Presentation at NYS DOH Minority Health Summit, January 13, 2009.

Figure 2
Percent of Race/Ethnicity Group Receiving Medicaid



Source: Adapted from P. J. Roohan, "Race/Ethnicity Differences in the Quality of Care for Medicaid Managed Care Enrollees in New York State," Presentation at NYS DOH Minority Health Summit, January 13, 2009.

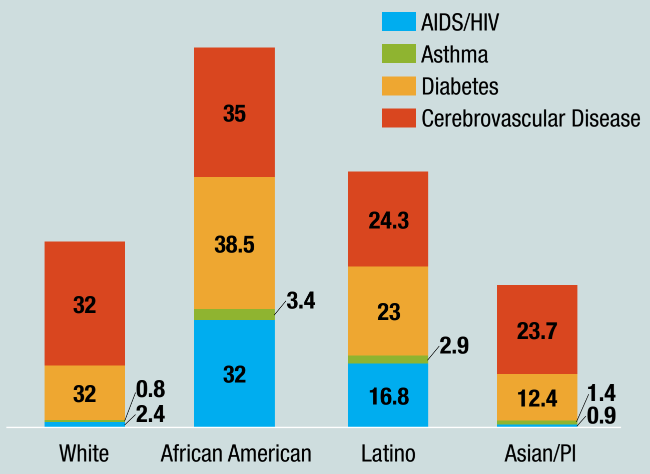
III. Analysis of Health Measures in New York's Public Insurance Programs by Enrollee Race and Ethnicity

CSS conducted an original data analysis to explore the possibility of harnessing New York's QARR (monitoring and surveillance) and New York's QI (pay-for-performance) systems in order to reduce disparities in New York's public insurance programs. To determine the best measures for this analysis, CSS reviewed available data describing the prevalence of racial and ethnic disparities in health care delivery, treatment, and outcomes in New York—which are considerable.

On a number of key health indicators, African Americans in New York suffer disproportionately worse outcomes compared to other groups. Latinos experience slightly better outcomes than African Americans. Asian and Pacific Islanders experience better outcomes than White New Yorkers.[19] These findings are consistent with national studies of racial and ethnic disparities in health.[20]

Drawing from this research, CSS requested the New York State Department of Health (DOH) to provide QARR data stratified by race and ethnicity for all Medicaid managed care enrollees (and Child Health Plus enrollees where applicable) for the three most recent years available in the areas of: managing diabetes, managing cardiovascular and respiratory conditions (controlling high blood pressure, asthma management), women's health (including breast cancer screening and prenatal care), and child preventive care (including immunization, asthma management and dental). While CSS requested three years of data, the data provided by the Department of Health in response to this request was predominately drawn from the 2007 QARR and reflects 12 of these measures.[21]

Figure 3
Age-Adjusted Death Rates per 100,000, by Disease and Race/Ethnicity (2004)



Source: Adapted from the New York State Department of Health, Office of Minority Health, New York State Minority Health Surveillance Report, September 2007.

In New York's public insurance programs, African Americans experience statistically significantly worse health outcomes than the total of all racial and ethnic groups on 10 out of 12 quality measures.

As Table 1 below describes, African Americans had statistically significantly worse outcomes than the total of all other racial and ethnic groups on 10 out of the 12 measures.[22] Latinos had statistically significantly better health outcomes on five out of the 12 measures reviewed, while Whites had mixed results. Asian/Pacific Islanders had statistically significantly better health outcomes compared to the total population on 10 out of 12 measures.

Indicators for African American enrollees are significantly worse than those for total of all other racial and ethnic groups in the areas of: dental visits, adult and childhood asthma management, mammography, and all diabetes indicators except for nephropathy screening (where all racial groups had had better outcomes than Whites). African American enrollees experienced similar performance as the reference population in only two areas: childhood immunization and nephropathy screening.

Asian/Pacific Islander enrollees had statistically significantly better health indicators than those for the total of all other racial and ethnic groups in every area except childhood immunization and nephropathy screening. As noted earlier, these findings are consistent with other New York health surveillance data.

In contrast to statewide and national surveillance data, Latino enrollees had statistically significantly better health indicators than the total of all other racial and ethnic groups on a number of measures, including: childhood immunizations, childhood dental visits, mammography screening, and two diabetes measures, lipid profile and lipid controls. Latinos experienced similar performance as the total of all other racial and ethnic groups on all other measures. Without further study, there is no way to know why Latino enrollees are experiencing better outcomes in this data set than state and national data would suggest.

White enrollees had statistically significantly better outcomes than the total of all other racial and ethnic groups on a number of indicators: childhood dental visits, childhood asthma, adult asthma, and poor control of HbA1c and blood pressure. However, White enrollees had significantly worse outcomes on three important measures: childhood immunizations, mammography, and nephropathy screening.

CSS's findings are consistent with two unpublished analyses of QARR data conducted this past year by DOH that focused on racial and ethnic disparities. The first analysis, presented in May 2008 to the Medicaid Managed Care Advisory Review Panel, assessed disparities in health deliv-

Table 1
Selected 2007 QARR Measures Presented by Race & Ethnicity

Measure (2007 QARR)	**Race/Ethnicity**					
	Asian / Pacific Islander	**African American**	**Latino**	**Other**	**White**	**Total Population**
Preventive Care/Care Mgmt						
Child Immunization	79.7%	77.6%	83.3%	78.0%	75.4%	78.9%
Dental Visit (2-21yo)	46.6%	35.6%	47.6%	42.8%	50.7%	44.8%
Child Asthma (5-17yo)	94.7%	90.4%	92.0%	92.2%	93.9%	92.0%
Adult Asthma (18-56yo)	95.3%	87.3%	89.1%	90.2%	91.0%	89.6%
Mammography (42-69yo)	67.9%	57.4%	71.4%	63.8%	57.1%	64.1%
Management of Diabetes						
HbA1c Testing	89.5%	83.6%	87.2%	88.9%	86.0%	86.4%
Poor HbA1c Control	26.5%	41.2%	36.2%	33.3%	33.6%	35.3%
Lipid Profile	88.6%	77.7%	85.3%	87.1%	82.3%	83.1%
Lipids Controlled	46.3%	34.3%	41.6%	41.1%	39.0%	39.6%
Blood Pressure Controlled	36.3%	24.5%	31.9%	32.4%	34.4%	31.4%
Dilated Eye Exam	71.6%	55.7%	62.2%	63.6%	61.2%	61.5%
Nephropathy Screening	83.4%	82.4%	82.9%	84.0%	80.2%	82.1%

Blue numbers indicate statistically significant better performance when compared to all other racial groups, red numbers indicate statistically significant worse performance, and black numbers indicate no statistically significant difference.

Source: CSS Analysis of New York State Department of Health QARR 2007 Data.

ery and treatment measures for children and adolescents in Medicaid Managed Care using 2005 QARR data and data from the New York State Medicaid Encounter Data System (MEDS).[23] DOH found that African American children did worse than Whites on five out of eight measures. Latino and Asian/Pacific Islander children did better than Whites on half of the measures.[24]

The second analysis, presented at the New York State Minority Health Summit in January 2009, examined health care delivery and outcome measures from QARR for diabetic adults in Medicaid Managed Care in 2007.[25] Of the six measures reviewed, African Americans did statistically significantly worse on five of the six measures when compared to the White population. Latino enrollees experienced no difference from the White enrollees with the exception of one measure: lipid control, where Latinos are 11 percent more likely to have their lipids in control. In all measures, Asian/Pacific Islanders with diabetes met or exceeded the performance of White adults with diabetes. In three of these measures Asian/Pacific Islander adults had statistically significant better outcomes than Whites (HbA1c control, lipid control, and eye exam).[26]

So far, New York State has not reported QARR results by enrollee race and ethnicity. The State's QARR and QI programs are important untapped resources for promoting health equity.

Nationally, a major barrier to improving quality in health care outcomes for racial and ethnic minorities has been poor quality data on health care measures, stratified by race and ethnicity.[27] Self-reported data is generally considered more accurate than observed race data.[28] New York's QARR data is considered relatively accurate as compared to other state-based data sets because it was substantially corroborated through the Department's cross-matching of self-reported and observed data sets. (See side bar on Quality of DOH Race Data).

To date in New York QARR data has been reported only by health plan and region, without indication of race and ethnicity.[29] The absence of this data has prevented regular monitoring or tracking of changes over time in health outcomes and indicators for specific populations—or with an eye to reducing racial and ethnic disparities in health outcomes. As a result, the State's QARR and QI programs are major untapped resources in developing policy solutions to improve health outcomes and reduce disparities.

Quality of DOH Race Data

The New York State Department of Health (DOH) collects racial and ethnic data based on the following census categories:

- African American
- White
- Asian/Pacific Islander
- Latino
- "Other"

In 2007, DOH analyzed the quality of the QARR race data by comparing self-reported data from beneficiaries, collected by the DOH in the Consumer Assessment of Healthcare Providers and System (CAHPS) survey, with mostly observational data collected on public assistance and public insurance applications by a case-worker or enroller and beneficiary, which is subsequently entered into the State's Welfare Management System (WMS).

DOH found that data collected by race and ethnicity had an overall 77 percent level of consistency between what beneficiaries reported as their race and what the state had separately collected through WMS.

- 90 percent accuracy for Latinos
- 75 percent to 80 percent for African Americans, Asian/Pacific Islanders, and Whites

IV. Policy Recommendations on Quality

Based on the findings described above, CSS developed the following recommendations to leverage existing resources in New York's public insurance system to reduce racial and ethnic disparities.

1. Monitor health plan quality indicators by racial and ethnic categories.

Analyzing health quality data by race and ethnicity is a necessary first step to help the State, health plans, providers, and enrollees to understand and, ideally, reduce health disparities. The State has not systematically integrated race and ethnicity data in its annual quality review and surveillance program, limiting access to this data for plans, providers and members. Analyzing all QARR measures annually by race and ethnicity, and sharing it with the participating managed care plans, the New York State Office of Minority Health and other government agencies would better integrate health equity goals into the State's overall quality surveillance and improvement programs.

To promote health equity, the State should analyze and report all public health insurance plan quality measures annually by race and ethnicity. The State should leverage its purchasing power to promote health equity through its existing pay-for-performance program.

2. Publicly disclose results of racial and ethnic disparities in health outcomes by plan.

The State should publish quality data stratified by race and ethnicity in the annual QARR report, which is posted on the DOH's website and distributed to key stakeholders and policymakers in print form. It should also be widely disseminated to community-based organizations, health advocates and communities of color. This would help foster and encourage public discussion about racial and ethnic disparities among plans, providers and beneficiaries, as well as policymakers and other stakeholders. Race and ethnicity data is currently not collected by commercial plans, and to report similar measures for the commercial plans would require a change in State law.

The State Insurance and Health Departments could also integrate this health equity data into their regularly published consumer guides on insurers and managed care plans to help inform consumer enrollment decisions. This would potentially create another incentive for plans to improve their quality data.

3. Leverage the State's purchasing power for health equity through pay-for-performance and monitoring.

The State could reward plans for reducing racial and ethnic disparities in health outcomes as a component of its pay-for-performance (QI) program. The current QI system has coincided with significant success in raising State improvements in quality benchmark scores for public insurance enrollees. One unpublished report indicates that financial incentives powerfully influence New York's health plans,[30] and there is no reason to believe that a similar infrastructure based on race and ethnicity would not be equally successful.

The State should adopt a set of measures that reflect priority areas for disparity reduction and are consistent with State priorities. Established measures that could be adopted immediately for adults are in the areas of: diabetes, HIV/AIDS, and mammography. Measures that could be adopted immediately for children are: well child visits, dental and asthma indicators. The State should establish a workgroup with the Office of Minority Health, providers, and health advocates to identify nationally recognized and vetted measures to adopt, and to help develop further health equity measures over time, as appropriate.

The State could leverage its purchasing in the following four ways:

A. Adopt a Competitive QI for Health Equity.

The State could adapt its QI program to provide payments on a competitive basis for those plans with top-ranking outcomes for targeted disparities indicators. This would encourage plans to compete for best outcomes in order to receive the bonus payment, with the potential additional benefit of larger improvements in health outcomes above those set by State quality benchmarks.

At the national level, pay-for-performance (P4P) initiatives are generally recognized as an important strategy for quality improvement,[31] and are being increasingly relied upon in the private context.[32]

While there is limited research available on plan-based P4P programs that address disparities, some researchers express the following reservations: providers might "teach to the test" (i.e. only focusing on improvement of certain quality measures that are in review in P4P programs); providers or plans may "cherry pick" to avoid patients perceived as potentially lowering quality scores due to poor health treatment outcomes; and there could be negative ramifications for physicians who practice in low-income, minority communities, who often have less available resources to invest in technology and other resources that facilitate participation in P4P.[33] New York's P4P program has integrated features that address some of these concerns (e.g. annual rotation of QARR measures in the QI program). In any event, a competitive P4P program should be stratified and risk-adjusted to address concerns that plans would "cherry pick" beneficiaries based on race and ethnicity or refuse or limit contracting with those providers who serve minority populations.

B. Adopt a Benchmark QI for Health Equity.

Secondly, the State could leverage its existing QI system by adopting a benchmark scoring system that rewards all plans who meet specific goals. This benchmark system should also be stratified appropriately, thereby alleviating concerns that plans might "cherry-pick" beneficiaries or providers based on the race or ethnicity.

C. Surveillance, Monitoring and Enforcement.

For those plans which have unacceptable levels of disparity in health outcomes, the State should also consider vigorously use its traditional surveillance, monitoring and enforcement mechanisms, which is currently implemented through the issuance of Statements of Deficiencies and Corrective Action Plans for those plans out of compliance of certain contractual terms. This process will help the State assess why disparities exist within certain plans and to assist low-performing plans in finding effective methods for improving quality of care for racial and ethnic minorities.

D. Encourage Quality Improvement Projects.

The State currently requires plans to adopt Quality Improvement Projects in its existing managed care contracts. These plan-based, and sometimes provider-based, projects are designed to test small-scale quality performance projects at an individual plan or provider level. For instance, Florida has used its contracting process to require Medicaid Managed Care plans to initiate a performance improvement program to reduce disparities.[34] The results of these projects are not yet reported. New York's past experience with quality performance improvement projects has not directly addressed the issue of health equity and has had limited success.[35] However, New York could use its contractual authority to standardize the current Quality Improvement Projects thereby adopting a coherent program-wide approach to reduce racial and ethnic disparities in health outcomes.

V. Conclusion

New York should enhance its efforts to address health equity in its public insurance programs. In a recent report commissioned by the New York State Minority Health Council, nationally recognized health equity expert Dr. Brian Smedley recommended the State to "leverage and expand its core system and mission functions" as the first strategy to reduce and eliminate disparities.[36] Citing the existing public health system as an underutilized tool for addressing disparities in health care, Dr. Smedley urged the State to use QARR data as a statewide mechanism for monitoring Medicaid Managed Care plan performance and improving quality of care.

> **"[T]he elimination of disparities should be a core goal in the State's Quality Assurance Reporting Requirements."**
>
> ***–Dr. Brian Smedley, in a report to the New York State Minority Health Council***

At the CSS Roundtable, State officials expressed concern about the complexity of addressing racial and ethnic disparities and certain data limitations with the QARR system. Nonetheless, they agreed that the State's data systems—including data concerning health measures based on race and ethnicity—should be harnessed to improve quality. They also indicated interest in the development of a useful measure (or perhaps index) of health equity. A representative from a Medicaid Managed Care plan expressed concern about how data is gathered, interpreted, and disseminated.[37] A health care provider identified a corollary issue about how plan-based interventions rarely end up becoming meaningful at the provider level—especially since many providers may be participating on a number of plans.[38]

Despite these legitimate and important issues, the time has come for the State to take the following important steps forward in promoting health equity, including:

- Monitor health plan quality indicators by racial and ethnic categories,
- Disclose the results of these findings by plan to the plans and the public; and
- Leverage the State's purchasing power with the plans to promote health equity through pay-for-performance program that rewards the reduction of health disparities by race and ethnicity.

Public insurance will prove to be an important foundation as New York—and perhaps the nation—moves forward towards achieving universal health coverage reform. Public insurance is also a vital force in achieving health equity in coverage for many racial and ethnic minorities in New York State.[39] Yet despite these gains in coverage, CSS's analysis shows that disparities in key quality measures persist in our public health insurance programs and remain for the most part unaddressed by State policy makers. The concrete steps proposed in this brief—such as reporting, public disclosure and financial rewards—can lead New York on the path to achieving greater health equity in New York's public insurance programs for our current enrollees and those of the future.

Appendix I – List of CSS Roundtable Attendees & Interviewees

On February 27, 2009, Community Service Society of New York presented "A Roundtable on Reducing Racial & Ethnic Disparities in Health Coverage & Outcomes in Public Insurance Programs."

Attendees

Abena Abboa-Offei, Affinity Health Plan
Marilyn Aguirre-Molina, Health Sciences Doctoral Programs, The Graduate Center, CUNY
Jacquie Anderson, Community Catalyst
Deborah Bachrach, Office of Health Insurance Programs, NYS Department of Health
Elisabeth Benjamin, Community Service Society
Howard Berliner, SUNY Downstate Medical Center
Carolyn Berry, Center for Health Strategies, Inc.
Kalpana Bhandarkar, Manatt Health Solutions
Michael Birnbaum, United Hospital Fund
Laura Braslow, Manatt Health Solutions
Marjorie Cadogan, Office of Citywide Health Insurance Access
Neil Calman, MD, Institute for Family Health
Juan Cartegena, Community Service Society
Colin Casey, Office of NYS Senator Thomas Duane
Nora Chaves, MCCAP, Community Service Society
Andrea Cohen, Manatt Health Solutions
Louise Cohen, Division of Health Care Access and Improvement, NYC DOHMH
Bob Cohen, Citizen Action of New York
Anne Marie Costello, Office of Health Insurance Programs, NYS Department of Health
Honorable Thomas Duane, New York State Senate
Melinda Dutton, Manatt Health Solutions
Marianne Engelman Lado, New York Lawyers for the Public Interest
C. Virginia Fields, National Black Leadership Commission on AIDS
Tony Fiori, Manatt Health Solutions
Janeene Freeman, Community Service Society
Arianne Garza, Community Service Society
Foster Gesten, MD, Office of Health Insurance Programs, NYS Department of Health
Honorable Richard Gottfried, New York State Assembly
Mark Hannay, Metro New York Health Care for All Campaign
Dennis Johnson, Children's Health Fund
Celeste M. Johnson, NYS Department of Health
David R. Jones, Community Service Society
Jay Laudato, Office of Health Insurance Programs, NYS Department of Health
Priya Mendon, MCCAP, Community Service Society
Christine Molnar, Community Service Society
Francesca Mueller, Community Service Society
Wendy Negron, Division of Health Care Access and Improvement, NYC DOHMH
Beth Osthimer, NYS Department of Health

Appendix I (Cont.)

David Sandman, New York State Health Foundation
Rodolfo Santos, NYS Department of Health
Lisa Sbrana, Legal Aid Society
Magda Schaler-Haynes, NYS Insurance Department
Melissa Seeley, New York State Health Foundation
Joseph A. Stankaitis, Monroe Plan for Medical Care
James R. Tallon, Jr., United Hospital Fund of New York
Lois Uttley, The MergerWatch Project
Patricia Wang, HealthFirst
Lea Webb, Citizen Action of New York
Joyce Weinstein, Division of Health Care Access and Improvement, NYC DOHMH
Jessica Wisneski, Citizen Action of New York

List of Interviewees

Foster Gesten, MD, Medical Director, Office of Health Insurance Programs, NYS Department of Health
Patrick Roohan, Director, Bureau of Quality Management and Outcomes Research, Office of Managed Care, NYS Department of Health
Wilma E. Waithe, Director, Office of Minority Health, NYS Department of Health
Jay Laudato, Director, Division of Managed Care, Office of Health Insurance Programs, NYS Department of Health
Joe Anarella, Director, Quality Measurement and Improvement, NYS Department of Health
Deborah Bachrach, Deputy Commissioner, Office of Health Insurance Programs, NYS Department of Health
Lindsay Cogan, Division of Quality and Evaluation, NYS Department of Health
Paul Henfield, Director of Managed Care, IPRO
Brian D. Smedley, Vice President and Director of the Health Policy Institute, Joint Center for Political and Economic Studies
Anne Beal, MD, Associate Vice President, Program on Health Disparities, Commonwealth Fund
Deborah N. McNamara, Quality Coordinator, Bureau of Quality Management, Florida Agency for Health Care Administration
Janet (Jessie) Sullivan, MD, Chief Medical Officer, Hudson Health Plan
Mark Santiago, Senior Vice President of Marketing and Communications, Hudson Health Plan
Joe Stankaitis, MD, Chief Medical Officer, Monroe Plan for Medical Care
Lani Alison, Vice President of Quality, HealthFirst

Appendix II – QARR Indicators Requested

Target Group:

Insurance Category: All Medicaid managed care enrollees and Child Health Plus B enrollees, where applicable
Race/ethnicity: Black non-Hispanic, Hispanic, White non-Hispanic, Asian, Other

Measures:

- Child Preventive Care (Medicaid, Child Health Plus B)
  - Childhood Immunization Status (Combo 2: 4-3-1-3-3-1) (% of 2-year-olds who were fully immunized)
  - Use of Appropriate Medications for Children with Asthma (% of children ages 5–17 (MA) and 5–18 (CHP) with persistent asthma who received appropriate medications to control their condition)
  - Annual Dental Visit

- Women's Health (Medicaid)
  - Breast Cancer Screening (% of women ages 40–69 who had a mammogram within the past two years)
  - Frequency of Ongoing Prenatal Care (% of women who "received" at least 81% of expected number of prenatal care visits, adjusted for gestational age and month the mother was enrolled in the plan)

- Managing Cardiovascular and Respiratory Conditions (Medicaid)
  - Controlling High Blood Pressure (% of members ages 18–85 who have hypertension and who have controlled their blood pressure = less than 140/90 mm Hg)
  - Use of Appropriate Medications for People with Asthma (% of members ages 18 to 56 with persistent asthma who received the appropriate medications to control their condition)

- Managing Diabetes (Medicaid)
  - Comprehensive Diabetes Care (% of diabetics ages 18 to 75 who received seven components of good diabetes care)
    1. Received a Hemoglobin A1C test within last year
    2. Most recent HbA1C test indicated good control (<7.0%)
    3. Had a cholesterol test done in the last year
    4. Had a cholesterol test done in the last year and whose most recent level of "bad cholesterol" was controlled (LDL-C < 100 mg/dL)
    5. Had a blood pressure measurement of <130/80 mm/Hg in the past year
    6. Had a retinal exam in the past two years
    7. Were monitored for kidney damage in the past year

Notes

1. Kaiser State Health Facts, available at: www.statehealthfacts.org.
2. With 2.1 million uninsured adult New Yorkers, the state ranks 21st in the national ranking of states. J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, "Aiming Higher: Results from a State Scorecard on Health System Performance," The Commonwealth Fund Commission on a High Performance Health System, June 2007.
3. In a multi-state assessment, New York's performance on a number of health measures was rated "weak." Agency for Healthcare Research and Quality, "National Healthcare Quality Report," 2007.
4. J. C. Cantor, *supra* n.2.
5. The term African American is used throughout this report to include all Black people, including Black people from the Caribbean.
6. P.J. Roohan, "Race/Ethnicity Differences in the Quality of Care for Medicaid Managed Care Enrollees in New York State," Presentation at New York State Department of Health Minority Health Summit, January 13, 2009.
7. J. McDonough, et al, "A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," The Commonwealth Fund, June 2004; H. Mead, et al., "Racial and Ethnic Disparities in U.S. Health Care: A Chartbook," The Commonwealth Fund, Volume 27, March 2008; B. Smedley, et al., "Identifying and Evaluating Equity Provisions in State Health Care Reform," The Commonwealth Fund, April 2008; A.C. Beal, "Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care," *Health Affairs*, Volume 23, Number 5, September 2004.
8. According to Current Population Survey data, approximately 22% of the adult African American population and 31% of the adult Latino population are uninsured, compared to only 13% of Whites. U.S. Bureau of the Census, 2008 Current Population Survey, Annual Social and Economic Supplement.
9. Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," March 15, 2007.
10. The QARR is a data set collected from health plans based on quality measures published by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS); New York State-specific measures are included. QARR performance measures are rotated annually and collected for categories such as child and adolescent health, women's health, adults living with illness, behavioral health, and satisfaction with care. QARR performance data is published in an annual report, available on the DOH website and in an annual consumer guide.
11. Health plans licensed under Article 44 of the New York State Public Health Law, including Medicaid Managed Care, Family Health Plus, Child Health Plus and commercial managed care plans, are required to submit data for QARR to the New York State Department of Health.
12. While the State uses Family Health Plus data for scoring the plans on quality, it does not provide financial rewards to Family Health Plus plans through per member per month rate increases.
13. Plan member experience data is collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
14. The State provides quality incentive payments to plans that participate in the Medicaid Managed Care, but not the Family Health Plus and Child Health Plus programs. Rewards include bonus premium payments ranging from 0.75% to up to 3%. In addition to the quality incentive payment, plans also receive a quality weight based on their QARR scores which feeds into the state's auto-assignment algorithm. This algorithm assigns beneficiaries who do not choose a specific Medicaid managed care plan, based on the plan's quality score.
15. J. Anarella, "New York Perspective: Pay-for-Performance in Medicaid Managed Care," Presentation at the 3rd Annual Pay for Performance Summit, February 28, 2008.
16. Reporting periods for indicators are as follows: complete immunizations are for 2002-2006; well child visits between 0-15 months are for 2002-2006; well child visits between 3-6 years are for 2002-2007; adolescents health visits are for 2002-2007; diabetes in poor control are for 2004-2007.
17. Personal communication with Joseph Anarella, Director of Quality Measurement and Improvement, NYS Department of Health.
18. P. Roohan, J. Anarella and F. Gesten, "Quality Oversight and Improvement in Medicaid Managed Care," *Journal of Public Health Management Practice*, 10(4), 2004 and J. Anarella, *supra* n. 15.
19. New York State Department of Health, Office of Minority Health, "New York State Minority Health Surveillance Report," September 2007.
20. As reported by the Centers for Disease Control and Prevention (CDC), African Americans are 3 times as likely and Hispanics are 1.1 times as likely to die from asthma as non-Hispanic Whites. African Americans are 2.2 times as likely and Hispanics are 1.6 times as likely to die from diabetes as non-Hispanic Whites. African American men are 60% as likely and African American women are 40% as likely to die from stroke, compared with non-Hispanic White men and women, respectively (this is lower within New York State). Hispanic men are 15% *less* likely and Hispanic women are 25% *less* likely to die from stroke, compared with non-Hispanic White men and women, respectively. African American men are more than 9 times as likely and African American women are more than 20 times as likely to die from HIV/AIDS as non-Hispanic White men and women, respectively. Hispanic men are 2.5 times as likely and Hispanic women are 3.2 times as likely to die from HIV/AIDS as non-Hispanic White men and women, respectively. Asian Americans have the lowest rates of death due to heart disease, diabetes, cancer, HIV/AIDS, and are less likely than Non-Hispanic Whites and African-Americans to die of stroke. Data on asthma from Centers for Disease Control and Prevention, National Surveillance for Asthma, US, 1998-2004, 2007; data on diabetes from Centers for Disease Control and Prevention, National Vital Statistic Report, Volume 56, Number 10, 2008; data on stroke and HIV/AIDS from Centers for Disease Control and Prevention, Health United States, 2007, 2007. All rates are age-adjusted.
21. The Department of Health also provided CSS with the QARR diabetes measures for 2006, however, the results were substantially similar to the 2007 QARR data described in this report.
22. To test statistical significance for each QARR measure, CSS compared the percentage of each racial and ethnic group meeting quality standards on that measure against the total percentage of all other racial groups meeting quality standards on that measure. CSS then used a statistical method called the Z-score for two proportions to test for significant differences between each racial/

ethnic group and the total of all other groups, at a significance level of p <0.05 (although we found significance at the p <0.01 or p < 0.001 level on many measures).

23. Measures studied were: childhood immunization status, lead testing of two year olds, well-child visits in the first 15 months of life and at 3-6 years, adolescent well-care visits, appropriate treatment for children with an upper respiratory infection (3 mos-18yrs), use of appropriate medications for people with asthma (5-17 yrs) and annual dental visits (12-21 yrs). M. B. Conroy, "Racial and Ethnic Differences in Medicaid Managed Care Child and Adolescent Care," Presentation to Medicaid Managed Care Advisory Review Panel, New York City, May 21, 2008.
24. *Id.*
25. This study reviewed six diabetes measures: HbA1C testing, poor HbA1C control, lipid profile, lipids controlled (<100 mg/dL); blood pressure controlled (<130/80 mm/Hg) and dilated eye exams. P.J. Roohan, *supra* n.6.
26. *Id.*
27. Institute of Medicine, *supra* n.9 ; K. Llanos and L. Palmer, "Using Data on Race and Ethnicity to Improve Health Care Quality for Medicaid Beneficiaries," Center for Health Care Strategies, June 2006; L.T. Bilheimer and J.E. Sisk, "Collecting Adequate Data On Racial and Ethnic Disparities in Health: The Challenges Continue," *Health Affairs*, Volume 27, No. 2, 2008.
28. *Id.*
29. In 2008, New York State began to provide race and ethnicity data to the plans.
30. Urban Institute report to the Commonwealth Fund, "Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program, February 2007.
31. S. Felt-Lisk, G. Gimm, and S. Peterson, "Making Pay-For-Performance Work In Medicaid," *Health Affairs*, Volume 26, Number 4, 2007, w516–w527; S. Trude, M. Au, and J. B. Christianson, "Health Plan Pay-for-Performance Strategies," *The American Journal Of Managed Care*; Volume 12, Number 9, 2006; S. D. Pearson, E. C. Schneider, K. P. Kleinman, K. L. Coltin, and J. A. Singer, "The Impact Of Pay-For-Performance On Health Care Quality In Massachusetts, 2001–2003," *Health Affairs*, Volume 27, Number 4, July/August 2008, pp.1167-1176.
32. More than 100 pay-for-performance and incentive programs have been launched in the private sector nationwide, with the highest prevalence of sponsorship among commercial health plans. Med-Vantage and Leapfrog Group, "Provider Pay-for-Performance Incentive Programs: 2006-2007 National Study," December 2007; Institute of Medicine, "Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series)," 2007.
33. L.P. Casalino, A. Elster, A. Eisenberg, E. Lewis, J. Montgomery, and D. Ramos, "Will Pay-for-Performance And Quality Reporting Affect Health Care Disparities," *Health Affairs*, Web Exclusive, April 10, 2007; *see also* Urban Institute *supra* n. 30 (expressing concern that plans are "teaching to the test" in New York's QI program).
34. In 2005, Florida integrated into its Medicaid managed care contract a requirement for plans to implement Quality Assessment Performance Improvement projects (QAPIs) in areas that address racial and ethnic health disparities. Plans have a choice of one of three project foci around which to design interventions: (1) language and culture; (2) clinical health care disparities; or (3) culturally or linguistically appropriate services. Examples of quality improvement interventions led by the health plans include: identifying health disparities in cholesterol management among their Latino population; improving quality in the health plan's French Creole membership; and improving cultural competency training at the provider level. The results of these projects are not yet available. Florida Agency for Health Care Administration, "Quality Assessment & Improvement Strategies: Florida Medicaid Managed Care Programs," 2007; Personal Communication, Deborah McNamara, Quality Coordinator, Florida Agency for Health Care Administration, June 2008.
35. New York State Department of Health, "Medicaid Managed Care Plans Performance Improvement Projects," October 2007.
36. B. Smedley, "Moving Toward Health Equity in New York: State Strategies to Eliminate Health Disparities, A Report for the Minority Health Council, New York State Department of Health," January 2009.
37. P. Wang, President & CEO Health First, Remarks at Community Service Society Roundtable, February 27, 2009.
38. N. Calman, President & CEO, Institute for Family Health, Remarks at Community Service Society Roundtable, February 27, 2009.
39. Community Service Society, "Promoting Equity & Coverage in New York's Public Insurance Programs," forthcoming May 2009.

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