

# 2021 Quality Incentive Report

A Report on the Quality Incentive Program  
in New York State



# Table of Contents

Section 1 Background.....3

Section 2 Quality Incentive Components and  
Calculation Process – 2021 Methodology.....5

Section 3 Quality Incentive Award Results .....13

New York's Medicaid Managed Care Quality Incentive Program began in early 2001. In 2002, the program was expanded to provide increased incentives for improvement. Plans became eligible to receive bonuses added to the premium based upon composite scores from quality measures and satisfaction measures. The Quality Incentive Program continues to evolve and includes new components and measures as well as a refined methodology to calculate current performance relative to peers.

The data sources used in the Quality Incentive Program include measures from the following sources:

- New York's Quality Assurance Reporting Requirements (QARR), which is largely comprised of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)
- State-specific performance measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Rates of performance in Medicaid managed care have increased steadily over the last decade. New York State Medicaid plans have demonstrated a high level of care compared to national averages, and for many domains of care the gap in performance between commercial and Medicaid managed care has been decreasing since the Quality Incentive Program was implemented. The use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources to promote high quality care. Incorporating financial incentives that tie payment directly to quality is an important approach to improving the quality of care, holds health plans accountable for the care they provide, and rewards those who invest in processes that improve care. State Medicaid programs have steadily increased the use of financial incentives or pay-for-performance (P4P) mechanisms in their payment systems.

Currently, the Quality Incentive Program has a defined methodology to determine the percentage of the potential financial incentive that a plan receives. Plans earn up to 100 percentage points from the categories of Quality of Care (80%) and Experience of Care (20%). Points are subtracted from the plan's total points if the plan had statements of deficiency in the Compliance category. A maximum of 10 points could be subtracted from the plan's total points for statements of deficiency associated with specific compliance areas.

## Section 1 Background

Summary of the current Quality Incentive structure components and possible points:

Component	Number of Measures	Points
Quality – QARR ( <b>HEDIS® and NYS-specific</b> )	30	100 points
Satisfaction – CAHPS® Health Plan Survey	3	20 points
Total Points		Sum of 80% of Quality points and Satisfaction points
Compliance ( <b>Subtracted from Total</b> )	7	Up to 10 points
Covid-19 Vaccine Equity Plan Bonus Points		Up to 10 bonus points
<b>Final Score</b>		<b>Up to 110 points</b>

In past incentive programs, plans have been grouped into one of five tiers to determine the incentive award. The five tiers are based on the percentage of points earned by the plans. Plans must achieve or exceed the threshold for the respective tier to be eligible for their award. Quality incentive payments are subject to the availability of State funding as determined by the Annual Budget process. A plan's performance in the Quality Incentive affects the auto-assignment algorithm. Plans achieving Tier 1 - Tier 4 of the Quality Incentive award receive the quality preference in the auto-assignment algorithm. The quality preference in the algorithm directs a proportion of auto-assignees only to plans that qualified for the preference. The quality preference for auto-assignment is not adjusted by the tier of the Quality Incentive award; rather, all tiers other than Tier 5 receive the same quality preference and share in the distribution of auto-assignees equally. Tier 1 indicates scores equal to or higher than 63.60, Tier 2 indicates scores between 48.28-63.59, Tier 3 indicates scores between 34.96-48.27, Tier 4 indicates scores between 28.65-34.95, and Tier 5 indicates scores lower than 28.65. Tiers were created before the introduction of the bonus points from the Covid-19 Vaccine Equity Plan (CVEP). Plans were only able to move up a maximum of one tier due to the CVEP bonus points. Plans were asked to meet targets of 10% improvement from baseline or a minimum threshold of at least 50% for each age group (5-11, 12-7, and 18+) for receipt of one dose of an approved COVID-19 vaccine. Due to the Omicron surge and the late introduction of the 5-11 vaccine into the pandemic, plans were not able to meet this goal for the 5-11 age group, and thus points were awarded based on meeting both the 12-17 and the 18+ target.

The 2021 Quality Incentive awards became effective for capitation rates and for auto-assignment preference on April 1, 2022.

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

The following three Quality Incentive components were used to determine the 2021 Quality Incentive results:

- **Quality of Care:** 2021 QARR results using 2021 data
- **Consumer Satisfaction:** The most recent CAHPS® survey for adults in Medicaid, which was administered in the fall of 2021 and results released in reports dated May 2022
- **Compliance:** Regulatory compliance information from 2020 and 2021

### Quality of Care: (100 points possible)

The methodology for awarding points for quality measures in the Quality Incentive is outlined below.

- The Quality Measures included align with the measures selected for the State's Value-Based Payment arrangements. Quality measures from Primary Care, Mental Health, Substance Use, Maternity, Children's Health, and HIV were included. This approach allows a more comprehensive view of quality and aligns with other uses of the data. It also minimizes the impact of one problematic area in the overall performance of the plan.
- For some measures with more than one indicator, we used a weighted average method (see equation below) to average each measure's individual indicator rates and calculate a measure score.

Indicators with larger denominators contributed more to the scoring than indicators with smaller denominators. The attached list of measures identifies the measures with multiple indicators where the scores were calculated as weighted averages.

The weighted average equation is as follows:

$$X = \frac{\sum_1^I n_i * x_i}{\sum_1^I n_i}$$

Where X is the final measure score that is the weighted average,  $x_i$  is the indicator score, and  $n_i$  is the indicator denominator.

- The allotted 100 points for quality were distributed evenly for all measure scores, and for measures with more than one indicator, each measure score was counted as one measure. For example, if there were 30 measures in the quality section, each measure was worth up to 3.33 points.
- If a measure has less than 30 members in the denominator, we considered it to be a Small Sample Size (SS), and we suppressed those results. There was no reweighting for SS. If plan results were SS, there was an overall reduction of base quality points. For example, with 30 measures worth 100 possible points, if the plan only has 29 measures, the base was reduced by the maximum value for that one measure.
- Measures were classified as Pay for Reporting (P4R) or Pay for Performance (P4P).

- For measures classified as P4R, full points were awarded for valid reporting of that measure regardless of the measure score. Hybrid measures reported administratively received full P4R points.
- For measures classified as P4P, plans were awarded 50 percent of possible points for a measure result at or above the 50<sup>th</sup> percentile, but less than the 75<sup>th</sup> percentile; 75 percent of possible points for a measure result at or above the 75<sup>th</sup> percentile, but less than the 90<sup>th</sup> percentile; and 100 percent of possible points for the measure at or above the 90<sup>th</sup> percentile.
- The determination of the 50<sup>th</sup>, 75<sup>th</sup>, and 90<sup>th</sup> percentiles, for both P4P and P4R measures, were based on the same measurement year of the results. To determine the plans achieving the percentiles the results were rounded to two decimal points prior to the percentile determination.
- Each plan's quality points were totaled and then divided by their base points. The resulting quality percentage points were weighted to be worth 80% of the final score. This weighting of quality percentage points allows this section of the Quality Incentive to continue to retain a similar weight in the makeup of the overall scores.



## Quality Measure Benchmarks for the 2021 Medicaid Quality Incentive

Measure Name	90 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	Points Possible
<b>Primary Care</b>				
Antidepressant Medication Management	52.08	51.11	49.71	3.33
Asthma Medication Ratio	68.79	63.9	61.38	3.33
Breast Cancer Screening	69.38	66.34	62.68	3.33
Cervical Cancer Screening	74.27	71.26	67.4	3.33
Chlamydia Screening in Women	80.32	75.1	69.95	3.33
Colorectal Cancer Screening	69.34	61.79	56.93	3.33
Comprehensive Diabetes Screening: Eye Exam	65.69	64.23	59.37	3.33
Comprehensive Diabetes Care: Poor Control*	26.42	30.96	35.77	3.33
Controlling High Blood Pressure	72.75	68.19	63.26	3.33
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	36.3	31.61	30.14	3.33
Kidney Health Evaluation for Patients with Diabetes	44.97	42	39.81	3.33
Statin Therapy for Patients with Cardiovascular Disease: Statin Adherence 80%	77.34	72.65	70.33	3.33
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	46.15	45.02	35.73	3.33
<b>Children's Health</b>				
Annual Dental Visit: Ages 2-18	58.98	58.02	54.75	3.33
Childhood Immunization: Combination 3	76.89	75.06	72.51	3.33
Immunizations for Adolescents: Combination 2	53.6	44.04	40.15	3.33
Well Child Visits in the First 30 Months of Life	78.93	77.86	75.43	3.33
Child and Adolescent Well-Care Visits	73.94	71.15	70.22	3.33
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	92.38	88.33	83.23	3.33
<b>Mental Health</b>				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	63.96	61.87	60.87	3.33
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.32	78.98	77.24	3.33
Follow-Up After Emergency Department Visit for Mental Illness: 7-day rate	72.99	61.98	54.37	3.33
Follow-Up After Hospitalization for Mental Illness: 7-day rate	67.47	65.26	64.81	3.33
Follow-Up Care for Children Prescribed ADHD Medication	64.68	61.25	57.16	3.33

Measure Name	90 <sup>th</sup> Percentile	75 <sup>th</sup> Percentile	50 <sup>th</sup> Percentile	Points Possible
Metabolic Monitoring for Children and Adolescents on Antipsychotics	49.74	42.53	38.43	3.33
<b>Substance Use</b>				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7-day rate	25.35	21.75	20.23	3.33
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	55.77	49.35	45.94	3.33
<b>Maternity</b>				
Timeliness of Prenatal Care	92.96	90.88	86.86	3.33
Postpartum Care	85.16	81.85	79.81	3.33
<b>HIV</b>				
Viral Load Suppression	79.88	78.8	74.42	3.33

\* A low rate is desirable



**CAHPS Experience of Care Survey: (20 points possible)**

Three CAHPS Experience of Care survey measures were included in the Quality Incentive. Twenty points were available and distributed based on whether a plan was at or above the statewide average for the most recent CAHPS survey. CAHPS is administered every year for Medicaid alternating adult and child surveys. For the 2021 Quality Incentive, the CAHPS scores from the survey conducted in fall 2021 with adults in Medicaid were used. Plans were awarded points based on their scores within the measurement year. Plans earned 6.66 points for measures with results significantly better than the statewide average, 3.33 points for measures with results not significantly different from the statewide average, and no points for measures with results significantly lower than the statewide average. Each plan's satisfaction points were totaled and then divided by their base points.

CAHPS Measure	Satisfaction Points
Rating of Health Plan	6.66 points
Getting Care Needed	6.66 points
Customer Service and Information	6.66 points
<b>Total</b>	<b>20 points</b>

**Compliance: (10 points for subtraction)**

The Compliance section includes seven areas: Statements of deficiency (SOD) for the Medicaid Managed Care Operating Report (MMCOR), Quality Assurance Reporting Requirements, plan network, provider directory, member services, behavioral health parity, and claims payment and/or denials. The Quality Reporting Requirement area for 2021 includes submission requirements for Care Management data, Performance Improvement Project reports, performance matrices action plans, and focused clinical studies. In the 2021 Quality Incentive, points from issues with Compliance were subtracted from the total points prior to calculating the final percentage scores. The number of points that may be subtracted is detailed below:

Category	Measure Description	Timeframe	Points
Medicaid Managed Care Operating Report	Any SOD for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted for the measurement year (2021).	MMCOR reports submitted for 2021	2 points for any SOD timeliness, completeness, or failure to meet reserves. No more than 2 points were moved for this category.
	Any SOD for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted the year prior to the measurement year (2020).	MMCOR reports submitted for 2020	
Quality Reporting Requirements	Any SOD for failure to submit required complete quality data for Care Management (SMART) data and QARR data (includes the required member-level file and the birth file) by the established deadlines for the measurement year (2021).	Quality Reporting Requirements for 2021 data	2 points for a SOD. No more than 2 points were removed for this category.
	Any SOD related to the Performance Improvement Projects or the quality performance matrix process.	Quality reporting requirements for 2021	
	Any statement of deficiency related to a Focused Clinical Study (FCS).	FCS reporting requirements for 2021	
Plan Network	Any SOD issued for the measurement year (2021) for failure to manage access to care to maintain network with at least 75% compliance with required appointment timeframes based on the Access and Appointment Availability survey conducted for the department.	Access and Availability survey results for 2021	1 point for any SOD. No more than 1 point was removed for this item in the category.

Category	Measure Description	Timeframe	Points
	Any SOD for timeliness, incomplete, or inaccurate Provider Network Directory System (PNDS) or Panel Submission for measurement year (2021).	PNDS Quarterly submission for 2021	
Provider Directory	Any SOD for incomplete or inaccurate provider listings and/or failure to maintain at least 75% provider participation rate for the measurement year (2021).	Provider Directory Information and Participation results for 2021	1 point for any SOD for either directory information or for provider participation. No more than 1 point removed for this item in the category.
Member Services	Any SOD or statement of findings for member services during the measurement year (2021) for failure to: maintain a functional member services phone line; provide correct information to callers; provide specific information upon written request.	Member services for 2021	1 point for any SOD or statement of findings for any of the three-member service items. No more than 1 point was removed for this category.
Behavioral Health Parity Reporting Requirement	Any SOD for timeliness, completeness, and/or accuracy or failure to meet requirements on Behavioral Health Parity reports submitted for the measurement year (2021).	Parity reports submitted for 2021	1 point for any SOD for timeliness, completeness or for accuracy. No more than 1 point was removed for this category.
Claims Payment and/or Denials	Any statement of deficiency or statement of findings related to claims payment and/or denials issues for year (2021).	Claims payment and/or denials data for 2021	2 points for a statement of deficiency or statement of findings. No more than 2 points were removed for this category.
<b>Total</b>			<b>10 points</b>

### Bonus Points

Plans had the opportunity to submit baseline and final one-dose COVID-19 vaccine rates for three age cohorts with demographic information. To receive bonus points, plans needed to submit three specific examples for improving equitable vaccination rates in children 5-11, adolescents 12-17, and adults 18+. The plans also needed to demonstrate that they had improved the vaccination rate by 10% or if the group was less than 50% vaccinated at the time

of the intervention then the target was to bring the group up to 50%. Due to the Omicron surge and the late introduction of the 5-11 vaccine into the pandemic, plans were not able to meet this goal for the 5-11 age group, and thus points were awarded based on meeting both the 12-17 and the 18+ target

**Quality Incentive Tiers:**

A percentage of total quality measure points and a percentage of satisfaction points is calculated for each plan. From those results, a blended final percentage is calculated weighting the final percentage 80% for quality points and adding the CAHPS Satisfaction points. Plans were grouped into one of five tiers based on the final percentage of the total score to determine the incentive award. Plans must achieve or exceed the threshold for the respective tier to be eligible for their award. Tier 1 indicates scores equal to or higher than 63.60, Tier 2 indicates scores between 48.28-63.59, Tier 3 indicates scores between 34.96-48.27, Tier 4 indicates scores between 28.65-34.95, and Tier 5 indicates scores lower than 28.65. Tiers were created before the introduction of the bonus points from the CVEP. Plans were only able to move up a maximum of one tier due to the CVEP bonus points. Quality incentive payments are subject to the availability of State funding as determined by the annual Budget process

## Section 3 Quality Incentive Award Results

For 2021, the thirteen NYS Medicaid Managed Care plans were grouped into five tiers based on their Quality Incentive scores. The table below shows the tier assigned to each plan. The 2021 Quality Incentive awards become effective for capitation rates and for auto-assignment preference on April 1, 2022.

MMC QUALITY INCENTIVE 2021								
INCENTIVE PREMIUM AWARD (%)	PLAN NAME	Quality Score (100 points)	Weighted Quality Score (80%)	Satisfaction Score (20 Points)	Sum of Quality and Satisfaction Scores	Compliance points (Up to - 10 points)	CVEP Bonus Points (10 points possible)	Total
TIER 1	Independent Health	64.1	51.28	16.65	67.93	-3	10	74.93
TIER 1	Healthfirst PHSP, Inc.	59.94	47.95	9.99	57.94	-1	10	66.94
TIER 1	Affinity Health Plan	66.6	53.28	13.32	66.6	-3	0	63.6
TIER 2	MetroPlus Health Plan	51.62	41.29	9.99	51.28	-3	0	48.28
TIER 3	CDPHP	47.45	37.96	9.99	47.95	-1	0	46.95
TIER 3	Excellus BlueCross BlueShield	41.63	33.3	13.32	46.62	-1	0	45.62
TIER 3	Highmark Western and Northeastern New York, Inc.	40.79	32.63	13.32	45.95	-1	0	44.95
TIER 3	Empire BlueCross BlueShield HealthPlus	34.97	27.97	9.99	37.96	-1	0	36.96
TIER 3	HIP (EmblemHealth)	34.97	27.97	9.99	37.96	-3	10	44.96
TIER 3	Fidelis Care New York, Inc.	32.47	25.97	9.99	35.96	-1	0	34.96
TIER 4	UnitedHealthcare Community Plan	29.97	23.98	9.99	33.97	-1	0	32.97
TIER 5	MVP Health Care	25.81	20.65	9.99	30.64	-2	0	28.64
TIER 5	Molina Healthcare	23.31	18.65	9.99	28.64	-1	0	27.64

If you have questions regarding the incentive premium award, please contact the Bureau of Managed Care Reimbursement at [bmcr@health.ny.gov](mailto:bmcr@health.ny.gov).

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

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