NEW YORK STATE | Department of Health

2020-2021 Quality Incentive Report

A Report on the Quality Incentive Program in New York State

QARR Report Series

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Section 1 Background

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 bonus was later increased in 2005 to its current value. 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 quality 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 (**HEDIS® and NYS-specific**)	30	100 points
Satisfaction – CAHPS® Health Plan Survey	3	20 points
Total Points		Sum of 80% of Quality points and 20% of Satisfaction points
Compliance (**Subtracted from Total**)	7	Up to 10 points
Final Score		Up to 100 points

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. For the 2020-2021 Incentive, the score thresholds for each tier were adjusted to blunt impacts in quality due to the COVID-19 pandemic. Tier 1 indicate scores higher than 70, Tier 2 indicates scores between 60-69.99, and Tier 3 indicates scores between 50-59.99. There were no Tiers 4 or 5 assigned to the 2020-2021 incentive results. The Quality Incentive methodology aligns with the Department's efforts to reward comprehensive quality care. The objective with the incentive methodology is to expand the scope of accountability and provide continued quality improvement.

The 2020-2021 Quality Incentive awards became effective for capitation rates and for auto-assignment preference on April 1, 2022.

Section 2 Quality Incentive Components and Calculation Process – 2020-2021 Methodology

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 2020-2021 Quality Incentive results:

- **Quality of Care**: 2020-2021 QARR results using 2020 data
- **Consumer Satisfaction**: The most recent CAHPS® survey for children in Medicaid, which was administered in the Fall of 2020 and results released in reports dated May 2021
- **Compliance**: Regulatory compliance information from 2019 and 2020

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 are included. This approach allows a 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 use a weighted average method (see equation below) to average each measure's individual indicator rates and calculate a measure score.

  Indicators with larger denominators contribute more to the scoring than indicators with smaller denominators. The attached list of measures identifies the measures with multiple indicators where the scores will be 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 are distributed evenly for all measure scores, and for measures with more than one indicator, each measure score will be counted as one measure. For example, if there are 30 measures in the quality section, each measure is worth up to 3.33 points.

- If a measure has less than 30 members in the denominator, we consider it to be a Small Sample Size (SS), and we suppress those results. There will be no reweighting for SS. If plan results are SS, there is an overall reduction of base quality points. For example, with 30 measures worth 100 possible points, if plan only has 29 measures, the base is reduced by the maximum value for that one measure.

- Measures are classified as Pay for Reporting (P4R) or Pay for Performance (P4P).

- For measures classified as P4R, full points are awarded for valid reporting of that measure regardless of the measure score. Hybrid measures reported administratively receive full P4R points.

- For measures classified as P4P, plans are awarded 50 percent of possible points for a measure result at or above the 50th percentile, but less than the 75th percentile; 75 percent of possible points for a measure result at or above the 75th percentile, but less than the 90th percentile; and 100 percent of possible points for the measure at or above the 90th percentile.

- The determination of the 50th, 75th, and 90th percentiles, for both P4P and P4R measures, are based on the same measurement year of the results. To determine the plans achieving the percentiles the results are rounded to two decimal points prior to the percentile determination.

- Each plan's quality points are totaled and then divided by their base points to achieve a quality score of up to 100%. The resulting quality score is 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.

Section 2 Quality Incentive Components and Calculation Process – 2020-2021 Methodology

Quality Measure Benchmarks for the 2020-2021 Medicaid Quality Incentive

Measure Name	90th Percentile	75th Percentile	50th Percentile	Points Possible
Primary Care				
Antidepressant Medication Management	50.75	50.21	47.00	3.33
Asthma Medication Ratio	66.59	66.03	64.02	3.33
Breast Cancer Screening	70.34	68.41	64.89	3.33
Cervical Cancer Screening	72.20	71.68	67.99	3.33
Chlamydia Screening in Women	77.08	76.21	67.61	3.33
Colorectal Cancer Screening	65.21	59.61	58.15	3.33
Comprehensive Diabetes Screening: Eye Exam	65.69	59.85	58.64	3.33
Comprehensive Diabetes Care: Poor Control *	32.15	36.98	39.26	3.33
Controlling High Blood Pressure	68.37	66.42	60.10	3.33
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	37.75	34.03	31.45	3.33
Kidney Health Evaluation for Patients With Diabetes	45.08	41.22	38.29	3.33
Statin Therapy for Patients with Cardiovascular Disease: Statin Adherence 80%	78.20	75.35	73.44	3.33
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	49.84	48.08	42.47	3.33
Children's Health				
Annual Dental Visit: Ages 2-18	53.38	52.33	49.07	3.33
Childhood Immunization: Combination 3	82.16	80.78	76.37	3.33
Immunizations for Adolescents: Combination 2	57.78	43.31	42.09	3.33
Well Child Visits in the First 30 Months of Life	80.37	79.95	74.89	3.33
Child and Adolescent Well-Care Visits	71.66	68.55	67.51	3.33
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	88.89	84.51	82.3	3.33
Mental Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.98	66.17	64.16	3.33
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.20	76.02	75.18	3.33
Follow-Up After Emergency Department Visit for Mental Illness: 7-day rate	72.17	63.67	52.87	3.33
Follow-Up After Hospitalization for Mental Illness: 7-day rate	68.53	65.93	63.60	3.33
Follow-Up Care for Children Prescribed ADHD Medication	68.75	62.84	58.77	3.33

Measure Name	90th Percentile	75th Percentile	50th Percentile	Points Possible
Metabolic Monitoring for Children and Adolescents on Antipsychotics	44.11	38.60	35.34	3.33
Substance Use				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 7-day rate	28.57	23.57	21.93	3.33
Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence	54.77	54.57	45.97	3.33
Maternity				
Timeliness of Prenatal Care	92.94	92.21	86.86	3.33
Postpartum Care	83.70	81.51	77.86	3.33
HIV				
Viral Load Suppression	81.97	80.44	74.82	3.33

* A low rate is desirable

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CAHPS Experience of Care Survey: (20 points possible)

Three CAHPS Experience of Care survey measures will be included in the Quality Incentive. Twenty points will be 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 2020-2021 Quality Incentive, the CAHPS scores from the children's survey conducted in the fall of 2020 was used. Plans are awarded points based on their scores **within the measurement year.** Plans earn 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 are totaled and then divided by their base points to achieve a satisfaction score of up to 100%. The resulting satisfaction score is weighted to be worth 20% of the final score.

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

Prevention Quality Indicators (PQIs): (0 points)

The Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) were not used in the 2020-2021 Quality Incentive.

Compliance: (10 points for subtraction)

The Compliance section includes seven categories: 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 2020-2021 includes submission requirements for Care Management data, Performance Improvement Project reports, performance matrices action plans, and focused clinical studies. In the 2020-2021 Quality Incentive, points from issues with Compliance will be subtracted from the total points prior to calculating the final percentage scores. The number of points 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 (2020).	MMCOR reports submitted for 2020	2 points for any SOD timeliness, completeness, or failure to meet reserves. No more than 2 points will be removed 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 (2019).	MMCOR reports submitted for 2019	
Quality Reporting Requirements	Any SOD for failure to submit required complete quality data for Care Management (CMART) data and QARR data (includes the required member-level file and the birth file) by the established deadlines for the measurement year (2020).	Quality Reporting Requirements for 2020 data	2 points for a SOD. No more than 2 points will be removed for this category.
	Any SOD related to the Performance Improvement Projects or the quality performance matrix process.	Quality reporting requirements for 2020	
	Any statement of deficiency related to a Focused Clinical Study (FCS).	FCS reporting requirements for 2020	

Section 2 Quality Incentive Components and Calculation Process – 2020-2021 Methodology

Category	Measure Description	Timeframe	Points
Plan Network	Any SOD issued for the measurement year (2019) 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 2020	1 point for any SOD. No more than 1 point will be removed for this item in the category.
	Any SOD for timeliness, incomplete, or inaccurate Provider Network Directory System (PNDS) or Panel Submission for measurement year (2020).	PNDS Quarterly submission for 2020 Panel Quarterly Submission for 2020	
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 (2020).	Provider Directory Information and Participation results for 2020	1 point for any SOD for either directory information or for provider participation. No more than 1 point will be removed for this item in the category.
Member Services	Any SOD or statement of findings for member services during the measurement year (2020) for failure to: maintain a functional member services phone line; provide correct information to callers; provide specific information upon written request.	Member services for 2020	1 point for any SOD or statement of findings for any of the three-member service items. No more than 1 point will be 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 (2020).	Parity reports submitted for 2020	1 point for any SOD for timeliness, completeness or for accuracy. No more than 1 point will be 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 (2020).	Claims payment and/or denials data for 2020	2 points for a statement of deficiency or statement of findings. No more than 2 points will be removed for this category.
Total			10 points

Section 2 Quality Incentive Components and Calculation Process – 2020-2021 Methodology

Quality Incentive Tiers:
A percentage of total quality measure points and 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 measures and 20% for CAHPS Satisfaction measures. Plans are grouped into one of three tiers based on the final percentage of the total score to determine the incentive award. The thresholds for the tiers are based on the distribution of the final percentage of points earned by the plans. As noted above, any award of funding associated with the determination of the final incentive tiers is subject to the availability of State funding as determined by the Annual Budget process.

Section 3 Quality Incentive Award Results

For 2020-2021, the thirteen NYS Medicaid Managed Care plans were grouped into three tiers based on their Quality Incentive scores. The table below shows the tier assigned to each plan. The 2020-2021 Quality Incentive awards become effective for capitation rates and for auto-assignment preference on April 1, 2022.

Medicaid Managed Care Quality Incentive Award 2020-2021

Incentive Premium Award	Plan Name	Initial Quality Score (up to 100%)	Initial Satisfaction Score (up to 100%)	80% of Quality Score	20% of Satisfaction Score	Compliance Points (up to 10 points for subtraction)	Total Score (up to 100%)
Tier 1	Independent Health	77.42	66.60	61.94	13.32	-1	74.26
Tier 2	CDPHP	74.09	49.95	59.27	9.99	-1	68.26
Tier 2	Highmark Western and Northeastern New York, Inc.	69.93	66.60	55.94	13.32	-1	68.26
Tier 2	MetroPlus Health Plan	77.42	33.30	61.94	6.66	-1	67.60
Tier 2	Excellus BlueCross BlueShield	71.60	49.95	57.28	9.99	-1	66.27
Tier 2	UnitedHealthcare Community Plan	66.60	66.60	53.28	13.32	-1	65.60
Tier 2	Fidelis Care New York, Inc.	69.93	49.95	55.94	9.99	-1	64.93
Tier 2	Affinity Health Plan	67.43	49.95	53.95	9.99	-1	62.94
Tier 2	MVP Health Care	62.44	66.60	49.95	13.32	-1	62.27
Tier 2	Healthfirst PHSP, Inc.	66.60	49.95	53.28	9.99	-1	62.27
Tier 2	Molina Healthcare	68.27	33.30	54.61	6.66	-1	60.27
Tier 3	Empire BlueCross BlueShield HealthPlus	61.61	49.95	49.28	9.99	-1	58.27
Tier 3	HIP (EmblemHealth)	65.77	33.30	52.61	6.66	-3	56.27

If you have questions regarding the incentive premium award, please contact the Bureau of Acute & Managed Care Reimbursement at (518) 473-8822.

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

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