



2016 Quality Assurance Reporting Requirements

Technical Specifications Manual (2016 QARR/ HEDIS® 2016)



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(2016 QARR/ HEDIS® 2016)

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I. Submission Requirements

2016 QARR consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®), Center for Medicare and Medicaid Services (CMS) QRS Technical Specifications, and New York State-specific measures. 2016 QARR incorporates measures from HEDIS® 2016. The major areas of performance included in the 2016 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, and Prenatal Care measures from the Live Birth file)

Organizations Required to Report

Article 44 licenses

- All managed care organizations and Medicaid HIV special needs plans certified by the New York State Department of Health (NYS DOH) prior to 2015 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2015 are required to submit Enrollment by Product Line and any other measures where members meet HEDIS eligibility criteria.
- Managed Long Term Care – Medicaid Advantage and Medicaid Advantage Plus plans (MA/MAPs) are not required to report QARR to NYS DOH.
- Fully Integrated Dual Advantage (FIDA) plans are not required to report QARR to the Office of Quality and Patient Safety. Please email FIDA@health.ny.gov for information on reporting requirements to the NYS DOH
- Health and Recovery Plans (HARP) are not required to report QARR. MCO's with HARP offerings should refer to page 6 for instructions on how handle 2016 reporting in MCO data for members enrolled in a HARP in 2015.

Article 32, Article 42, Article 43, and Article 47 licenses

- All Preferred Provider Organizations/Exclusive Provider Organizations (PPO/EPO) licensed by the New York State Department of Financial Services (DFS) prior to 2015 must report all QARR measures if there are more than 30,000 members residing in New York State in PPO/EPO products as of December 31, 2015 (unless the insurer is also a QHP then follow guidance from CMS on minimum threshold). Members with dental-only, vision-only, catastrophic-only, and student coverage-only products are excluded when determining eligible membership for QARR.

Article 1113(a) licenses

- All insurers offering Qualified Health Plans licensed by the New York State Department of Financial Services (DFS) prior to 2015 must report all QARR measures. Members with dental-only, and catastrophic-only products are excluded when determining eligible membership for QARR.

Reporting Requirement Guidelines

- Table 1 lists, by product, the NYS-specific and HEDIS® 2016 measures required for submission. This manual describes in detail only the NYS-specific measures. Plans must purchase the HEDIS® 2016 Technical Specifications for descriptions of the required HEDIS® measures. Qualified Health Plans should follow all technical guidance outlined in the Quality Rating System Measure Technical

I. Submission Requirements

Specifications. Plans should always apply HEDIS® 2016 guidelines for each applicable product line when calculating continuous enrollment periods for NYS-specific measures. All submitted data must be audited by certified auditors from NCQA Licensed Organizations. Plans required to provide CAHPS data must use a NCQA-certified CAHPS vendor.

- All clarifications to the 2016 QARR will be distributed electronically to plan representatives and be made available on our web site (www.health.ny.gov/health_care/managed_care/plans/index.htm) under the 'Health Plan Guidelines' section. All clarifications must be incorporated into the 2016 QARR specifications.
- Plans must report required measures for which there is an eligible population. Plans may not elect to suppress reporting or designate a measure as 'NR –plan chose not to report'.
- Only data for New York State residents should be included in QARR and CAHPS measures. Members living outside of New York State should be removed from all QARR and CAHPS calculations, including Enrollment by Product. In situations where 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. However, commercial plans should limit this to contracts originating in New York State and amend QARR processing in future cycles to limit out-of-state members. NYS DOH calculates CAHPS results for commercial PPO and Commercial HMO plans and all responses from out-of-state residents are removed. Therefore NYS DOH calculations may be different than results from plans' CAHPS vendors or NCQA.
- Health insurers offering Qualified Health Plans should follow all CMS guidance on reporting by Marketplace product line.
- For those measures in QARR that are not listed in CMS guidance, insurers offering a Qualified Health Plan (QHP) should follow HEDIS and NYS QARR Technical Specifications for commercial product lines.
- Insurers offering a QHP should follow CMS guidance on the combination of both individual and Small Business Health Options Program (SHOP) members in the same Marketplace data collection unit as per CMS for QARR reporting.

Specific Instructions for Product Lines:

Commercial PPO (CPPO):

- PPO product data should be reported separately for all licensed organizations with sufficient enrollment unless there is agreement from NCQA authorizing the combining of PPO and HMO/POS data or the combining of PPO and EPO data.
- If plans are submitting combined PPO and HMO data, the NCQA agreement needs to be submitted electronically to NYS DOH by March 4, 2016. NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- If plans are submitting combined PPO and EPO data, the NCQA agreement needs to be submitted electronically to NYS DOH by March 4, 2016. NYSDOH incorporates combined PPO/EPO submissions with PPO data tables.
- 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 is included in applicable measures.
- Commercial specifications should be followed for all required HEDIS® 2016 and QARR 2016 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- PPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Member-level files are required.

Commercial EPO (CEPO):

- If a plan intends to report their EPO population separately from their PPO population they

I. Submission Requirements

must contact the Quality Measurement and Evaluation Unit at nysqarr@health.ny.gov by January 15, 2016.

- If plans are submitting combined PPO and EPO data, the NCQA agreement needs to be submitted electronically to NYS DOH by March 4, 2016. NYSDOH incorporates combined PPO/EPO submissions with PPO data tables.
- 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 is included in applicable measures.
- Commercial specifications should be followed for all required HEDIS® 2016 and QARR 2016 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- EPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Member-level files are required.

Commercial HMO/POS (CHMO):

- HMO/POS product data should be reported separately for all licensed organizations with sufficient enrollment unless there is agreement from NCQA authorizing the combining of PPO or EPO, and HMO/POS data.
- If plans are submitting combined PPO/EPO and HMO data, the NCQA agreement needs to be submitted electronically to NYS DOH by March 4, 2016. NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- If plans are including their POS members with their HMO, plans must state on the 2016 QARR New York State Data Submission System that POS is included in their commercial HMO rates. Follow HEDIS® 2016 instructions regarding commercial point-of-service products.
- Commercial specifications should be followed for all required HEDIS® 2016 and QARR 2016 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- HMO/POS plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Member-level files are required.

Qualified Health Plan PPO (QPPO):

- PPO product data should be reported separately for all licensed organizations with sufficient enrollment and plans should follow CMS guidance on reporting by product.
- 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 is included in applicable measures.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. If a required measure **or measure numerator** does not have QRS Technical Specifications, insurers offering QHP should use the commercial specifications as outlined in HEDIS® 2016 instructions.
- PPO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Member-level files are required.

Qualified Health Plan PPO (QEPO):

- EPO product data should be reported separately for all licensed organizations with sufficient enrollment and plans should follow CMS guidance on reporting by product.
- 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 is included in applicable measures.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. If a required measure **or measure numerator** does not have QRS

I. Submission Requirements

Technical Specifications, insurers offering QHP should use the commercial specifications as outlined in HEDIS® 2016 instructions.

- EPO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Member-level files are required.

Qualified Health Plan HMO (QHMO):

- HMO product data should be reported separately for all licensed organizations with sufficient enrollment and plans should follow CMS guidance on reporting by product.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. If a required measure **or measure numerator** does not have QRS Technical Specifications, insurers offering QHP should use the commercial specifications as outlined in HEDIS® 2016 instructions.
- HMO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Member-level files are required.

Qualified Health Plan POS (QPOS):

- POS product data should be reported separately for all licensed organizations with sufficient enrollment and plans should follow CMS guidance on reporting by product.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. If a required measure **or measure numerator** does not have QRS Technical Specifications, insurers offering QHP should use the commercial specifications as outlined in HEDIS® 2016 instructions.
- POS plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Member-level files are required.

Child Health Plus (CHP):

- Plans with both CHP and Medicaid products will combine members for the two products for measure calculation and reporting. Information will be included in 'Medicaid' results on the DSS.
- Member-level files are required. The fee-for-service (FFS) enhancement files are optional.

Health and Recovery Plan (HARP):

- Plans with both HARP and Medicaid products will combine members for the two products for measure calculation and reporting for 2016 QARR only. Information will be included in 'Medicaid' results on the DSS.
- Member-level files are required. The fee-for-service (FFS) enhancement files are optional.

Medicaid HMO/PHSP (MA):

- Plans with both CHP and Medicaid products will combine members for the two products for measure calculation and reporting. Information will be included in 'Medicaid' results. CHP members will be included in all measures where the members meet eligibility criteria.
- Plans with both HARP and Medicaid products will combine members for the two products for measure calculation and reporting. Information will be included in 'Medicaid' results. HARP members will be included in all measures where the members meet eligibility criteria.
- Plans should follow Medicaid specifications in HEDIS® 2016 and QARR 2016 NYS-specific measures for the required measures. If a required measure has only commercial specifications, Medicaid organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Member-level files are required. The fee-for-service (FFS) enhancement files are optional.

Medicaid HIV Special Needs Plans (HIVSNP):

- Plans should follow Medicaid specifications in HEDIS® 2016 and QARR 2016 NYS-specific measures. If a required measure has only commercial specifications, Medicaid organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Member-level files are required. The fee-for-service (FFS) enhancement files are optional.

Medicare and Dual Eligibles:

I. Submission Requirements

- Plans should **NOT** submit Medicare information.

Measure Retirement / Rotation

Per NCQA general guidelines 12-16 Measure Rotation was retired. All measures will be reported this year.

Retired: Use of Appropriate Medications for People with Asthma

New Measure Requirements

There are five new measures required for 2016 QARR:

- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
- Statin Therapy for Patients With Cardiovascular Disease
- Statin Therapy for Patients With Diabetes
- Inpatient Hospitalization Utilization
- Emergency Department Utilization

Use of Supplemental Databases

What are they?

Supplemental databases contain information gathered from sources other than claims and encounters about health care services members have received. There are various sources of information described by HEDIS® 2016 (General Guideline 39, Volume 2, HEDIS® 2016) with direction on the manner in which the data may be used in the calculation of measures and how the information will be processed and validated with proof-of-service documents from the legal health record.

The types of files, data sources and collection processes dictate how the data must be captured, managed and verified in order to incorporate information from the database into HEDIS®/QARR reporting. NYS DOH is not adding or changing any of the HEDIS® guidelines regarding the use of supplemental databases.

How are supplemental databases used by health plans?

According to HEDIS® guidelines, health plans are permitted to use supplemental databases to capture information on services and events used for: 1) numerator compliance; 2) optional exclusions; and 3) eligible population required exclusions not related to the timing of the denominator event or diagnosis. Supplemental databases should not be used to determine denominator events, to capture for chronic conditions that may change over time or to correct billing information.

The information captured from data sources must comply with HEDIS® 2016 guidelines for timing, file type, data elements, collection 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 as early as possible to ensure information is allowed for HEDIS® /QARR reporting.

NYS DOH Reporting Requirements

NYS DOH added a data element to collect numerator events by supplemental data to all Effectiveness of Care (EOC) measures and Utilization measures similar to EOC measures (i.e., Frequency of Ongoing Prenatal Care, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Adolescent Well-Care Visits). The reporting of numerator events in the Data Submission System (DSS) is optional.

I. Submission Requirements

How to Submit QARR

All plans must submit QARR data on the New York State Data Submission System (DSS), which will be sent directly to plans by our External Quality Review Organization (EQRO). Estimated distribution date for the 2016 DSS is March 2016.

Where to Submit QARR

- All files will be sent electronically to our External Quality Review Organization (EQRO) via a secure file transfer facility. No materials will be mailed. All files including: 1) DSS files, 2) commercial CAHPS files, 3) QHP Enrollee Survey files 4) Member-level files, 5) Live Birth files, and 6) Medicaid optional enhancement files, (all due no later than 5:00 p.m. ET on June 15, 2016) should be submitted to our EQRO via the secure transfer facility site.
- FTP site arrangements can be made with Paul Henfield of IPRO. Mr. Henfield can be reached at phenfield@ipro.org.
- Any plan which 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 will be affected by these statements of deficiency.

What to Send for QARR Submission

All must be received electronically by 5:00 p.m. ET on June 15, 2016 by NYS DOH EQRO via FTP.

- QARR 2016 DSS database file for all payers. DSS files must be locked by auditor.
- CAHPS de-identified member-specific file for CPPO, CEPO, CHMO
- Enrollee Survey de-identified member-specific file for QEPO, QPPO, QHMO, QPOS
- Member level file for all payers
- Optional enhancement files for MA and HIVSNP
- Prenatal Care Live Birth files for all payers

Questions concerning the 2016 QARR submission

- Data Submission System (DSS): nysqarr@health.ny.gov
- HEDIS® 2016 measures: Updates can be found on NCQA's web site: www.ncqa.org. Questions can be submitted to NCQA's Policy Support System at the web site. 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 and Evaluation Unit of NYS DOH at nysqarr@health.ny.gov or (518) 486-9012.
- The Health Insurance Marketplace Quality Rating System Measure Technical Specifications can be found on CMS web site: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2016-QRS-Measure-Technical-Specifications.pdf> NYS DOH is not responsible for the interpretation of The Health Insurance Marketplace specifications or updating information. Plans should always refer to CMS specifications when calculating the QRS measures as part of QARR.

II. Reporting Requirements

✓: Required measure
NR: Not required

Table 1: 2016 QARR/HEDIS®2016 - Table of Required Measures

Method	Measure	Flag	Product Lines						Specifications	Member Level File Required			
			Commercial		Qualified Health Plans		Medicaid			COMM	QHP	MA	HIV
			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
Effectiveness of Care													
A	Adherence to Antipsychotic Medications for People with Schizophrenia		NR	NR	NR	NR	✓	✓	HEDIS 2016			●	●
H	Adolescent Preventive Care Measures	1	✓	✓	✓	✓	✓	✓	NYS Specific	●	●	●	●
H	Adult BMI Assessment		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Annual Monitoring for Patients on Persistent Medications		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Antidepressant Medication Management		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Appropriate Testing for Children with Pharyngitis		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Appropriate Treatment for Children with Upper Respiratory Infection		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
S	Aspirin Discussion and Use	4	✓	✓	✓	✓	✓	✓	CAHPS 5.0H				
A	Asthma Medication Ratio		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis		✓	✓	✓	✓	✓	NR	HEDIS 2016	●	●	●	
A	Breast Cancer Screening		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		NR	NR	NR	NR	✓	✓	HEDIS 2016			●	●
H	Cervical Cancer Screening		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●

Method A – admin, H – hybrid, S – survey
E- Electronic
Product lines
EPO- Exclusive Provider Organization
PPO – Preferred Provider Organization
HMO – Health Maintenance Organization
POS - Point of Service
PHSP – Prepaid Health Services Plan
HIV SNP – HIV Special Needs Plan

Flag
1 = Use members in WCC for 12-17 stratum.
2 = Enhanced for Medicaid; separate file needed.
3 = Enhanced for Medicaid; file not needed.
4 = DOH conducting Medicaid CAHPS.
5 = Administrative method only for QARR.
6 = Medicaid follow commercial specifications.
7 = Commercial plans follow Medicaid specs.

Member Level File
COMM = Commercial
QHP= Qualified Health Plan
MA = Medicaid HMO/PHSP/ Child Health Plus
HIV = Medicaid HIV SNP

Shading – Purple– Not required Orange – New

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			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
H	Childhood Immunization Status		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Chlamydia Screening in Women	3	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
H	Colorectal Cancer Screening	3,6	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
H	Comprehensive Diabetes Care		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
H	Controlling High Blood Pressure		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Diabetes Monitoring for People with Diabetes and Schizophrenia		NR	NR	NR	NR	✓	✓	HEDIS 2016			●	●
A	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications		NR	NR	NR	NR	✓	✓	HEDIS 2016			●	●
A	Disease-Modifying Anti-Rheumatic Drugs for RA		✓	✓	✓	✓	✓	NR	HEDIS 2016	●	●	●	
S	Flu Shots for Adults Ages 18 - 64	4	✓	✓	✓	✓	✓	✓	CAHPS 5.0H				
A	Follow-Up After Hospitalization for Mental Illness	2	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Follow-Up Care for Children Prescribed ADHD Medication	2	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	HIV/AIDS Comprehensive Care		NR	NR	NR	NR	✓	✓	NYS Specific			●	●
H	HPV Vaccine for Female Adolescents		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●

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			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
H	Immunizations for Adolescents		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
H	Lead Screening in Children		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
S	Medical Assistance with Smoking Cessation	4	✓	✓	✓	✓	✓	✓	CAHPS 5.0H				
A	Medication Management for People with Asthma		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Metabolic Monitoring for Children and Adolescents on Antipsychotics		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Non-Recommended Cervical Cancer Screening in Adolescent Females		✓	✓	✓	✓	✓	NR	HEDIS 2016	●	●	●	
A	Persistence of Beta-Blocker Treatment After a Heart Attack		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Pharmacotherapy Management of COPD Exacerbation		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Proportion of Days Covered		NR	NR	✓	✓	NR	NR	PQA 2016				
A	Statin Therapy for Patients With Cardiovascular Disease		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Statin Therapy for Patients With Diabetes		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Use of Imaging Studies for Low Back Pain		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●

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			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
A	Use of Multiple Concurrent Antipsychotics in Children and Adolescents		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Use of Spirometry Testing in The Assessment and Diagnosis of COPD		✓	✓	NR	NR	✓	✓	HEDIS 2016	●		●	●
H	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
Access / Availability of Care													
A	Adult Access to Preventive/Ambulatory Care		✓	✓	NR	NR	✓	✓	HEDIS 2016				
A	Annual Dental Visit		NR	NR	✓	✓	✓	NR	HEDIS 2016		●	●	
A	Children's Access to PCPs		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment		✓	✓	✓	✓	✓	✓	HEDIS 2016				
H	Prenatal and Postpartum Care		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
Health Plan Descriptive Information													
	Board Certification		✓	✓	✓	✓	✓	✓	HEDIS 2016				

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HIV SNP – HIV Special Needs Plan

Flag
1 = Use members in WCC for 12-17 stratum.
2 = Enhanced for Medicaid; separate file needed.
3 = Enhanced for Medicaid; file not needed.
4 = DOH conducting Medicaid CAHPS.
5 = Administrative method only for QARR.
6 = Medicaid follow commercial specifications.
7 = Commercial plans follow Medicaid specs.

Member Level File
COMM = Commercial
QHP= Qualified Health Plan
MA = Medicaid HMO/PHSP/ Child Health Plus
HIV = Medicaid HIV SNP

Shading – Purple– Not required Orange – New

II. Reporting Requirements

✓: Required measure
NR: Not required

Table 1: 2016 QARR/HEDIS®2016 - Table of Required Measures

Method	Measure	Flag	Product Lines						Specifications	Member Level File Required			
			Commercial		Qualified Health Plans		Medicaid			COMM	QHP	MA	HIV
			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
	Enrollment by Product Line		✓	✓	✓	✓	✓ (ENP-1a)	✓ (ENP-1a)	HEDIS 2016				
Cost of Care													
	Relative Resource Use for People with Asthma		NR	NR	NR	NR	NR	NR	HEDIS 2016				
	Relative Resource Use for People with Cardiovascular Conditions		NR	NR	NR	NR	NR	NR	HEDIS 2016				
	Relative Resource Use for People with COPD		NR	NR	NR	NR	NR	NR	HEDIS 2016				
	Relative Resource Use for People with Diabetes		NR	NR	NR	NR	NR	NR	HEDIS 2016				
	Relative Resource Use for People with Hypertension		NR	NR	NR	NR	NR	NR	HEDIS 2016				
Use of Services													
A	Well-Child Visits in the First 15 Months of Life	5	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	5	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Adolescent Well-Care Visits	5	✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
A	Ambulatory Care		✓	✓	✓	✓	✓	✓	HEDIS 2016				
H	Frequency of Ongoing Prenatal Care		NR	NR	NR	NR	✓	✓	HEDIS 2016			●	●
A	Bariatric Weight Loss Surgery		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Tonsillectomy		✓	✓	✓	✓	✓	✓	HEDIS 2016				

Method A – admin, H – hybrid, S – survey
E- Electronic
Product lines
EPO- Exclusive Provider Organization
PPO – Preferred Provider Organization
HMO – Health Maintenance Organization
POS - Point of Service
PHSP – Prepaid Health Services Plan
HIV SNP – HIV Special Needs Plan

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			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
A	Hysterectomy, vaginal & abdominal		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Cholecystectomy, open & laparoscopic		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Back Surgery		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Percutaneous Coronary Intervention (PCI)	6	✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Cardiac Catheterization	6	✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Coronary Artery Bypass Graft (CABG)	6	✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Prostatectomy	6	✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Mastectomy		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Lumpectomy		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Identification of Alcohol and Other Drug Services		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	All Cause Readmission		✓	✓	✓	✓	NR	NR	HEDIS 2016				
A	Inpatient Utilization (General Hospital-Acute Care)		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Inpatient Hospital Utilization		✓	✓	NR	NR	NR	NR	HEDIS 2016				
A	Emergency Department Utilization		✓	✓	NR	NR	NR	NR	HEDIS 2016				
A	Mental Health Utilization		✓	✓	✓	✓	✓	✓	HEDIS 2016				
A	Antibiotic Utilization		✓	✓	✓	✓	✓	✓	HEDIS 2016				

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Method	Measure	Flag	Product Lines						Specifications	Member Level File Required			
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			PPO/EPO	HMO/POS	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP					
Satisfaction with the Experience of Care													
S	Satisfaction Survey	4	✓	✓	✓	✓	✓ Adult Survey	✓ Adult Survey	CAHPS 5.0H	De-identified member file			
Measures Collected Using Electronic Clinical Data Systems													
E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		✓	✓	✓	✓	✓	✓	HEDIS 2016	●	●	●	●
NYS-Specific Prenatal Care Measures													
	Risk-Adjusted Low Birth Weight	These prenatal care measures will be calculated by the Office of Quality and Patient Safety using the birth data submitted by plans and the Department's Vital Statistics Birth File. All product lines are required to submit live birth files.											
	Prenatal Care in the First Trimester												
	Risk-Adjusted Primary Cesarean Section												
	Vaginal Births after Cesarean Section												

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Product lines

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III. Audit Requirements

Audit Requirements

- All organizations must contract with an NCQA-licensed audit organization for an audit of their Commercial PPO, Commercial EPO, Commercial HMO, Qualified Health Plan PPO, Qualified Health Plan EPO, Qualified Health Plan HMO, Qualified Health Plan POS, Medicaid and HIV SNP QARR data, as applicable.
- All organizations must send a copy of the written agreement with an NCQA-licensed audit organization by March 4, 2016. The copy can be sent via email to:
Quality Measurement Unit
Office of Quality and Patient Safety
Email: nysqarr@health.ny.gov
- Commercial PPO, Commercial EPO, and Commercial HMO health plans must use a certified CAHPS vendor for the CAHPS survey and have the sample frame reviewed and approved by their auditor.
- Insurers offering a Qualified Health Plan PPO, Qualified Health Plan EPO, Qualified Health Plan HMO, and Qualified Health Plan POS must use a certified CAHPS vendor for the Enrollee Survey and have the sample frame reviewed and approved by their auditor.
- It is recommended that health plans provide a draft version of the DSS to their auditor along with the Medicaid enhancement files, member-level files, and live birth files prior to the June 15 deadline (recommended by June 8, 2016). Auditors should check for accuracy and that the specified variables in these files and the DSS reconcile.
- A copy of the Final Audit Report (FAR), including identified problems, corrective actions and measure-specific results, must be submitted to the Office of Quality and Patient Safety upon receipt from your auditor (due to the Office of Quality and Patient Safety by July 29, 2016 via email to nysqarr@health.ny.gov). The FAR must contain audit validation signatures.
- NYS DOH 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 4, 2016 To: NYS DOH via email nysqarr@health.ny.gov	<ul style="list-style-type: none"> • All products lines
QARR Submission		
Data Submission System (DSS) file of the access database It is encouraged that plans send a version of the DSS to their auditor 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, 2016 by 5:00 p.m. ET To: IPRO vis secure FTP	<ul style="list-style-type: none"> • All product lines
Additional File Submission		
<ol style="list-style-type: none"> 1. Live Birth File (required for all product lines) 2. Member-level file (required for all product lines) 3. Enhancement files (optional for MA and HIVSNP) <p>It is encouraged that plans send a version of the files to their auditor 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, 2016 by 5:00 p.m. ET To: IPRO via FTP site	<ul style="list-style-type: none"> • All product lines
CAHPS Files		
Commercial Adult Survey – de-identified member-level files of CAHPS responses are required. Follow NCQA CAHPS file layout for file submission. CAHPS sample frames must be reviewed by auditor prior to CAHPS administration. Insurers with Qualified Health Plans- de-identified member-level files of Enrollee Survey responses are required.	Due: June 15, 2016 by 5:00 p.m. ET To: IPRO via FTP site	<ul style="list-style-type: none"> • CPPO • CHMO • CEPO • QPPO • QEPO • QHMO • QPOS
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 29, 2016 To: NYS DOH via email nysqarr@health.ny.gov	<ul style="list-style-type: none"> • All product lines

NYS DOH requires all reporting entities to submit the NYS Data Submission System database on June 15, 2016 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, 2016. Sufficient reasons for the extension request must be provided with the request and only those requests that have been approved will be acknowledged.

V. Measures Specific to New York State Reporting

ADOLESCENT PREVENTIVE CARE MEASURES

CPPO, CEPO, CHMO, QPPO, QEPO, QHMO, QPOS, MA and HIVSNP

CHANGES TO THE MEASURE:

Added ICD-10 diagnosis codes

DESCRIPTION

The percentage of adolescents ages 12 to 17 who had at least one outpatient visit with a PCP or OB/GYN practitioner during the measurement year, and received 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:

- 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 practitioner. This applies to both administrative and medical record data.
- The health plan may include sick visits that occur within the measurement year.
- 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 EPO, Commercial HMO/POS, Qualified Health Plans HMO, Qualified Health Plans POS, Qualified Health Plans EPO, Qualified Health Plans PPO, Medicaid HMO/PHSP (including Child Health Plus) and HIV SNP

The eligible population for these measures will be derived from the systematic sample generated for Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) denominator from HEDIS® 2016, using the hybrid method. 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 plans using the hybrid method with a systematic sample for the WCC measure, the WCC denominator of the 12 – 17 age stratum will be used for the eligible population the APC measures.
- For plans using an administrative method to collect the WCC measure, the eligible population for the APC measures will need to be generated using the WCC eligible population for ages 3 to 17 and creating a systematic sample using the HEDIS guidelines for sampling (including the index number to generate the sample). The WCC denominator of the 12-17 age stratum of the sample will then be used as the eligible population for the APC measures. The sample for WCC should be generated from the entire eligible population of 3 to 17 years. It should not be limited to the 12 to 17 age group. For example, if 212 members are in the 3 - 11 age group and 199 members are in the 12 - 17 age group of the systematic sample, the eligible population for the APC measures are the 199 members in the 12 - 17 age group. Plans using an administrative method for WCC should not be generating a full sample (411) for the Adolescent

V. Measures Specific to New York State Reporting

Preventive Care measures. (see table below)

Identifying the Eligible Population for Adolescent Preventive Care Measures		
Specifications	Administrative Method for WCC Measure	Hybrid Method for WCC Measure
HEDIS- WCC	1. Determine eligible population for WCC per HEDIS specification for ages 3 to 17.	1. Determine eligible population for WCC per HEDIS specification for ages 3 to 17.
HEDIS- WCC	2. If applying optional exclusion for WCC, remove members meeting exclusion criteria.	2. Generate systematic sample of 411, with oversample as necessary, using the HEDIS index number.
HEDIS- WCC	3. Generate systematic sample of 411 from the eligible population (minus exclusions if applicable) using the HEDIS index number.	3. If applying optional exclusion, remove members meeting exclusion criteria.
HEDIS- WCC	4. Determine members in the sample who are in the 12 to 17 year old age group.	4. Determine members in the sample who are in the 12 to 17 year old age group.
QARR-APC	5. The members in the WCC sample in the 12-17 year old age group become the denominator for the Adolescent Preventive Care measures.	5. The members in the WCC sample for the 12-17 year old age group become the denominator for the Adolescent Preventive Care measures. If members are excluded from WCC, they should be excluded from the Adolescent Preventive Care denominator. The members in the WCC denominator for the 12-17 age stratum should be the same as the members in the APC denominator.

COLLECTION METHOD

All plans must use hybrid method for collection of these measures for all numerator non-compliant members.

- Administrative codes have been included in the respective numerator sections where available. If administrative data includes a qualifying code for a numerator, the member is numerator compliant based on the administrative code alone; no additional medical record information is needed for that numerator. If a member is not numerator compliant for all four numerators based on administrative data alone, then medical records should be used to complete the compliance determination. Administrative codes are not comprehensive for all qualifying numerator criteria and therefore plans must utilize the medical record collection for all numerator non-compliant members in the sample. For example, administrative codes regarding abstinence counseling do not exist. Therefore plans may not limit collection to administrative data only for numerator non-compliant members. The inclusion of administrative codes is to facilitate comprehensive collection of data.
- Results calculated with administrative collection only for these numerators will be invalidated by NYS DOH if they are determined to be under-reported by NYS DOH even if the auditor determined the result to be reportable.

MEDICAL RECORD SPECIFICATIONS

Use of Questionnaires and Acronyms/Other Terms

- Notation that a particular tool was used without noting which areas were assessed, counseled or discussed, does not count as a positive numerator finding. If a checklist is used and included in the medical record or if there is reference to the areas covered, the notations will be counted as positive numerator findings for the respective areas. For example, a notation that states 'AMA GAPS was done' will not be acceptable. If the notation states the tool was used and sexual activity, depression, tobacco and substance use were

V. Measures Specific to New York State Reporting

reviewed; these will be considered positive numerator findings for the four topic areas.

- The use of acronyms to document topics covered during a visit may be allowed if the acronym is widely used and if the provider states 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 all topics were covered would be numerator-compliant for all four numerators. A notation of HEADSS alone, without indication from the provider that all topics are covered, should not be counted. 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

Description				
Assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity during the measurement year. Risk behaviors and preventive actions for sexual activity include: abstinence, current behaviors, family planning, condom use, contraceptives, HIV, STIs, pregnancy prevention, and safe sex.				
Administrative Specifications				
Codes for Counseling Related to Sexual Activity				
Description	ICD-9-CM Diagnosis	ICD-10-CM Diagnosis	CPT II Codes	HCPCS
Counseling for HIV	V65.44	Z71.7		
Counseling for Other STIs	V65.45			
Counseling of Oral and Other Contraceptives	V25.0, V25.01, V25.02, V25.03, V25.04, V25.09	Z30.0, Z30.01, Z30.011, Z30.012, Z30.013, Z30.014, Z30.018, Z30.019, Z30.02, Z30.09		
Screening for high risk sexual behavior		Z72.5, Z72.51, Z72.52, Z72.53, Z70., Z70.1, Z70.2, Z70.3, Z70.8, Z70.9	4293F	G0445
NOTE: Administrative Codes are not available for all types of assessment or counseling that would be considered a positive finding for this numerator. Medical records should be used in conjunction with administrative codes to accurately calculate this numerator.				
Medical Record Specifications				
The following are positive findings:				
<ul style="list-style-type: none"> 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 HIV, STIs, or pregnancy Notation of counseling for HIV, STIs, or pregnancy Notation of referral for HIV, STIs, or pregnancy 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 				

V. Measures Specific to New York State Reporting

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, an STI test 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

Numerator 2: Assessment or Counseling or Education on Depression

Description

Assessment or counseling or education on depression during the measurement year. Depression has an affective component (mood, interest, and enjoyment) and a physical component (changes in appetite, sleep pattern and concentration). Use of assessment tool or provider interview have been determined to be more effective methods for identification of depression than relying on patient self-report.

Administrative Specifications

Codes for Depression Screening

Description	ICD-9-CM Diagnosis	ICD-10-CM Diagnosis	CPT II	HCPCS
Depression screening	V79.0	None	1220F, 3085F, 3351F, 3352F, 3353F, 3354F, 3725F	G0444, G8431, G8510, G8511, G8930, S3005

NOTE: Administrative Codes are not available for all types of assessment or counseling that would be considered a positive finding for this numerator. Medical records should be used in conjunction with administrative codes to accurately calculate this numerator.

Medical Record Specifications

The following are positive findings:

- Use of a standardized depression questionnaire (such as Beck’s Depression Inventory, Patient Health Questionnaire, Reynolds Adolescent Depression Screen, Mood and Feelings Questionnaire)
- Use of a checklist indicating that depression or affective and physical symptoms of depression were addressed (sad, down, hopeless or suicidal ideation, loss of interest, poor appetite, change in sleep pattern and difficulty concentrating)
- Notation of the presence or absence of adolescent’s depressive symptoms(both affective and physical as listed above) during the measurement year
- Notation of findings from assessment of depression (e.g. “denies symptoms of depression”, “depression symptoms– none or risks noted”, “depression-yes or no”)
- Notation of counseling or referral for treatment of depression
- Diagnosis of depression during the measurement year
- Notation of treatment for depression in the measurement year
- Prescription of antidepressant medications or discussion of antidepressants for depression (not for off label uses such as smoking cessation)
- 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:

V. Measures Specific to New York State Reporting

- 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

Description				
Assessment or counseling or education about the risks of tobacco use during the measurement year. Tobacco use includes, but is not limited to, cigarettes, cigars, chew, or other forms of smokeless tobacco.				
Administrative Specifications				
Codes for Tobacco Cessation Counseling or Services				
Description	ICD-10-CM Diagnosis or Procedure	CPT	CPT II	HCPCS
Tobacco Use Assessment			1000F, 1031F, 1032F, 1033F, 1034F, 1035F, 1036F	
Tobacco Cessation Counseling or Services	Z71.6	99406, 99407	4000F, 4001F, 4004F	G0436, G0437
Tobacco Cessation Classes				S9453
<p>NOTE: Administrative Codes are not available for all types of assessment or counseling that would be considered a positive finding for this numerator. Medical records should be used in conjunction with administrative codes to accurately calculate this numerator.</p>				
Medical Record Specifications				
<p>The following are positive findings:</p> <ul style="list-style-type: none"> • 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 <p>The following are NOT positive findings:</p> <ul style="list-style-type: none"> • No assessment or counseling or education about the risks of tobacco usage • Assessment or counseling or 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 				

V. Measures Specific to New York State Reporting

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

Description					
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.					
Administrative Specifications					
Codes for Alcohol and Substance Use Counseling or Services					
Description	ICD-9-CM Diagnosis or Procedure	ICD-10-CM Diagnosis or Procedure	CPT	CPT II	HCPCS
Alcohol and/or drug assessment or screening	V79.1		99408, 99409	3016F, 4290F	G0396, G0397, H0001, H0049
Alcohol and or Drug Use Counseling Services	V65.42	Z71.41 Z71.51		4306F, 4320F	G0443, H0005, H0006, H0007, H0022, H0047, H0050, T1007
NOTE: Administrative Codes are not available for all types of assessment or counseling that would be considered a positive finding for this numerator. Medical records should be used in conjunction with administrative codes to accurately calculate this numerator.					
Medical Record Specifications					
The following are positive findings:					
<ul style="list-style-type: none"> • 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:					
<ul style="list-style-type: none"> • Assessment or counseling or education about proper use of prescription drug(s) intended for the adolescent • No assessment or counseling or education about the risks of substance use • Assessment or counseling or education about tobacco use only • Assessment or counseling or 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 MA and HIVSNP

Changes to the measure: Added ICD-10 Diagnosis codes

Description:

The percentage of members who qualified through at least one method as living with HIV/AIDS during the year prior to the measurement year, and received the following three components of care during the measurement year:

1. Two outpatient visits for primary care or HIV related care during the measurement year with at least one visit in the first half of the measurement year and at least one visit in the second half of the measurement year.
2. Two viral load tests conducted during the measurement year with at least one viral load test in the first half of the measurement year and at least one viral load test in the second half of the measurement year.
3. One syphilis test conducted during the measurement year.

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

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of HIV (HIV Value Set) or an inpatient DRG for HIV during the year prior to the measurement year (Table HIV-A)

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

Description	NYS APRDRG Codes		MS DRG Codes
Inpatient DRG	890, 892, 893, 894 (all severity levels included)		969-970, 974-977
Description	ICD-9-CM	ICD-10-CM	Codes
Diagnosis Codes with CPT		B20, Z21, 098.7,	<u>WITH</u> 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
Diagnosis Codes with Revenue	042, V08	098.71, 098.711, 098.712, 098.713, 098.719, 098.72, 098.73	<u>WITH</u> 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987

V. Measures Specific to New York State Reporting

Method 2 At least two outpatient visits (Ambulatory Visits Value Set/ Table HIV-C), WITH a primary or secondary diagnosis indicating HIV/AIDS (HIV Value Set/ Table HIV-B) AND two antiretroviral (ARV) dispensing events (Table HIV-D) during 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, a prescription with a 84 day supply would be 2.8 and round down to count as 2 dispensing events;

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

Description	ICD-9-CM Diagnosis	ICD-10-CM Diagnosis
HIV/AIDS	042, V08	B20, Z21, O98.7, O98.71, O98.711, O98.712, O98.713, O98.719, O98.72, O98.73

Table HIV-C: Codes to Identify Outpatient Visits

Description	CPT	HCPCS	UB Revenue	ICD-9-CM Diagnosis	ICD-10_CM Diagnosis
Outpatient Visit	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439, G0463, T1015	051x, 0520- 0523, 0526- 0529, 0982, 0983	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	Z00.00, Z00.01, Z00.4 Z00.12, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z01.4, Z01.41, Z01.411, Z01.419 Z01.8, Z01.81, Z01.810, Z01.812, Z01.818 Z02.0–Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9

Method 3 At least three outpatient visits (Ambulatory Visits Value Set/ Table HIV-C) with a primary or secondary diagnosis code indicating HIV/AIDS (HIV Value Set /Table HIV-B) on different dates of service during the year prior to the measurement year;

Method 4 Four dispensing events for ARV medications (Table HIV-D) during the year prior to the measurement year AND without a primary or secondary diagnosis of Hepatitis B or HTLV-1 (Table HIV-E) in any setting (Acute Inpatient Value Set, Ambulatory Visits Value Set, Table HIV-A, and Table HIV-C) during the year prior to the measurement year; Members identified as having HIV/AIDS because of at least four dispensing events, where Truvada (Tenofovir disoproxil fumarate + emtricitabine or TDF/FTC) or Stribild was the sole medication dispensed, must also have at least one diagnosis of HIV/AIDS (HIV Value Set / Table HIV-B) during 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;

Table HIV-D: NDC Codes to Identify Antiretroviral Medications will be posted on the website http://www.health.ny.gov/health_care/managed_care/plans/index.htm

V. Measures Specific to New York State Reporting

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

Description	ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
Hepatitis B	070.20, 070.21, 070.22, 070.23, 070.30, 070.31, 070.32, 070.33, V02.61	B16.0., B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
HTLV 1	079.51	B97.33 B18.0, B18.1,

Required Exclusion: Remove all members from the denominator who are Medicare and Medicaid dual eligible as of December 31 of the measurement year.

Optional Exclusion: Any member found to be HIV negative during the measurement year or the year prior. Members who are excluded must be removed from all three measures regardless of numerator compliance.

- 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 but must be dated after the event associated with identification of HIV status. For example, a member identified with an ICD-9/ ICD-10 code during an inpatient stay from January 7 through January 10 of the year prior to the measurement year would need an attestation stating HIV status negative dated between January 11 of the year prior to the measurement year and December 31 of the measurement year.
- Attestations may be obtained from providers after the measurement year as long as the document specifies the measurement year or the year prior. Attestations from providers must be from all providers associated with the qualifying events in determining the eligible population. For example, if two providers are involved in method 2 (two visits and 2 ARV prescriptions), then both providers would need to complete attestations. Obtaining attestations from all involved providers is necessary to ensure that the appropriate providers associated with the diagnosis are the ones attesting to the HIV negative status.
- Exclude from the eligible population all members who had a nonacute inpatient stay during the measurement year.

Engaged in Care

The percentage of members from the eligible population who had at least one outpatient visit for physician services of primary care or HIV related care occurring during each half of the measurement year. Any member with at least one visit occurring on or between January 1 and June 30 and at least one visit occurring on or between July 1 and December 31 of the measurement year would be numerator compliant for this measure.

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

V. Measures Specific to New York State Reporting

should 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 are not 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 of the measurement year.
- Numerator: Outpatient Visits (Ambulatory Visits Value Set) are defined by Tables HIV-C. For numerator compliance, each member will have at least one visit meeting criteria for Table HIV-C with practitioners managing the HIV and preventive care needs, occurring on or between January 1 and June 30 and at least one qualifying visit occurring on or between July 1 and December 31 of the measurement year.

Viral Load Monitoring

The percentage of members from the eligible population who had a viral load test performed at least once during the measurement year.

ADMINISTRATIVE SPECIFICATIONS

- Denominator: All members of the eligible population ages 2 and older as of December 31 of the measurement year.
- Numerator: At least one viral load test (Table HIV-F) conducted on or between January 1 and June 30 and at least one viral load test conducted on or between July 1 and December 31 of the measurement year.

Table HIV-F: Codes to Identify a Viral Load Test:

Description	CPT Codes	LOINC
Viral Load Test	87534-87536, 87537-87539	10351-5, 20447-9, 21008-8, 21333-0, 23876-6, 24013-5, 25835-0, 25836-8, 29539-4, 29541-0, 41513-3, 41514-1, 41515-8, 41516-6, 48510-2, 48511-0, 48551-6, 48552-4, 49890-7, 5017-9, 51780-5, 59419-2, 62469-2, 69353-1, 69354-9, 70241-5

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

Table HIV-G: Codes to Identify a Syphilis Screen:

Description	CPT Codes	LOINC
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V. Measures Specific to New York State Reporting

Syphilis Test	86592-86593, 86780	11084-1, 11597-2, 13288-6, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 20507-0, 20508-8, 22461-8, 22462-6, 22585-4, 22587-0, 22590-4, 22592-0, 22594-6, 24110-9, 24312-1, 26009-1, 26658-5, 29310-0, 31147-2, 34147-9, 34382-2, 34954-8, 39231-6, 40679-3, 40680-1, 47236-5, 47237-3, 47238-1, 50690-7, 51838-1, 51839-9, 5291-0, 5292-8, 53605-2, 5392-6, 5393-4, 5394-2, 57032-5, 63464-2, 6561-5, 6562-3, 68502-4, 71793-4, 8041-6
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V. Measures Specific to New York State Reporting

PRENATAL CARE MEASURES/BIRTH FILE CPPO, CEPO, CHMO, QPPO, QEPO, QHMO, QPOS, MA and HIVSNP

The following prenatal care performance measures will be calculated by the Office of Quality and Patient Safety using the birth data submitted by plans and from the Department's Vital Records Birth File.

- Risk-Adjusted Low Birthweight Rate
The adjusted rate for live infants weighing less than 2500 grams among all deliveries by women continuously enrolled in a plan for 10 or more months.
- 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.
- Risk-Adjusted Primary C-section
The adjusted rate of live infants born by cesarean delivery to women, continuously enrolled for 10 or more months, who had no prior cesarean deliveries.
- Vaginal Birth After C-section
The percentage of women continuously enrolled for 10 or more months who delivered a live birth vaginally after having had a prior cesarean delivery.

CALCULATION OF MEASURES

Upon receipt of the list of mothers who gave birth during the measurement year (January 1, 2015 through December 31, 2015) DOH staff will employ a multistage matching algorithm to link information provided by plans to the Vital Records Birth File. Risk-adjustment models will also be used to calculate low birthweight and primary C-section 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 Records 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, 2015 to December 31, 2015 to the Office of Quality and Patient Safety. Information provided will be used to link to the Vital Records 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

V. Measures Specific to New York State Reporting

- 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 Records Birth File. The mother's admission date is not on the Vital Records 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 Quality and Patient Safety 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 Commerce System (HCS). To access the listing, go to the HCS Main Page, under the Applications tab select Managed Care Provider Network Data System, in the File Downloads section, select Operating Facility File downloads, Hospitals. Valid birth center PFI codes can be found in the Diagnostic & Treatment Centers (clinics) file, also under the Operating Facility File download page.)
- Mother's Date of Admission
- Number of Enrollment Days Prior to Delivery
- Most Recent Enrollment Date
- Most Recent Disenrollment Date
- Plan ID
- Product Line
- Mother's Client ID Number
- Baby's Client 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 file containing commercial PPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Commercial EPO: Submit one file containing commercial EPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Commercial HMO/POS: Submit one file containing commercial HMO/POS members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Qualified Health Plan PPO: Submit one file containing Qualified Health Plan PPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Qualified Health Plan EPO: Submit one file containing Qualified Health Plan EPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Qualified Health Plan HMO: Submit one file containing Qualified Health Plan HMO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Qualified Health Plan POS: Submit one file containing Qualified Health Plan POS members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-98.

Medicaid HMO/PHSP: Submit one file containing Medicaid, HARP, and CHP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-114. This includes CHP births.

Medicaid HIVSNP: Submit one file containing HIVSNP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-114.

V. Measures Specific to New York State Reporting

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, 2015 to December 31, 2015. 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® 2016 specifications for the Access/Availability of Care: Prenatal and Postpartum Care for identification of the eligible group. Mothers with more than one birth during the measurement year or with multiple live births will be listed in the file more than once.

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., 1985)
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., 2015)
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., 2015)
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.
Plan ID	90-96	Left Justified	Enter the Plan's numeric or alpha-numeric seven-digit ID.
Product Line	97-98	Left Justified	1 = MA 2 = HIV SNP 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO

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Element Name	Location	Coding	Notes
			10=CEPO
Mother's Client ID Number (CIN)	99-106	For Medicaid: AA#####A For CHP: 0##### or 5#####	Omit for commercial; it is not applicable. (Medicaid and CHP only)
Baby's Client ID Number* (CIN)	107-114	For Medicaid: AA#####A For CHP: 0##### or 5#####	Omit for commercial; it is not applicable. (Medicaid and CHP only)

***REMINDER: Failure to adequately 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 Commerce System (HCS). To access the listing, go to the HCS Main Page, under the "My Content" toolbar selection, choose "All Applications". Select "M" and click on the "Managed Care Provider Network Data System" link. Under the "Queries and Lookups" group of links, click "File Downloads". Click "Operating Facility File Downloads" and on the next screen highlight "All Facilities" and click the "Select" button. Right-click the "Download File" link on the next screen and select "Save Target As..." to download a comma-delimited TXT file or a csv file with all available PFI information.)

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	CPPO, CEPO, CHMO, QPPO, QEPO, QHMO, QPOS, Medicaid, or HIVSNP
Number of deliveries on file	39-43	Right justified
Date file written	44-51	DDMMYYYY

Technical Assistance: If you need clarification of prenatal data requirements and/or assistance creating a flat ASCII file, please contact the Quality Assurance Reporting Requirements Unit at (518) 486-9012.

VI. Member-Level File Submission

Member-level File and Optional Enhancements File Submissions

The Office of Quality and Patient Safety (OQPS) will be evaluating measures using the Medicaid Encounter Data 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.

Required Member-level File

Plans are required to submit these member-level files for all product lines required to report the measure. For the measures listed in the table with the symbol present, submit a file listing all the members included in the denominator of at least one measure according to the file layout.

Retired Measures and Member-level File

Please note retired measures were removed from the member-level file specifications this year. For measures that are not required for a product the columns will be zero filled.

Measures included in the Member-level File for 2016 QARR:

Measure	Required Member-Level File				Optional Medicaid Enhancements
	Comm	QHP	MA	HIV	
Adolescent Preventive Care Measures	●	●	●	●	
Adult BMI Assessment	●	●	●	●	
Annual Monitoring for Patients on Persistent Medications	●	●	●	●	
Antidepressant Medication Management	●	●	●	●	
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	●	●	●	●	
Cervical Cancer Screening	●	●	●	●	
Childhood Immunization Status	●	●	●	●	
Chlamydia Screening in Women	●	●	●	●	Member level file
Comprehensive Diabetes Care	●	●	●	●	
Controlling High Blood Pressure	●	●	●	●	
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	●	●	●		
Follow Up after Hospitalization for Mental Illness	●	●	●	●	Enhancement file
Follow Up Care for Children Prescribed Attention-Deficit/Hyperactivity disorder (ADHD) Medication	●	●	●	●	Enhancement file
HIV Comprehensive Care			●	●	
Immunizations for Adolescents	●	●	●	●	
Lead Screening in Children	●	●	●	●	
Pharmacotherapy Management of COPD Exacerbation	●	●	●	●	
Use of Imaging Studies for Low Back Pain	●	●	●	●	

VI. Member-Level File Submission

Measure	Required Member-Level File				Optional Medicaid Enhancements
	Comm	QHP	MA	HIV	
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		●	●		
Prenatal and Postpartum Care	●	●	●	●	
Proportion of Days Covered					
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	●	●	●	●	
Frequency of Ongoing Prenatal Care			●	●	
Colorectal Cancer Screening	●	●	●	●	Member level file
HPV Vaccine for Female Adolescents	●	●	●	●	
Medication Management for People with Asthma	●	●	●	●	
Persistence of Beta-Blocker Treatment after a Heart Attack	●	●	●	●	
Adherence to Antipsychotic Medications for People with Schizophrenia			●	●	
Asthma Medication Ratio	●	●	●	●	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia			●	●	
Diabetes Monitoring for People with Diabetes and Schizophrenia			●	●	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications			●	●	
Non-recommended Cervical Cancer Screening in Adolescent Females	●	●	●		
Metabolic Monitoring for Children and Adolescents on Antipsychotics	●	●	●	●	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	●	●	●	●	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	●	●	●	●	
Statin Therapy for Patients With Cardiovascular Disease	●	●	●	●	
Statin Therapy for Patients With Diabetes	●	●	●	●	
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	●	●	●	●	

VI. Member-Level File Submission

2016 QARR Member-Level File Specifications

Prepare a fixed width text file in the following format. Include one row for every member who was enrolled in the product and who meets criteria for one or more of the specified QARR measures for 2016 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 files are due on June 15, 2016. The file should be named PlanNameMember.txt.

Member-Level File Notes:

- Reporting of member-level data should encompass only those members included and timeframes employed in the 2016 QARR and HEDIS® 2016 specifications.
- 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. The exceptions to this are Childhood Immunization Status and HPV for Female Adolescents.
- Only include those measures which pass audit in the member-level file submission. If a measure fails audit please zero fills those applicable columns in the member-level file.
- The Client Identification Number (CIN) is eight digits in length. The CIN is a unique identifier for each member. For commercial and Qualified Health Plan product lines, enter a unique identifier for each member in the member level file. The identifier can be numeric or a mix of alpha and numeric characters. For CHP, the unique ID is seven characters in length and is numeric, while Medicaid CIN is eight characters in length and a mix of alpha and numeric. For CINs less than 8 digits in length, the columns preceding the ID should be zero filled, such as 7 digits would have Column 9 filled with '0'. The values in columns 10 through 17 will be treated as text.
- For Marketplace enrolled Child Health Plus (CHP) members, instead of the plan generated id we have advised Health Plans to use the Member Policy number assigned by the Marketplace to send to KIDS as the CHP CIN in the Member level file (8 digits beginning with 5). Health Plans are to use the 8 digit Member Policy number, beginning with a 5, for encounter reporting of Marketplace enrolled members and in the Member level file for QARR reporting. Health plans are to use the KIDS assigned 8 digit number for non-marketplace enrolled members for encounter reporting and in the Member level file for QARR.
- Include one row for each member for each product. Except for combined Medicaid and Child Health Plus (CHP) reporting, if a member is in at least one measure for more than one product, the member should have more than one row. For example, if a member is in URI for QHMO and in Pharyngitis for MA, the member would be in two rows:
 - Row 1 with Member in QHMO (first 16 columns) – 1234567601111111
 - Row 2 with Member in MA (first 16 columns) – 12345671AA111111A
- Report combined Medicaid, HARP and CHP reporting under your Medicaid product.
- Commercial Plans with approval from NCQA and NYSDOH to combine report their HMO and PPO membership should put these members in their CHMO product line.
- Commercial Plans with approval from NCQA and NYSDOH to combine report their EPO and PPO membership should put these members in their CPPO product line.
- Members enrolled in different product lines (Medicaid, CHP, HARP) at different times during the measurement year or year prior should report the member CIN for the product which they belonged to at the end of the measurement year. For example, a member

VI. Member-Level File Submission

enrolled in the CHP product line who switches to the Medicaid product line during the measurement year, the Medicaid CIN is reported in the member-level file

- Measures that are not applicable to the member should be zero-filled.
- Commercial PPO, Commercial EPO, Commercial HMO/POS, Qualified Health Plan PPO, Qualified Health Plan EPO, Qualified Health Plan HMO, and Qualified Health Plan POS will report information in all columns 1- 201, 202-230. Medicaid and HIV SNP plans will provide information in columns 1-201. Columns 202-230 should be zero-filled for MA, and HIV.

Column Placement	Name	Direction	Allowed Values	Retired
Column 1-7	Plan ID	Enter the Plan's numeric or alpha-numeric seven-digit ID.	#####	
Column 8-9	Product line	A member's product line. The field should be filled in with the code for the product line the member is in for the associated measures. If a member is in two different products for different measures the member should appear in two rows.	1 = MA 2 = HIV SNP 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10= CEPO	
Column 10-17	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! <ul style="list-style-type: none"> • For commercial HMO, EPO, and PPO and Qualified Health Plan PPO, EPO, HMO, and POS, enter a unique identifier for each member in the member level file. The identifier can be numeric or a mix of alpha and numeric, and will be eight digits in length. • The CIN entered in this field should be for the CIN for the measurement period. For example, CINs for 2015 should be used. • For Medicaid, use the 8 digit alpha-numeric CIN. • For CHP CINs, column 10 should be '0' or '5' and then followed by the seven digits of the CHP ID • If the Medicaid/CHP CIN is invalid, the member will not be eligible for enhancement, if applicable. 	For Commercial – 8 digits, 0 fill to the left if shorter than 8 digits 000##### For Medicaid - AA#####A For CHP – 0##### or 5#####	
Column 18	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.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 19	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.	1 = Yes 0 = No	
Column 20	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.	1 = Yes 0 = No	
Column 21	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.	1 = Yes 0 = No	
Column 22	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.	1 = Yes 0 = No	
Column 23	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.	1 = Yes 0 = No	
Column 24	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	1 = Yes 0 = No	
Column 25	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.	1 = Yes 0 = No	
Column 26	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.	1 = Yes 0 = No	
Column 27	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.	1 = Yes 0 = No	
Column 28	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.	1 = Yes 0 = No	
Column 29	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 30	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.	1 = Yes 0 = No	
Column 31	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.	1 = Yes 0 = No	
Column 32	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.	1 = Yes 0 = No	
Column 33	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.	1 = Yes 0 = No	
Column 34	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.	1 = Yes 0 = No	
Column 35	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.	1 = Yes 0 = No	
Column 36	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.	1 = Yes 0 = No	
Column 37	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.	1 = Yes 0 = No	
Column 38	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.	1 = Yes 0 = No	
Column 39	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 40	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.	1 = Yes 0 = No	
Column 41	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.	1 = Yes 0 = No	
Column 42	Denominator for Cervical Cancer Screening	Enter a '1' if this member is in the denominator of the Cervical Cancer Screening measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 43	Numerator for Cervical Cancer Screening	Enter a '1' if this member is in the numerator of the Cervical Cancer Screening measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 44	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.	1 = Yes 0 = No	
Column 45	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.	0-9	
Column 46	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.	0-9	
Column 47	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.	0-9	
Column 48	Numerator 4 for CIS – Three HiB	Enter the number of times this member has a vaccination meeting HEDIS specifications for HiB in numerator of the CIS – Three HiB measure. Enter '0' if this member did not receive any HiB vaccinations meeting HEDIS specifications.	0-9	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 49	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.	0-9	
Column 50	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.	0-9	
Column 51	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.	0-9	
Column 52	Numerator 8 for CIS – One Hepatitis A	Enter the number of times this member has a vaccination meeting HEDIS specifications for Hepatitis A in numerator of the CIS – One Hepatitis A measure. Enter '0' if this member did not receive any Hepatitis A vaccinations meeting HEDIS specifications. Enter '1' if the member has a history of illness or seropositive result.	0-9	
Column 53	Flag for CIS – Rotavirus Vaccine Two Dose Schedule	Enter '1' if the member is reported using the type of Rotavirus vaccine with the two dose schedule (CPT 90681) for the Rotavirus in numerator of the CIS – Two or Three Rotavirus measure. Enter '0' if the member is reported using the three dose version or a combination of the two versions of the Rotavirus vaccine.	1 = Yes 0 = No	
Column 54	Numerator 9 for CIS – Two or Three Rotavirus	Enter the number of times this member has a vaccination meeting HEDIS specifications for Rotavirus in numerator of the CIS – Two or Three Rotavirus measure. Enter '0' if this member did not receive any Rotavirus vaccinations meeting HEDIS specifications.	0-9	
Column 55	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.	0-9	
Column 56	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 57	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.	1 = Yes 0 = No	
Column 58	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.	1 = Yes 0 = No	
Column 59	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.	1 = Yes 0 = No	
Column 60	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.	1 = Yes 0 = No	
Column 61	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.	1 = Yes 0 = No	
Column 62	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).	1 = Yes 0 = No	
Column 63	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.	1 = Yes 0 = No	
Column 64	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.	1 = Yes 0 = No	
Column 65	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.	1 = Yes 0 = No	
Column 66	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.	1 = Yes 0 = No	
Column 67	Denominator for CDC - HbA1c Control for	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
	Selected Population (<7.0%)			
Column 68	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.	1 = Yes 0 = No	
Column 69	Denominator for Controlling High Blood Pressure (CBP)	Enter a '1' if this member is in the denominator of the CBP measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 70	Numerator for Controlling High Blood Pressure (CBP)	Enter a '1' if this member is in the numerator of the CBP measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 71	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.	1 = Yes 0 = No	
Column 72	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.	1 = Yes 0 = No	
Column 73-74	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.	0-98	
Column 75-76	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.	0-98	
Column 77-78	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.	0-98	
Column 79	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.	1 = Yes 0 = No	
Column 80	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 81	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.	1 = Yes 0 = No	
Column 82	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.	1 = Yes 0 = No	
Column 83	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.	1 = Yes 0 = No	
Column 84	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.	1 = Yes 0 = No	
Column 85	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.	1 = Yes 0 = No	
Column 86	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.	1 = Yes 0 = No	
Column 87	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.	1 = Yes 0 = No	
Column 88	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.	1 = Yes 0 = No	
Column 89	Denominator for Immunizations for Adolescents (IMA)	Enter a '1' if this member is in the denominator of the Immunizations for Adolescents measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 90	Numerator 1 for IMA – Meningococcal	Enter a '1' if this member is in the numerator for Meningococcal in the IMA – Meningococcal measure. Enter '0' if this member is not in the numerator of this measure or if the information is missing.	1 = Yes 0 = No	
Column 91	Numerator 2 for IMA – Tdap/Td	Enter a '1' if this member is in the numerator for Tdap/Td in the IMA – Tdap/Td measure. Enter '0' if this member is not in the numerator of this measure or if the information is missing.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 92	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.	1 = Yes 0 = No	
Column 93	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.	1 = Yes 0 = No	
Column 94-95	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.	0-98	
Column 96-97	Numerator 1 for Pharmacotherapy Mgmt of COPD Exacerbation, Corticosteroid	Enter the number of times this member appears in numerator 1 of the Pharmacotherapy Management of COPD Exacerbation, Corticosteroid dispensed; '0' if the member is not in the numerator of this measure or the information is missing.	0-98	
Column 98-99	Numerator 2 for Pharmacotherapy Mgmt of COPD Exacerbation, Bronchodilator	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.	0-98	
Column 100	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.	1 = Yes 0 = No	
Column 101	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.	1 = Yes 0 = No	
Column 102	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.	1 = Yes 0 = No	
Column 103	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 104	Denominator 1 for Weight Assessment & Counseling for Nutrition and Physical Activity for Children (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.	1 = Yes 0 = No	
Column 105	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.	1 = Yes 0 = No	
Column 106	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.	1 = Yes 0 = No	
Column 107	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.	1 = Yes 0 = No	
Column 108	Denominator 2 for Weight Assessment & Counseling for Nutrition and Physical Activity for 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.	1 = Yes 0 = No	
Column 109	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.	1 = Yes 0 = No	
Column 110	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.	1 = Yes 0 = No	
Column 111	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.	1 = Yes 0 = No	
Column 112	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.	1 = Yes 0 = No	
Column 113	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.	1 = Yes 0 = No	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 114	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.	1 = Yes 0 = No	
Column 115	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.	1 = Yes 0 = No	
Column 116	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.	1 = Yes 0 = No	
Column 117	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.	1 = Yes 0 = No	
Column 118	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.	1 = Yes 0 = No	
Column 119	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.	1 = Yes 0 = No	
Column 120	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.	1 = Yes 0 = No	
Column 121	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.	1 = Yes 0 = No	
Column 122	Denominator 6 for Annual Dental Visits (19-20 years)	Enter a '1' if this member is in the denominator of the Annual Dental Visits (19-20 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 123	Numerator 6 for Annual Dental Visits (19-20 years)	Enter a '1' if this member is in the numerator of the Annual Dental Visits (19-20 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 124	Denominator for Prenatal and Postpartum Care (PPC)	Enter the number of times this member is in the denominator of the Prenatal and Postpartum Care measures, '0' if the member is not in the denominator of this measure.	0 - 2	
Column 125	Numerator 1 for PPC – Timeliness of Prenatal Care	Enter the number of times this member is in numerator of PPC – Timeliness of Prenatal Care measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	

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Column Placement	Name	Direction	Allowed Values	Retired
Column 126	Numerator 2 for PPC – Postpartum Care	Enter the number of times this member is in the numerator of PPC – Postpartum Care measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 127	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. <u>Each member in the denominator will have only one of the 7 numerators selected</u>	1 = Yes 0 = No	
Column 128	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.	1 = Yes 0 = No	
Column 129	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.	1 = Yes 0 = No	
Column 130	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.	1 = Yes 0 = No	
Column 131	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.	1 = Yes 0 = No	
Column 132	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.	1 = Yes 0 = No	
Column 133	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.	1 = Yes 0 = No	
Column 134	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.	1 = Yes 0 = No	
Column 135	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.	1 = Yes 0 = No	
Column 136	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.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 137	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.	1 = Yes 0 = No	
Column 138	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.	1 = Yes 0 = No	
Column 139	Denominator for Frequency of Ongoing Prenatal Care (FPC)	Enter the number of times this member is in the denominator of the Frequency of Ongoing Prenatal Care measure, '0' if the member is not in the denominator of this measure.	0 - 2	
Column 140	Numerator 1 for FPC (<21%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care <21% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 141	Numerator 2 for FPC (21% to 40%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 21% to 40% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 142	Numerator 3 FPC (41% to 60%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 41% to 60% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 143	Numerator 4 for FPC (61% to 80%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 61% to 80% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 144	Numerator 5 for FPC (81% or more)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 81% or more measure, '0' if the member is not in the numerator or the information is missing.	0 - 2	
Column 145	Denominator for Colorectal Cancer Screening	Enter a '1' if this member is in the denominator of the Colorectal Cancer Screening measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 146	Numerator for Colorectal Cancer Screening	Enter a '1' if this member is in the numerator of the Colorectal Cancer Screening measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 147	Denominator for HPV Vaccine for Female Adolescents	Enter a '1' if this member is in the denominator of the HPV Vaccine for Female Adolescents measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 148	Numerator for HPV Vaccine for Female Adolescents	Enter the number of times this member has a vaccination meeting HEDIS specifications for HPV in numerator of the HPV Vaccine for Female Adolescents measure.	0 - 9	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
		Female Adolescents measure. Enter '0' if this member did not receive any HPV vaccinations meeting HEDIS specifications.		
Column 149	Denominator 1 for Medication Management for People with Asthma (5-11 years)	Enter a '1' if this member is in the denominator of the Medication Management for People with Asthma (5-11 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 150	Numerator 1A for Medication Management for People with Asthma (5-11 years)	Enter a '1' if this member is in the numerator of $\geq 50\%$ medication compliance of the Medication Management for People with Asthma (5-11 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 151	Numerator 1B for Medication Management for People with Asthma (5-11 years)	Enter a '1' if this member is in the numerator of $\geq 75\%$ medication compliance of the Medication Management for People with Asthma (5-11 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 152	Denominator 2 for Medication Management for People with Asthma (12-18 years)	Enter a '1' if this member is in the denominator of the Medication Management for People with Asthma (12-18 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 153	Numerator 2A for Medication Management for People with Asthma (12-18 years)	Enter a '1' if this member is in the numerator of $\geq 50\%$ medication compliance of the Medication Management for People with Asthma (12-18 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 154	Numerator 2B for Medication Management for People with Asthma (12-18 years)	Enter a '1' if this member is in the numerator of $\geq 75\%$ medication compliance of the Medication Management for People with Asthma (12-18 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 155	Denominator 3 for Medication Management for People with Asthma (19-50 years)	Enter a '1' if this member is in the denominator of the Medication Management for People with Asthma (19-50 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 156	Numerator 3A for Medication Management for People with Asthma (19-50 years)	Enter a '1' if this member is in the numerator of $\geq 50\%$ medication compliance of the Medication Management for People with Asthma (19-50 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 157	Numerator 3B for Medication Management	Enter a '1' if this member is in the numerator of $\geq 75\%$ medication compliance of the Medication Management for People with Asthma	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
	for People with Asthma (19-50 years)	(19-50 years) measure, '0' if the member is not in the numerator or the information is missing.		
Column 158	Denominator 4 for Medication Management for People with Asthma (51-64 years)	Enter a '1' if this member is in the denominator of the Medication Management for People with Asthma (51-64 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 159	Numerator 4A for Medication Management for People with Asthma (51-64 years)	Enter a '1' if this member is in the numerator of $\geq 50\%$ medication compliance of the Medication Management for People with Asthma (51-64 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 160	Numerator 4B for Medication Management for People with Asthma (51-64 years)	Enter a '1' if this member is in the numerator of $\geq 75\%$ medication compliance of the Medication Management for People with Asthma (51-64 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 161	Denominator 5 for Medication Management for People with Asthma (65-85 years)	Enter a '1' if this member is in the denominator of the Medication Management for People with Asthma (65-85 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 162	Numerator 5A for Medication Management for People with Asthma (65-85 years)	Enter a '1' if this member is in the numerator of $\geq 50\%$ medication compliance of the Medication Management for People with Asthma (65-85 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 163	Numerator 5B for Medication Management for People with Asthma (65-85 years)	Enter a '1' if this member is in the numerator of $\geq 75\%$ medication compliance of the Medication Management for People with Asthma (51-64 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 164	Denominator for Persistence of Beta-Blocker Treatment after a Heart Attack	Enter a '1' if this member is in the denominator of the Persistence of Beta-Blocker Treatment after a Heart Attack measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 165	Numerator for Persistence of Beta-Blocker Treatment after a Heart Attack	Enter a '1' if this member is in the numerator of the Persistence of Beta-Blocker Treatment after a Heart Attack measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 166	Denominator for Adherence to Antipsychotic Medications for People with Schizophrenia	Enter a '1' if this member is in the denominator of the Adherence to Antipsychotic Medications for People with Schizophrenia measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 167	Numerator for Adherence to Antipsychotic Medications for People with Schizophrenia	Enter a '1' if this member is in the numerator of the Adherence to Antipsychotic Medications for People with Schizophrenia measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 168	Denominator 1 for Asthma Medication Ratio (5-11 years)	Enter a '1' if this member is in the denominator of the Asthma Medication Ratio (5-11 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 169	Numerator 1 for Asthma Medication Ratio (5-11 years)	Enter a '1' if this member is in the numerator of the Asthma Medication Ratio (5-11 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 170	Denominator 2 for Asthma Medication Ratio (12-18 years)	Enter a '1' if this member is in the denominator of the Asthma Medication Ratio (12-18 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 171	Numerator 2 for Asthma Medication Ratio (12-18 years)	Enter a '1' if this member is in the numerator of the Asthma Medication Ratio (12-18 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 172	Denominator 3 for Asthma Medication Ratio (19-50 years)	Enter a '1' if this member is in the denominator of the Asthma Medication Ratio (19-50 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 173	Numerator 3 for Asthma Medication Ratio (19-50 years)	Enter a '1' if this member is in the numerator of the Asthma Medication Ratio (19-50 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 174	Denominator 4 for Asthma Medication Ratio (51-64 years)	Enter a '1' if this member is in the denominator of the Asthma Medication Ratio (51-64 years) measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 175	Numerator 4 for Asthma Medication Ratio (51-64 years)	Enter a '1' if this member is in the numerator of the Asthma Medication Ratio (51-64 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 176	Denominator 5 for Asthma Medication Ratio (65-85 years)	Enter a '1' if this member is in the denominator of the Asthma Medication Ratio (65-85 years) measure, '0' if the member is not in the denominator or the information is missing.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 177	Numerator 5 for Asthma Medication Ratio (65-85 years)	Enter a '1' if this member is in the numerator of the Asthma Medication Ratio (65-85 years) measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 178	Denominator for Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Enter a '1' if this member is in the denominator of the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 179	Numerator for Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	Enter a '1' if this member is in the numerator of the Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 180	Denominator for Diabetes Monitoring for People with Diabetes and Schizophrenia	Enter a '1' if this member is in the denominator of the Diabetes Monitoring for People with Diabetes and Schizophrenia measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 181	Numerator for Diabetes Monitoring for People with Diabetes and Schizophrenia	Enter a '1' if this member is in the numerator of the Diabetes Monitoring for People with Diabetes and Schizophrenia measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 182	Denominator for Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	Enter a '1' if this member is in the denominator of the Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 183	Numerator for Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	Enter a '1' if this member is in the numerator of the Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 184	Denominator for Non-Recommended Cervical Cancer Screening for Adolescent Females	Enter a '1' if this member is in the denominator of the Non-Recommended Cervical Cancer Screening for Adolescent Females measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 185	Numerator for Non-Recommended Cervical Cancer Screening for Adolescent Females	Enter a '1' if this member is in the numerator of the Non-Recommended Cervical Cancer Screening for Adolescent Females measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 186	Denominator for Metabolic Monitoring for Children and Adolescents on Antipsychotics	Enter a '1' if this member is in the denominator of the Metabolic Monitoring for Children and Adolescents on Antipsychotics, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 187	Numerator for Metabolic Monitoring for Children and Adolescents on Antipsychotics	Enter a '1' if this member is in the numerator of the Metabolic Monitoring for Children and Adolescents on Antipsychotics, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 188	Denominator for Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Enter a '1' if this member is in the denominator of the Use of Multiple Concurrent Antipsychotics in Children and Adolescents, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 189	Numerator for Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Enter a '1' if this member is in the numerator of the Use of Multiple Concurrent Antipsychotics in Children and Adolescents, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 190	Denominator for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Enter a '1' if this member is in the denominator of the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 191	Numerator for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Enter a '1' if this member is in the numerator of the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 192	Denominator for Statin Therapy for Patients With Cardiovascular Disease	Enter a '1' if this member is in the denominator of the Statin Therapy for Patients With Cardiovascular Disease, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 193	Numerator 1 for Statin Therapy for Patients With Cardiovascular Disease	Enter a '1' if this member is in the numerator of received statin therapy, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
Column 194	Numerator 2 for Statin Therapy for Patients With Cardiovascular Disease	Enter a '1' if this member is in the numerator of statin adherence $\geq 80\%$, '0' if the member is not in the numerator of this measure.	1 = Yes 0 = No	
Column 195	Denominator for Statin Therapy for Patients With Diabetes	Enter a '1' if this member is in the denominator of the Statin Therapy for Patients With Diabetes, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 196	Numerator 1 for Statin Therapy for Patients With Diabetes	Enter a '1' if this member is in the numerator of received statin therapy, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No	
Column 197	Numerator 2 for Statin Therapy for Patients With Diabetes	Enter a '1' if this member is in the numerator of statin adherence $\geq 80\%$, '0' if the member is not in the numerator of this measure.	1 = Yes 0 = No	
Column 198	Denominator 1 for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Enter a '1' if this member is in the denominator of this measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No	
Column 199	Numerator 1 Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Enter a '1' if this member is in the numerator this measure, '0' if the member is not in the numerator of this measure.	1 = Yes 0 = No	
Column 200	Denominator 2 Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Enter the number of times this member appears in the denominator of Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults, '0' if the member is not in the denominator of this measure.	0 - 3	
Column 201	Numerator 2 Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Enter the number of times this member appears in the numerator of Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults, '0' if the member is not in the numerator of this measure.	0 - 3	
Column 202-203	Age Grouping for the member as of December 31 of the measurement year	Enter the age grouping for the member's age as of December 31 of the measurement year.	00 = < 1 year 01 = 1-4 yrs 02 = 5-9 yrs 03 = 10-14 yrs 04 = 15-17 yrs 05 = 18-19 yrs 06 = 20-24 yrs	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
			07 = 25-29 yrs 08 = 30-34 yrs 09 = 35-39 yrs 10 = 40-44 yrs 11 = 45-49 yrs 12 = 50-54 yrs 13 = 55-59 yrs 14 = 60-64 yrs 15 = 65 and up 99 = Unknown	
Column 204	Gender	Enter the member's gender.	1 = Male 2 = Female 9 = Unknown	
Column 205	Race	Enter the member's race	1=White 2=Black 3=Asian/Pacific Islander 4=American Indian/Alaskan Native 5=Other 9=Unknown 0=Declined	
Column 206	Ethnicity	Enter the Member's ethnicity as '1' if the member is of Spanish, Mexican, Puerto Rican or Cuban Origin and '2' if the member is not of any of these ethnicities. If the Member's ethnicity is unknown enter '9' and if the member declined to release this information enter '0'.	1=Hispanic 2=Non-Hispanic 9=Unknown 0=Declined	
Column 207	Language Spoken	Enter '1' if the member's spoken language is English, and '2' if the member's spoken language is non-English. If the language spoken is unknown enter '9' and if the member declined to release this information enter '0'.	1=English 2=Non-English 9=Unknown 0=Declined	
Column 208-210	County of Residence	Enter the 3 digit county FIPS code for each member's residence of county. See the attachment for codes and values to enter here.	### = FIPS Code 000= Outside of NYS	

VI. Member-Level File Submission

Column Placement	Name	Direction	Allowed Values	Retired
			999 = Unknown	
Column 211-213	Indirect Race Estimate - White	Enter the indirectly estimated probability of the member's race being White as a percentage of 100	0 – 100	
Column 214-216	Indirect Race Estimate - Black	Enter the indirectly estimated probability of the member's race being Black as a percentage of 100	0 – 100	
Column 217-219	Indirect Race Estimate - Asian/Pacific Islander	Enter the indirectly estimated probability of the member's race being Asian/Pacific Islander as a percentage of 100	0 – 100	
Column 220-222	Indirect Race Estimate - American Indian/Alaskan Native	Enter the indirectly estimated probability of the member's race being American Indian/Alaskan Native as a percentage of 100	0 – 100	
Column 223-225	Indirect Race Estimate - Other	Enter the indirectly estimated probability of the member's race being Other as a percentage of 100	0 – 100	
Column 226-228	Indirect Race Estimate - Hispanic	Enter the indirectly estimated probability of the member's ethnicity being Hispanic as a percentage of 100	0 – 100	
Column 229	Metal Level	Enter the Metal level of coverage the enrollee is covered under.	1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 5 = Catastrophic 9 = Unknown	
Column 230	Marketplace Product	Enter the '1' if the member enrolled through the Marketplace in an individual benefit, '2' if the member enrolled outside of the Marketplace in an individual benefit, '3' if the member enrolled in the Small Business Health Options Program (SHOP) through the Marketplace, '4' if the member enrolled in the Small Business outside the Marketplace, and '9' if unknown.	1 = Indv In 2 = Indv Out 3 = SHOP In 4 = Small Business Out 9 = Unknown	

VI. Member-Level File Submission

NYS Counties	FIPS Code	NYS Counties	FIPS Code	NYS Counties	FIPS Code
ALBANY	001	JEFFERSON	045	ST LAWRENCE	089
ALLEGANY	003	KINGS	047	SARATOGA	091
BRONX	005	LEWIS	049	SCHENECTADY	093
BROOME	007	LIVINGSTON	051	SCHOHARIE	095
CATTARAUGUS	009	MADISON	053	SCHUYLER	097
CAYUGA	011	MONROE	055	SENECA	099
CHAUTAUQUA	013	MONTGOMERY	057	STEUBEN	101
CHEMUNG	015	NASSAU	059	SUFFOLK	103
CHENANGO	017	NEW YORK	061	SULLIVAN	105
CLINTON	019	NIAGARA	063	TIOGA	107
COLUMBIA	021	ONEIDA	065	TOMPKINS	109
CORTLAND	023	ONONDAGA	067	ULSTER	111
DELAWARE	025	ONTARIO	069	WARREN	113
DUTCHESS	027	ORANGE	071	WASHINGTON	115
ERIE	029	ORLEANS	073	WAYNE	117
ESSEX	031	OSWEGO	075	WESTCHESTER	119
FRANKLIN	033	OTSEGO	077	WYOMING	121
FULTON	035	PUTNAM	079	YATES	123
GENESEE	037	QUEENS	081	OUTOFSTATE	000
GREENE	039	RENSSELAER	083	UNKNOWN/MISSING	999
HAMILTON	041	RICHMOND	085		
HERKIMER	043	ROCKLAND	087		

VII. Medicaid HMO/PHSP, HIVSNP and CHP Enhancement File Submission

Enhancements (Optional) for Medicaid and HIVSNP

The Office of Quality and Patient Safety will enhance results for several measures for this reporting year (Chlamydia Screening, Colorectal Cancer Screening, Follow Up after Hospitalization for Mental Illness, and Follow Up Care for Children Prescribed ADHD Medication). Enhancement files for two of the five measures should be submitted for all members from the 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 more than one product should submit one enhancement file for each measure as applicable.

PLEASE NOTE:

- Only valid CINs will be included in the enhancement process.
- All discharges included in the denominator for the Follow-up After Hospitalization for Mental Illness must be included in the enhancement file submitted.
- 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.
- Report combined Medicaid, HARP, and CHP reporting under your Medicaid product.
- Members enrolled in different product lines (Medicaid, HARP, CHP) at different times during the measurement year or year prior should report the member CIN for the product which they belonged to at the end of the measurement year. For example, a member enrolled in the CHP product line who switches to the Medicaid product line during the measurement year, the Medicaid CIN is reported in the member-level file
- **Chlamydia Screening, and Colorectal Cancer Screening:** The Office of Quality and Patient Safety 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 measures. 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. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these discharges with admissions to a State Operated Psychiatric Facility. Any discharge with a readmission within 30 days to a State Operated Psychiatric Facility will be removed. The Office of Quality and Patient safety will use the remaining discharges and Medicaid FFS data to determine whether out-of-plan services were used, for either of these components of the measure. The optional files should include the CIN and the discharge date for each qualifying index event for every event in the denominator; the count of records in the file should match the denominator in the DSS. The files require elements in addition to the CIN. The files will include: the discharge date, the date of any qualifying visit within 7 days, and the date of any qualifying visit within 30 days. 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.

VII. Medicaid HMO/PHSP, HIVSNP and CHP Enhancement File Submission

Measure	Data Elements	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
	Product Line (1 = Medicaid 2 = HIV SNP)	8	
	CIN	9-16 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	Discharge Date (YYYYMMDD)	17-24	
	7-Day Follow-up Visit Date (YYYYMMDD)	25-32	
	30-Day Follow-up Visit Date (YYYYMMDD)	33-40	

- Follow-Up Care for Children Prescribed ADHD Medication:** The Office of Quality and Patient Safety 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. The optional files should include the CIN and the index episode start date for each member in the denominator; the count of records in the file should match the denominator in the DSS. Please note that, per HEDIS® 2016 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 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. Any missing or not applicable dates should be submitted as zeros in the YYYYMMDD format (00000000).

Measure	Data Elements	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
	Product Line (1 = Medicaid 2 = HIV SNP)	8	
	CIN (‘0’ fill the first position of this for CHP CINs)	9-16 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	Included in Denominator 1? (1=Yes; 0=No)	17	
	Index Episode Start Date (YYYYMMDD)	18-25	
	Subsequent Visit Date1 (YYYYMMDD)	26-33	

VII. Medicaid HMO/PHSP, HIVSNP and CHP Enhancement File Submission

Measure	Data Elements	Fields	File Name
	Indicator of Prescribing Provider for Visit Date1 (1=Yes; 0=No)	34	
	Indicator of Numerator Compliance for Initiation measure (1=Yes; 0=No)	35	
	Included in Denominator 2? (1=Yes; 0=No)	36	
	Subsequent Visit Date2 (YYYYMMDD)	37-44	
	Subsequent Visit Date3 (YYYYMMDD)	45-52	
	Indicator of Numerator Compliance for Continuation and Maintenance measure (1=Yes; 0=No)	53	

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

VIII. DRG Crosswalk

2016 QARR / HEDIS® 2016 Crosswalk of MS-DRG and NYS APRDRG

Measure	Description	MS-DRG Value Set	NYS-APRDRG
Inpatient Utilization: General Hospital/Acute Care	Total Inpatient	001-008, 010-014, 016-017, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-265, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 570-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 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	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, , 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	765-770, 774-782	540-542, 544-546, 560-561, 563-566
	Surgery	001-008, 010-014, 016-017, 020-042, 113-117, 129-139, 163-168, 215-265, 326-358, 405-425, 453-517, 570-585, 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	001-006, 020-024, 026, 070, 073, 089-093, 095, 097-098, 120-121, 160-163, 165-167, 169-171, 173-177, 180, 191-192, 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, , 650-651, 680-681, 710-711, 791, 841-842, 850, 910-912, 950-952
	Medicine	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, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977	040-058, 080, 082, 110-111, 113-115, 130-144, 190, 193-194, 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, 660-663, 690-694, 720-724, 811-813, 815-816, 843-844, 861-863, 890, 892-894, 930