

2009 Quality Assurance Reporting Requirements

Technical Specifications Manual

(2009 QARR/ HEDIS® 2010)



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2009 Quality Assurance Reporting Requirements
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(2009 QARR/ HEDIS® 2010)

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I. Submission Requirements

2009 QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and New York State-specific measures. This version of QARR incorporates measures from HEDIS® 2010. The major areas of performance included in the 2009 QARR are:

- 1) Effectiveness of Care
 - 2) Access to/Availability of Care
 - 3) Satisfaction with the Experience of Care
 - 4) Use of Services
 - 5) Health Plan Descriptive Information
 - 6) NYS-specific measures (Adolescent Preventive Care, HIV/AIDS Comprehensive Care, Appropriate Asthma Medications 3 or more controllers, Prenatal Care measures from the Live Birth file, and Enrollment by Product Line)
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Who Must Report

- Article 44 licenses**
- All managed care organizations certified by the New York State Department of Health (NYS DOH) prior to 2009 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
 - Plans certified during 2009 are required to submit **Enrollment by Product Line** and any other measures where members meet HEDIS eligibility criteria.
 - Special Needs Plans certified prior to 2009 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Article 32, Article 43, and Article 47 licenses**
- All Preferred Provider Organizations/Exclusive Provider Organizations (PPO/EPO) licensed by the New York State Department of Insurance (DOI) prior to 2009 must report all QARR measures **if there are more than 30,000 members** from New York State in PPO/EPO products as of December 31, 2009. **Members with dental-only, vision-only, and student coverage-only products are excluded when determining eligible membership for QARR.**
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What to Report

Table 1 lists, by product, the NYS-specific and HEDIS® 2010 measures required for submission. This manual describes in detail only the NYS-specific measures. Plans must purchase the HEDIS® 2010 Technical Specifications for descriptions of the required HEDIS® measures. Plans should always follow HEDIS® 2010 guidelines when calculating continuous enrollment periods.

Important Note: Only data for **New York State residents** should be used to calculate results for QARR and CAHPS measures. Members living outside of New York State should be removed from all QARR and CAHPS calculations, including Enrollment by Product. If commercial organizations are unable to remove out-of-state residents due to inclusion of contractual groups in their QARR process, the out-of-state members may be included in the calculations. However, commercial plans should limit this to contracts originating in New York State. NYS DOH calculates CAHPS results for commercial PPO and Commercial HMO plans and all responses from out-of-state residents are removed.

Reporting by payer is as follows:

- **Commercial PPO (CPPO):** PPO/EPO plans are required to submit all measures indicated in the Reporting Requirements section (Table 1). PPO/EPO product data should be reported separately for all licensed organizations with sufficient enrollment unless there is agreement

I. Submission Requirements

from NCQA authorizing the combining of PPO and HMO/POS data. **REMINDER: Plans must report required measures for which there is an eligible population. Plans may not designate a measure as 'NR –plan chose not to report'.**

- Members who have any of the 'medical' benefit, as defined by HEDIS® should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and should be included in applicable measures.
 - **Commercial HMO/POS (CHMO):** Commercial plans are required to submit all measures indicated in the Reporting Requirements section (Table 1). **REMINDER: Plans must report required measures for which there is an eligible population. Plans may not designate a measure as 'NR –plan chose not to report'.**
 - Point of Service (POS): Follow HEDIS® 2010 instructions regarding commercial point-of-service products. Plans must state on the 2009 QARR New York State Data Submission System whether POS is included in their commercial HMO rates.
 - PPO/EPO: If plans are submitting combined PPO and HMO data, the NCQA agreement needs to be submitted to NYS DOH and plans must state on the 2009 QARR New York State Data Submission System whether PPO is included in their commercial HMO rates.
 - **Family Health Plus Employer Buy-In (FHPEBI):** FHPEBI plans are required to submit all measures indicated in the Reporting Requirements section (Table 1). Plans should follow commercial specifications in HEDIS® 2010 and QARR 2009 NYS specific measures for the required measures.
 - **Child Health Plus (CHP):** Child Health Plus (CHP) plans are required to submit all measures indicated in the Reporting Requirements section (Table 1) and CHP plans should follow the Medicaid specifications in HEDIS® 2010.
 - **Medicaid HMO/PHSP (MA):** Medicaid managed care plans are required to submit all measures indicated in the Reporting Requirements section (Table 1). Plans should include Family Health Plus enrollees in their Medicaid product line for the 2009 reporting year submission. Family Health Plus members should also be included in all Medicaid file submissions.
 - Medicaid member-level files are required. The fee-for-service (FFS) enhancement files are optional.
 - **Medicaid HIV Special Needs Plans (HIVSNP):** HIVSNPs are required to submit all measures indicated in the Reporting Requirements section (Table 1). Plans should follow Medicaid specifications in HEDIS® 2010 and QARR 2009 NYS specific measures.
 - Medicaid member-level files are required. The fee-for-service (FFS) enhancement files are optional.
 - **Medicare:** With the exception of Enrollment by Product Line, plans should **not** submit Medicare information. Plans participating in Medicaid Advantage (dual eligible program) are **NOT** required to submit Medicare data for QARR 2009.
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Measure Rotation

The following HEDIS®/QARR measures will be rotated for the 2009 measurement year, according to the HEDIS® 2010 rotation schedule with one addition from New York State. Plans are not required to submit these measures. For reporting purposes, previous year's rates will be used for rotated measures.

- Frequency of Ongoing Prenatal Care
 - Controlling High Blood Pressure
 - Cervical Cancer Screening for Medicaid (CPPO and CHMO must report this measure for QARR 2009)
 - Prenatal and Postpartum Care
 - Relative Resource Use measures (all six conditions)
-

I. Submission Requirements

New Measure Requirements

There is one new measure required for the QARR 2009 measurement year: (indicates product lines)

- CAHPS: Aspirin Use and Discussion (CPPO, CHMO)

HEDIS® 2010 has a new measure which **will not** be required for QARR 2009

- Immunization of Adolescents (CPPO, CHMO, MA, CHP) **WILL NOT** be required for QARR 2009

Plans should follow the designated specifications noted on Table 1.

Use of Supplemental Databases

What are they?

Supplemental databases are sources of information designated by HEDIS® 2010 (General Guidelines 39 and 40, Volume 2, HEDIS® 2010) which may be used like administrative data in the calculation of measures. Supplemental data is intended to allow for additional information to be gathered that is relevant to the HEDIS® measures and is not captured in the transaction systems of administrative data.

The types of files, data sources and transformation processes dictate how the data must be collected, managed and audited in order to allow the incorporation of information in the database for HEDIS®/QARR reporting.

How are supplemental databases used by health plans?

Health plans use supplemental databases to capture information on services and events used for numerator-compliance and optional exclusions for various HEDIS®/QARR measures. The information may also contain data that could affect eligible population criteria. However information from supplemental databases can only be used for eligible population criteria for hybrid measures before the denominator of a measure is determined. Once the denominator of a hybrid measure has been determined, members cannot be removed or added from the denominator due to information in the supplemental database that affects eligibility criteria.

The information captured from data sources must comply with HEDIS® 2010 guidelines for timing, file type, data elements, transformation processes and procedures for maintaining systems and data integrity. All supplemental databases must be approved by the organization's auditor for inclusion in rate calculation. Plans are encouraged to contact auditors and seek approval of processes and tools as early as possible to ensure information is allowed for HEDIS® /QARR reporting. NYS DOH sought clarification from NCQA regarding supplemental databases and their application to measures.

- Databases may contain data from ongoing projects. The projects may include the entire membership, the HEDIS® population or the non-compliant members. Plans are encouraged to gather data throughout the measurement year or early in the reporting year.
- Plans must capture the appropriate data elements and have approved policy and procedures in place for the data collection, transmission, and management of information. This must be reviewed and approved by the organization's auditor.
- Data transformation needs documentation of mapping of codes or details of crosswalks containing relevant codes, descriptions and clinical information. **Auditors must review the transformation processes and crosswalks to verify clinical appropriateness of the transformation and approve the transformation.** All transformation documents must be submitted with the Final Audit Report from the plan. For example, if the plan is using documentation in medical records to gather information about co-morbid conditions, the crosswalk of codes with clinical documentation descriptions used for the transformation would be required for submission with the Final Audit Report.

I. Submission Requirements

- Primary source verification for each data source used in the supplemental database will be conducted by the organization's auditor. Auditor results of the primary source verification for each data source will be required and collected in the New York State Data Submission System (DSS). For external standard and non-standard files, the auditor will indicate 'Pass' or 'Fail' for the primary source verifications result on the DSS. For internal files, the primary source verification results will be the number of records passing review over the number of records reviewed. The information included on the DSS will be the name of each database, the measures that included data from the database in the rate calculation, the data source(s) for each database, and the result of primary source verification for each data source. For example, if a plan used one supplemental database with two data sources, the primary source verification result for each of the two data sources will be included.
- Primary source verification for databases using medical records (both EMR and paper) is similar to the over-read conducted for hybrid measures. Results of the primary source verification will be included on the DSS. Transformation documents detailing the crosswalk of clinical documentation descriptions to codes will be submitted with the Final Audit Report from the plan.

All NYS plans will be submitting information about supplemental databases on the New York State Data Submission System (DSS), and with the Final Audit Report. The information for each supplemental database includes:

Completed by the organization's auditor on the DSS:

1. **name** of the supplemental database;
2. all **measures** that used information from the supplemental database;
3. the **data sources**; and
4. the **primary source verification result** for each data source.

Submitted with the Final Audit Report from the plan:

5. If the data source involves code mapping or data transformation, the **procedure used to map codes or transform data** should be included.
6. If documentation from medical records (either paper records or EMRs) is being transformed into codes, **the crosswalk of relevant codes, descriptions and clinical information and all related tools (such as abstraction tools or provider attestation forms)** should be included.

All Medicaid managed care plans will need to have this information submitted in order for their data to be used in the Quality Incentive for Medicaid managed care.

How to Report

All plans must submit QARR data on the New York State Data Submission System (DSS), which will be sent directly to plans by IPRO. Estimated completion date for the 2009 DSS is March 2010. It will be sent to all reporting organizations shortly thereafter.

Where to Report

All files will be sent electronically for QARR 2009. No materials will be mailed.

Any plan who fails to submit the files by 5:00 p.m. ET on the date due will receive a Statement of Deficiency for failure to comply with quality program requirements. For Medicaid plans, the compliance portion of the Quality Incentive may be affected by these statements of deficiency.

I. Submission Requirements

The completed QARR DSS files and commercial CAHPS files, must be received by NYS DOH no later than **5:00 p.m. ET on June 15, 2010**. All files should be emailed to Maria Amodeo at mca01@health.state.ny.us.

The Medicaid optional enhancement files, Medicaid member-level files, and the Live Birth files (all due no later than 5:00 p.m. ET on June 15, 2010) should be submitted electronically to IPRO via an FTP site. FTP site arrangements can be made with Paul Henfield of IPRO. Mr. Henfield can be reached at phenfield@ipro.org.

What to Send for Submission

All must be received electronically by 5:00 p.m. ET on June 15, 2010 by the designated party.

- DSS database file for CPPO, CHMO, FHPEBI, CHP, MA, and HIVSNP (email to Maria Amodeo at mca01@health.state.ny.us)
 - CAHPS member-specific file for CPPO and CHMO (email password-protected to Maria Amodeo at mca01@health.state.ny.us with the password sent in a separate email)
 - Medicaid member level file for MA and HIVSNP (to IPRO via FTP)
 - Optional enhancement files for MA and HIVSNP (to IPRO via FTP)
 - Prenatal Care Live Birth files for CPPO, CHMO, FHPEBI, MA and HIVSNP (to IPRO via FTP)
-

Questions concerning the 2009 submission should be directed to the following individuals:

- **Data Submission System (DSS):** Lisa Balistreri (ebalistreri@ipro.org) of IPRO at (516) 326-7767 ext. 357.
- **FTP sites:** Paul Henfield (phenfield@ipro.org) of IPRO at (516) 326-7767 ext. 670.
- **HEDIS® 2010 measures:** Updates can be found on NCQA's web site: www.ncqa.org. Questions can be submitted to policysupport@ncqa.org. NYS DOH is not responsible for the interpretation of HEDIS specifications or updating HEDIS information. Plans should always refer to HEDIS specifications when calculating HEDIS measures as part of QARR.
- **All other questions:** Quality Measurement Unit of NYS DOH at nysqarr@health.state.ny.us or (518) 486-9012.

II. Reporting Requirements

✓: Required measure
NR: Not required

Table 1: 2009 QARR/HEDIS 2010 - Table of Required Measures

Measure	Flag	Product Lines						Specifications To Use	Medicaid Member Level File Required
		Commercial		FHP EBI	Child Health Plus	Medicaid/FHP			
		PPO	HMO/POS			HMO/PHSP	HIV SNP		
Effectiveness of Care									
Adolescent Preventive Care Measures	1	✓	✓	NR	✓	✓	NR	NYS Specific	Yes
Adult BMI Assessment		✓	✓	NR	NR	✓	✓	HEDIS 2010	Yes
Annual Monitoring for Patients on Persistent Medications		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Antidepressant Medication Management		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Appropriate Asthma Medications 3 or more controller dispensing events		✓	✓	✓ (12-50)	✓ (5-11)	✓	✓ (12-50)	NYS Specific	Yes
Appropriate Testing for Children with Pharyngitis		✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Appropriate Treatment for Children with Upper Respiratory Infection		✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis		✓	✓	✓	NR	✓	NR	HEDIS 2010	Yes
Breast Cancer Screening		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Cervical Cancer Screening	2	✓	✓	✓	NR	NR	NR	HEDIS 2010	No
Childhood Immunization Status		✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Chlamydia Screening in Women	3	✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Cholesterol Management for Patients with Cardiovascular Conditions		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Colorectal Cancer Screening		✓	✓	NR	NR	NR	NR	HEDIS 2010	No
Comprehensive Diabetes Care		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Controlling High Blood Pressure	4	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		✓	✓	✓	NR	✓	NR	HEDIS 2010	Yes
Flu Shots for Adults Ages 50 - 64	5	✓	✓	NR	NR	✓	NR	CAHPS 4.0H	No
Follow-Up After Hospitalization for Mental Illness	3	✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes

PPO – Preferred Provider Organization
HMO/POS – Health Maintenance Organization/Point of Service
FHP EBI – Family Health Plus Employer Buy-In
PHSP – Prepaid Health Services Plan
HIVSNP – HIV Special Needs Plan

Flag

1 = Use members in WCC for 12-17 strata.
2 = Rotated for Medicaid 2009 MY per HEDIS.
3 = Enhancement file optional for Medicaid.
4 = Rotated for 2009 MY per HEDIS.

5 = DOH conducting Medicaid CAHPS.
6 = Rotated for 2009 MY per DOH.
7 = Administrative method only for QARR.
8 = Medicaid follow commercial proc. codes
9 = Commercial plans follow Medicaid specs.

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Follow-Up Care for Children Prescribed ADHD Medication	3	✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
HIV/AIDS Comprehensive Care		NR	NR	NR	NR	✓	✓	NYS Specific	Yes
Immunizations for Adolescents	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Lead Screening in Children	9	✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Medical Assistance with Smoking Cessation	5	✓	✓	NR	NR	✓	NR	CAHPS 4.0H	No
Persistence of Beta-Blocker Treatment After a Heart Attack		✓	✓	✓	NR	NR	NR	HEDIS 2010	No
Pharmacotherapy Management of COPD Exacerbation		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Use of Appropriate Medications for People with Asthma		✓	✓	✓ (12-50)	✓ (5-11)	✓	✓ (12-50)	HEDIS 2010	Yes
Use of Imaging Studies for Low Back Pain		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Use of Spirometry Testing in The Assessment and Diagnosis of COPD		✓	✓	✓	NR	✓	✓	HEDIS 2010	Yes
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Access / Availability of Care									
Adult Access to Preventive/Ambulatory Care		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Annual Dental Visit		NR	NR	NR	✓	✓	NR	HEDIS 2010	Yes
Children's Access to PCPs		✓	✓	NR	✓	✓	NR	HEDIS 2010	No
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment		✓	✓	NR	NR	NR	NR	HEDIS 2010	No
Prenatal and Postpartum Care	4	NR	NR	NR	NR	NR	NR	HEDIS 2010	No

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		Commercial		FHP EBI	Child Health Plus	Medicaid/FHP			
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Health Plan Descriptive Information									
Board Certification		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Enrollment by Product Line		✓	✓	✓	✓	✓	✓	NYS-Specific	No
Cost of Care									
Relative Resource Use for People with Asthma	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Relative Resource Use for People with Acute Low Back Pain	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Relative Resource Use for People with Cardiovascular Conditions	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Relative Resource Use for People with COPD	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Relative Resource Use for People with Diabetes	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Relative Resource Use for People with Uncomplicated Hypertension	6	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Use of Services									
Well-Child Visits in the First 15 Months of Life	7	✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Well-Child Visits in the 3rd, 4th, 5th & 6th Year	7	✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Adolescent Well-Care Visits	7	✓	✓	NR	✓	✓	NR	HEDIS 2010	Yes
Ambulatory Care		✓	✓	✓	✓	✓	✓	HEDIS 2010	No
Frequency of Ongoing Prenatal Care	4	NR	NR	NR	NR	NR	NR	HEDIS 2010	No
Frequency of Selected Procedures									
Myringotomy		✓	✓	NR	✓	✓	NR	HEDIS 2010	No
Tonsillectomy		✓	✓	NR	✓	✓	NR	HEDIS 2010	No
Non-obstetric Dilation & Curettage		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Hysterectomy, vaginal & abdominal		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Cholecystectomy, open & closed		✓	✓	✓	NR	✓	✓	HEDIS 2010	No

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		PPO	HMO/POS			HMO/PHSP	HIV SNP		
Back Surgery		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Angioplasty (PTCA)	8	✓	✓	✓	NR	✓	NR	HEDIS 2010	No
Cardiac Catheterization	8	✓	✓	✓	NR	✓	NR	HEDIS 2010	No
Coronary Artery Bypass Graft (CABG)	8	✓	✓	✓	NR	✓	NR	HEDIS 2010	No
Prostatectomy	8	✓	✓	✓	NR	✓	NR	HEDIS 2010	No
Mastectomy		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Lumpectomy		✓	✓	✓	NR	✓	✓	HEDIS 2010	No
Identification of Alcohol and Other Drug Services		✓	✓	NR	NR	NR	NR	HEDIS 2010	No
Inpatient Utilization (General Hospital-Acute Care)		✓	✓	✓	✓ (0 -18)	✓	✓	HEDIS 2010	No
Mental Health Utilization		✓	✓	✓	NR	✓	NR	HEDIS 2010	No
Antibiotic Utilization		✓	✓	✓	✓ (0 -18)	✓	✓	HEDIS 2010	No
Satisfaction with the Experience of Care									
Satisfaction Survey	5	✓	✓	NR	NR	✓	NR	CAHPS 4.0H	Commercial de-identified member file
NYS-Specific Prenatal Care Measures									
Risk-Adjusted Low Birth Weight	These prenatal care measures will be calculated by the Office of Health Insurance Programs using the birth data submitted by plans and the Department's Vital Statistics Birth File. Commercial PPO, HMO/POS, FHP EBI, Medicaid HMO/PHSP and Medicaid HIVSNP are required to submit live birth files.								
Prenatal Care in the First Trimester									
Access to Facilities for High-Risk Deliveries									

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7 = Administrative method only for QARR.
8 = Medicaid follow commercial proc. codes.
9 = Commercial plans follow Medicaid specs.

III. Audit Requirements

- All organizations must contract with an NCQA-licensed audit organization for an audit of their commercial PPO, commercial HMO, FHP EBI, Child Health Plus, Medicaid HMO QARR data, as applicable.
- The Prepaid Health Services Plans (PHSPs) will be participating in a NYS DOH-sponsored audit conducted by IPRO. When applicable, the NYS DOH-sponsored audit of the PHSPs will include CHP. HIVSNPs will be participating in a NYS DOH-sponsored audit.
- All organizations must send a copy of the written agreement with an NCQA-licensed audit organization by **March 1, 2010**. PHSPs and HIVSNPs participating in the NYS DOH-sponsored audit do not have to submit this agreement. **The copy can be sent via email to:**

Maria Amodeo
Division of Quality and Evaluation
Office of Health Insurance Programs
Email: mca01@health.state.ny.us

- It is recommended that health plans provide a draft version of the DSS to their auditor along with the Medicaid enhancement files, Medicaid member-level files, and live birth files prior to the June 15 deadline (recommended by June 1, 2010). Auditors should check for accuracy and that the specified variables in these files and the DSS reconcile.
- All NYS plans will be submitting information about supplemental databases on the New York State Data Submission System (DSS), and with the Final Audit Report. The information for each supplemental database includes:

Completed by the organization's auditor on the DSS:

1. **name** of the supplemental database;
2. all **measures** that used information from the supplemental database;
3. the **data sources**; and
4. the **primary source verification result** for each data source.

Submitted with the Final Audit Report from the plan:

5. If the data source involves code mapping or data transformation, the **procedure used to map codes or transform data** should be included.
6. If documentation from medical records (either paper records or EMRs) is being transformed into codes, **the crosswalk of relevant codes, descriptions and clinical information and all related tools (such as abstraction tools or provider attestation forms)** should be included.

All Medicaid managed care plans will need to have this information submitted in order for their data to be used in the Quality Incentive for Medicaid managed care.

- A copy of the Final Audit Report, including identified problems, corrective actions and measure-specific results, must be submitted to the Office of Health Insurance Programs upon receipt from your auditor (due to the Office of Health Insurance Programs by **July 30, 2010** via email to mca01@health.state.ny.us). The Final Audit Report must contain audit validation signatures.
- The Office of Health Insurance Programs requires plans to submit data for all measures for which there is an eligible population. Plans may not designate a measure as 'NR--plan chose not to report this measure'.

IV. Reporting Schedule

The following table includes the dates when various components are due and to whom the submission should be sent.

	Due Date and Destination	Organizations
NCQA Licensed Audit Organization		
Copy of written agreement with a NCQA licensed organization that indicates all products included in the audit.	Due: March 1, 2010 To: NYS DOH via email	<ul style="list-style-type: none"> • PPO • HMO/POS • FHPEBI
QARR Submission		
Data Submission System (DSS) file of the access database It is encouraged that plans send a version of the DSS two weeks prior to the submission deadline. This review may pick up issues that can be corrected prior to submission and will help plans make the submission deadline.	Due: June 15, 2010 by 5:00 p.m. ET To: NYS DOH via email	<ul style="list-style-type: none"> • PPO • HMO/POS • PHSP • FHPEBI • HIVSNP
Additional File Submission		
<ol style="list-style-type: none"> 1. Live Birth File (required for Commercial PPO, Commercial HMO/POS, FHPEBI, Medicaid HMO/PHSP, and Medicaid HIVSNP plans) 2. Medicaid Member-level file (required for Medicaid HMO/PHSP and HIVSNP plans) 3. Medicaid Enhancement files (optional for Medicaid HMO/PHSP and HIVSNP plans) <p>It is encouraged that plans send a version of the DSS and additional files two weeks prior to the submission deadline. This review may pick up issues that can be corrected prior to submission and will help plans make the submission deadline.</p>	Due: June 15, 2010 by 5:00 p.m. ET To: IPRO via FTP site	<ul style="list-style-type: none"> • PPO • HMO/POS • PHSP • FHPEBI • HIVSNP
CAHPS Files		
Commercial Adult Survey – de-identified member-level files of CAHPS responses are required. Follow NCQA CAHPS file layout for file submission.	Due: June 15, 2010 by 5:00 p.m. ET To: NYS DOH via password-protected email	<ul style="list-style-type: none"> • PPO • HMO/POS
Final Audit Reports		
A copy of the Final Audit Report, including findings, corrective actions and measure-specific results with signatures is required. Final Audit Report submissions are required to include the specified information for all supplemental database use.	Due: July 30, 2010 To: NYS DOH via email	<ul style="list-style-type: none"> • PPO • HMO/POS • PHSP • FHPEBI • HIVSNP

NYS DOH requires all reporting entities to submit the NYS Data Submission System database on June 15, 2010 before close of business (5:00 p.m. ET). Organizations who do not submit the database by this deadline will be given a Statement of Deficiency for failure to meet program requirements for performance data reporting. Plans unable to meet the deadline submission may request an extension for submission **prior** to June 15, 2010. Sufficient reasons for the extension request must be provided with the request and only those requests that have been approved will be acknowledged.

NYS DOH email: Maria Amodeo mca01@health.state.ny.us
 IPRO FTP site: Paul Henfield phenfield@ipro.org

V. Measures Specific to New York State Reporting

ADOLESCENT PREVENTIVE CARE MEASURES

Commercial PPO, Commercial HMO/POS, Child Health Plus, and Medicaid HMO/PHSP

Description

The percentage of adolescents ages 12 to 17 who had at least one had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, receiving the following four components of care during the measurement year:

1. Assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity,
2. Assessment or counseling or education for depression,
3. Assessment or counseling or education about the risks of tobacco usage, and
4. Assessment or counseling or education about the risks of substance use (including alcohol and excluding tobacco).

Note:

- o The health plan may count services that occur over multiple visits toward this measure as long as all services occur within the measurement year and were provided by a PCP or OB/GYN.
 - o The health plan may include sick visits that occur within the measurement year.
 - o The health plan is encouraged to include all visits and records in this review, even if the visits were provided by a practitioner other than the one to which the member is assigned.
-

Eligible Population

Product lines: Commercial PPO, Commercial HMO/POS, Child Health Plus, and Medicaid HMO/PHSP

The eligible population for these measures will be derived from the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) denominator from HEDIS® 2010. Adolescents in the denominator of the 12 to 17 year old cohort of the WCC measure become the denominator for the NYS-specific Adolescent Preventive Care (APC) measures. For example, plans using the hybrid method with a sample for the WCC measure will use the members in the sample in the 12 to 17 age strata as the eligible population for this NYS-specific measure.

Plans should follow the HEDIS® 2010, Volume 2 specifications for Weight Assessment and Counseling for Nutrition and Physical Activity (WCC). The organizations using a hybrid sample for the WCC should use the same sample for APC. **If the organization applies optional exclusions to WCC measure and uses the WCC systematic sample, the same members will be excluded from the APC measures. Plans may not apply optional exclusions to the APC that were not removed from the WCC measure.**

Screening Tools

Notation that a particular tool was used without noting which areas were assessed, counseled or discussed, would not be a positive numerator finding. If a checklist is used and included in the medical record or there is a reference to the areas covered, the notations would be positive numerator events. For example, a notation that AMA GAPS was done would not be acceptable.

V. Measures Specific to New York State Reporting

If the notation stated the tool was used and sexual activity, depression, tobacco and substance use were reviewed; these would be considered positive numerator findings for the four topic areas.

Acronyms and Other Terms

The use of acronyms to document topics covered during a visit may be allowed if the acronym is widely used and if there is a statement from the provider about what the acronym references. For example, HEADSS may be noted in a record, and may count as evidence of addressing topics if the provider indicates that the acronym stands for **H**ome environment, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence AND that all topics are covered when the acronym is used in the records. In literature regarding HEADSS, the drugs topic includes tobacco. For this example, providers who use HEADSS as a notation with the statement that this indicates all topics were covered would be numerator-compliant for all four numerators. Acronyms and terms that are not commonly used or are developed by a provider or practice are not accepted as notation unless there is a statement from the provider that the acronym or term indicates a particular topic each time the provider uses the acronym or term.

Numerator 1: Assessment or Counseling or Education on Risk Behaviors and Preventive Actions Associated with Sexual Activity

Documentation in the medical record of assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity during the measurement year.

Discussion on **abstinence, current behaviors, family planning, condom use, contraceptives, HIV, STDs, pregnancy prevention, and safe sex** are positive findings. The documentation can include:

- Notations of assessment of current behaviors (e.g. abstinent, sexually active)
- Use of a checklist indicating any of the above noted topics were discussed
- Notation of assessment for treatment or testing for HIV/STDs
- Notation of counseling for treatment or testing for HIV/STDs
- Notation of referral for treatment or testing for HIV/STDs
- Notation of a prescription or dispensing for contraceptives with any of the above mentioned documentation, including assessment
- Notation of discussion on “sex”, “safe dating”
- Distribution of educational materials to the member, specifically geared towards risk behaviors and preventive actions

The following are not positive findings:

- No evidence of assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity
- Assessment or counseling or education prior to or after the measurement year
- A pregnancy test alone or an STD or HIV test alone, without any of the above mentioned documentation, including assessment
- Notation of a prescription or dispensing for contraceptives, without any of the above mentioned documentation, including assessment
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that sexual activity topics were addressed

V. Measures Specific to New York State Reporting

Numerator 2: Assessment or Counseling or Education on Depression

Documentation in the medical record of assessment or counseling or education on depression during the measurement year. The documentation can include:

- Notation from a health assessment about the adolescent's depressive symptoms during the measurement year
- Notation of assessment for behavior and mood (may include comprehensive findings related to depressive symptoms such as sleep, stress, coping. The assessment should be in the context of screening for depression, rather than assessment of a single symptom alone.)
- Use of a checklist indicating that depression or symptoms of depression were addressed (sad, down, hopeless or suicidal ideation, behavior and mood)
- Inquiry of depression (e.g. "denies depression", "depression – none", "depression-yes or no")
- Inquiry as to whether the member felt down, depressed, hopeless or suicidal ideation
- Inquiry as to whether the member felt little interest or pleasure in doing things
- Notation of counseling or referral for treatment of depression
- Diagnosis of depression during the measurement year
- Prescription of antidepressant medications or discussion of antidepressants (for depression and not for off label uses such as smoking cessation)
- Notation of treatment for depression in the measurement year
- Notation of counseling on symptoms of depression or where to get help
- Notation of education on symptoms, treatment or strategies to deal with depression
- Distribution of educational material which may include symptoms of depression, treatment alternatives, red flag warnings and where to get help

The following are not positive findings:

- No assessment or counseling or education on depression
- Mental health treatment for other conditions (e.g. ADHD)
- Assessment or counseling or education on depression prior to or after the measurement year
- Use of 'psychiatric' or 'mental health' check boxes or global statements of 'normal' without indication that depression screening specifically included
- Use of a checklist indicating mental health was addressed, without specific reference to depression
- Notation of assessment or counseling or education of a single symptom, such as sleep patterns, without any other reference to screening for other symptoms related to depression
- Prescription of antidepressant medications for smoking cessation

Numerator 3: Assessment or Counseling or Education About the Risks of Tobacco Usage

Documentation in the medical record of assessment or counseling or education about the risks of tobacco use during the measurement year. Tobacco use includes, but is not limited to, cigarettes, chew, or cigars. The following elements are positive findings:

- Notations about current or past behavior regarding tobacco use
- Use of a checklist indicating topic was addressed
- Notation of counseling or treatment referral
- Notation of prescription for smoking cessation medication
- Distribution of educational materials to the member, pertaining to tobacco use
- Notation of "anticipatory guidance" for tobacco use
- Notation of discussion of exposure to secondhand smoke

V. Measures Specific to New York State Reporting

The following are not positive findings:

- No Assessment/ Counseling/ Education about the risks of tobacco usage
- Assessment/ Counseling/ Education prior to or after the measurement year
- Prescription or dispensing of medications that have uses beyond cessation (such as antidepressants) without any of the above documentation.
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that tobacco use was addressed

Numerator 4: Assessment or Counseling or Education About the Risks of Substance Use (Including Alcohol and Excluding Tobacco Use)

Documentation in the medical record of an assessment or counseling or education about the risks of substance use during the measurement year. Substance use includes, but is not limited to, alcohol, street drugs, non-prescription drugs, prescription drugs misuse, and inhalant use.

The following elements are positive findings:

- Notations about current or past behavior regarding substance use or alcohol use.
- Use of a checklist indicating topic was addressed
- Notation of counseling or treatment referral
- Distribution of educational materials to the member pertaining to substance or alcohol use (not tobacco)
- Notation of “anticipatory guidance” for substance use or alcohol use
- Only one topic is needed for a positive numerator finding. For example, assessments do not need to include both alcohol and marijuana to count.

The following are not positive findings:

- Assessment/ Counseling/ Education about proper use of prescription drug(s) intended for the adolescent
- No Assessment/ Counseling/ Education about the risks of substance use
- Assessment/ Counseling/ Education about tobacco use only
- Assessment/ Counseling/ Education prior to or after the measurement year
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that substance use was addressed

V. Measures Specific to New York State Reporting

HIV/AIDS Comprehensive Care Medicaid HMO/PHSP and Medicaid HIVSNP

HIV/AIDS Comprehensive Care measures include quality indicators of recommended treatment and preventive care for people living with HIV/AIDS who are enrolled in Medicaid managed care. The measures are New York State specific and were primarily derived from quality of care indicators used by the Department's AIDS Institute.

Three measures for QARR 2009 are required and will included in all public reports for 2010. Cervical Cancer screening is rotated for QARR 2009 and will not be reported to NYS DOH.

Eligible Population:

Product Line: Medicaid HMO/PHSP, Medicaid HIVSNP

Ages: See specific measures

Continuous Enrollment: 12 months continuous enrollment for the measurement year. The allowable gap is no more than one month during the measurement year.
Anchor Date: December 31 of the measurement year.

Index Episode Event: Identify members as having HIV or AIDS who met at least one of the following criteria **during the year prior to the measurement year** with at least one of the 4 methods listed below:

Method 1 One inpatient stay with HIV/AIDS as the DRG or a primary or secondary diagnosis from the facility during an inpatient stay (Table HIV-A);

Table HIV-A: Inpatient DRG and ICD-9-CM Codes for HIV and AIDS

Description	NYS APDRG Codes	NYS APRDRG Codes	MS DRG Codes	ICD-9-CM Diagnosis Codes
HIV/AIDS	700-716	890, 892, 893, 894 (severity levels 1-4 for all APRDRG)	969-977	042

Method 2 Two outpatient visits with primary or secondary diagnosis (Table HIV-B) and two antiretroviral (ARV) dispensing events (Table HIV-C) between January 1, 2008 and December 31, 2008 (the year prior to the measurement year). A dispensing event is one prescription of an amount lasting 30 days or less. To convert dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down. For example, one ARV prescription dispensed on 1/1/2008 with a 60 day supply would count as 2 dispensing events;

Table HIV-B: ICD-9-CM Diagnosis Codes for HIV and AIDS

Description	ICD-9-CM Diagnosis
HIV/AIDS	042

V. Measures Specific to New York State Reporting

- Method 3 Three encounters in any outpatient setting with a primary or secondary diagnosis code indicating HIV/AIDS (Table HIV-B) on different dates of services between January 1, 2008 and December 31, 2008 (the year prior to the measurement year);
- Method 4 Four dispensing events for ARV medications (Table HIV-C) between January 1, 2008 and December 31, 2008 (the year prior to the measurement year) **AND** without a primary or secondary diagnosis of Hepatitis B or HTLV-1 in any setting (Table HIV- D). A dispensing event is one prescription of an amount lasting 30 days or less. To convert dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down. For example, a prescription with a 90 day supply would count as 3 dispensing events;

Table HIV- C: 2008 NDC Codes to Identify Antiretroviral Medications

NDC Codes
00003196401, 00003196501, 00003196601, 00003196701, 00003196801, 00003362312, 00003362412, 00003363112, 00004024515,
00004038039, 00006057062, 00006057143, 00006057318, 00006057340, 00006057342, 00006057354, 00006057362, 00006057465,
00056047030, 00056047330, 00056047492, 00056051030, 00074194063, 00074395646, 00074395977, 00074663322, 00087663241,
00087663341, 00087667117, 00087667217, 00087667317, 00087667417, 00173010793, 00173010855, 00173010856, 00173011318,
00173047001, 00173047100, 00173050100, 00173059500, 00173059502, 00173066100, 00173066101, 00173066200, 00173066300,
00173066400, 00173069100, 00173071400, 00597004660, 00597004724, 49999006206, 49999011906, 52959050712, 52959050718,
52959050724, 52959050802, 52959050804, 52959050806, 52959050808, 52959050814, 52959050815, 52959050860, 52959050906,
52959050912, 52959050918, 52959050920, 52959050924, 52959050928, 52959050930, 52959054602, 52959054603, 52959054604,
52959054606, 52959054608, 52959054628, 54348061809, 54348061902, 54569405300, 54569405400, 54569422100, 54569452400,
54569452401, 54569452402, 54569453800, 54569454303, 54569456100, 54569461100, 54569488300, 54569517600, 54569519100,
54569533400, 54569537400, 54569548000, 54569550100, 54569550400, 54569552100, 54569552500, 54569862000, 54868197400,
54868197402, 54868197403, 54868250401, 54868335200, 54868335201, 54868335300, 54868336000, 54868344800, 54868369300,
54868369900, 54868369901, 54868369902, 54868378201, 54868378203, 54868384400, 54868384401, 54868394700, 54868411300,
54868411400, 54868452000, 54868452200, 54868466600, 54868466900, 54868485300, 54868485400, 54868485700, 55289038904,
55289038906, 55289038920, 55289039203, 55289047727, 58016069018, 60760001018, 60760001063, 60760059504, 60760059514,
61958040101, 61958060101, 63010001030, 63010001190, 63010002036, 63010002118, 00173072100, 54569553000, 54569553200,
54868495400, 54569555000, 58016069900, 58016069930, 58016069960, 58016069990, 52959050730, 52959054610, 52959054614,
52959028930, 58016068900, 58016068930, 58016068960, 58016068990, 58016079500, 58016079530, 58016079560, 58016079590,
58016069000, 58016069030, 58016069060, 58016069090, 58016086400, 58016086430, 58016086460, 58016086490, 58016069800,
58016069830, 58016069860, 58016069890, 63010002770, 54868506100, 49999038618, 61958070101, 49999043103, 00173074200,
49999006210, 54868514100, 54569558800, 54569560200, 54569559400, 54569557300, 00555058801, 00555058901, 00555059001,
54569564200, 54569564300, 00074663330, 00004024451, 68115009006, 54569565600, 55887023030, 55887023060, 55887023090,
55887023130, 54569566400, 68115036006, 00597000302, 00054005221, 63304092060, 65862002460, 65862004824, 00074679922,
61958060201, 54569575200, 68258914201, 68258910701, 68258910801, 68258912601, 68258900301, 68258902101, 68258902001,
68258915801, 16590006418, 16590006430, 16590006460, 16590006490, 16590006106, 58016045500, 58016045502, 58016045530,
58016045560, 58016045590, 54569578100, 54868556600, 55045348201, 55045348103, 52959013418, 54868559500, 54868466800,
54868560000, 55289094712, 65862010701, 59676056001, 15584010101, 54569580500, 55045354901, 13411019102, 13411019103,
13411019106, 13411019109, 13411019110, 13411019202, 13411019203, 13411019206, 13411019209, 13411019210, 13411019302,
13411019303, 13411019306, 13411019309, 13411019310, 54569581400, 00003362212, 00490702600, 00490702630, 00490702660,
00490702690, 00490702800, 00490702802, 00490702830, 00490702860, 00490702890, 54569586400, 55289038914, 54868563100,
23490708706, 49999006260, 00173072700, 54868452201, 54868369302, 00069080760, 00069080860, 00006022761, 54868541600,
00074052260, 67253010910, 54569603400, 35356006860, 35356006760, 00006057301, 35356007560, 35356006530, 35356006624,
35356007460, 35356007330, 35356006990, 35356007160, 35356007224, 35356007030, 35356006430, 54868564300, 54868580900,
54868583800, 54868546400, 59676057001, 16590006110, 35356011006, 35356011406, 35356011330, 35356011701, 35356007306,
35356011506, 35356010906, 35356007006, 35356011160, 35356011201, 35356011606, 35356006406, 54868586400, 35356007106,
35356006806, 35356006706, 35356013960, 35356013830, 35356007506, 35356011230, 52959038706, 54868011700, 59676056201,
35356020860, 35356020960, 35356020660, 35356011060, 35356020760, 35356011301, 35356020530, 35356011530, 35356010930,
35356011660, 31722050960, 35356011430, 35356013918, 35356025930, 52959054615, 35356028460, 35356028560

V. Measures Specific to New York State Reporting

Table HIV-D: ICD-9-CM Diagnosis Codes for Hepatitis B or HTLV 1

Description	ICD-9-CM Diagnosis Codes
Hepatitis B	070.30, 070.31, 070.32, 070.33, V02.61
HTLV 1	079.51

- Exclusions:
- 1.) Medicare and Medicaid dual eligible members as of December 31 of the measurement year.
 - 2.) Any member found to be HIV negative during the measurement year or the year prior. Evidence for determining HIV negative status include: negative HIV or PCR test result, documentation in the medical record of HIV negative status, or provider attestation of HIV negative status for the member. Evidence must be dated for the measurement year or the year prior. Attestations may be obtained from providers after the measurement year as long as the document specifies the measurement year or the year prior. For example, in reviewing a record in March 2010, no evidence of HIV is found and this is confirmed with the provider. An attestation dated in March 2010 stating the member's HIV negative status for 2008 – 2009 would be accepted as evidence for excluding this member from the eligible population.

The measures will have denominators from the eligible population as appropriate to the indicator.

Engaged in Care

The percentage of members from the eligible population who had 2 outpatient visits for physician services of primary care or HIV related care, on two different dates of service occurring at least 182 days apart. The intent of this indicator is to measure the percentage of members who are receiving ongoing primary care for their HIV and preventive health care needs. Plans may include practitioners who are primarily responsible for a member's HIV related care. In this measure, all primary care providers would be included (family practice, internal medicine, pediatricians and OB/GYN), as well as infectious disease providers. Do not count visits with specialists that may provide a service related to HIV, but would not be the primary provider for HIV care (such as cardiologist, dermatologist, etc.). In addition, services that do not involve physician services should not be counted (such as laboratory and transportation services).

ADMINISTRATIVE SPECIFICATIONS

- Denominator: All members of the eligible population ages 2 and older as of December 31, 2009.
- Numerator: Outpatient Visits are defined by Tables HIV-E and HIV-F. For numerator compliance, each member will have two visits meeting criteria for Table HIV-E **OR** HIV-F occurring at least 182 days apart, within the measurement year.

V. Measures Specific to New York State Reporting

Table HIV-E: Codes to Identify Outpatient Visits

Description	CPT	UB-92 Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	
Prolonged services	99354-99355	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	
Other evaluation and management services	99499	
Clinic		051x
Freestanding clinic		052x
Professional fee, outpatient services		0982
Professional fees, clinic		0983

Table HIV-F: Codes to Identify Well Child Visits

Diagnosis Codes (V-codes)	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
Procedure Codes (CPT codes)	99381 – 99385, 99391 – 99395

Viral Load Monitoring

The percentage of members from the eligible population who had two viral load tests performed at least 182 days apart during the measurement year.

ADMINISTRATIVE SPECIFICATIONS

Denominator: All members of the eligible population ages 2 and older as of December 31, 2009.

Numerator: Two viral load tests (Table HIV-H) conducted on different dates of service at least 182 days apart within the measurement year.

Table HIV-H: CPT Codes to Identify a Viral Load Test:

CPT Codes	87534-87536
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Syphilis Screening Rate

The percentage of members from the eligible population who have had one syphilis screen performed within the measurement year.

ADMINISTRATIVE SPECIFICATIONS

Denominator: All members of the eligible population ages 19 and older as of December 31, 2009.

Numerator: One syphilis screening test performed in the measurement year (Table HIV-J).

Table HIV-J: CPT Codes to Identify a Syphilis Screen:

CPT Codes	86592-86593
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V. Measures Specific to New York State Reporting

Appropriate Asthma Medication Three or More Controller Dispensing Events Commercial PPO, Commercial HMO/POS, Child Health Plus, FHPEBI, Medicaid HMO/PHSP and HIVSNP

This measure reflects the percentage of individuals with persistent moderate to severe asthma who had 3 or more dispensing events of qualifying controller medications during the measurement year. This NYS-specific measure uses the HEDIS® 2010 Use of Appropriate Medications for People with Asthma for ages 5 – 50 to establish the denominator. HEDIS® 2010 NDC codes for controller medications will also be used. Numerator-compliant members will have three or more dispensing events.

Product lines:

Commercial PPO, Commercial HMO, and Medicaid HMO/PHSP for ages 5-50
Child Health Plus for ages 5-11
FHPEBI and HIVSNP for ages 12-50

Eligible Population and Denominator: Follow HEDIS® 2010 specifications for Use of Appropriate Medications for People with Asthma (ASM) (Volume 2). This is not age stratified. Report all members ages 5 to 50 together. If plans are applying optional exclusions for this NYS-specific measure, the denominator may be different from the ASM denominator.

	HEDIS ASM (1 controller)	QARR NYS Asthma (3 or more controllers)
Eligible Population	HEDIS p123 Step 1 and 2	HEDIS p123 Step 1 and 2
Optional Exclusion Definition	Members noncompliant for one qualifying controller medication dispensing event for HEDIS with valid exclusions removed	Members noncompliant for three or more qualifying controller medication dispensing events for QARR with valid exclusions removed
	*As the source code programs for the two measures are separate, members with valid exclusions may be in the HEDIS denominator and not in the QARR denominator due to the difference in the definition of numerator noncompliance between the two measures.	
Denominator	Eligible Population minus HEDIS exclusions	Eligible Population minus QARR exclusions
Numerator Events	HEDIS numerator compliant	QARR numerator compliant
Measure Rate	HEDIS rate	QARR rate

Administrative Specification

Numerator: For each person, determine three dispensing events for preferred therapy during the measurement year (refer to Table ASM-D, HEDIS® 2010, Volume 2). If the member was numerator compliant for the HEDIS measure, the dispensing event for the HEDIS measure should be included in dispensing events for this measure.

- Use the HEDIS® 2010 definitions to determine dispensing events.
- Plans that have members in different product lines throughout the measurement year should use pharmacy data from each product to determine numerator compliance.

V. Measures Specific to New York State Reporting

Definitions

Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.
Multiple prescriptions dispensed on the same day	<p>Multiple prescriptions for different medications dispensed on the same day should be assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, the organization should sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.</p> <ul style="list-style-type: none">• <i>Two prescriptions</i> for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each)• <i>Two prescriptions</i> for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each)• <i>Two prescriptions</i> for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days)• <i>Two prescriptions</i> for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days)
Inhaler/Injection dispensing event	Inhalers and injections count as one dispensing event. For example, an inhaler with a 90-days supply is considered one dispensing event. In addition, multiple inhalers or injections of the same medication (as identified by Drug ID in the NDC list) filled on the same date of service should be counted as one dispensing event. For example, a member may obtain two inhalers on the same day (one for home and one for work), but intend to use both during the same 30-day period. The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

V. Measures Specific to New York State Reporting

PRENATAL CARE MEASURES/BIRTH FILE

Commercial PPO, Commercial HMO/POS, FHPEBI, Medicaid HMO/PHSP and HIVSNP

The following prenatal care performance measures will be calculated by the Office of Health Insurance Programs using the birth data submitted by plans and from the Department's Vital Statistics Birth File.

- Risk-Adjusted Low Birthweight Rate
The adjusted rate for infants with birth weights less than 2500 grams. Only live births are used in this analysis.
- Prenatal Care in the First Trimester
The rate of continuously enrolled (ten months or more) women with a live birth who had their first prenatal care visit in the first trimester, defined as a prenatal care visit within 90 days of the date of last normal menses. For this analysis, the first prenatal care visit is defined as the date of the first physical and pelvic examinations performed by a physician, nurse practitioner, physician's assistant and/or certified nurse midwife at which time pregnancy is confirmed and a prenatal care treatment regimen is initiated.
- Low Birthweight Deliveries at Facilities for High-Risk Deliveries and Neonates
The percentage of women delivering a live low birthweight or very low birthweight baby at a high-risk facility (Perinatal Care Level II/III/IV).

Calculation of the Measures

Upon receipt of the list of mothers who gave birth during **the measurement year (January 1, 2009 through December 31, 2009)** DOH staff will employ a multistage matching algorithm to link information provided by plans to the Vital Statistics Birth File. Risk-adjustment models will also be used to calculate low birthweight rates. Using the data submitted by the plans, and from the Department's Vital Statistics Birth File, risk factors or confounding factors such as race, age, plurality, education level and complications of labor and delivery will be used to construct a predictive model. Risk-adjusted rates are more comparable across plans because the methodology takes into account that these risk factors are beyond the plans' control.

The Vital Statistics File provides information on the first prenatal care visit, the number of visits, birthweight, type of delivery, age, race, level of education and maternal risk factors associated with labor and delivery. Matching plan data to the birth certificate data improves the data reporting by allowing for: 1) the calculation of performance measures using the same DOH data source, and, 2) the risk adjustment of the measures when applicable.

Reporting Requirements

Plans are to report all live births that occurred during the period of **January 1, 2009 to December 31, 2009** to the Office of Health Insurance Programs. Information provided will be used to link to the Vital Statistics Birth File. The following information is required:

- Mother's Last Name: (List mother more than once in cases of multiple births.)
- Mother's First Name
- Mother's Date of Birth
- Mother's Resident Zip Code at Time of Delivery
- Date of Delivery. (The date of delivery is a critical field for matching to the Department's Vital Statistics Birth File. The mother's admission date is not on the Vital Statistics Birth File, nor is it necessarily the same as the date of delivery. However, if the date of delivery is truly

V. Measures Specific to New York State Reporting

unavailable, the Office of Health Insurance Programs will use the mother's admission date to obtain the highest match rate possible.)

- Hospital of Delivery (PFI). (A list of current hospital PFI codes appears on the Health Provider Network. To access the listing, go to the HPN Main Page, select Programs, Office of Managed Care, Provider Network Data Systems, Operating Facility Codes, Hospital Listing. If delivery occurred at a Birthing Center a valid PFI can be found in the Diagnostic & Treatment Centers (clinics) file, also under Operating Facility Codes.)
- Mother's Date of Admission
- Number of Enrollment Days Prior to Delivery
- Most Recent Enrollment Date
- Most Recent Disenrollment Date
- Mother's Medicaid ID Number
- Baby's Medicaid ID Number

The plan's data will be formatted in a file as described in the following reporting Specifications:

Format: Standard ASCII file with all entries left justified unless otherwise indicated.

Separate files for each product line.

Commercial PPO: Submit one diskette containing commercial PPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-89.

Commercial HMO/POS: Submit one diskette containing commercial HMO/POS members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-89.

FHPEBI: Submit one diskette containing FHPEBI members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-89.

Medicaid HMO/PHSP: Submit one diskette containing Medicaid members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-105.

Medicaid HIVSNP: Submit one diskette containing HIVSNP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-105.

Eligible Group

The eligible group will include all deliveries resulting in live births, to New York State residents occurring during the period of January 1, 2009 to December 31, 2009. Identify the women who had at least one live birth during the measurement period for whom the plan is the primary payer. Please follow HEDIS® 2010 specifications for the Access/Availability of Care: Prenatal and Postpartum Care for identification of the eligible group.

Record Format for all Product lines

Element Name	Location	Coding	Notes
Mother's Last Name	1-20	Left Justified	No numeric entries. List mother more than once in the case of multiple births.
Mother's First Name	21-35	Left Justified	Do not include middle initial or punctuation
Mother's Date of Birth	36-43	DDMMYYYY	Year must include four digits (e.g., 1975)
Mother's Resident Zip Code at Time of Delivery	44-48	Right Justified	No blanks, use 99999 if unknown

V. Measures Specific to New York State Reporting

Element Name	Location	Coding	Notes
Date of Delivery	49-56	DDMMYYYY	Year must include four digits (e.g., 2009)
Hospital of Delivery	57-61	Left Justified	Please use 88888 for 'out of state'; 99999 for 'unknown hospital'; and 11111 for 'not in hospital' birth. <i>PFI numbers for birth centers are now available, see note below for coding these facilities. If using a four digit PFI*, it must be LEFT justified. Do not add a leading zero.</i>
Mother's Date of Admission	62-69	DDMMYYYY	Year must include four digits (e.g., 2009)
Number of Enrollment Days Prior to Delivery	70-73	Right Justified	Number of days that the mother was enrolled in the plan during the 12 month period immediately prior to delivery. Cannot be a negative number.
Most Recent Enrollment Date	74-81	DDMMYYYY	Most recent enrollment date prior to delivery. Do not count the annual renewal date as the Most Recent Enrollment Date if already enrolled.
Most Recent Disenrollment Date	82-89	DDMMYYYY	Most recent disenrollment date prior to delivery. If there is no disenrollment date, enter 99999999. Enrollment and Disenrollment Dates are requested to indicate any break in prenatal care while in the managed care plan.
Mother's Medicaid ID Number	90-97	AA#####A	Omit for commercial; it is not applicable. (Medicaid only)
Baby's Medicaid ID Number *	98-105	AA#####A	Omit for commercial; it is not applicable. (Medicaid only)

***New for 2009 QARR: Failure to report the Baby's Medicaid ID number could result in a penalty in the Medicaid Quality Incentive**

Important Note: A list of current hospital PFI codes appears on the Health Provider Network (HPN). To access the listing, go to the HPN Main Page, select Programs, Division of Managed Care, Provider Network Data Systems, Operating Facility Codes, Hospitals. *Valid birth center PFI codes can be found in the Diagnostic & Treatment Centers (clinics) file, also under the Operating Facility Codes page.*

V. Measures Specific to New York State Reporting

Header Record: To be submitted in standard ASCII format as the first record on the file.

HEADER FORMAT:

Element	Location	Coding
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified
Product Line	21-38	Commercial PPO, Commercial HMO/POS, FHPEBI, Medicaid HMO/PHSP, or HIVSNP
Number of deliveries on diskette	39-43	Right justified
Date diskette written	44-51	DDMMYYYY

Technical Assistance: If you need clarification of prenatal data requirements and/or assistance creating a flat ASCII file, please contact Raina Josberger at (518) 486-9012.

V. Measures Specific to New York State Reporting

ENROLLMENT BY PRODUCT LINE

Commercial PPO, Commercial HMO/POS, FHPEBI, Child Health Plus, Medicaid HMO/PHSP and HIVSNP

Data Collection Specifications

Plans will report the member months, stratified by age and gender, for enrollees for the measurement year for each of the following product lines, as applicable:

- Commercial Preferred Provider Organization/Exclusive Provider Organization (excluding dental, vision and student blanket enrollment)
- Commercial HMO/POS (include Healthy NY and direct pay members as applicable)
- Family Health Plus Employer Buy-In
- Child Health Plus
- Medicaid HMO/PHSP (include Family Health Plus)
- Medicaid HIVSNP

Plans will use the HEDIS® 2010 Enrollment by Product format (Table ENP-1/2/3, Volume 2) for reporting the data. Unlike HEDIS®, Medicaid members will not be broken into subcategories. All Medicaid members should be reported collectively and will also include Family Health Plus members.

Calculate the subtotal percentages within each eligibility category by dividing the total subtotal member months into total member months by sex (e.g., [the number of member months of enrolled Medicaid males, 0–19 divided by the number of member months for all Medicaid males, i.e., 0–90+ and age unknown] x 100 = the percent of member months for Medicaid males, 0–19 years of all male Medicaid member months).

Table ENP-1/2/3: Member Months of Enrollment by Product Line

Age	Male	Female	Total
<1	_____	_____	_____
1-4	_____	_____	_____
5-9	_____	_____	_____
10-14	_____	_____	_____
15-17	_____	_____	_____
18-19	_____	_____	_____
<i>0-19 Subtotal:</i>	_____	_____	_____
<i>0-19 Subtotal (%):</i>	_____ %	_____ %	_____ %
20-24	_____	_____	_____
25-29	_____	_____	_____
30-34	_____	_____	_____
35-39	_____	_____	_____
40-44	_____	_____	_____
<i>20-44 Subtotal:</i>	_____	_____	_____
<i>20-44 Subtotal (%):</i>	_____ %	_____ %	_____ %

V. Measures Specific to New York State Reporting

Age	Male	Female	Total
45-49	_____	_____	_____
50-54	_____	_____	_____
55-59	_____	_____	_____
60-64	_____	_____	_____
<i>45-64 Subtotal:</i>	_____	_____	_____
<i>45-64 Subtotal (%):</i>	_____ %	_____ %	_____ %
65-69	_____	_____	_____
70-74	_____	_____	_____
75-79	_____	_____	_____
80-84	_____	_____	_____
85-89	_____	_____	_____
≥90	_____	_____	_____
<i>≥65 Subtotal:</i>	_____	_____	_____
<i>≥65 Subtotal (%):</i>	_____ %	_____ %	_____ %
Age unknown	_____	_____	_____
<i>Total:</i>	_____	_____	_____

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Medicaid Member-level File and Optional Enhancements File Submissions

Medicaid Member-level File for Medicaid HMO/PHSP and HIVSNP

The Office of Health Insurance Programs (OHIP) will be evaluating measures using the Medicaid Encounter Data System (MEDS II) and member-level data. Additionally, applicable measures will be evaluated using fee-for-service data to determine whether out-of-plan services were used by enrollees and would possibly impact plan rates. For specific file formats, refer to the specifications for the member-level file and the enhancement files that follow.

Measure	Required Medicaid Member-level File	Optional Enhancements
Adolescent Preventive Care	✓	
Adult BMI Assessment	✓	
Annual Monitoring for Patients on Persistent Mediations	✓	
Antidepressant Medication Management	✓	
Appropriate Asthma Medications 3 or More Controller Dispensing Events	✓	
Appropriate Testing for Children with Pharyngitis	✓	
Appropriate Treatment for Children with Upper Respiratory Infection	✓	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓	
Breast Cancer Screening	✓	
Childhood Immunization Status	✓	
Chlamydia Screening in Women	✓	✓
Cholesterol Management for Patients with Cardiovascular Conditions	✓	
Comprehensive Diabetes Care	✓	
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓	
Follow Up after Hospitalization for Mental Illness	✓	✓
Follow Up Care for Children Prescribed Attention-Deficit/Hyperactivity disorder (ADHD) Medication	✓	✓
HIV Comprehensive Care	✓	
Lead Screening in Children	✓	
Pharmacotherapy Management of COPD Exacerbation	✓	
Use of Appropriate Medications for People with Asthma	✓	
Use of Imaging studies for Low Back Pain	✓	
Use of Spirometry Testing in Assessment and Diagnosis of COPD	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓	
Annual Dental Visit	✓	
Well Child Visits in the First 15 months of life	✓	
Well Child Visits in the 3 rd , 4 th , 5 th & 6 th year	✓	
Adolescent Well Care Visits 12-21 years	✓	

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Medicaid Member-level File (Required)

For the measures listed above, please submit a file for each product as applicable for Medicaid HMO/PHSP and Medicaid HIVSNP, listing all the members included in the denominator according to the following layout. Plans are required to submit these member-level files for their Medicaid product lines. For measures that are not required for HIVSNPs, the columns will be zero filled.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

QARR 2009 Member-Level File Specifications

Prepare a fixed width text file in the following format. Include one header record per submission per product line. Include one row for every member who was enrolled in the product and who meets criteria for one or more QARR measures for 2009 measurement year. Numeric values should be right justified and blank filled to the left of the value; text fields should be left-justified and blank filled to the right of the value. All member-level Medicaid data are due on June 15, 2010. The Medicaid HMO/PHSP file should be named Member_hmo.txt and the Medicaid HIVSNP file should be named Member_snp.txt.

Header Record

Column 1 – 7	Column 8 – 57	Column 58 – 64
Plan ID	Organization Name	Product Line

Column 1 – 7: Enter the numeric Plan ID
Column 8 – 57: Organization Name
Column 58 – 64: Product Line (HMOPHSP or HIVSNP)

Notes:

1. Reporting of member-level data should encompass only those members included and timeframes employed in the QARR 2009 and HEDIS® 2010 specifications.
2. The sum of the field should equal the numerator or denominator for the corresponding measure entered in the NYS Data Submission System (DSS) for that measure and product.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Detail Record – Include one row for each member

Column 1-8	Column 9	Column 10	Column 11	Column 12	Column 13	Column 14	Column 15
CIN	Denominator – Adolescent Preventive Care (APC) (1 = Yes, 0 = No)	Numerator 1 – APC Sexual Activity (1 = Yes, 0 = No)	Numerator 2 – APC Depression (1 = Yes, 0 = No)	Numerator 3 – APC Tobacco Use (1 = Yes, 0 = No)	Numerator 4 – APC Substance Use (1 = Yes, 0 = No)	Denominator – Adult BMI Assessment (1 = Yes, 0 = No)	Numerator – Adult BMI Assessment (1 = Yes, 0 = No)

Column 1-8: **CIN**

A member's client identification number. The field should be continuous without any spaces or hyphens. The field is alpha-numeric and should be treated as a text field. This field is mandatory – do not leave it blank! The CIN entered in this field should be for the CIN for the measurement period. For example, CINs for 2008 should be used. If the CIN is invalid, the member will not be eligible for enhancement, if applicable.

Column 9: **Denominator for Adolescent Preventive Care**

Enter a '1' if this member is in the denominator of the Adolescent Preventive Care measures, '0' if the member is not in the denominator of this measure or if the information is missing.

Column 10: **Numerator 1 for Adolescent Preventive Care – Sexual Activity**

Enter a '1' if this member is in the numerator of the APC Sexual Activity measure, '0' if the member is not in the numerator or the information is missing.

Column 11: **Numerator 2 for Adolescent Preventive Care – Depression**

Enter a '1' if this member is in the numerator of the APC Depression measure, '0' if the member is not in the numerator or the information is missing.

Column 12: **Numerator 3 for Adolescent Preventive Care – Tobacco Use**

Enter a '1' if this member is in the numerator of the APC Tobacco Use measure, '0' if the member is not in the numerator or the information is missing.

Column 13: **Numerator 4 for Adolescent Preventive Care – Substance Use**

Enter a '1' if this member is in the numerator of the APC Substance Use measure, '0' if the member is not in the numerator or the information is missing.

Column 14: **Denominator for Adult BMI Assessment**

Enter a '1' if this member is in the denominator of the Adult BMI Assessment measure, '0' if the member is not in the denominator of this measure.

Column 15: **Numerator for Adult BMI Assessment**

Enter a '1' if this member is in the numerator of the Adult BMI Assessment measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 16	Column 17	Column 18	Column 19	Column 20	Column 21	Column 22	Column 23
Denominator – Annual Monitoring of Persistent Meds – ACE Inhibitors or ARBs (1 = Yes 0 = No)	Numerator – Annual Monitoring of Persistent Meds – ACE Inhibitors or ARBs (1 = Yes 0 = No)	Denominator – Annual Monitoring of Persistent Meds – Digoxin (1 = Yes 0 = No)	Numerator – Annual Monitoring of Persistent Meds – Digoxin (1 = Yes 0 = No)	Denominator – Annual Monitoring of Persistent Meds – Diuretics (1 = Yes 0 = No)	Numerator – Annual Monitoring of Persistent Meds – Diuretics (1 = Yes 0 = No)	Denominator – Annual Monitoring of Persistent Meds – Anticonvulsants (0 - 9)	Numerator – Annual Monitoring of Persistent Meds – Anticonvulsants (0 - 9)

- Column 16: **Denominator for Annual Monitoring of Persistent Medications – ACE Inhibitors or ARBs**
Enter a '1' if this member is in the denominator of the Annual Monitoring of Persistent Medications – ACE Inhibitors or ARBs measure, '0' if the member is not in the denominator of this measure.
- Column 17: **Numerator for Annual Monitoring of Persistent Medications – ACE Inhibitors or ARBs**
Enter a '1' if this member is in the numerator of the Annual Monitoring of Persistent Medications – ACE Inhibitors or ARBs measure, '0' if the member is not in the numerator or the information is missing.
- Column 18: **Denominator for Annual Monitoring of Persistent Medications – Digoxin**
Enter a '1' if this member is in the denominator of the Annual Monitoring of Persistent Medications – Digoxin measure, '0' if the member is not in the denominator of this measure.
- Column 19: **Numerator for Annual Monitoring of Persistent Medications – Digoxin**
Enter a '1' if this member is in the numerator of the Annual Monitoring of Persistent Medications – Digoxin measure, '0' if the member is not in the numerator or the information is missing.
- Column 20: **Denominator for Annual Monitoring of Persistent Medications – Diuretics**
Enter a '1' if this member is in the denominator of the Annual Monitoring of Persistent Medications – Diuretics measure, '0' if the member is not in the denominator of this measure.
- Column 21: **Numerator for Annual Monitoring of Persistent Medications – Diuretics**
Enter a '1' if this member is in the numerator of the Annual Monitoring of Persistent Medications – Diuretics measure, '0' if the member is not in the numerator or the information is missing.
- Column 22: **Denominator for Annual Monitoring of Persistent Medications – Anticonvulsants**
Enter the number of times this member appears in the denominator of the Annual Monitoring of Persistent Medications – Anticonvulsants measure, '0' if the member is not in the denominator of this measure.
- Column 23: **Numerator for Annual Monitoring of Persistent Medications – Anticonvulsants**
Enter the number of times this member is in the numerator of the Annual Monitoring of Persistent Medications – Anticonvulsants measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 24	Column 25	Column 26	Column 27	Column 28	Column 29	Column 30	Column 31
Denominator – Antidepressant Medication Management (1 = Yes, 0 = No)	Numerator – Antidepressant Medication Management – Effective Acute Phase Treatment (1 = Yes, 0 = No)	Numerator – Antidepressant Medication Management – Effective Continuation Phase Treatment (1 = Yes, 0 = No)	Denominator – Appropriate Asthma Medications 3 or More Controller Dispensing Events (1 = Yes, 0 = No)	Numerator – Appropriate Asthma Medications 3 or More Controller Dispensing Events (1 = Yes, 0 = No)	Denominator – Appropriate Testing of Children with Pharyngitis (1 = Yes, 0 = No)	Numerator – Appropriate Testing of Children with Pharyngitis (1 = Yes, 0 = No)	Denominator – Appropriate Treatment of Children with URI (1 = Yes, 0 = No)

Column 24: **Denominator for Antidepressant Medication Management**

Enter a '1' if this member is in the denominator of the Antidepressant Medication Management measures, '0' if the member is not in the denominator of this measure.

Column 25: **Numerator for Antidepressant Medication Management – Effective Acute Phase Treatment**

Enter a '1' if this member is in the numerator of the Antidepressant Medication Management – Effective Acute Phase Treatment measure, '0' if the member is not in the numerator or the information is missing.

Column 26: **Numerator for Antidepressant Medication Management – Effective Continuation Phase Treatment**

Enter a '1' if this member is in the numerator of the Antidepressant Medication Management – Effective Continuation Phase Treatment measure, '0' if the member is not in the numerator or the information is missing.

Column 27: **Denominator for Appropriate Asthma Medications 3 or more controller dispensing events (Ages 5 – 50)**

Enter a '1' if this member is in the denominator of the Appropriate Asthma Medications 3 or more controller dispensing events measure, '0' if the member is not in the denominator of this measure.

Column 28: **Numerator for Appropriate Asthma Medications 3 or more controller dispensing events (Ages 5 – 50)**

Enter a '1' if this member is in the numerator of the Appropriate Asthma Medications 3 or more controller dispensing events measure, '0' if the member is not in the numerator or the information is missing.

Column 29: **Denominator for Appropriate Testing of Children with Pharyngitis**

Enter a '1' if this member is in the denominator of the Appropriate Testing of Children with Pharyngitis measure, '0' if the member is not in the denominator of this measure.

Column 30: **Numerator for Appropriate Testing of Children with Pharyngitis**

Enter a '1' if this member is in the numerator of the Appropriate Testing of Children with Pharyngitis measure, '0' if the member is not in the numerator or the information is missing.

Column 31: **Denominator for Appropriate Treatment of Children with URI**

Enter a '1' if this member is in the denominator of the Appropriate Treatment of Children with URI measure, '0' if the member is not in the denominator of this measure.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 32	Column 33	Column 34	Column 35	Column 36	Column 37	Column 38	Column 39
Numerator – Appropriate Treatment of Children with URI (1 = Yes 0 = No)	Denominator – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (1 = Yes 0 = No)	Numerator – Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (1 = Yes 0 = No)	Denominator – Breast Cancer Screening (1 = Yes 0 = No)	Numerator – Breast Cancer Screening (1 = Yes 0 = No)	Denominator – Childhood Immunization (CIS) (1 = Yes 0 = No)	Numerator 1 – CIS – Four DTaP (0-9)	Numerator 2 – CIS – Three IPV (0-9)

Column 32: Numerator for Appropriate Treatment of Children with URI

Enter a '1' if this member is in the numerator of the Appropriate Treatment of Children with URI measure, '0' if the member is not in the numerator or the information is missing.

Column 33: Denominator for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Enter a '1' if this member is in the denominator of the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure, '0' if the member is not in the denominator of this measure.

Column 34: Numerator for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Enter a '1' if this member is in the numerator of the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure, '0' if the member is not in the numerator or the information is missing.

Column 35: Denominator for Breast Cancer Screening

Enter a '1' if this member is in the denominator of the Breast Cancer Screening measure, '0' if the member is not in the denominator of this measure.

Column 36: Numerator for Breast Cancer Screening

Enter a '1' if this member is in the numerator of the Breast Cancer Screening measure, '0' if the member is not in the numerator or the information is missing.

Column 37: Denominator for Childhood Immunization (CIS)

Enter a '1' if this member is in the denominator of the CIS measure, '0' if the member is not in the denominator of this measure.

Column 38: Numerator 1 for CIS – Four DTaP

Enter the number of times this member has a vaccination meeting HEDIS specifications for DTaP in numerator of the CIS– Four DTaP measure. Enter '0' if this member did not receive any DTaP vaccinations meeting HEDIS specifications.

Column 39: Numerator 2 for CIS – Three IPV

Enter the number of times this member has a vaccination meeting HEDIS specifications for IPV in numerator of the CIS – Three IPV measure. Enter '0' if this member did not receive any IPV vaccinations meeting HEDIS specifications.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 40	Column 41	Column 42	Column 43	Column 44	Column 45	Column 46	Column 47
Numerator 3 – CIS - One MMR (0-9)	Numerator 4 – CIS - Two HiB (0-9)	Numerator 5 – CIS - Three Hepatitis B (0-9)	Numerator 6 – CIS - One VZV (0-9)	Numerator 7 – CIS - Four Pneumococcal Conjugate (0-9)	Numerator 8 – CIS - Two Hepatitis A (0-9)	Numerator 9 – CIS – Rotovirus Vaccine Two Dose Schedule (1 = Yes 0 = No)	Numerator 9 – CIS - Two or Three Rotovirus (0-9)

Column 40: Numerator 3 for CIS – One MMR

Enter the number of times this member has a vaccination meeting HEDIS specifications for MMR in numerator of the CIS– One MMR measure. Enter ‘0’ if this member did not receive any MMR vaccinations meeting HEDIS specifications. Enter ‘1’ if the member has a history of illness or seropositive result.

Column 41: Numerator 4 for CIS – Two HiB

Enter the number of times this member has a vaccination meeting HEDIS specifications for HiB in numerator of the CIS – Two HiB measure. Enter ‘0’ if this member did not receive any HiB vaccinations meeting HEDIS specifications.

Column 42: Numerator 5 for CIS – Three Hepatitis B

Enter the number of times this member has a vaccination meeting HEDIS specifications for Hepatitis B in numerator of the CIS – Three Hepatitis B measure. Enter ‘0’ if this member did not receive any Hepatitis B vaccinations meeting HEDIS specifications. Enter ‘3’ if the member has a history of illness or seropositive result.

Column 43: Numerator 6 for CIS – One VZV

Enter the number of times this member has a vaccination meeting HEDIS specifications for VZV in numerator of the CIS – One VZV measure. Enter ‘0’ if this member did not receive any VZV vaccinations meeting HEDIS specifications. Enter ‘1’ if the member has a history of illness or seropositive result.

Column 44: Numerator 7 for CIS – Four Pneumococcal Conjugate

Enter the number of times this member has a vaccination meeting HEDIS specifications for Pneumococcal Conjugate in numerator of the CIS - Four Pneumococcal Conjugate measure. Enter ‘0’ if this member did not receive any Pneumococcal Conjugate vaccinations meeting HEDIS specifications.

Column 45: Numerator 8 for CIS – Two Hepatitis A

Enter the number of times this member has a vaccination meeting HEDIS specifications for Hepatitis A in numerator of the CIS – Two Hepatitis A measure. Enter ‘0’ if this member did not receive any Hepatitis A vaccinations meeting HEDIS specifications. Enter ‘2’ if the member has a history of illness or seropositive result.

Column 46: Numerator 9 for CIS – Rotovirus Vaccine Two Dose Schedule

Enter ‘1’ if the member received the type of Rotovirus vaccine with the two dose schedule (CPT 90681) for the Rotovirus in numerator of the CIS – Two or Three Rotovirus measure. Enter ‘0’ if this member did not the type of Rotovirus vaccine with the two dose schedule (CPT 90681).

Column 47: Numerator 9 for CIS – Two or Three Rotovirus

Enter the number of times this member has a vaccination meeting HEDIS specifications for Rotovirus in numerator of the CIS – Two or Three Rotovirus measure. Enter ‘0’ if this member did not receive any Rotovirus vaccinations meeting HEDIS specifications.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 48	Column 49	Column 50	Column 51	Column 52	Column 53	Column 54	Column 55
Numerator 10 – CIS - Two Influenza (0-9)	Denominator – Chlamydia Screening in Women (16 – 20 Years) (1 = Yes 0 = No)	Numerator – Chlamydia Screening in Women (16 – 20 Years) (1 = Yes 0 = No)	Denominator – Chlamydia Screening in Women (21 – 24 Years) (1 = Yes 0 = No)	Numerator – Chlamydia Screening in Women (21 – 24 Years) (1 = Yes 0 = No)	Denominator – Cholesterol Management for Cardiovascular Conditions (CMC) (1 = Yes 0 = No)	Numerator 1 – CMC – LDL-C Screen (1 = Yes 0 = No)	Numerator 2 – CMC - LDL-C Control (1 = Yes 0 = No)

- Column 48: **Numerator 10 for CIS – Two Influenza**
Enter the number of times this member has a vaccination meeting HEDIS specifications for Influenza in numerator of the CIS – Two Influenza measure. Enter ‘0’ if this member did not receive any Influenza vaccinations meeting HEDIS specifications.
- Column 49: **Denominator for Chlamydia Screening in Women (16 – 20 Years)**
Enter a ‘1’ if this member is in the denominator of the Chlamydia Screening in Women (16 – 20 Years) measure, ‘0’ if the member is not in the denominator of this measure.
- Column 50: **Numerator for Chlamydia Screening in Women (16 – 20 Years)**
Enter a ‘1’ if this member is in the numerator of the Chlamydia Screening in Women (16 – 20 Years) measure, ‘0’ if the member is not in the numerator or the information is missing.
- Column 51: **Denominator for Chlamydia Screening in Women (21 – 24 Years)**
Enter a ‘1’ if this member is in the denominator of the Chlamydia Screening in Women (21-24 Years) measure, ‘0’ if the member is not in the denominator of this measure.
- Column 52: **Numerator for Chlamydia Screening in Women (21 – 24 Years)**
Enter a ‘1’ if this member is in the numerator of the Chlamydia Screening in Women (21-24 Years) measure, ‘0’ if the member is not in the numerator or the information is missing.
- Column 53: **Denominator for Cholesterol Management for Cardiovascular Conditions (CMC)**
Enter a ‘1’ if this member is in the denominator of the CMC measures, ‘0’ if the member is not in the denominator of this measure.
- Column 54: **Numerator 1 for CMC – LDL-C Screen**
Enter a ‘1’ if this member is in the numerator of the CMC LDL-C Screen measure, ‘0’ if the member is not in the numerator or the information is missing.
- Column 55: **Numerator 2 for CMC – LDL-C Control (<100 mg/dL)**
Enter a ‘1’ if this member is in the numerator of the CMC LDL-C Control measure, ‘0’ if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 56	Column 57	Column 58	Column 59	Column 60	Column 61	Column 62	Column 63	Column 64
Denominator – Comprehensive Diabetes Care (CDC) (1 = Yes 0 = No)	Numerator 1 – CDC HbA1c Test (1 = Yes 0 = No)	Numerator 2 – CDC HbA1c Poor Control (1 = Yes 0 = No)	Numerator 3 – CDC HbA1c Control (<8.0%) (1 = Yes 0 = No)	Numerator 4 – CDC Eye Exam (1 = Yes 0 = No)	Numerator 5 – CDC LDL-C Screen (1 = Yes 0 = No)	Numerator 6 – CDC LDL-C Control (1 = Yes 0 = No)	Numerator 7 – CDC Nephropathy monitor (1 = Yes 0 = No)	Numerator 8 – CDC BP below 140/90 (1 = Yes 0 = No)

Column 56: Denominator for Comprehensive Diabetes Care (CDC)

Enter a '1' if this member is in the denominator of the CDC measures, '0' if the member is not in the denominator of this measure.

Column 57: Numerator 1 for CDC – HbA1c Test

Enter a '1' if this member is in the numerator of the CDC HbA1c Test measure, '0' if the member is not in the numerator or the information is missing.

Column 58: Numerator 2 for CDC – HbA1c Poor Control (>9%)

Enter a '1' if this member is in the numerator of the CDC HbA1c Poor Control measure (which includes no test performed and test result missing from the record), '0' if the member is not in the numerator or if the member's information is missing for all numerators of CDC (such as the member's record could not be located).

Column 59: Numerator 3 for CDC – HbA1c Control (<8.0%)

Enter a '1' if this member is in the numerator of the CDC HbA1c Control (<8.0%) measure, '0' if the member is not in the numerator or the information is missing.

Column 60: Numerator 4 for CDC – Eye Exam

Enter a '1' if this member is in the numerator of the CDC Eye Exam measure, '0' if the member is not in the numerator or the information is missing.

Column 61: Numerator 5 for CDC – LDL-C Screen

Enter a '1' if this member is in the numerator of the CDC LDL-C Screen measure, '0' if the member is not in the numerator or the information is missing.

Column 62: Numerator 6 for CDC – LDL-C Control (<100 mg/dL)

Enter a '1' if this member is in the numerator of the CDC LDL-C Control measure, '0' if the member is not in the numerator or the information is missing.

Column 63: Numerator 7 for CDC – Nephropathy Monitor

Enter a '1' if this member is in the numerator of the CDC Nephropathy Monitor measure, '0' if the member is not in the numerator or the information is missing.

Column 64: Numerator 8 for CDC – BP below 140/90

Enter a '1' if this member is in the numerator of the CDC BP below 140/90 measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 65	Column 66	Column 67	Column 68	Column 69	Column 70-71	Column 72-73	Column 74-75
Numerator 9 – CDC BP below 130/80 (1 = Yes, 0 = No)	Denominator – CDC - HbA1c Control for Selected Population (<7.0%) (1 = Yes, 0 = No)	Numerator – CDC - HbA1c Control for Selected Population (<7.0%) (1 = Yes, 0 = No)	Denominator – Disease Modifying Anti-Rheumatic Drug Therapy (1 = Yes, 0 = No)	Numerator – Disease Modifying Anti-Rheumatic Drug Therapy (1 = Yes, 0 = No)	Denominator – Follow-Up After Hosp for MI (0-98)	Numerator 1 – Follow-Up After Hosp for MI – 7 days (0-98)	Numerator 2 – Follow-Up After Hosp for MI – 30 days (0-98)

- Column 65: **Numerator 9 for CDC – BP below 130/80**
Enter a '1' if this member is in the numerator of the CDC BP below 130/80 measure, '0' if the member is not in the numerator or the information is missing.
- Column 66: **Denominator for CDC - HbA1c Control for Selected Population (<7.0%)**
Enter a '1' if this member is in the denominator of the CDC HbA1c Control for Selected Population measure, '0' if the member is not in the denominator of this measure.
- Column 67: **Numerator for CDC - HbA1c Control for Selected Population (<7.0%)**
Enter a '1' if this member is in the numerator of the CDC HbA1c Control for Selected Population (<7.0%) measure, '0' if the member is not in the numerator or the information is missing.
- Column 68: **Denominator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)**
Enter a '1' if this member is in the denominator of the DMARD measure, '0' if the member is not in the denominator of this measure.
- Column 69: **Numerator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)**
Enter a '1' if this member is in the numerator of the DMARD measure, '0' if the member is not in the numerator or the information is missing.
- Column 70-71: **Denominator for Follow-Up After Hospitalization for Mental Illness**
Enter the number of times this member appears in the denominator of the Follow-Up After Hospitalization for Mental Illness; '0' if the member is not in the denominator of this measure.
- Column 72-73: **Numerator 1 for Follow-Up After Hospitalization for Mental Illness, 7 days after discharge**
Enter the number of times this member appears in numerator 1 of the Follow-Up After Hospitalization for Mental Illness, 7 days after discharge. '0' if the member is not in the numerator or the information is missing.
- Column 74-75: **Numerator 2 for Follow-Up After Hospitalization for Mental Illness, 30 days after discharge**
Enter the number of times this member appears in numerator 2 of the Follow-Up After Hospitalization for Mental Illness, 30 days after discharge. '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 76	Column 77	Column 78	Column 79	Column 80	Column 81	Column 82	Column 83
Denominator 1 – ADHD Medication Follow-Up - Initiation Phase (1 = Yes 0 = No)	Numerator 1 – ADHD Medication Follow Up - Initiation Phase (1 = Yes 0 = No)	Denominator 2 – ADHD Medication Follow Up - Continuation Phase (1 = Yes 0 = No)	Numerator 2 – ADHD Medication Follow Up - Continuation Phase (1 = Yes 0 = No)	Denominator – HIV/AIDS Comprehensive Care – Engaged in Care (1 = Yes 0 = No)	Numerator – HIV/AIDS Comprehensive Care – Engaged in Care (1 = Yes 0 = No)	Denominator – HIV/AIDS Comprehensive Care – Viral Load Monitoring (1 = Yes 0 = No)	Numerator – HIV/AIDS Comprehensive Care – Viral Load Monitoring (1 = Yes 0 = No)

Column 76: Denominator 1 for ADHD Medication Follow-Up - Initiation Phase

Enter a '1' if this member is in the denominator of the ADHD Medication Follow-Up - Initiation Phase measure, '0' if the member is not in the denominator of this measure.

Column 77: Numerator 1 for ADHD Medication Follow-Up - Initiation Phase

Enter a '1' if this member is in the numerator of the ADHD Medication Follow-Up - Initiation Phase measure, '0' if the member is not in the numerator or the information is missing.

Column 78: Denominator 2 for ADHD Medication Follow-Up - Continuation Phase

Enter a '1' if this member is in the denominator of the ADHD Medication Follow-Up - Continuation Phase measure, '0' if the member is not in the denominator of this measure.

Column 79: Numerator 2 for ADHD Medication Follow-Up - Continuation Phase

Enter a '1' if this member is in the numerator of the ADHD Medication Follow-Up - Continuation Phase measure, '0' if the member is not in the numerator or the information is missing.

Column 80: Denominator for HIV/AIDS Comprehensive Care – Engaged in Care

Enter a '1' if this member is in the denominator of the HIV/AIDS Comprehensive Care – Engaged in Care measure, '0' if the member is not in the denominator of this measure.

Column 81: Numerator for HIV/AIDS Comprehensive Care – Engaged in Care

Enter a '1' if this member is in the numerator of the HIV/AIDS Comprehensive Care – Engaged in Care measure, '0' if the member is not in the numerator of this measure or the information is missing.

Column 82: Denominator for HIV/AIDS Comprehensive Care – Viral Load Monitoring

Enter a '1' if this member is in the denominator of the HIV/AIDS Comprehensive Care – Viral Load Monitoring measure, '0' if the member is not in the denominator of this measure.

Column 83: Numerator for HIV/AIDS Comprehensive Care – Viral Load Monitoring

Enter a '1' if this member is in the numerator of the HIV/AIDS Comprehensive Care – Viral Load Monitoring measure, '0' if the member is not in the numerator of this measure or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 84	Column 85	Column 86	Column 87	Column 88-89	Column 90-91	Column 92-93
Denominator – HIV/AIDS Comprehensive Care – Syphilis Screening (1 = Yes 0 = No)	Numerator – HIV/AIDS Comprehensive Care – Syphilis Screening (1 = Yes 0 = No)	Denominator – Lead Screening (1 = Yes 0 = No)	Numerator – Lead Screening (1 = Yes 0 = No)	Denominator – Pharmacotherapy Management of COPD Exacerbation (0-98)	Numerator 1 – Pharmacotherapy Management of COPD Exacerbation - Steroids (0-98)	Numerator 2 – Pharmacotherapy Management of COPD Exacerbation - Bronchodilators (0-98)

- Column 84: **Denominator for HIV/AIDS Comprehensive Care – Syphilis Screening**
Enter a '1' if this member is in the denominator of the HIV/AIDS Comprehensive Care – Syphilis Screening measure, '0' if the member is not in the denominator of this measure.
- Column 85: **Numerator for HIV/AIDS Comprehensive Care – Syphilis Screening**
Enter a '1' if this member is in the numerator of the HIV/AIDS Comprehensive Care – Syphilis Screening measure, '0' if the member is not in the numerator of this measure or the information is missing.
- Column 86: **Denominator for Lead Screening in Children**
Enter a '1' if this member is in the denominator of the Lead Screening in Children measure, '0' if the member is not in the denominator of this measure.
- Column 87: **Numerator for Lead Screening in Children**
Enter a '1' if this member is in the numerator of the Lead Screening in Children measure, '0' if the member is not in the numerator or the information is missing.
- Column 88-89: **Denominator for Pharmacotherapy Management of COPD Exacerbation**
Enter the number of times this member appears in the denominator of the Pharmacotherapy Management of COPD Exacerbation; '0' if the member is not in the denominator of this measure.
- Column 90-91: **Numerator 1 for Pharmacotherapy Management of COPD Exacerbation, Steroid Dispensed**
Enter the number of times this member appears in numerator 1 of the Pharmacotherapy Management of COPD Exacerbation, Steroid dispensed; '0' if the member is not in the numerator of this measure or the information is missing.
- Column 92-93: **Numerator 2 for Pharmacotherapy Management of COPD Exacerbation, Bronchodilator Dispensed**
Enter the number of times this member appears in numerator 2 of the Pharmacotherapy Management of COPD Exacerbation, Bronchodilator dispensed; '0' if the member is not in the numerator of this measure or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 94	Column 95	Column 96	Column 97	Column 98	Column 99
Denominator 1 – Use of Appropriate Medications for People with Asthma (5-11 years) (1 = Yes 0 = No)	Numerator 1 – Use of Appropriate Medications for People with Asthma (5-11 years) (1 = Yes 0 = No)	Denominator 2 – Use of Appropriate Medications for People with Asthma (12-50 years) (1 = Yes 0 = No)	Numerator 2 – Use of Appropriate Medications for People with Asthma (12-50 years) (1 = Yes 0 = No)	Denominator – Use of Imaging Studies for Low Back Pain (1 = Yes 0 = No)	Numerator – Use of Imaging Studies for Low Back Pain (1 = Yes 0 = No)

- Column 94: **Denominator 1 for Use of Appropriate Medications for People with Asthma (5-11 years)**
Enter a '1' if this member is in the denominator of the Use of Appropriate Medications for People with Asthma (5-11 years) measure, '0' if the member is not in the denominator of this measure.
- Column 95: **Numerator 1 for Use of Appropriate Medications for People with Asthma (5-11 years)**
Enter a '1' if this member is in the numerator of the Use of Appropriate Medications for People with Asthma (5-11 years) measure, '0' if the member is not in the numerator or the information is missing.
- Column 96: **Denominator 2 for Use of Appropriate Medications for People with Asthma (12-50 years)**
Enter a '1' if this member is in the denominator of the Use of Appropriate Medications for People with Asthma (12-50 years) measure, '0' if the member is not in the denominator of this measure.
- Column 97: **Numerator 2 for Use of Appropriate Medications for People with Asthma (12-50 years)**
Enter a '1' if this member is in the numerator of the Use of Appropriate Medications for People with Asthma (12-50 years) measure, '0' if the member is not in the numerator or the information is missing.
- Column 98: **Denominator for Use of Imaging Studies for Low Back Pain**
Enter a '1' if this member is in the denominator of the Use of Imaging Studies for Low Back Pain measure, '0' if the member is not in the denominator of this measure.
- Column 99: **Numerator for Use of Imaging Studies for Low Back Pain**
Enter a '1' if this member is in the numerator of the Use of Imaging Studies for Low Back Pain measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 100	Column 101	Column 102	Column 103	Column 104	Column 105	Column 106	Column 107
Denominator – Use of Spirometry Testing in Assessment and Diagnosis of COPD (1 = Yes 0 = No)	Numerator – Use of Spirometry Testing in Assessment and Diagnosis of COPD (1 = Yes 0 = No)	Denominator 1 – WCC (3 – 11 Years) (1 = Yes 0 = No)	Numerator 1A – WCC BMI Percentile (3 – 11 Years) (1 = Yes 0 = No)	Numerator 1B – WCC Counseling for Nutrition (3 – 11 Years) (1 = Yes 0 = No)	Numerator 1C – WCC Counseling for Physical Activity (3 – 11 Years) (1 = Yes 0 = No)	Denominator 2 – WCC (12 - 17 Years) (1 = Yes 0 = No)	Numerator 2A – WCC BMI Percentile (12 - 17 Years) (1 = Yes 0 = No)

Column 100: Denominator for Use of Spirometry Testing in Assessment and Diagnosis of COPD

Enter a '1' if this member is in the denominator of the Use of Spirometry Testing in Assessment and Diagnosis of COPD measure, '0' if the member is not in the denominator of this measure.

Column 101: Numerator for Use of Spirometry Testing in Assessment and Diagnosis of COPD

Enter a '1' if this member is in the numerator of the Use of Spirometry Testing in Assessment and Diagnosis of COPD measure, '0' if the member is not in the numerator or the information is missing.

Column 102: Denominator 1 for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (3 – 11 Years)

Enter a '1' if this member is in the denominator of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (3 – 11 Years) measure, '0' if the member is not in the denominator of this measure.

Column 103: Numerator 1A for WCC – BMI Percentile (3 – 11 Years)

Enter a '1' if this member is in the numerator of the WCC – BMI Percentile (3 – 11 Years) measure, '0' if the member is not in the numerator or the information is missing.

Column 104: Numerator 1B for WCC – Counseling for Nutrition (3 – 11 Years)

Enter a '1' if this member is in the numerator of the WCC – Counseling for Nutrition (3 – 11 Years) measure, '0' if the member is not in the numerator or the information is missing.

Column 105: Numerator 1C for WCC – Counseling for Physical Activity (3 – 11 Years)

Enter a '1' if this member is in the numerator of the WCC – Counseling for Physical Activity (3 – 11 Years) measure, '0' if the member is not in the numerator or the information is missing.

Column 106: Denominator 2 for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (12 – 17 Years)

Enter a '1' if this member is in the denominator of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (12 – 17 Years) measure, '0' if the member is not in the denominator of this measure.

Column 107: Numerator 2A for WCC – BMI Percentile (12 – 17 Years)

Enter a '1' if this member is in the numerator of the WCC – BMI Percentile (12 – 17 Years) measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 108	Column 109	Column 110	Column 111	Column 112	Column 113	Column 114	Column 115
Numerator 2B – WCC Counseling for Nutrition (12 - 17 Years) (1 = Yes 0 = No)	Numerator 2C – WCC Counseling for Physical Activity (12 - 17 Years) (1 = Yes 0 = No)	Denominator 1 – Annual Dental Visits (2-3 years) (1 = Yes 0 = No)	Numerator 1 – Annual Dental Visits (2-3 years) (1 = Yes 0 = No)	Denominator 2 – Annual Dental Visits (4-6 years) (1 = Yes 0 = No)	Numerator 2 – Annual Dental Visits (4-6 years) (1 = Yes 0 = No)	Denominator 3 – Annual Dental Visits (7-10 years) (1 = Yes 0 = No)	Numerator 3 – Annual Dental Visits (7-10 years) (1 = Yes 0 = No)

Column 108: Numerator 2B for WCC – Counseling for Nutrition (12 – 17 Years)

Enter a '1' if this member is in the numerator of the WCC – Counseling for Nutrition (12 – 17 Years) measure, '0' if the member is not in the numerator or the information is missing.

Column 109: Numerator 2C for WCC – Counseling for Physical Activity (12 – 17 Years)

Enter a '1' if this member is in the numerator of the WCC – Counseling for Physical Activity (12 – 17 Years) measure, '0' if the member is not in the numerator or the information is missing.

Column 110: Denominator 1 for Annual Dental Visits (2-3 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (2-3 years) measure, '0' if the member is not in the denominator of this measure.

Column 111: Numerator 1 for Annual Dental Visits (2-3 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (2-3 years) measure, '0' if the member is not in the numerator or the information is missing.

Column 112: Denominator 2 for Annual Dental Visits (4-6 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (4-6 years) measure, '0' if the member is not in the denominator of this measure.

Column 113: Numerator 2 for Annual Dental Visits (4-6 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (4-6 years) measure, '0' if the member is not in the numerator or the information is missing.

Column 114: Denominator 3 for Annual Dental Visits (7-10 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (7-10 years) measure, '0' if the member is not in the denominator of this measure.

Column 115: Numerator 3 for Annual Dental Visits (7-10 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (7-10 years) measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 116	Column 117	Column 118	Column 119	Column 120	Column 121
Denominator 4 – Annual Dental Visits (11-14 years) (1 = Yes 0 = No)	Numerator 4 – Annual Dental Visits (11-14 years) (1 = Yes 0 = No)	Denominator 5 – Annual Dental Visits (15-18 years) (1 = Yes 0 = No)	Numerator 5 – Annual Dental Visits (15-18 years) (1 = Yes 0 = No)	Denominator 6 – Annual Dental Visits (19-21 years) (1 = Yes 0 = No)	Numerator 6 – Annual Dental Visits (19-21 years) (1 = Yes 0 = No)

Column 116: Denominator 4 for Annual Dental Visits (11-14 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (11-14 years) measure, '0' if the member is not in the denominator of this measure.

Column 117: Numerator 4 for Annual Dental Visits (11-14 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (11-14 years) measure, '0' if the member is not in the numerator or the information is missing.

Column 118: Denominator 5 for Annual Dental Visits (15-18 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (15-18 years) measure, '0' if the member is not in the denominator of this measure.

Column 119: Numerator 5 for Annual Dental Visits (15-18 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (15-18 years) measure, '0' if the member is not in the numerator or the information is missing.

Column 120: Denominator 6 for Annual Dental Visits (19-21 years)

Enter a '1' if this member is in the denominator of the Annual Dental Visits (19-21 years) measure, '0' if the member is not in the denominator of this measure.

Column 121: Numerator 6 for Annual Dental Visits (19-21 years)

Enter a '1' if this member is in the numerator of the Annual Dental Visits (19-21 years) measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 122	Column 123	Column 124	Column 125	Column 126	Column 127	Column 128	Column 129
Denominator – Well Care Visits in the First 15 Months of Life (1 = Yes 0 = No)	Numerator 1 – Well Care Visits in the First 15 Months of Life (0 Visits) (1 = Yes 0 = No)	Numerator 2 – Well Care Visits in the First 15 Months of Life (1 Visit) (1 = Yes 0 = No)	Numerator 3 – Well Care Visits in the First 15 Months of Life (2 Visits) (1 = Yes 0 = No)	Numerator 4 – Well Care Visits in the First 15 Months of Life (3 Visits) (1 = Yes 0 = No)	Numerator 5 – Well Care Visits in the First 15 Months of Life (4 Visits) (1 = Yes 0 = No)	Numerator 6 – Well Care Visits in the First 15 Months of Life (5 Visits) (1 = Yes 0 = No)	Numerator 7 – Well Care Visits in the First 15 Months of Life (6 Visits) (1 = Yes 0 = No)

Column 122: Denominator for Well Care Visits in the First 15 Months of Life

Enter a '1' if this member is in the denominator of the Well Care Visits in the First 15 Months of Life measures, '0' if the member is not in the denominator of this measure.

EACH MEMBER IN THE DENOMINATOR WILL HAVE ONLY ONE OF THE 7 NUMERATORS SELECTED

Column 123: Numerator 1 for Well Care Visits in the First 15 Months of Life – 0 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 0 visits measure, '0' if the member is not in the numerator or the information is missing.

Column 124: Numerator 2 for Well Care Visits in the First 15 Months of Life – 1 Visit

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 1 visit measure, '0' if the member is not in the numerator or the information is missing.

Column 125: Numerator 3 for Well Care Visits in the First 15 Months of Life – 2 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 2 visits measure, '0' if the member is not in the numerator or the information is missing.

Column 126: Numerator 4 for Well Care Visits in the First 15 Months of Life – 3 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 3 visits measure, '0' if the member is not in the numerator or the information is missing.

Column 127: Numerator 5 for Well Care Visits in the First 15 Months of Life – 4 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 4 visit measure, '0' if the member is not in the numerator or the information is missing.

Column 128: Numerator 6 for Well Care Visits in the First 15 Months of Life - 5 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 5 visits measure, '0' if the member is not in the numerator or the information is missing.

Column 129: Numerator 7 for Well Care Visits in the First 15 Months of Life – 6 Visits

Enter a '1' if this member is in the numerator of the Well Care Visits in the First 15 Months of Life – 6 visits measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Column 130	Column 131	Column 132	Column 133
Denominator – Well Child Visits 3 rd , 4 th , 5 th , and 6 th years (1 = Yes 0 = No)	Numerator – Well Child Visits 3 rd , 4 th , 5 th , and 6 th years (1 = Yes 0 = No)	Denominator – Adolescent Well Care Visits (1 = Yes 0 = No)	Numerator – Adolescent Well Care Visits (1 = Yes 0 = No)

Column 130: Denominator for Well Child Visits 3rd, 4th, 5th, and 6th years

Enter a '1' if this member is in the denominator of the Well Child Visits 3rd, 4th, 5th, and 6th years measure, '0' if the member is not in the denominator of this measure.

Column 131: Numerator for Well Child Visits 3rd, 4th, 5th, and 6th years

Enter a '1' if this member is in the numerator of the Well Child Visits 3rd, 4th, 5th, and 6th years measure, '0' if the member is not in the numerator or the information is missing.

Column 132: Denominator for Adolescent Well Care Visits

Enter a '1' if this member is in the denominator of the Adolescent Well Care Visits measure, '0' if the member is not in the denominator of this measure.

Column 133: Numerator for Adolescent Well Care Visits

Enter a '1' if this member is in the numerator of the Adolescent Well Care Visits measure, '0' if the member is not in the numerator or the information is missing.

VI. Medicaid HMO/PHSP and HIVSNP File Submission

Medicaid Enhancements (Optional) for Medicaid HMO/PHSP and HIVSNP

The Office of Health Insurance Programs will enhance results for several measures for this reporting year (**Chlamydia Screening, Follow Up after Hospitalization for Mental Illness, and Follow Up Care for Children Prescribed ADHD Medication**). Enhancement files for two of the three measures should be submitted for those enrollees included in **denominator** for plans wishing to have applicable measures screened for out-of-plan services. The submission of these enhancement files is optional. Plans will be notified of their updated rates subsequent to the incorporation of out-of-plan numerator events. Plans with both HMO/PHSP and HIVSNP products should submit two separate enhancement files, one for each product.

PLEASE NOTE: Only valid CINs will be included in the enhancement process. Plans should be using the CINs relevant to the measurement year. For example, if a member has a previous CIN and a CIN from the measurement year, the CIN from the measurement year should be the one on the file.

- Chlamydia Screening:** The Office of Health Insurance Programs will use the member-level file to evaluate Medicaid fee-for-service (FFS) data to determine whether out-of-plan services were received by members noted to be numerator non-compliant for the measure. No additional data elements are needed for this enhancement process.
- Follow-Up After Hospitalization for Mental Illness:** There are two time periods in which a follow-up visit must have taken place in order to be considered a numerator “hit”; up to seven days after hospital discharge, and up to 30 days after discharge. If you would like the Office of Health Insurance Programs to evaluate Medicaid FFS data to determine whether out-of-plan services were used for either of these components of the measure, in addition to the CIN, please include: the date of the 7-day follow-up visit, and the date of the 30-day follow-up visit. If there is a 7-day follow-up visit, but no visit between 8 and 30 days after discharge, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Follow-Up After Hospitalization for Mental Illness: 1) 7-Day and 2) 30 Day	OMC Plan ID (Refer to DSS)	1-7	Followup.txt
	CIN	8-15	
	Discharge Date (YYYYMMDD)	16-23	
	7-Day Follow-up Visit Date (YYYYMMDD)	24-31	
	30-Day Follow-up Visit Date (YYYYMMDD)	32-39	

- Follow-Up Care for Children Prescribed ADHD Medication:** The Office of Health Insurance Programs will use Medicaid FFS data to determine whether out-of-plan services were used for the two numerators of the measure. Members not meeting the numerator criteria for Initiation Phase or Continuation and Maintenance Phase will be eligible for enhancement in the FFS data. Please note that, per HEDIS® 2010 specifications, **the initiation phase visit must be with a prescribing practitioner** to count as a numerator “hit”. If members have more than three visits in the specified time period, please select the visits that allowed the member to qualify. For example, if a member

VI. Medicaid HMO/PHSP and HIVSNP File Submission

had two visits in the first 30 days, and the second visit is with a prescribing practitioner, the plan would include the 2nd visit date for the initiation numerator. Members indicated as not being compliant for the two numerators will be reviewed with FFS data to determine if visits occurred and which facilities were used for the visits. OHIP will review the data involving Office of Mental Health clinics before determining whether to enhance all rates or exclude applicable members from denominators. Any missing or not applicable dates should be submitted as zeros in the YYYYMMDD format (00000000).

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Follow-Up Care for Children Prescribed ADHD Medication: 1.) Initiation Phase 2.) Continuation and Maintenance Phase	OMC Plan ID (Refer to DSS)	1-7	Add.txt
	CIN	8-15	
	Included in Denominator 1? (1=Yes; 0=No)	16	
	Index Episode Start Date (YYYYMMDD)	17-24	
	Subsequent Visit Date1 (YYYYMMDD)	25-32	
	Indicator of Prescribing Provider for Visit Date1 (1=Yes; 0=No)	33	
	Indicator of Numerator Compliance for Initiation measure (1=Yes; 0=No)	34	
	Included in Denominator 2? (1=Yes; 0=No)	35	
	Subsequent Visit Date2 (YYYYMMDD)	36-43	
	Subsequent Visit Date3 (YYYYMMDD)	44-51	
	Indicator of Numerator Compliance for Continuation and Maintenance measure (1=Yes; 0=No)	52	

Technical Assistance: If you need clarification on these files, please contact the Quality Measurement Unit at (518) 486-9012.

VII. DRG Crosswalk

2009 QARR / HEDIS® 2010

Crosswalk of MS-DRG, NYS APDRG and NYS APRDRG

Measure	Description	MS-DRG	NYS-APDRG	NYS-APRDRG
Frequency of Selected Procedures	Back Surgery	FSP-A: 453-460	FSP-A: 755, 756, 757, 758, 806, 807, 836, 837, 864, 865, 884	FSP-A: 023, 303, 304, 310, 321
	Coronary Angioplasty	FSP-A: 246-251	FSP-A: 112, 808, 852, 853, 854	FSP-A: 174, 175
	Cardiac Catheterization	FSP-A: 216-218, 222-225, 286, 287	FSP-A: 104, 124, 125, 849, 850	FSP-A: 162, 191, 192
	CABG	FSP-A: 231-236	FSP-A: 106, 107, 109, 546	FSP-A: 165, 166
	Mastectomy	FSP-A: N/A	FSP-A: 257, 258, 259, 260	FSP-A: 362
	Lumpectomy	FSP-A: 584, 585	FSP-A: 262	FSP-A: 363
	Prostatectomy	FSP-A: 665-667	FSP-A: 336, 337	FSP-A: 482
Inpatient Utilization: General Hospital/Acute Care	Total Inpatient	IPU-A: 001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999	IPU-A: 1-2, 6-19, 21-23, 34-80, 82-90, 92-97, 99-183, 185-189, 191-213, 216-230, 232-341, 344-382, 392-395, 397-399, 401-404, 406-410, 413-414, 417-423, 439-455, 461, 463-471, 476-480, 482, 491, 493-494, 530-536, 538-541, 543-589, 602-624, 626-631, 633-641, 650-652, 700-716, 730-734, 737-740, 752-787, 789-829, 832-833, 836-839, 849-854, 864-867, 874-901	IPU-A: 001-006, 020-024, 026, 040-058, 070, 073, 080, 082, 089-093, 095, 097-098, 110-111, 113-115, 120-121, 130-144, 160-163, 165-167, 169-171, 173-177, 180, 190-194, 196-201, 203-207, 220-229, 240-249, 251-254, 260-264, 279-284, 301-305, 308-310, 312-317, 320-321, 340-344, 346-347, 349, 351, 361-364, 380-385, 401, 403-405, 420-425, 440-447, 460-463, 465-466, 468, 480-484, 500-501, 510-514, 517-519, 530-532, 540-542, 544-546, 560-561, 563-566, 580-581, 583, 588-589, 591, 593, 602-603, 607-609, 611-614, 621-623, 625-626, 630-631, 633-634, 636, 639-640, 650-651, 660-663, 680-681, 690-694, 710-711, 720-724, 791, 811-813, 815-816, 841-844, 850, 861-863, 890, 892-894, 910-912, 930, 950-952
	Maternity	IPU-B: 765-770, 774-782	IPU-B: 370-382, 650-652, 885-886	IPU-B: 540-542, 544-546, 560-561, 563-566
	Surgery	IPU-B: 001-013, 020-042, 113-117, 129-139, 163-168, 215-264, 326-358, 405-425, 453-517, 573-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989	IPU-B: 1-2, 6-8, 36-42, 49-63, 75-77, 103-120, 146-171, 185-187, 191-201, 209-213, 216-230, 232-234, 257-270, 285-293, 302-315, 334-341, 344-345, 353-365, 392-394, 401-402, 406-408, 439-443, 461, 468, 471, 476-480, 482, 491, 493-494, 530-531, 534, 536, 538-539, 545-550, 553-556, 558-559, 564-565, 567, 571, 573, 575, 579, 581, 583,	IPU-B: 001-006, 020-024, 026, 070, 073, 089-093, 095, 097-098, 120-121, 160-163, 165-167, 169-171, 173-177, 180, 220-229, 260-264, 301-305, 308-310, 312-317, 320-321, 361-364, 401, 403-405, 440-447, 480-484, 510-514, 517-519, 588, 603, 608-609, 614, 630-631, 650-651, 680-681, 710-711, 791, 841-842, 850, 910-912, 950-952

VII. DRG Crosswalk

Measure	Description	MS-DRG	NYS-APDRG	NYS-APDRG
			585, 606, 609-610, 615-616, 622-624, 700-704, 730-732, 737-739, 755-759, 786-787, 789-793, 795-798, 803-809, 811, 817-819, 821, 823-824, 829, 833, 836-839, 849-854, 864-867, 874-875, 877, 879, 883-884, 892-893, 896, 898-899	
	Medicine	IPU-B: 052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 789-795, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977	IPU-B: 9-19, 21-23, 34-35, 43-48, 64-74, 78-80, 82-90, 92-97, 99-102, 121-145, 172-183, 188-189, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 395, 397-399, 403-404, 409-410, 413-414, 417-423, 444-455, 463-467, 469-470, 532-533, 535, 540-541, 543-544, 551-552, 557, 560-563, 566, 568-570, 572, 574, 576-578, 580, 582, 584, 586-589, 602-605, 607-608, 611-614, 617-621, 626-631, 633-641, 705-716, 733-734, 740, 752-754, 760-785, 794, 799-802, 810, 812-816, 820, 822, 825-826, 828, 832, 876, 878, 880-882, 887-891, 894-895, 897, 900-901	IPU-B: 040-058, 080, 082, 110-111, 113-115, 130-144, 190-194, 196-201, 203-207, 240-249, 251-254, 279-284, 340-344, 346-347, 349, 351, 380-385, 420-425, 460-463, 465-466, 468, 500-501, 530-532, 580-581, 583, 589, 591, 593, 602, 607, 611-613, 621-623, 625-626, 633-634, 636, 639-640, 660-663, 690-694, 720-724, 811-813, 815-816, 843-844, 861-863, 890, 892-894, 930
Mental Health Utilization	MH Inpatient Services	MPT-B: 876, 880-887; exclude discharges with ICD-9-CM principal diagnosis of 317-319	MPT-B: 424-432	MPT-B: 740, 750-760