



## Statistical Brief #8

Office of Quality and Patient Safety  
Division of Performance Improvement and  
Patient Safety

April, 2015

### Medicaid Managed Care Quality Performance among Individuals with Developmental Disabilities, New York State, 2013

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#### Introduction

Over 110,000 Medicaid recipients in New York State (NYS) are currently identified as living with developmental disabilities (DD), such as intellectual disabilities, cerebral palsy, Down syndrome, and autism spectrum disorders. Medicaid benefits for these individuals have traditionally been delivered under a Fee-for-Service (FFS) payment system through four distinct state agencies: the Office for People with Developmental Disabilities (OPWDD), the Department of Health (DOH), the Office of Mental Health (OMH), and the Office of Alcohol and Substance Abuse Services (OASAS). Upon approval of the People First Waiver through the Center for Medicare and Medicaid Services (CMS), OPWDD will begin to transition DD services into capitated managed care models known as Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs). Eventually, Medicaid recipients requiring DD services will be mandatorily enrolled in DISCOs statewide. The DISCO benefit package will initially include all waiver services currently provided by OPWDD, as well as long-term care, and behavioral health. Acute care services (including emergency room and physician visits, inpatient care, and pharmacy) will continue to be paid for through Medicaid FFS and added to the DISCO benefit package in the future. While the transition to capitated managed care offers the potential for substantial cost savings through more efficient delivery of care, a critical question is whether the quality of and satisfaction with care will also improve.

The NYS DOH currently oversees capitated Medicaid managed care (MMC) plans including “mainstream” MMC, the comprehensive and traditional health plan model with a benefit package that covers acute, chronic, and preventive care services. Home and Community Based waiver Services (HCBS) provided by OPWDD, including habilitation services, respite care,

#### Highlights

- For 36 of 44 quality measures calculated, performance did not differ between the statewide Medicaid managed care population and the population of individuals with developmental disabilities who were voluntarily enrolled in a Medicaid managed care plan during 2013.
- Management of asthma medications among the adolescent population with developmental disabilities was 13 percentage points better than the statewide average for both the 50% and 75% “days covered” measures.
- Chlamydia screening and nephropathy monitoring for diabetics among the population with developmental disabilities were at least 20 points worse than the statewide average.
- Measures addressing testing for diabetes, monitoring specific medications in adults, appropriate treatment for upper respiratory infections in adults and pharyngitis in children, and compliance with annual dental visits among children, had a significant gap in performance and appear ripe for improvement as the DD population transitions into a capitated model.



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service coordination, and adaptive technologies, are currently excluded from mainstream MMC. Enrollment of individuals living with DD into MMC is currently voluntary. While DISCOs will offer a benefit package very different than that provided by MMC plans, the quality of managed care performance will largely be evaluated following reporting requirements of MMC, with additional DD-specific measures incorporated as necessary.

As a way to measure the quality of care, the DOH has been collecting performance data from its MMC plans through its Quality Assurance Reporting Requirements (QARR) initiative since 1994. QARR is largely based on the National Committee on Quality Assurance (NCQA) measures, plus additional measures developed by the DOH to monitor the delivery of primary and chronic care services. At this time, NYS's QARR publications do not present DD performance separately.

The purpose of this report is to present QARR performance data specific to the DD population voluntarily enrolled in MMC during 2013, to establish an understanding of MMC plan performance in delivering care to this population, and identify variation in the quality of care received between the DD population and statewide MMC. For this analysis, the DD population was defined as those individuals eligible for ongoing residential, day, case management, or HCBS overseen by OPWDD. A small portion of the eligible population was not actively receiving OPWDD services in 2013, but would nevertheless be eligible to receive those services if they choose.

## Data Sources and Methods

Data for this analysis were extracted from New York State's Medicaid Data Warehouse (MDW), the Office of Health Insurance Programs (OHIP) Data Mart, and QARR member-level data files. The MDW is the data repository for all Medicaid claims, encounters, reimbursement, and member profile information. Data in the MDW are submitted by Medicaid providers and health plans throughout the year, per requirements set forth by the DOH. The OHIP Data Mart is a collection of data tables that have been compiled for use by DOH researchers and program administrators. Tables in the OHIP Data Mart are refreshed on a monthly basis with new data from the MDW. QARR member-level data are submitted annually by health plans and contain the Medicaid Client Identification Number (CIN) and numerator and denominator compliance for each QARR measure.

For this analysis, Medicaid enrollees qualifying for DD services were identified within the MDW using the Restriction Exemption Code. This code categorizes a Medicaid enrollee's qualifying condition or situation allowing for exemption from mandatory enrollment into MMC. Member CINs with a Restriction Exemption Code equal to 95 (RE95), designating an individual's eligibility to receive ongoing residential, day, case management, or HCBS overseen by OPWDD, were extracted from the MDW. The list was then matched to Medicaid eligibility files contained in the OHIP Data Mart to analyze enrollment characteristics, such as payer, product, and duration of continuous enrollment. The CINs were then matched against the 2014 QARR member-level file to identify those individuals eligible for QARR measures during the 2013 measurement year. Demographic information on those eligible for at least one QARR measure was obtained from the Data Mart. Performance on specific QARR measures was calculated using the member-level files. Performance rates were not calculated for any measure with fewer than 30 individuals. The rates were compared to the statewide average (SWA) for each measure, as calculated based on MMC plan QARR data, inclusive of the DD population. All analyses were completed in SAS 9.3.

## Findings

A total of 111,880 DD individuals were initially identified as eligible for Medicaid benefits during the 2013 calendar year, with 108,978 (97.4%) enrolled. Of those enrolled, 14,244 (13.1%) voluntarily had their care managed by a mainstream MMC plan at some point during the 2013. The member-level-file revealed that 7,998 (56.1%) of those individuals qualified for QARR measurement in 2013, based on measure denominator specifications. The vast majority of these



individuals, 6,788 (84.9%), were eligible for Supplemental Security Income (SSI). Only 18 (0.2%) were dually eligible for Medicare and Medicaid.

As seen in Table 1, the enrolled population was 60.2% male, 48.9% white, 58.8% children between five- and 17 years of age, and primarily residents of Western Region (30.2%) or New York City (NYC) (28.0%). Performance for 44 QARR measures from the 2013 measurement year are presented in Table 2. The eligible DD population for most measures was relatively small, thus resulting in large confidence intervals around many rate calculations. Rates were not calculated for 23 additional measures found to have a sample size less than 30 (Table 3).

Few significant differences were seen between performance among the statewide population and the DD population. There were only four measures for which performance was observed to be better than the statewide average, and of those, two were addressing medical management of asthma in the child and adolescent population. There were eight measures for which performance was significantly worse than the statewide average, two of which are components of the Comprehensive Diabetes Care measure.

Variability in performance outcomes was notable for medication management. While, the annual monitoring of patients on persistent anticonvulsants (75%) was eight points better than the statewide average (67%), the combined rate for monitoring persistent medications (anticonvulsants, ACE inhibitors/ARBs, Digoxin, and Diuretics- 84%) was seven points below average (91%). Adherence to antipsychotic medications for individuals with schizophrenia (72%) was significantly better than statewide (63%), but follow-up care for children prescribed ADHD medication in the initiation phase (49%) was significantly worse (statewide average 56%). Follow-up care in the continuation phase was not statistically different from statewide, but still represented a nine percentage point performance gap (56% compared to 65% statewide). Management of asthma medications among the adolescent population with developmental disabilities was 13 percentage points better than the statewide average for both the 50% and 75% “days covered” measures, while differences on these measures across the adult populations were not statistically different.

While the annual dental visit measure for enrollees between 19 and 21 years of age (46%) was not significantly different from the statewide average (44%), this measure was worse for those between 2 and 18 years of age (58% in the DD population compared to 61% statewide). Appropriate testing for pharyngitis (81%) and appropriate treatment for upper respiratory infections (89%) were significantly worse than statewide averages (87% and 92%, respectively).

Both nephropathy monitoring (63%) and the composite diabetes testing (37%) measures were more than 10 points below the statewide population performance (83% and 51%, respectively), the former a full 20 points below.

## Conclusions

Among the vast majority of measures, significant differences in performance between the statewide and DD populations were not observed. This observation is encouraging especially in light of the fact that NYS’s Medicaid managed care population consistently outperforms national averages. Assessment of plan performance for the DD population is currently difficult to reliably quantify in light of small sample sizes for many of the measures; the confidence intervals for most measures were large.

This first look at these performance data suggests potential shortfalls that may need to be discussed. It should be noted that compared to the overall MMC population, the DD MMC population tends to be more white, male, and with a higher percentage residing in the Western Region of NYS as compared to NYC. While, it is the policy of the DOH not to risk adjust QARR process measures based on demographic characteristics when evaluating health plan performance, there are historical differences in performance within the subpopulations of MMC that may be impacting these results. In



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particular, Western NY performance has remained steady while NYC and other regions of NYS have continued to improve.

Continued monitoring of DD MMC performance will be of interest while the previously exempt DD population is slowly integrated into a managed care model. As the eligible population increases in number, evaluation of quality performance will become more reliable, and allow for targeted improvement efforts. DOH will continue to actively work with OPWDD and other stakeholders on quality improvement activities within the MMC subpopulations as part of the State's Medicaid managed care Quality Strategy.

### Limitations

It is worth noting that a DD population voluntarily enrolled in MMC may be inherently different from those individuals who received services through Medicaid FFS. We do not have comparable data for those individuals in FFS. Small sample sizes existed for many of the measures.

**Table 1. Demographic information on individuals eligible for developmental disabilities services regulated by the Office for People with Developmental Disabilities, who qualified for New York State QARR performance measurement, based on enrollment in 2013.**

	N	%
<b>Total</b>	7,998	
<b>Gender</b>		
Male	4,813	60.2
Female	3,185	39.8
<b>Race</b>		
White	3,911	48.9
Black	1,703	21.3
Hispanic	1,496	18.7
Asian/Pacific Island	224	2.8
Other	664	8.3
<b>Age</b>		
Age 0 to 4 Years	366	4.6
Age 5 to 17 Years	4,710	58.9
Age 18 to 49 Years	2,640	33.0
Age 50 to 64 Years	280	3.5
Age 65+ Years	2	0.0
<b>Region</b>		
Western	2,418	30.2
Central	1,265	15.8
Northeast	933	11.7
Hudson Valley	706	8.8
New York City	2,236	28.0
Long Island	439	5.5

Note: As of December 1<sup>st</sup>, 2013



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Table 2. 2014\* QARR performance among individuals eligible for developmental disability (DD) services provided by the Office for People with Developmental Disabilities (OPWDD), who were voluntarily enrolled in a Medicaid managed care plan during 2013.

Measure	N	DD Rate (95%CI)	Statewide Average	Significance
<b>ADULT HEALTH</b>				
Adult Body Mass Index (BMI) Assessment	62	85 (77 - 94 )	85	NS
Annual Dental Visit (Ages 19-21)	1,071	46 (43 - 49 )	44	NS
Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	330	91 (88 - 94 )	92	NS
Annual Monitoring for Patients on Persistent Medications- Anticonvulsants	488	75 (71 - 78 )	67	+
Annual Monitoring for Patients on Persistent Medications- Combined Rate	1,043	84 (81 - 86 )	91	-
Annual Monitoring for Patients on Persistent Medications- Diuretics	216	92 (89 - 96 )	91	NS
Appropriate Testing for Pharyngitis	335	81 (77 - 85 )	87	-
Appropriate Treatment for Upper Respiratory Infection (URI)	600	89 (86 - 91 )	92	-
Avoidance of Antibiotic Therapy in Adults with Acute Bronchitis	130	27 (19 - 35 )	26	NS
Comprehensive Diabetes Control - HbA1c Control (<8.0%)	52	62 (48 - 75 )	57	NS
Comprehensive Diabetes Control - HbA1c Control for Selected Population (<7.0%)	39	46 (31 - 62 )	41	NS
Comprehensive Diabetes Control BP below 140/90	52	73 (61 - 85 )	69	NS
Comprehensive Diabetes Control Eye Exam	52	58 (44 - 71 )	63	NS
Comprehensive Diabetes Control HbA1c Poor Control**	52	37 (23 - 50 )	32	NS
Comprehensive Diabetes Control HbA1c Test	52	83 (72 - 93 )	89	NS
Comprehensive Diabetes Control LDL-C Control <100	52	37 (23 - 50 )	43	NS
Comprehensive Diabetes Control LDL-C Screen	52	81 (70 - 91 )	88	NS
Comprehensive Diabetes Control Nephropathy monitor	52	63 (50 - 77 )	83	-
Follow-Up After Hospitalization for Mental Illness Within 30 Days	43	79 (67 - 91 )	78	NS
Follow-Up After Hospitalization for Mental Illness Within 7 Days	43	60 (46 - 75 )	63	NS
Managing Diabetes Outcomes - HbA1c and Lipids Controlled	52	27 (15 - 39 )	35	NS
Medical Management for People with Asthma 50% Days Covered (Ages 19-64)	174	61 (54 - 68 )	68	NS
Medical Management for People with Asthma 75% Days Covered (Ages 19-64)	174	41 (34 - 49 )	45	NS
Monitoring Diabetes - Received All Tests	52	37 (23 - 50 )	51	-
Use of Appropriate Medications for People with Asthma (Ages 19-64)	209	83 (78 - 88 )	80	NS



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Use of Imaging Studies for Low Back Pain	168	71 (64 - 78 )	77	NS
<b>BEHAVIORAL HEALTH</b>				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	109	72 (64 - 81 )	63	+
Antidepressant Medication Management: Acute Phase	159	42 (34 - 50 )	50	NS
Antidepressant Medication Management: Continuation Phase	159	29 (22 - 36 )	35	NS
Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	120	83 (77 - 90 )	82	NS
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	89	56 (46 - 66 )	65	NS
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	239	49 (42 - 55 )	56	-
<b>CHILD AND ADOLESCENT HEALTH</b>				
Adolescent Well-Care Visits	3,785	65 (63 - 67 )	64	NS
Annual Dental Visit (Ages 2-18)	4,480	58 (57 - 60 )	61	-
Immunizations for Adolescents (IMA) - Combo	40	75 (62 - 88 )	72	NS
Medical Management for People with Asthma 50% Days Covered (Ages 5-18)	173	66 (59 - 73 )	53	+
Medical Management for People with Asthma 75% Days Covered (Ages 5-18)	173	42 (35 - 50 )	29	+
Use of Appropriate Medications for People with Asthma (Ages 5-18)	205	84 (79 - 89 )	86	NS
Body Mass Index (BMI) Percentile	40	85 (74 - 96 )	75	NS
Counseling for Nutrition	40	80 (68 - 92 )	77	NS
Counseling for Physical Activity	40	73 (59 - 86 )	68	NS
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	713	82 (79 - 85 )	83	NS
<b>WOMEN'S HEALTH</b>				
Breast Cancer Screening	193	67 (60 - 73 )	72	NS
Chlamydia Screening (Ages 16-24)	723	49 (45 - 52 )	72	-

\*2013 measurement year

\*\* A lower rate is desirable

**NS** = Not Significant

**+** = Significantly Better than Statewide Average

**-** = Significantly Worse than Statewide Average

**NA** = Not Available (due to small sample size)



**Table 3. QARR measures for which performance rates specific to the developmental disability could not be calculated due to small sample size during 2013 enrollment**

Adolescent Preventive Care: Sexual Activity
Adolescent Preventive Care: Depression
Adolescent Preventive Care: Substance Use
Adolescent Preventive Care: Tobacco Use
Annual Monitoring for Patients on Persistent Medications- Digoxin
Appropriate Asthma Medications- 3+ Controllers (Ages 5-18)
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
Cervical Cancer Screening
Childhood Immunization Status (Combo 3)
Cholesterol Management for Patients with Cardiovascular Conditions - LDL-C Control <100
Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C Screen
Colon Cancer Screening
Chronic Obstructive Pulmonary Disease: Bronchitis
Chronic Obstructive Pulmonary Disease: Steroids
Diabetes Monitoring for People with Diabetes and Schizophrenia
Drug Therapy for Rheumatoid Arthritis
Engaged in Care
HIV VIRAL
Lead Testing
Persistence of Beta-Blocker Treatment
Syphilis Screening
Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)

### Contact Information

We welcome questions, comments, and feedback. Please contact us at:

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