

December 26, 2012

RE: Clarification #1 for 2013 Quality Assurance Reporting Requirements Technical Specifications

Dear Colleague:

This clarification contains additional guidance for data collection for the 2013 Quality Assurance Reporting Requirements Technical specifications manual (dated October 12, 2012). The information contained in this clarification should be incorporated into the 2013 QARR manual and in plans processing for QARR production.

A. Inclusion of Pharmacy Claim Reversals in Effectiveness of Care measures

For 2013 QARR reporting by Medicaid and CHP plans, inclusion of reversed pharmacy claims in Effectiveness of Care measures will NOT be allowed. NCQA issued a memo (dated November 9, 2012) allowing plans to choose between two options in calculation of results for Effectiveness of Care measures. The options differ by the inclusion or exclusion of reversed pharmacy claims and NCQA specified that organizations must implement their choice consistently across all measures and product lines. Per the NCQA memo, the two options are:

1. Implement the current requirement:

"Report all services for the Effectiveness of Care measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center; or services for which payment was denied because they were not properly authorized; or prescriptions even if the claim was reversed (e.g., because the member did not pick up the prescription or the organization denied the pharmacy claim).

The organization must include all paid, suspended, pending, reversed and denied claims, and is ultimately responsible for the quality of care it provides to members."

2. Revert to the HEDIS 2012 requirement:

"Report all services for the Effectiveness of Care measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center, or services for which payment was denied because they were not properly authorized.

The organization must include all paid, suspended, pending and denied claims, and is ultimately responsible for the quality of care it provides to members."

We try to align QARR requirements with NCQA guidelines wherever possible. However, we are requiring Medicaid and Child Health Plus plans to report 2013 QARR results using Option 2 (excluding reversed pharmacy claims). We are requiring Option 2 to promote consistency in data collection, comparability between plans, and relevance to previous year results.

Commercial plans can use either option, per NCQA guidelines, and we will collect the plans' method selection with an indicator on the main page of the Data Submission system (DSS). If plans are submitting Medicaid data to NCQA, the plan can choose either method for reporting for NCQA, but must use Option 2 for 2013 QARR reporting.

B. Loss of Medical Records or Operations due to Superstorm Sandy

NCQA issued information about modifications to NCQA requirements in response to Superstorm Sandy (dated November 27, 2012). Plans who are reporting to NCQA for HEDIS will follow the guidance by NCQA and work with NCQA to determine the appropriate level of modification for HEDIS reporting. Plans need to provide NCQA with an assessment, including impact to HEDIS and CAHPS.

For 2013 QARR, plans may use their approved modification from NCQA, with the exception of allowing rotation of a required measure for QARR. Directions for expanded oversampling and record substitution from NCQA should be followed. For plans not reporting to NCQA, an assessment of impact for HEDIS should be sent to the Department (nysqarr@health.state.ny.us) by January 31, 2013. The assessment should describe the measure(s) and estimate of eligibles potentially affected by the storm. 'Affected' is defined as lost medical records (paper or electronic), data systems, or providers no longer in operation since the storm. We will work with the plan's auditor to determine modifications to collection. For example, a 15% oversampling may be allowed for affected measures and records could be substituted if a record (medical or electronic) is unable to be retrieved due to loss of record/system or inability to interact with closed practices. Plans will document the substitutions as denominator exclusions. Any record which cannot be retrieved for reasons other than the loss, closure of the facility and inability to find the provider due to the storm, cannot be substituted. Auditors will need to monitor the substitution reasons to assure the issue is related to the storm.

C. Inclusion of Mental Health Services Delivered by Unlicensed Providers

Medicaid plans are required to reimburse Mental Health Clinics licensed by the Office of Mental Health for services provided by unlicensed providers due to a temporary exemption in a scope of practice law.

The New York State Office Of Mental Health , 14 NYCRR Part 599, "Clinic Treatment Programs": Interpretive/Implementation Guidance; 01-04-2012 specifies "In 2002, New York State adopted a "scope of practice law" that established four new types of mental health practitioners and required anyone proposing to provide psychotherapy to obtain a license to do so. This law also contains a temporary exemption for programs licensed, operated or funded by the Office of Mental Health. However, unless extended, the exemption provision expires on July 1, 2013. Given New York State law, Part 599 establishes licensing requirements for most services provided in OMH licensed mental health clinics. On and after July 1, 2013, all services must be delivered by licensed staff unless the exemption is extended and the Commissioner approves other qualified staff."

This document also provides direction for how clinics bill for these services:
Claims by non-licensed practitioners. *When claiming for services provided by a non-licensed practitioner (including students), the OMH unlicensed practitioner ID (02249154) is the ONLY practitioner information that should be put on the claim. Use the ID in place of the NPI and be sure that ALL other information - name, license etc. - is blank.*

Medicaid plans can include claims for services meeting the numerator criteria as a qualifying service when the practitioner ID is 02249154. Use of the practitioner code will qualify as a service by a mental health provider for inclusion in QARR reporting.

These clarifications should be incorporated into the 2013 QARR Technical Specifications Manual and shared with auditors and vendors as applicable. If there are any questions about the changes or the specifications, please feel free to contact me at (518) 486-9012.

Sincerely,

Anne Schettine
Director, Quality Measurement Unit
Office of Quality and Patient Safety