NEW YORK STATE | Department of Health

2024 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 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®)
- Regulatory Compliance information

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 – 2024 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 2024 Quality Incentive results:

- **Quality of Care**: 2024 Quality Assurance Reporting Requirements
- **Consumer Satisfaction**: The most recent CAHPS® survey for Medicaid, which was administered in the fall of 2024, with results released in reports dated May 2025
- **Compliance**: Regulatory compliance information from 2023 and 2024

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 here 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 on 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:

$$X = \frac{\sum_1^i n_i \times x_i}{\sum_1^i n_i}$$

  Where *X* is the final measure score, which 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 had less than 30 members and more than 1 in the denominator, we considered it to be a Small Sample (SS) size and 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 had only 29 measures, the base was reduced by the maximum value for that one measure.

Section 2 Quality Incentive Components and Calculation Process – 2024 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 required a minimum denominator of 30. Denominators with sizes of 1 to 30 are SS. If there was a denominator of 0 then there were 0 points awarded and there was no reweighting.

- Follow-Up After Emergency Department Visit for Mental Illness (7 Days) was reclassified as P4R in the 2024 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 50th percentile, but less than the 75th percentile; 75 percent of possible points for a measured 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, was 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.

- The Department 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 – 2024 Methodology

Quality Measure Benchmarks for the 2024 Medicaid Quality Incentive

Measure Name	90th Percentile	75th Percentile	50th Percentile	Points Possible
Primary Care				
Adult Immunization Status Influenza (Ages19-65)	21.97	21.43	18.99	2.78
Antidepressant Medication Management-84 days and 180 days (Composite)	59.92	59.29	56.30	2.78
Asthma Medication Ratio (Ages 5-64)	80.54	79.80	77.29	2.78
Breast Cancer Screening (ECDS)	68.97	67.48	65.99	2.78
Cervical Cancer Screening (ECDS)	68.22	66.67	65.41	2.78
Chlamydia Screening (Ages 16-24)	80.85	75.80	71.80	2.78
Colorectal Cancer Screening (Total) (ECDS)	57.51	56.31	54.24	2.78
Controlling High Blood Pressure	77.61	75.20	71.32	2.78
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Meds	84.21	83.11	81.49	2.78
Eye Exam for Patients With Diabetes	69.39	66.74	62.27	2.78
Glycemic Status Assessment for Patients With Diabetes (Glycemic status >9%)*	19.90	21.90	26.82	2.78
Initiation and Engagement in SUD Dependence Treatment (Composite)	36.21	33.49	30.43	2.78
Kidney Health Evaluation for Patients With Diabetes (Total)	54.15	49.25	47.21	2.78
COVID-19 Immunization Status	4.60	4.17	3.26	2.78
Children's Health				
Adolescent Immunization (Combo 2) (ECDS)	53.16	45.81	39.20	2.78
Oral Evaluation, Dental Services	52.76	50.75	47.59	2.78
Child and Adolescent Well-Care Visits (Total)	77.33	74.52	72.73	2.78
Childhood Immunization Status (Combo 3) (ECDS)	75.19	72.81	67.23	2.78
Developmental Screening in the First Three Years of Life (Total)	49.69	35.81	15.90	2.78
Well-Child Visits in the First 30 Months of Life (First 30 Months)	82.42	81.79	78.92	2.78
Mental Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.88	68.73	65.30	2.78
Follow-Up After Emergency Department Visit for Mental Illness Within 7 days	64.80	63.08	56.03	2.78
Follow-Up After Hospitalization for Mental Illness Within 7 Days	72.73	69.69	64.00	2.78

Measure Name	90th Percentile	75th Percentile	50th Percentile	Points Possible
Follow-up for Children Prescribed ADHD Medication-Initiation and Continuation (Composite)(ECDS)	68.50	61.21	58.08	2.78
Metabolic Monitoring for Children and Adolescents on Antipsychotics	53.41	52.08	43.07	2.78
Depression Screening and Follow-Up for Adolescents and Adults (Composite) (ECDS)	32.84	21.20	5.88	2.78
Substance Use				
Follow-Up After High-Intensity Care for Substance Use Disorder Within 7 Days	49.22	47.31	43.29	2.78
Follow-up After Emergency Department Visit for Substance Use Within 7 Days	40.60	34.45	30.03	2.78
Initiation of Pharmacotherapy Upon New Episode of Opioid Use Disorder	61.75	59.96	49.33	2.78
Pharmacotherapy for Opioid Use Disorder	37.76	35.23	30.98	2.78
Maternity				
Postpartum Care	90.41	87.92	85.40	2.78
Postpartum Depression Screening and Follow-Up (ECDS)	17.11	11.20	7.57	2.78
Prenatal Immunization Status Combination (ECDS)	27.81	27.47	24.32	2.78
Timeliness of Prenatal Care	93.20	92.36	87.71	2.78
HIV				
Viral Load Suppression	82.44	80.98	78.28	2.78
Social Needs				
Social Need Screening and Intervention (ECDS)	14.94	2.11	0.95	2.78

* A low rate is desirable
ECDS: Electronic Clinical Data System.

Section 2 Quality Incentive Components and Calculation Process – 2024 Methodology

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 2024 Quality Incentive, the CAHPS scores from the survey conducted in fall 2024 with children 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.

CAHPS Measure	Satisfaction Points Possible
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 included seven areas: Statements of deficiency (SOD) for the Medicaid Managed Care Operating Report (MMCOR), QARR, plan network, provider directory, member services, behavioral health parity, and claim payments and/or denials. The Quality Reporting Requirement area for 2024 included submission requirements for Care Management data, Performance Improvement Project reports, performance matrices action plans, and focused clinical studies. In the 2024 Quality Incentive, points from issues with Compliance were subtracted from the total points prior to calculating the final percentage scores. The description and the number of points that may be subtracted are found below:

Category	Measure Description	Timeframe	Points
Medicaid Managed Care Operating Report (MMCOR)	Any SOD for timeliness, completeness, or failure to meet reserve requirements of MMCOR reports submitted for the measurement year (2024).	MMCOR reports submitted for 2024	2 points for any SOD timeliness, completeness, or failure to meet reserves. No more than 2 points were 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 (2023).	MMCOR reports submitted for 2023	
Quality Reporting Requirements	Any SOD for failure to submit required complete quality data for Care Management Assessment Reporting Tool	Quality Reporting Requirements for 2024 data	2 points for a SOD. No more than 2 points were removed for this category.

Category	Measure Description	Timeframe	Points
	(CMART) data and QARR data (includes the required member-level file and the birth file) by the established deadlines for the measurement year (2024).		
	Any SOD related to the Performance Improvement Projects or the quality performance matrix process.	Quality reporting requirements for 2024	
	Any SOD related to a Focused Clinical Study (FCS).	FCS reporting requirements for 2024	
Plan Network	Any SOD 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 2024	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.	PNDS Quarterly for 2024 Panel Quarterly for 2024	
Provider Directory	Any SOD for incomplete or inaccurate provider listings and/or failure to maintain at least 75% provider participation rate.	Provider Directory Information and Participation results for 2024	1 point for any SOD for either directory information or for provider participation. No more than 1 point were removed for this item in the category.
Member Services	Any SOD or statement of findings for member services for failure to maintain a functional member services phone line; provide correct information to callers; or provide specific information upon written request.	Member services for 2024	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.	Parity reports for 2024	1 point for any SOD for timeliness, completeness, or accuracy. No more than 1 point was removed for this category.

Category	Measure Description	Timeframe	Points
Claims Payment and/or Denials	Any statement of deficiency or statement of findings related to claims payment and/or denials issues for the year (2024).	Claims payment and/or denials data for 2024	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

A percentage of total quality measure points and a percentage of satisfaction points were calculated for each plan. From those results, a blended final percentage was calculated, weighting the final percentage 80% for quality measures and 20% for CAHPS satisfaction measures. Compliance points were 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. Plans must achieve or exceed the threshold for the respective tier to be eligible for their award. Tier 1 indicates scores at 61.60 or higher, Tier 2 indicates scores between 57.24−61.59, Tier 3 indicates scores between 34.63−57.23, Tier 4 indicates scores between 29.36−34.62, and Tier 5 indicates scores at 29.35 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 2024, 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 2024 Quality Incentive awards became effective for capitation rates on April 1, 2026.

Tier	Plan Name	Quality Score (100 points)	Weighted Quality Score (80%)	Satisfaction Points (20 Points)	Sum of Weighted Quality Scores and Satisfaction Points	Compliance Points (Up to -10 Points)	Total Score
Tier 1	Healthfirst PHSP, Inc.	72.98	58.38	9.99	68.37	-4	64.37
Tier 1	MetroPlus Health Plan	73.67	58.94	6.66	65.60	-4	61.60
Tier 2	Independent Health	62.55	50.04	16.65	66.69	-6	60.69
Tier 3	Highmark Western and Northeastern New York, Inc.	51.43	41.14	16.65	57.79	-4	53.79
Tier 3	CDPHP	49.35	39.48	16.65	56.13	-5	51.13
Tier 3	MVP Health Care	48.65	38.92	9.99	48.91	-4	44.91
Tier 3	Excellus BlueCross BlueShield	45.18	36.14	9.99	46.13	-3	43.13
Tier 3	HIP (EmblemHealth)	39.62	31.69	13.32	45.01	-6	39.01
Tier 3	Molina Healthcare	36.14	28.91	9.99	38.90	-4	34.90
Tier 4	Fidelis Care New York, Inc.	35.45	28.36	9.99	38.35	-4	34.35
Tier 5	Anthem BlueCross and BlueShield HP	33.36	26.69	6.66	33.35	-4	29.35
Tier 5	UnitedHealthcare Community Plan	29.19	23.35	6.66	30.01	-4	26.01

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

Section 3 Quality Incentive Award Results

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

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