NEW YORK STATE | Department of Health

# 2023 Medicaid Managed Care Quality Incentive Report

## A Report on the Medicaid Managed Care 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 on 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 the 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, holding health plans accountable for the care they provide, and rewarding 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. Each plan's quality points were totaled and then divided by their base points to achieve a quality score of up to 100%. The resulting quality percentage scores were weighted to be worth 80% of the final score. This weighting of the quality scores allows this section of the Quality Incentive to continue to retain a similar weight in the makeup of the overall scores. Each plan's satisfaction points were totaled up to 20 points maximum, resulting in a satisfaction score to be worth 20% of the final score. A maximum of 10 possible compliance 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**) | 36 | 100 points |
| Satisfaction – CAHPS® Health Plan Survey | 3 | 20 points |
| Total Points | | Sum of 80% of Quality points and 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.

# Section 2 Quality Incentive Components and Calculation Process – 2023 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 2023 Quality Incentive results:

- **Quality of Care**: 2023 Quality Assurance Reporting Requirements (QARR) (Measurement year 2023)
- **Consumer Satisfaction**: The most recent CAHPS® survey for Medicaid, which was administered in the fall of 2023 with results released in May 2024; and
- **Compliance**: Regulatory compliance information from 2022 and 2023

### 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, HIV, and Social Needs 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:

$$X = \frac{\sum_1^i \mathbf{n}_i * \mathbf{x}_i}{\sum_1^i \mathbf{n}_i}$$

  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 and more than 1 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.

## Section 2 Quality Incentive Components and Calculation Process – 2023 Methodology

- 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. Valid reporting of the measure requires a minimum denominator of 30. Denominator with sizes of 1 to 30 are SS. If there is a denominator of 0 then there will be 0 points awarded and there will be no reweighting.

- Follow-Up After Emergency Department Visit for Mental Illness (7 Days) was reclassified as P4R in the 2023 Quality Incentive and plans were awarded full points for this measure.

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

- The determination of the 50$^{th}$, 75$^{th}$, and 90$^{th}$ 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 to achieve a quality score of up to 100%. The resulting quality percentage scores were weighted to be worth 80% of the final score. This weighting of the quality scores allows this section of the Quality Incentive to continue to retain a similar weight in the makeup of the overall scores.

- NYS DOH reserves the ability to convert a P4P measure to a P4R if the measure has major updates that impact performance within the measurement year.

# Section 2 Quality Incentive Components and Calculation Process – 2023 Methodology

**Quality Measure Benchmarks for the 2023 Medicaid Quality Incentive**

| Measure Name | 90th Percentile | 75th Percentile | 50th Percentile | Points Possible |
|---|---|---|---|---|
| **Primary Care** | | | | |
| Adult Immunization Status Influenza (Ages 19-65) | 23.49 | 21.36 | 19.58 | 2.78 |
| Antidepressant Medication Management-84 days and 180 days (Composite) | 53.58 | 52.37 | 49.5 | 2.78 |
| Asthma Medication Ratio (Ages 5-64) | 74.69 | 73.31 | 71.05 | 2.78 |
| Breast Cancer Screening (ECDS) | 67.88 | 65.92 | 63.43 | 2.78 |
| Cervical Cancer Screening (ECDS) | 67.86 | 66.18 | 64.32 | 2.78 |
| Chlamydia Screening (Ages 16-24) | 80.43 | 76.13 | 71.26 | 2.78 |
| Colorectal Cancer Screening (Total) (ECDS) | 52.69 | 52.43 | 49.32 | 2.78 |
| Controlling High Blood Pressure | 74.21 | 72.5 | 68.5 | 2.78 |
| Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Using Antipsychotic Meds | 82.24 | 81.5 | 79.42 | 2.78 |
| Eye Exam for Patients With Diabetes | 68.13 | 61.8 | 59.56 | 2.78 |
| Hemoglobin A1c Control for Patients With Diabetes Poor HbA1c Control * | 26.13 | 27.25 | 29.49 | 2.78 |
| Initiation and Engagement in SUD Dependence Treatment (Composite) | 35.19 | 33.41 | 30.48 | 2.78 |
| Kidney Health Evaluation for Patients With Diabetes (Total) | 47.15 | 45.45 | 42.71 | 2.78 |
| COVID-19 Immunization Status (Composite) | 47.51 | 43.57 | 38.65 | 2.78 |
| **Children's Health** | | | | |
| Adolescent Immunization (Combo 2) (ECDS) | 51.83 | 45.95 | 39.76 | 2.78 |
| Oral Evaluation, Dental Services | NA | NA | NA | 2.78 |
| Child and Adolescent Well-Care Visits (Total) | 75.07 | 72.94 | 70.05 | 2.78 |
| Childhood Immunization Status (Combo 3)(ECDS) | 75.48 | 73.91 | 69.61 | 2.78 |
| Developmental Screening in the First Three Years of Life (Total) | 35.93 | 22.44 | 9.02 | 2.78 |
| Well-Child Visits in the First 30 Months of Life (First 30 Months) | 80.09 | 79.54 | 75.84 | 2.78 |
| **Mental Health** | | | | |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 66.18 | 64.34 | 61.87 | 2.78 |
| Follow-Up After Emergency Department Visit for Mental Illness Within 7 days | 63.91 | 59.06 | 55.72 | 2.78 |
| Follow-Up After Hospitalization for Mental Illness Within 7 Days | 74.21 | 68.17 | 65.29 | 2.78 |
| Follow-up for Children Prescribed ADHD Medication-Initiation and Continuation (Composite)(ECDS) | 67.3 | 63 | 59.03 | 2.78 |

| Measure Name | 90th Percentile | 75th Percentile | 50th Percentile | Points Possible |
|---|---|---|---|---|
| Metabolic Monitoring for Children and Adolescents on Antipsychotics | 52.35 | 50.98 | 44.65 | 2.78 |
| Depression Screening and Follow-Up for Adolescents and Adults (Composite) (ECDS) | 18.93 | 13.23 | 3.005 | 2.78 |
| **Substance Use** | | | | |
| Follow-Up After High-Intensity Care for Substance Use Disorder Within 7 Days | 45.15 | 43.15 | 39.81 | 2.78 |
| Follow-up After Emergency Department Visit for Substance Use Within 7 Days | 37.65 | 30 | 27.65 | 2.78 |
| Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder | 53.66 | 52.67 | 48.4 | 2.78 |
| Pharmacotherapy for Opioid Use Disorder | 35.84 | 35.55 | 32.98 | 2.78 |
| **Maternity** | | | | |
| Postpartum Care | 86.03 | 85.25 | 83.94 | 2.78 |
| Postpartum Depression Screening and Follow-Up (ECDS) | 13.37 | 9.43 | 6.68 | 2.78 |
| Prenatal Immunization Status Combination | 30.95 | 30.45 | 25.98 | 2.78 |
| Timeliness of Prenatal Care | 92.24 | 91.27 | 88.08 | 2.78 |
| **HIV** | | | | |
| Viral Load Suppression | 80.93 | 77.45 | 75.66 | 2.78 |
| **Social Needs** | | | | |
| Social Need Screening and Intervention (ECDS) | NA | NA | NA | 2.78 |

ECDS: Electronic Clinical Data System.

* 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 2023 Quality Incentive, the CAHPS scores from the survey conducted in fall 2023 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. If a plan had less than 30 people answer at least one of the questions used in a composite measure, then the measure is suppressed and noted with a SS. If a plan's results were SS, there was an overall reduction of base satisfaction points. Each plan's satisfaction points were totaled and then divided by their base points to achieve a satisfaction score of up to 100%. The resulting satisfaction percentage points were 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** |

### 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 2023 includes submission requirements for Care Management data, Performance Improvement Project reports, performance matrices action plans, and focused clinical studies. In the 2023 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 (2023). | MMCOR reports submitted for 2023 | 2 points for any SOD timeliness, completeness, or failure to meet reserves. No more |

| Category | Measure Description | Timeframe | Points |
|---|---|---|---|
| | Any SOD for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted the year prior to the measurement year (2022). | MMCOR reports submitted for 2022 | than 2 points were moved for this category. |
| 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 (2023). | Quality Reporting Requirements for 2023 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 2023 | |
| | Any statement of deficiency related to a Focused Clinical Study (FCS). | FCS reporting requirements for 2023 | |
| Plan Network | Any SOD issued for the measurement year (2023) 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 2023 | 1 point for any SOD. No more than 1 point were 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 (2023). | PNDS Quarterly submission for 2023 | |
| 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 (2023). | Provider Directory Information and Participation results for 2023 | 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. |

# Section 2 Quality Incentive Components and Calculation Process – 2023 Methodology

| Category | Measure Description | Timeframe | Points |
|---|---|---|---|
| Member Services | Any SOD or statement of findings for member services during the measurement year (2023) for failure to: maintain a functional member services phone line; provide correct information to callers; provide specific information upon written request. | Member services for 2023 | 1 point for any SOD or statement of findings for any of the three-member service items. No more than 1 point were 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 (2023). | Parity reports submitted for 2023 | 1 point for any SOD for timeliness, completeness or for accuracy. No more than 1 point were 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 (2023). | Claims payment and/or denials data for 2023 | 2 points for a statement of deficiency or statement of findings. No more than 2 points were removed for this category. |
| Total | | | 10 points |

# Section 3 Quality Incentive Award Results

**Quality Incentive Tiers**

The maximum number of points available for the incentive is 120, with 100 points from quality measures and 20 points from satisfaction measures. From those results, a final percentage is calculated based on an 80% weighting of the quality points and 20 available satisfaction points. Compliance points are subtracted from the total points. Plans were grouped into one of five tiers based on the final percentage of the total score to determine the incentive award. The thresholds for the five tiers were based on the distribution of the final percentage of points earned by the plans. Tier 1 indicates scores at 70.03 or higher, Tier 2 indicates scores between 62.26−70.02, Tier 3 indicates scores between 43.86−62.25, Tier 4 indicates scores between 35.81−43.85, and Tier 5 indicates scores at 35.80 or lower. 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.

For 2023, the twelve 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 2023 Quality Incentive awards become effective for capitation rates on April 1, 2025.

**MMC QUALITY INCENTIVE 2023**

February 2025

| Tier | 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) | Total Score |
|---|---|---|---|---|---|---|---|
| TIER 1 | Healthfirst PHSP, Inc. | 75.76 | 60.6 | 13.32 | 73.92 | -2 | 71.92 |
| TIER 1 | Independent Health | 66.72 | 53.38 | 16.65 | 70.03 | 0 | 70.03 |
| TIER 2 | CDPHP | 60.47 | 48.37 | 16.65 | 65.02 | 0 | 65.02 |
| TIER 3 | MetroPlus Health Plan | 74.37 | 59.49 | 0 | 59.49 | 0 | 59.49 |
| TIER 3 | Excellus BlueCross BlueShield | 51.43 | 41.14 | 16.65 | 57.79 | 0 | 57.79 |
| TIER 3 | Highmark Western and Northeastern New York, Inc. | 50.04 | 40.03 | 13.32 | 53.35 | 0 | 53.35 |
| TIER 3 | MVP Health Care | 47.26 | 37.81 | 13.32 | 51.13 | 0 | 51.13 |
| TIER 3 | Fidelis Care New York, Inc. | 54.21 | 43.37 | 6.66 | 50.03 | -2 | 48.03 |
| TIER 3 | HIP (EmblemHealth) | 47.26 | 37.81 | 9.99 | 47.8 | -2 | 45.8 |
| TIER 4 | Anthem BlueCross and BlueShield HP | 42.4 | 33.92 | 9.99 | 43.91 | -2 | 41.91 |
| TIER 5 | UnitedHealthcare Community Plan | 38.92 | 31.14 | 6.66 | 37.8 | -2 | 35.8 |
| TIER 5 | Molina Healthcare | 35.45 | 28.36 | 6.66 | 35.02 | 0 | 35.02 |

## Section 3 Quality Incentive Award Results

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

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

**Bureau of Quality Measurement and Evaluation**
**Office of Health Services Quality and Analytics**
Corning Tower, Room 1938
Empire State Plaza
Albany, New York 12237

Telephone: (518) 486-9012
Fax: (518) 486-6098
E-mail: nysqarr@health.ny.gov