Quality Assurance Reporting Requirements (QARR)

Overview

New York State Department of Health
Office of Health Insurance Programs
Division of Quality Improvement and Evaluation

OPEN Data NY

Quality Assurance Reporting Requirements (QARR)

GENERAL DESCRIPTION:

Public Health Law (Article 29-D Section 2995) stipulates the collection of health care data for the purposes of increasing the information available to patients about health care providers and health care plans, and improving the quality of health care in this state, by creating a statewide health information system, collecting health information for dissemination by means of such system, and studying additional uses of such information. The New York State Department of Health (NYSDOH) collects the health care data through an annual public reporting system called the Quality Assurance Reporting Requirements (QARR). Managed care organizations (licensed pursuant to Article 44) and preferred provider organizations (licensed pursuant to Article 32, 43 or 47) must report all applicable QARR measures annually.

QARR is largely based on measures of quality established by the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) with New York State-specific measures added to address public health issues of particular importance in New York. QARR also includes information collected using a national satisfaction survey methodology called CAHPS® (Consumer Assessment of Healthcare Providers and Systems). CAHPS data are collected every year for commercial enrollees. The NYSDOH sponsors a CAHPS survey for Medicaid managed care enrollees every two years. The most recent survey available was conducted in 2009.

Using QARR, you can determine how well a health plan performed in the areas of provider network, access and utilization, child and adolescent health, women's health, adult health, behavioral health, and satisfaction with care.

DATA COLLECTION METHODOLOGY:

Managed care health plans follow three sets of specifications when preparing QARR:

- HEDIS® Volume 2: Technical Specifications- for more information on the technical specifications see NCQA website (www.ncqa.org);
- Quality Assurance Reporting Requirements Technical Specifications Manual- for more information see the NYSDOH website (http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2011/docs/qarr_specifications_manual_2011.pdf); and
- CAHPS specifications- for more information see the AHRQ website (http://www.cahps.ahrq.gov/).

STATISTICAL AND ANALYTICAL ISSUES:

The data collection method used dictates how the statewide averages are represented for each measure. For the administrative data collection method, which includes all eligible members, statewide averages are calculated by taking the sum of the numerators divided by the sum of the denominators across plans. For the hybrid data collection method, due to the fact that these measures are based on a sample of the health plan eligible members, the statewide average is

calculated as a weighted average. Each health plan's rate is multiplied by their eligibles for that measure and then summed across plans and divided by the sum of the eligibles to create a weighted statewide average. For the survey data collection method statewide averages are the means of the case-mix adjusted plan means per the CAHPS methodology. When results are reported as a percentage of the eligible population (rates) level of significance denotes whether the plan's rate is statistically above (+) or below (-) the statewide average. A 95% confidence interval is calculated around each plan-specific rate using the formula below:

$$p \pm 1.96 \times \sqrt{\frac{p(1-p)}{n}}$$

where p = the organization's rate and n = the sample size

The plan rates are said to be statistically above or below the statewide average if the statewide average falls outside of the 95% confidence interval.

LIMITATIONS OF DATA USE:

QARR data is collected by health plans and the information is validated by a licensed organization. Only valid information is included in the data. Not all measures are collected each year. Some services require more resource intensive methods of collection, and these measures are often rotated to control collection burden.

Measure specification changes and health plan mergers and closures limit the ability to trend this data over time. Please use caution when attempting to compare measures and/or health plans over time. Please review each measure description carefully as some measures have different specifications for payers and cannot be compared across payers even within each year.

Several measures are reported as reported as inverted rates please refer to the measure descriptions. Numerators for inverted measures identify events of inappropriate care. The percentage of people getting inappropriate care is subtracted from 1 to allow presentation of the result as percentage receiving appropriate care. Caution should be used when analyzing numerators for inverted measures.

Plan-specific rates (percentages) are accompanied by a symbol to denote whether the plan's rate is statistically above (+) or below (-) the statewide average. When comparing plan rates and associated significance ratings, you may notice plans that have the same numerical rating but a different significance rating. While this may seem like an error, plan significance ratings are based on how much a plan's rate differs from the statewide average and the number of individuals included in the rate. Therefore, plans can have the same rate but have different significance ratings because their rates are based on different numbers of enrollees.

Variations and/or extremes in utilization are difficult to interpret for plans with low enrollment. For this reason, plans with fewer than 30 eligible members are excluded from the statistical calculations of the percentiles, but are still included in the calculation of the statewide averages. All rates based on denominators of less than 30 are suppressed.