

**2006 Quality Assurance Reporting Requirements
Specifications Manual
(2006 QARR/ HEDIS® 2007)**

Bureau of Quality Management and Outcomes Research
Office of Managed Care

November 2006

2006 Quality Assurance Reporting Requirements Specifications Manual (2006 QARR/ HEDIS® 2007)

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I. Submission Requirements

2006 QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data Information Set (HEDIS®) and New York State-specific (NYS-specific) measures. This version of QARR incorporates measures from HEDIS® 2007. The major areas of performance included in the 2006 QARR are:

- 1) Effectiveness of Care
- 2) Access to/Availability of Care
- 3) Satisfaction with the Experience of Care
- 4) Health Plan Stability
- 5) Use of Services
- 6) Health Plan Descriptive Information
- 7) Cost of Care
- 8) NYS-specific Prenatal Care Measures

Who Must Report

- All managed care organizations certified by the New York State Department of Health (DOH) prior to 2006 must report all QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2006 are required to submit **Enrollment by County**, and with any other measures that meet HEDIS eligibility criteria.

What to Report

Table 1 lists, by payer, the NYS-specific and HEDIS® 2007 measures required for submission. This manual describes in detail only the NYS-specific measures. Plans must purchase the HEDIS® 2007 technical specifications for descriptions of the required HEDIS® measures. Plans should always follow HEDIS® 2007 guidelines when calculating continuous enrollment periods.

Important Note: Only data for New York State residents should be included in the data used to calculate QARR measures.

Reporting by payer is as follows:

- **Commercial (CO):** The measures commercial plans are required to submit found in the Reporting Requirements section (Table 1).
 - Point of Service (POS): Follow HEDIS® 2007 instructions regarding commercial point-of-service products. Plans must state on the 2006 QARR Submission Cover Sheet whether POS is included in their rates (see Attachment 1) as well as indicate on the New York State Data Submission System (NYSDSS).
 - Live Birth file is required for submission.
- **Medicaid (MA):** The measures Medicaid plans are required to submit are found in the

- Reporting Requirements section (Table 1).
- The Chlamydia Screening and the three Well Care rates for children and adolescents are calculated by DOH using data from the Medicaid Encounter Data System (MEDS).
 - Medicaid member-level files are required. The fee-for-service (FFS) Enhancement files are optional. For Antidepressant Medication Management, the required member-level file will be used for enhancements.
- **Family Health Plus:** Plans should include Family Health Plus enrollees in their Medicaid product line for the 2006 reporting year submission. Family Health Plus members should also be included in all Medicaid file submissions.
 - **Child Health Plus (CHP):** The measures Child Health Plus (CHP) plans are required to submit are found in the Reporting Requirements section (Table 1) and CHP plans should follow the commercial specifications. However, because CHP enrollment is monthly, plans will use the 30-day break in enrollment criterion.
 - **Medicare:** With the exception of Enrollment by County, plans should **not** submit Medicare information.

Measure Rotation

The following HEDIS®/QARR measures will be rotated for the 2006 reporting year, according to the HEDIS® 2007 rotation schedule. Plans are not required to submit these measures for their commercial, Medicaid, or Child Health Plus populations. For reporting purposes, previous year's rates will be used for rotated measures.

- Childhood Immunization
- Lead Testing
- Colorectal Cancer Screening
- Beta Blocker Treatment After Heart Attack
- Well-Child Visits in the First 15 Months of Life (Commercial and Child Health Plus only)
- Well-Child Visits in the 3rd, 4th, 5th, & 6th Year of Life (Commercial and Child Health Plus only)
- Adolescent Well-Care Visits (Commercial and Child Health Plus only)

New Measure Requirements

As indicated in Table 1, the following measures are new QARR requirements for the 2006 measurement year:

- Relative Resource Use for People with Diabetes
- Relative Resource Use for People with Asthma
- Relative Resource Use for People with Acute Low Back Pain

Plans should follow HEDIS® 2007 specifications for reporting all these measures. Plans will submit all three measures for their commercial and Medicaid populations; Only Relative

Resource Use for People with Asthma is required for the Child Health Plus population.

How to Report

All plans must submit QARR data on the New York State Data Submission System (NYS DSS), which will be sent directly to plans by IPRO. Estimated completion date for the 2006 NYS DSS is March 2007. It will be sent to plans shortly thereafter.

Where to Report

The FFS enhancement files, Medicaid member-level files, and the commercial and Medicaid Live Birth files (all due June 15, 2007) should be sent to:

<p>Paul Henfield IPRO 1979 Marcus Avenue Lake Success NY 11042-1002</p>

The completed QARR submission, including commercial CAHPS results, should be sent by June 15, 2007 to:

<p>Susan Anderson Bureau of Quality Management and Outcomes Research Office of Managed Care New York State Department of Health Rm. 1864 ESP Corning Tower Albany NY 12237-0094</p>

Please remember to include the cover sheet labeled as Attachment 1 as part of your QARR submission.

Questions

Questions concerning the 2006 submission should be directed to the following individuals:

- **Data Submission System (NYS DSS):**
Lisa Balistreri (ebalistreri@ipro.org) of IPRO at (516) 326-7767 ext. 357.
- **HEDIS® 2007 measures:** NCQA - (202) 955-3500. Updates can be found on NCQA's web site: www.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:** Anne Schettine (ams13@health.state.ny.us) and Raina Josberger (rej03@health.state.ny.us) of NYSDOH at (518) 486-9012.

II. Reporting Requirements

Table 1: 2006 QARR/HEDIS 2007 - Table of Required Measures					
Measure	Commercial	Medicaid	CHPlus	Specifications	Additional Comments
Effectiveness of Care					
Childhood Immunization	NR	NR	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS.
Lead Testing	NR	NR	NR	NYS-Specific	Rotated for 2006 reporting per HEDIS.
Appropriate Treatment for Children with Upper Respiratory Infection	✓	✓	✓	HEDIS 2007	
Appropriate Testing for Children with Pharyngitis	✓	✓	✓	HEDIS 2007	
Colorectal Cancer Screening	NR	NR	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS.
Breast Cancer Screening	✓	✓	NR	HEDIS 2007	
Cervical Cancer Screening	✓	✓	NR	HEDIS 2007	Enhancement file optional for Medicaid.
Chlamydia Screening in Women	✓	DOH	NR	HEDIS 2007	Calculated using MEDS by DOH for Medicaid only. LOINC file optional for Medicaid.
Controlling High Blood Pressure	✓	✓	NR	HEDIS 2007	Medicaid Member-level file required.
Beta Blocker Treatment after Heart Attack	NR	NR	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS.
Persistence of Beta-Blocker Treatment	✓	NR	NR	HEDIS 2007	
Cholesterol Management for Patients with Cardiovascular Conditions	✓	✓	NR	HEDIS 2007	Medicaid Member-level file required.
Comprehensive Diabetes Care	✓	✓	NR	HEDIS 2007	Medicaid Member-level file required.
Use of Appropriate Medications for People with Asthma	✓	✓	✓	HEDIS 2007	
Medical Assistance with Smoking Cessation	✓	NR	NR	CAHPS 4.0H	
Follow-Up After Hospitalization for Mental Illness	✓	✓	NR	HEDIS 2007	Enhancement file optional for Medicaid.
Antidepressant Medication Management	✓	✓	NR	HEDIS 2007	Medicaid Member-level file required.
Use of Imaging Studies for Low Back Pain	✓	✓	NR	HEDIS 2007	
Use of Spirometry Testing in The Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease	✓	✓	NR	HEDIS 2007	
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓	✓	NR	HEDIS 2007	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	✓	✓	✓	HEDIS 2007	First year measure for Continuation and Maintenance measure.
Annual Monitoring for Patients on Persistent Medications	✓	✓	NR	HEDIS 2007	

Table 1: 2006 QARR/HEDIS 2007 - Table of Required Measures					
Measure	Commercial	Medicaid	CHPlus	Specifications	Additional Comments
Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	✓	✓	NR	HEDIS 2007	
Adolescent Screening and Counseling Measures	✓	✓	✓	NYS-Specific	Medicaid Member-level file required.
Access / Availability of Care					
Adult Access to Preventive/Ambulatory Care	✓	✓	NR	HEDIS 2007	
Children's Access to PCPs	✓	✓	✓	HEDIS 2007	
Prenatal and Postpartum Care	✓	✓	NR	HEDIS 2007	
Annual Dental Visit	NR	✓	✓	HEDIS 2007	
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	✓	NR	NR	HEDIS 2007	
Health Plan Descriptive Information					
Board Certification	✓	✓	NR	HEDIS 2007	
Enrollment by County	✓	✓	✓	NYS-Specific	Include Family Health Plus membership under Medicaid line of business.
Cost of Care					
Relative Resource Use for People with Diabetes	✓	✓	NR	HEDIS 2007	New Measure for 2006 Reporting
Relative Resource Use for People with Asthma	✓	✓	✓	HEDIS 2007	New Measure for 2006 Reporting
Relative Resource Use for People with Acute Low Back Pain	✓	✓	NR	HEDIS 2007	New Measure for 2006 Reporting
Use of Services					
Well-Child Visits in the First 15 Months of Life	NR	DOH	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS. Calculated using MEDS by DOH for Medicaid only.
Well-Child Visits in the 3rd, 4th, 5th & 6th Year	NR	DOH	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS. Calculated using MEDS by DOH for Medicaid only.
Adolescent Well-Care Visits	NR	DOH	NR	HEDIS 2007	Rotated for 2006 reporting per HEDIS. Calculated using MEDS by DOH for Medicaid only.
Frequency of Ongoing Prenatal Care	NR	✓	NR	HEDIS 2007	
Frequency of Selected Procedures					
Myringotomy	✓	✓	✓	HEDIS 2007	
Tonsillectomy	✓	✓	✓	HEDIS 2007	
Dilation & Curettage	✓	✓	NR	HEDIS 2007	

Table 1: 2006 QARR/HEDIS 2007 - Table of Required Measures

Measure	Commercial	Medicaid	CHPlus	Specifications	Additional Comments
Hysterectomy, vaginal & abdominal	✓	✓	NR	HEDIS 2007	
Cholecystectomy, open & closed	✓	✓	NR	HEDIS 2007	
Back Surgery	✓	✓	NR	HEDIS 2007	
Angioplasty (PTCA)	✓	NR	NR	HEDIS 2007	
Cardiac Catheterization	✓	NR	NR	HEDIS 2007	
Coronary Artery Bypass Graft (CABG)	✓	NR	NR	HEDIS 2007	
Prostatectomy	✓	NR	NR	HEDIS 2007	
Mastectomy	✓	✓	NR	HEDIS 2007	
Lumpectomy	✓	✓	NR	HEDIS 2007	
Inpatient Utilization	✓	✓	✓	HEDIS 2007	
Ambulatory Care	✓	✓	✓	HEDIS 2007	
Discharges and ALOS Maternity Care	✓	✓	NR	HEDIS 2007	
Births and ALOS Newborns	✓	✓	NR	HEDIS 2007	
Inpatient Mental Health Utilization	✓	✓	NR	HEDIS 2007	
Inpatient Chemical Dependency Utilization	✓	✓	NR	HEDIS 2007	
Identification of Alcohol and Other Drug Services	✓	NR	NR	HEDIS 2007	
Satisfaction with the Experience of Care					
Satisfaction Survey	✓	NR	NR	CAHPS 4.0H	Commercial plans will submit CAHPS results for their adult membership.
NYS-Specific Prenatal Care Measures					
Risk-Adjusted Low Birth Weight	These prenatal care measures will be calculated by the Office of Managed Care using the birth data submitted by plans and the Department's Vital Statistics Birth File.				
Prenatal Care in the First Trimester					
Access to Facilities for High-Risk Deliveries					

III. Audit Requirements

- HMOs must contract with an NCQA-certified auditor for a full audit of their commercial, Medicaid and Child Health Plus QARR data, as applicable.
- The Prepaid Health Services Plans (PHSPs) will be participating in a department-sponsored audit conducted by IPRO.
- Plans that serve CHP enrollees must include the CHP population in the audit. When applicable, the department-sponsored audit of the PHSPs will include CHP.
- Non-PHSPs must send a copy of the written agreement with an independent auditor to the following address by **March 1, 2007**.

Susan Anderson Bureau of Quality Management & Outcomes Research Office of Managed Care New York State Department of Health Rm. 1864 ESP Corning Tower Albany NY 12237-0094

- It is recommended that health plans provide a draft version of the NYS DSS to their independent auditor along with the Medicaid enhancement files, Medicaid member-level files, and commercial and Medicaid birth files prior to the June 15 deadline (Recommended by June 1, 2007). Auditors should check for accuracy and that the specified variables in these files and the NYS DSS correspond.
- **A copy of the Audit Designation Table (from the NYS DSS) must be submitted to the Office of Managed Care with your QARR submission by June 15, 2007.**
- A copy of the report of Final Audit Findings, including identified problems, corrective actions and measure-specific results, must be submitted to the Office of Managed Care upon receipt from your auditor (due to the Office of Managed Care by **July 31, 2007**). The final audit report must contain audit validation signatures.
- The Office of Managed Care 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

Table 2: The following table includes due dates and destinations for the various components of the QARR submission.

Submission Requirement	HMOs		PHSPs	
	Due Date	Destination	Due Date	Destination
<ul style="list-style-type: none"> A copy of a written agreement with an independent auditor. (Indicate that CHPlus is included in the audit, if applicable.) 	March 1, 2007	NYSDOH	N/A	N/A
<ul style="list-style-type: none"> 2006 QARR Submission Cover Sheet Data Submission System (DSS) diskette (For all plans, the first version of the DSS is due to auditors 2 weeks prior to submission deadline to NYS) Hard copy of 2006 QARR DSS submission, including the name(s) and phone number(s) of individuals to contact with questions Audit Designation Table (Commercial, Medicaid, & CHPlus), printed as part of the 2006 NYS DSS 	June 1, 2007 June 15, 2007	Auditor NYSDOH	June 1, 2007 June 15, 2007	I PRO NYSDOH
<ul style="list-style-type: none"> Medicaid Enhancement Files Medicaid Member-level Files Birth Diskette (Commercial & Medicaid) <p>For all plans, DOH recommends that the first version of the DSS be sent to auditors 2 weeks prior to the submission deadline to NYSDOH. Auditors will compare Diskettes to DSS for accuracy before they lock the DSS.</p>	June 1, 2007 June 15, 2007	Auditor I PRO	June 1, 2007	I PRO
<ul style="list-style-type: none"> Commercial CAHPS Survey (plans must instruct CAHPS Survey vendors to submit a diskette containing enrollee-specific data following NCQA specifications to NYSDOH). 	June 15, 2007	NYSDOH	N/A	N/A
<ul style="list-style-type: none"> Full report of Final Audit Findings, including identified problems, corrective actions and measure-specific results containing original validation signatures. 	July 31, 2007	NYSDOH	N/A	N/A

V. New York State-Specific Measures

ADOLESCENT PREVENTIVE CARE MEASURES Commercial, Medicaid, and Child Health Plus

Description

The percentage of adolescents ages 14 to 18 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an OB/GYN practitioner during the measurement year, receiving the following six components of care during the measurement year:

1. Body Mass Index (BMI) screening,
2. Assessment or counseling or education on nutrition **and** exercise,
3. Counseling or education on risk behaviors associated with sexual activity and preventive actions,
4. Assessment for depression,
5. Assessment or counseling or education about the risks of tobacco usage, and
6. Assessment or counseling or education about the risks of substance use (including alcohol and excluding tobacco).

Note:

- The MCO may count services that occur over multiple visits toward this measure as long as all services occur within the timeframe established in the measure and were provided by a PCP or OB/GYN.
 - The MCO may include sick visits that occur within the timeframe.
 - The MCO 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, Medicaid, and Child Health Plus

Age: Adolescents 14 to 18 years old as of December 31, 2006

Continuous Enrollment: The measurement year (Jan. 1 – Dec. 31, 2006)

Allowable Gap: For Commercial, the member may have no more than one gap in enrollment of up to 45 days during the measurement year. For Medicaid and Child Health Plus, the member may not have more than a 1-month gap in coverage.

Anchor Date: Enrolled as of December 31 of the measurement year.

Event: Administrative data of at least one well care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below are considered to have received a well care visit. (Table AWC-A: Codes to Identify Adolescent Well-Care Visits from

HEDIS® 2007, Volume 2).

CPT Codes	ICD-9-CM Codes
99383 – 99385, 99393 - 99395	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Denominator

Step 1: For each product line, members who are 14 to 18 years old as of December 31, 2006 and who met the continuous enrollment criteria with the respective gap allowances for each product, who were enrolled as of December 31, 2006 and had a well care visit in administrative data with a PCP or OB/GYN during the measurement year.

Step 2: Remove from the denominator members who are identified as being pregnant during the measurement year. Codes to identify pregnant members can be found in HEDIS® 2007, Volume 2 - Disease Modifying Anti-Rheumatic Drug Therapy Measure, Table ART-D: Codes to Identify Exclusions – Pregnancy only.

Step 3: A systematic sample drawn from the MCO's eligible population. The measure will be based on 100 eligible members, with a 10% oversample. If the eligible population is less than 110, the entire eligible population should be used.

Random Number (RAND) for the Adolescent Preventive Care Measures

Measure	RAND
Adolescent Preventive Care Measures	.67

Step 4: If a member is identified through medical record review to have had pregnancy related care, beyond a test for pregnancy during the measurement year, the member should be removed from the denominator and substituted with a record from the oversample.

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

Numerator 1: Screening for a Weight Issue Using Body Mass Index (BMI)

Documentation in the medical record of a BMI or BMI percentile during the measurement year.

Any of the following elements are positive findings:

- Notation of BMI calculation in the medical record
- Notation of BMI percentile in the medical record
- Notation of BMI on graph
- Notation of BMI percentile on graph.

The following are not positive findings:

- No evidence of BMI calculation or percentile written in medical record or plotted on graph
- BMI noted prior to or after the measurement year
- Documentation of Weight/Height only

Numerator 2: Assessment or Counseling or Education on Nutrition and Exercise

Documentation in the medical record of **nutrition** assessment or counseling or education being provided during the measurement year **and exercise** assessment or counseling or education being provided during the measurement year. Any of the following elements are positive findings:

- Notations of assessment of current behaviors (e.g. eating habits, exercise routine, participation in sports activities, etc.)
- Use of a checklist indicating both topics were addressed
- Notation of counseling or referral (includes community programs known to address both nutrition and activity, such as Weight Watchers)
- Distribution of educational materials to the member, specifically geared towards nutrition and exercise
- Notation of “anticipatory guidance” for nutrition and exercise
- Notation regarding each topic even if the activity (assessment vs. counseling) is different for the individual topics. For example, assessment of exercise and counseling of nutrition would count.

The following are not positive findings:

- No assessment/ Counseling/ Education on nutrition and exercise
- Assessment and counseling in ONE area alone (nutrition without exercise or vice versa)
- Assessment/ Counseling/ Education prior to or after the measurement year
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that nutrition and exercise were addressed

Numerator 3: Counseling or Education on Risk Behaviors Associated with Sexual Activity and Preventive Actions

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

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

- Use of a checklist indicating any of the above noted topics were discussed
- Notation of counseling or referral for treatment or testing for HIV/STDs
- Notation of a prescription or dispensing for contraceptives with any of the above mentioned topics discussed
- 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 Counseling/Education on risk behaviors associated with sexual activity and preventive actions
- Counseling/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
- Notation of a prescription or dispensing for contraceptives, without any of the above mentioned documentation
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that sexual activity topics were addressed
- Inquiry of sexual history without any of the above mentioned documentation

Numerator 4: Assessment for Depression

Documentation in the medical record of an assessment for depression during the measurement year. The documentation can include:

- Notation from a health assessment about the adolescent’s depressive symptoms during the measurement year
- Use of a checklist indicating that the topic was addressed
- Inquiry of depression (e.g. “denies depression”, “depression – none”, “depression-yes or no”)
- Inquiry as to whether the member felt down, depressed, or hopeless
- Inquiry as to whether the member felt little interest or pleasure in doing things
- Notation of the mental health status and/or suicide ideation
- Notation of counseling or referral for treatment
- Discussion of antidepressant medications
- Notation of treatment for depression in the measurement year
- Notation of assessment for behavior and mood

The following are not positive findings:

- No assessment for depression
- Prescription for antidepressant without any of the above-mentioned documentation
- Mental health treatment for other conditions (e.g., ADHD)
- Assessment for depression prior to or after the measurement year
- Diagnosis of depression only (no assessment/inquiry or treatment noted)
- Inquiries regarding sleep, stress, coping without being related to a depression screening

Numerator 5: 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

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 6: 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, 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:

- 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

CHLAMYDIA SCREENING IN WOMEN

Medicaid

This measure is calculated by DOH for the Medicaid population only. Plans submitting information about their commercial members should follow HEDIS[®] 2007 specifications.

The Department calculates this rate using the Medicaid Encounter Data System (MEDS). Plans do not need to submit HEDIS/QARR data for this measure for their Medicaid population. If plans wish to have LOINC data included in the DOH calculation, an optional file may be submitted (refer to Section VI. *Medicaid File Submissions*). The specifications presented here can also be found on the MEDS Home Page on the Health Provider Network (HPN).

Description

The percentage of females enrolled in Medicaid managed care (MMC) ages 16 through 25 who were identified as being sexually active and who had at least one test for Chlamydia during the measurement year (January 1, 2006 – December 31, 2006). This measure is based on HEDIS[®] 2007 specifications.

Eligible Population

Female enrollees ages 16 to 25 years as of December 31, 2006.

Continuous Enrollment

The measurement year (January 1, 2006 - December 31, 2006).

Denominator Criteria

The eligible population who were sexually active during the measurement year as indicated by having at least one claim/encounter with diagnosis, procedure and/or pharmacy codes as specified by Table CHL-A in HEDIS[®] 2007 (Technical Specifications Vol.2, page 91).

Please note: MEDS II does not contain LOINC (Logical Observation Identifiers Names and Codes) data. If plans want to include LOINC data in the calculation of their screening rates, an optional enhancement file must be submitted with the LOINC information. Unlike other enhancement files that include just denominator members, the plans should submit all members who meet the eligible population and continuous enrollment criteria AND who have an appropriate LOINC code from Table CHL-B in HEDIS[®] 2007 (Technical Specifications Vol.2, page 92). Data from plan-submitted files will be matched to MEDS claims and encounters. In order for a plan to be allowed an additional numerator “hit”, a corresponding MEDS encounter must be identified.

Numerator Criteria

Individuals within the denominator who had at least one Chlamydia test (CPT procedure codes: 87110, 87270, 87320, 87490, 87491, 87492, and 87810) during the measurement year.

Exclusions

Optional exclusions will not be calculated.

Data Sources

MEDS encounter data and fee-for-service claims.

WELL-CHILD AND ADOLESCENT WELL-CARE VISITS

Medicaid

These Medicaid-only measures are calculated by DOH:

1. Well-Child Health Visits in the First 15 Months of Life
2. Well-Child Health Visits in the Third, Fourth, Fifth, and Sixth Years of Life
3. Adolescent Well-Care Visits

The Department calculates these rates using the Medicaid Encounter Data System (MEDS). Plans do not need to submit any HEDIS/QARR data for these measures for their Medicaid population. The specifications presented here can also be found on the MEDS Home Page on the Health Provider Network (HPN).

1. Well-Child Visits in the First 15 Months of Life

Description

The percentage of Medicaid managed care (MMC) enrollees who turned 15 months old during the measurement year, who received five or more well-child visits or EPSDT Preventive Care Services during their first 15 months of life. (Based on HEDIS[®] 2007 specifications)

Eligible Population

Children turning 15 months old during the measurement period (January 1, 2006 – December 31, 2006).

Continuous Enrollment

Enrolled in Medicaid for 14 months

Denominator Criteria

The eligible population enrolled in Medicaid as of December 31 of the measurement year.

Numerator Criteria

Individuals within the denominator who had at least five or more well-child visits during the measurement year (See **Table1**).

Data Source

MEDS encounter data.

Table 1. Codes Used to Identify Well-Child Visits

Diagnosis Codes (V-codes)	V03, V035, V036, V037, V038, V0381, V0382, V0389, V039, V04, V040, V042, V043, V046, V053, V054, V058, V059, V06, V061, V063, V064, V065, V068, V069, V20, V200, V201, V202, V700, V703, V705, V706, V708, V709
Procedure Codes (CPT codes)	83655, 85013, 85014, 85018, 90471, 90472, 90645, 90646, 90647, 90648, 90669, 90700 – 90713, 90716, 90718 – 90721, 90723, 90731, 90740, 90744, 90745, 90747, 90748, 99381 – 99385, 99391 – 99395, 99432
Procedure Codes (ICD-9 codes)	9936, 9937, 9938, 9939, 9945, 9946, 9947, 9948
Provider Specialty Codes	050, 055, 056, 058, 060, 089, 092, 150, 158, 159, 169, 182, 185, 247, 252, 253, 254, 270, 401, 402, 403, 404, 601, 602, 620, 621, 776, 777,

779, 782, 904, 905, 906, 908, 914, 936, 978, 990, 991

2. Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life

Description

The percentage of Medicaid managed care (MMC) enrollees ages three to six years old who received one or more well-child visits with a primary care practitioner during the measurement year (January 1, 2006 – December 31, 2006).

Eligible Population

Children, ages three-six years old as of December 31, 2006.

Continuous Enrollment

The measurement year.

Denominator Criteria

The eligible population enrolled in Medicaid as of December 31st of the measurement year.

Numerator Criteria

Individuals within the denominator who had at least one well-child visit with a primary care practitioner during the measurement year (**See Table 2**).

Data Source

MEDS encounter data.

Table 2. Codes Used to Identify Well-Child Visits

Diagnosis Codes (V-codes)	V03, V035, V036, V037, V038, V0381, V0382, V0389, V039, V04, V040, V042, V043, V046, V053, V054, V058, V059, V06, V061, V063, V064, V065, V068, V069, V20, V200, V201, V202, V700, V703, V705, V706, V708, V709
Procedure Codes (CPT codes)	90471, 90472, 90645 – 90648, 90669, 90700 – 90713, 90716, 90718 – 90721, 90723, 90731, 90740, 90744, 90745, 90747, 90748, 99381 – 99385, 99391 -99395, 99432
Procedure Codes (ICD-9)	9936, 9937, 9938, 9939, 9945, 9946, 9947, 9948
Provider Specialty Codes	050, 055, 056, 058, 060, 089, 092, 150, 158, 159, 169, 182, 185, 247, 252, 253, 254, 270, 401, 402, 403, 404, 601, 602, 620, 621, 776, 777, 779, 782, 904, 905, 906, 908, 914, 936, 978, 990, 991

3. Adolescent Well-Care Visits

Description

The percentage of Medicaid managed care (MMC) enrollees ages twelve – twenty-one years old who received one or more well-child visits with a primary care practitioner during the measurement year (January 1, 2006 – December 31, 2006).

Eligible Population

Adolescents ages twelve – twenty-one years old as of December 31, 2006.

Continuous Enrollment

The measurement year.

Denominator Criteria

The eligible population enrolled in Medicaid as of December 31st of the measurement year.

Numerator Criteria

Individuals within the denominator who had at least one well child visit with a primary care practitioner during the measurement year (**See Table 3**).

Data Source

MEDS encounter data.

Table 3. Codes Used to Identify Well-Child Visits

Diagnosis Codes (V-codes)	V03, V035, V036, V037, V038, V0381, V0382, V0389, V039, V04, V040, V042, V043, V046, V053, V054, V058, V059, V06, V061, V063, V064, V065, V068, V069, V20, V200, V201, V202, V700, V703, V705, V706, V708, V709
Procedure Codes (CPT codes)	90471, 90472, 90645 – 90648, 90669, 90700 – 90713, 90716, 90718 – 90721, 90723, 90731, 90740, 90744, 90745, 90747, 90748, 99381 – 99385, 99391 - 99395, 99432
Procedure Codes (ICD-9)	9936, 9937, 9938, 9939, 9945, 9946, 9947, 9948
Provider Specialty Codes	050, 055, 056, 058, 060, 089, 092, 150, 158, 159, 169, 182, 185, 247, 252, 253, 254, 270, 401, 402, 403, 404, 601, 602, 620, 621, 776, 777, 779, 782, 904, 905, 906, 908, 914, 936, 978, 990, 991

PRENATAL CARE MEASURES/BIRTH DISK
Medicaid/Commercial

The following prenatal care performance measures will be calculated by the Office of Managed Care using the birth data submitted by plans and 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, 2006 through December 31, 2006)*** 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 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.

****Please note that this differs from prior years where the HEDIS timeframe was used.***

Reporting Requirements

Plans are to report all live births that occurred during the period of **January 1, 2006 to December 31, 2006** to the Office of Managed Care. 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 unavailable, the Office of Managed Care 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, Lookups-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

The plan's data will be formatted on a CD/diskette as described in the following reporting Specifications:

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

Medicaid: Submit one diskette containing Medicaid members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-97.

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

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, 2006 to December 31, 2006. 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® 2007 Technical Specifications for identification of the eligible group. Plans using the New York State AP-DRGs should use the following codes to identify deliveries.

Description	Federal DRGs	NYS AP-DRGs
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Identify Live Births	370-375	370-375, 650-652
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Further identification of deliveries and verification of live births should be done using the ICD-9-CM diagnosis codes and CPT procedure codes according to HEDIS® 2007 specifications.

Record Format for Medicaid and Commercial

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
Date of Delivery	49-56	DDMMYYYY	Year must include four digits (e.g., 2006)
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., 2006)
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

Element Name	Location	Coding	Notes
			plan.
Mother's Medicaid ID Number	90-97	AA#####A	Omit for commercial; it is not applicable. (Medicaid only)

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, Office of Managed Care, Provider Network Home Page, Operating Facility Codes, Hospitals – Updated October, 2006. *Valid birth center PFI codes can be found in the Diagnostic & Treatment Centers (clinics) file, also under the Operating Facility Codes page.*

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

HEADER FORMAT:

Element	Location	Coding
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified
Number of deliveries on diskette	21-25	Right justified
Date diskette written	26-33	DDMMYYYY

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

ENROLLMENT BY COUNTY

All Payors

Data Collection Specifications

Plans will report the number of enrollees per payer type in the plan as of **December 31, 2006**. Each member is to be reported only once regardless of duration of enrollment. The enrollee's county of residence as of **December 31, 2006** should be used for designation of county. The enrollee may be included in only one of the following categories, also determined through the member's status as of **December 31, 2006**.

- C Commercial Point of Service (POS)
- C Commercial/HMO Only
- C Direct Pay
- C Medicare Risk
- C Medicaid (*include Family Health Plus*)
- C Child Health Plus

"Commercial/HMO Only" includes large and small group plans and individual policies. "Direct Pay" enrollment includes members covered under individual direct payments contracts consistent with the provisions of Chapter 501 of the Laws of 1992. COBRA conversions should not be included in direct pay enrollment.

Please note that all enrolled members should be included in one of the above categories. Membership counted in calculation of QARR measures should be included in the appropriate category. Enrollment category of "Other" is not available on the NYS DSS.

Data Collection Tool

Plans will report data on the 2006 QARR NYS DSS.

VI. Medicaid File Submissions

Medicaid Member-level Files and Optional Enhancements

The Office of Managed Care (OMC) will be evaluating select measures using the Medicaid Encounter Data System 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. Client Identification Numbers (CINs) should be submitted for these enrollees included in the denominator for the measures specified below.

Measure	Required Member-level File	Optional Enhancements
Cervical Cancer Screening		✓
Chlamydia Screening		✓ (LOINC)
Controlling High Blood Pressure	✓	
Cholesterol Management for Patients with Cardiovascular Conditions	✓	
Comprehensive Diabetes Care	✓	
Follow-up After Hospitalization for Mental Illness		✓
Antidepressant Medication Management	✓	
Adolescent Preventive Care Measures	✓	

Medicaid Member-level Files (Required)

For the measures listed below, please submit a separate file for each, listing all the recipients included in the denominator along with an indicator showing whether each was included in the numerator, according to the following layout.

- Eligible members in the denominator should only be counted once.
- Plans should check for duplicate members in the diskette prior to submission.
- Conduct edit checks to make sure the denominator file matches the aggregate denominator and numerator reported in the NYS DSS.
- Plans should provide these materials to their auditor for comparison prior to the auditor lock of the DSS.
- The OMC Plan Identification number must be included for each member included in the denominator; this number can be referenced from the NYS DSS.
- The data must be saved as a file with a PRN file extension; dates must be YYYYMMDD.

Include these files on a separate diskette or CD-ROM. Plans are required to submit these member-level files for their Medicaid product lines.

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Controlling High Blood Pressure	OMC Plan ID (Refer to NYS DSS)	1-7	HighBP.prn
	CIN	8-15	
	Included in Numerator? (1=Yes; 0=No)	16	
Cholesterol	OMC Plan ID (Refer to NYS DSS)	1-7	Cholesterol.pr

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Management for Patients with Cardiovascular Conditions	CIN	8-15	n
	Included in Numerator for LDL-C Screening? (1=Yes; 0=No)	16	
	Included in Numerator for LDL-C <100mg/dL? (1=Yes; 0=No)	17	
Comprehensive Diabetes Care	OMC Plan ID (Refer to NYS DSS)	1-7	Diabetes.prn
	CIN	8-15	
	Included in Numerator for HbA1c Tested? (1=Yes; 0=No)	16	
	Included in Numerator for HbA1c >9.0%? (1=Yes; 0=No)	17	
	Included in Numerator for HbA1c <7.0%? (1=Yes; 0=No)	18	
	Included in Numerator for Eye Exam? (1=Yes; 0=No)	19	
	Included in Numerator for LDL-C Screening? (1=Yes; 0=No)	20	
	Included in Numerator for LDL-C <100mg/dL? (1=Yes; 0=No)	21	
	Included in Numerator for Nephropathy? (1=Yes; 0=No)	22	
	Included in Numerator for Blood Pressure <140/90 mm Hg? (1=Yes; 0=No)	23	
	Included in Numerator for Blood Pressure <130/80 mm Hg? (1=Yes; 0=No)	24	
Adolescent Preventive Care Measures	OMC Plan ID (Refer to NYS DSS)	1-7	AdolPrev.prn
	CIN	8-15	
	Included in Numerator1 for BMI? (1=Yes; 0=No)	16	
	Included in Numerator2 for Nutrition and exercise? (1=Yes; 0=No)	17	
	Included in Numerator3 for Sexual activity and Preventive actions? (1=Yes; 0=No)	18	
	Included in Numerator4 for Depression? (1=Yes; 0=No)	19	
	Included in Numerator5 for Tobacco usage? (1=Yes; 0=No)	20	
Included in Numerator6 for Substance use? (1=Yes; 0=No)	21		
Antidepressant Medication Management: 1) Optimal	OMC Plan ID (Refer to NYS DSS)	1-7	Antidep.prn
	CIN	8-15	
	Included in Numerator 1? (1=Yes; 0=No)	16	
	Index Episode Start Date (YYYYMMDD)	17-24	

Measure	Data Elements – MEDICAID ONLY	Fields	File Name
Practitioner Contacts, 2) 84 Day Acute Phase, and 3) 180 Day Effective Phase Treatment	Subsequent Visit Date1 (YYYYMMDD)	25-32	For Provider Information: For each visit, in the MMIS field, please use 88888888 for “out of state” providers; 99999999 for “unknown provider”. If the provider is a facility, use the facility MMIS Number. Please make every attempt to identify the individual provider. If provider license or name is unknown, leave blank.
	Provider MMIS Number	33-40	
	Provider License Number	41-46	
	Provider Last Name	47-71	
	Indicator of Prescribing Provider? (1=Yes; 0=No)	72	
	Subsequent Visit Date2 (YYYYMMDD)	73-80	
Provider MMIS Number	81-88		
Provider License Number	89-94		
Provider Last Name	95-119		
Indicator of Prescribing Provider? (1=Yes; 0=No)	120		
Subsequent Visit Date3 (YYYYMMDD)	121-128		
Provider MMIS Number	129-136		
Provider License Number	137-142		
Provider Last Name	143-167		
Indicator of Prescribing Provider? (1=Yes; 0=No)	168		
Included in Numerator 2? (1=Yes; 0= No)	169		
Included in Numerator 3? (1=Yes; 0=No)	170		

Antidepressant Medication Management – Optimal Practitioner Contacts for Medication

Management: The Office of Managed Care will use Medicaid fee-for-service (FFS) data to determine whether out-of-plan services were used for this component of the measure. Members not meeting the criteria for Numerator 1 will be used for enhancement in the FFS data.

Medicaid Enhancements (Optional)

Client Identification Numbers (CINs) for the following 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.

- 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 Managed Care 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.

- **Cervical Cancer Screening:** If you would like the Office of Managed Care to evaluate Medicaid FFS data to determine whether out-of-plan services were used for this measure, in addition to the CIN, please include an indicator (1 = Yes; 0 = No) if the member was included in the numerator.

LOINC Data

Client Identification Numbers (CINs) for the Chlamydia screening measure should be submitted for those enrollees who meet eligibility criteria and continuous enrollment criteria AND who have an appropriate LOINC code. The plan should not determine if eligibles are in the denominator (meeting codes for identifying sexual activity). Data from plan-submitted files will be matched to MEDS claims and encounters. In order for a plan to be allowed an additional numerator “hit”, a corresponding MEDS encounter must be identified.

- **Chlamydia Screening:** If you would like the Office of Managed Care to use the plan LOINC data in the calculation of your screening rate, in addition to the CIN, include a service date and the LOINC code. Only those instances where there is a corresponding encounter in MEDS, will the additional numerator event be given to the plan.

For the following Medicaid measures, please submit a separate file for each measure, listing all recipients included in the denominator (or eligible group for Chlamydia Screening), according to the following layout. Please note that the OMC Plan Identification number must be included for each member included in the denominator. This ID number can be referenced from the NYS DSS. Please also note that the data must be saved as a file with a PRN file extension; dates must be YYYYMMDD. Incorrectly submitted files (e.g., incorrect number of CINs) may not be processed for enhancements.

Conduct edit checks to make sure the denominator file matches the aggregate denominator and numerator reported in the NYS DSS. Plans should provide these materials to their auditor for comparison prior to the auditor lock of the DSS. The exception to the edit check will be the Chlamydia Screening file as it is not calculated by the plan.

Measure	Data Elements Needed	Fields	File Name
Follow-Up After Hospitalization for Mental Illness: 1) 7 Day and 2) 30 Day	OMC Plan ID (Refer to NYS DSS)	1-7	Followup.prn
	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	
Cervical Cancer Screening	OMC Plan ID (Refer to NYS DSS)	1-7	Cervical.prn
	CIN	8-15	
	Included in Numerator? (1=Yes; 0=No)	16	
Chlamydia Screening (for submitting LOINC codes)	OMC Plan ID (Refer to NYS DSS)	1-7	Chlamydia.prn
	CIN	8-15	
	Service Date (YYYYMMDD)	16-23	

Measure	Data Elements Needed	Fields	File Name
	LOINC Code (Left Justified, no hyphen, no leading zeros)	24-29	

Plans will be advised of their updated rates subsequent to the incorporation of out-of-plan numerator events.

VII. Federal DRGs and NYS All Patient DRGs (AP-DRGs)

Table 3 on the next page has been developed to assist health plans with HEDIS measure specifications that refer to federal Diagnosis Related Groups (DRGs).

New York State's version of federal DRGs is referred to as the All Patient Diagnosis Related Groups (AP-DRGs) and was developed by the New York State Department of Health and 3M Health Information Systems.

Although both federal DRGs and New York State's AP-DRGs are assigned to appropriate Major Diagnostic Categories (MDCs) based upon principal diagnosis, AP-DRG assignment is not always a direct match with a federal DRG assignment. There are AP-DRG codes with no federal DRG equivalent. Therefore, a "direct crosswalk" is not possible between these two classification systems.

HEDIS measures with an inpatient component refer to the federal grouper for DRG assignment. Plans using the New York State-specific grouper and AP-DRGs should be aware of differences that may exist between the two groupers. Table 3 lists those HEDIS measures with DRGs included in the specifications and the corresponding AP-DRGs.

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.

Questions on technical updates to federal DRGs in the current version of HEDIS should be directed to NCQA at www.ncqa.org or 1-888-275-7585. For further information on AP-DRGs or how to purchase the updated grouper software, plans can contact the department's Division of Health Care Financing at (518) 474-6350

Table 3. AP-DRGs for HEDIS measures with DRGs included in the specifications

Measure	Description	NYS AP-DRG
Effectiveness of Care		
Antidepressant Medication Management	Major Depression	426
	Prior Depressive Episodes	426
Beta Blocker Treatment After Heart Attack	AMI	121, 122, 808, 853
Persistence of Beta Blocker Treatment After Heart Attack	AMI	121, 122, 808, 853
Cholesterol Management for Patients With Cardiovascular Conditions	AMI (Inpatient only)	121, 122, 808
	PTCA	112, 808, 852-854
	CABG (Inpatient only)	106, 107, 109, 546
	Stable angina	140
	Ischemia	832
Comprehensive Diabetes Care	Diabetes Diagnosis	294, 295
	Evidence of Diagnosis of or treatment for nephropathy	316, 317, 568
Follow-Up After Hospitalization for Mental Illness	Identify Mental Health Diagnosis	426, 430
Annual Monitoring for Patients on Persistent Medications	Identify Total Inpatient Discharges	1-2, 6-25, 34-46, 47, 48, 49-80, 82-90, 92-97, 99-183,185-189, 191-213, 216-230, 232-335,336-345, 346-382, 392-395,397-399, 401-404, 406-410, 413-423, 424-432, 439-455, 461,462, 463-469,470,471, 476-480, 482, 491, 493-494, 530-536, 538-541,543-587, 588, 589, 602, 603, 604, 605, 606, 607, 608, 609-624, 626-631, 633-634, 635, 636, 637- 641, 650-652, 700-716, 730-734, 737-740, 743-751,752-787, 789-829, 832-833, 836-839, 849-854, 864-867, 874-876, 877-886
Access and Availability of Care		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Identify Inpatient Services	750-751
Prenatal and Postpartum Care Measures	Identify Live Births	370-375, 650-652
Use of Services		
Births & ALOS: Newborns	Identify Total Newborns	602-624, 626-630, 635, 637-641
Chemical Dependency Utilization-Inpatient Discharges and ALOS	Identify Inpatient Services	749-751, 743-748
Discharges and ALOS: Maternity Care	C-Sections and Vaginal Deliveries	650-652, 370-375
Mental Health Utilization-Inpatient Discharges and ALOS	Identify Inpatient Services	424-432, 753

Measure	Description	NYS AP-DRG
Use of Services		
Frequency of Selected Procedures	Angioplasty (PTCA)	112, 808, 852-854
	Back Surgery	806, 807, 836, 837
	Cardiac catheterization	104, 124-125, 849, 850
	Cholecystectomy, open & closed	195-198
	Coronary artery bypass graft (CABG)	106-107, 109, 546
	Dilation & Curettage	363, 364
	Hysterectomy, vaginal & abdominal	353
	Lumpectomy	259, 260, 262
	Mastectomy	257, 258
	Myringotomy	61, 62
	Prostatectomy	306, 307
	Tonsillectomy	57, 58, 59, 60
Identification of Alcohol and Other Drug Services	Identify Inpatient Services	743-751
Inpatient Utilization -Non Acute Care	Identify -Non Acute Care	462
Use of Services		
Inpatient Utilization: General Hospital/Acute Care	Total Inpatient	1-2, 6-25, 34-46, 47, 48, 49-80, 82-90, 92-97, 99-183,185 189, 191-213, 216-230, 232-335,336-345, 346- 382, 392-395, 397-399, 401-404, 406-410, 413-423, 439-455, 461,463-468, 469,470 471, 476- 480, 482, 491, 493-494, 530-536, 538-541, 543-589, 631,633-634, 636, 650-652, 700-716, 730-734, 737-740, 752-787, 789-829, 832-833, 836-839, 849-854, 864-867, 874-876, 877-886
	Maternity	370-382, 650-652
	Surgery	1-2, 6-8, 36-42, 49-63, 75-77, 103-120, 146-171, 191-201, 209-213, 216-230, 232-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394, 401-402, 406-408, 415, 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, 585, 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, 874-875,877-878, 879,883-885,
Medicine	9-25, 34-35, 43-46,47-48, 64-74, 78-80, 82-90, 92-97, 99-102, 121-145, 172-183, 185-189 , 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369,395,397-399, 403-404, 409-410, 413-414, 416-423, 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, 586-587,588,589, 631, 633-634, 636, 705-716, 733-734, 740, 752-754, 760-785, 794, 799-802, 810, 812-816, 820, 822, 825-828, 832, 876, 880-882, 886	

VIII. Attachments

Attachment 1 –

2006 QARR SUBMISSION COVER SHEET

Plan Name: _____

QARR Contact: _____

Address: _____

City: _____ State: _____ ZIP: _____

E-mail: _____

Phone: _____ Fax: _____

Commercial Plans Only:

Is POS included in commercial calculations? YES NO

Medicaid Plans Only:

Is Family Health Plus included in Medicaid calculations? YES NO

Please check the items that you have included in this **NYS submission** package due to the department by COB **June 15, 2007**:

- QARR data submission diskette containing NYS DSS extraction file dss_dex.mdb
- Hard copy of 2006 QARR data submission
- Audit Designation Table – including targeted (core or expanded) audit measures and measure-specific audit results.
- Commercial CAHPS enrollee-specific data diskette

The following items should be sent to **IPRO** by **COB June 15, 2007**:

1. Birth diskette (Commercial & Medicaid)
2. Medicaid Enhancement Files (Inclusion of these files is optional.)
3. Medicaid Member-level Files (Inclusion of these files is required.)