



# 2017 Quality Assurance Reporting Requirements

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## Technical Specifications Manual (2017 QARR/ HEDIS® 2017)



New York State Department of Health  
Office of Quality and Patient Safety  
ESP, Corning Tower, Room 1938  
Albany, New York 12237  
T: (518) 486-9012  
e: [NYSQARR@health.ny.gov](mailto:NYSQARR@health.ny.gov)

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Technical Specifications Manual  
(2017 QARR/ HEDIS® 2017)

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## I. Submission Requirements

2017 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. 2017 QARR incorporates measures from HEDIS® 2017. The major areas of performance included in the 2017 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, Viral Load Suppression, and Prenatal Care measures from the Live Birth file)

### Organizations Required to Report

#### Article 44 licenses

- All managed care organizations and Medicaid Managed Care plans (including HIV Special Needs Plans, and Health and Recovery Plans (HARP)) certified by the New York State Department of Health (NYSDOH) prior to 2016 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2016 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 NYSDOH.
- 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](mailto:FIDA@health.ny.gov) for information on reporting requirements to the NYSDOH

#### 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 2016 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, 2016 (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 2016 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® 2017 measures required for submission. This manual describes in detail only the NYS-specific measures. Plans must purchase the HEDIS® 2017 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 Specifications. Plans should always apply HEDIS® 2017 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.

## ***I. Submission Requirements***

- Plans required to provide CAHPS data must use a NCQA-certified CAHPS vendor.
- All clarifications to the 2017 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](http://www.health.ny.gov/health_care/managed_care/plans/index.htm)) under the 'Health Plan Guidelines' section. All clarifications must be incorporated into the 2017 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'.
- We prefer that only data for New York State residents should be included in QARR and CAHPS measures. 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.
- Health insurers offering Qualified Health Plans should follow all CMS guidance on reporting by Marketplace product line.
- 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.
- Collection Method: If a measure is denoted as Hybrid (H) in table 1 all plans must use hybrid method for collection for all numerator non-compliant members. Results calculated with administrative collection only for these measures will be invalidated by NYSDOH if they are determined to be under-reported even if the auditor determined the result to be reportable. If a measure is denoted as Administrative or Hybrid (A/H) NYSDOH will accept the administrative collection and reporting of these measures, unless the rate deviates significantly from the statewide average or last year's rate.
- For all NYS specific measures, follow NCQA general guideline 17 and 18 for members with dual enrollment in Commercial/Medicaid.
- NYS Specific measures will not be reported via NCQA IDSS. NYS specific measures will be reported using the NYS Specific Patient-Level Detail file.
- If plans are reporting HbA1c control (<7.0%) for selected populations to NCQA then NYSDOH will accept this data and plans do not need to collect information on a separate sample to fulfill QARR requirements.
- Organizations should use a sample size of 411 if they do not report the HbA1c Control <7% for a Selected Population indicator to NCQA.

### **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 NYSDOH by March 3, 2017. 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 NYSDOH by March 3, 2017. 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® 2017 and QARR 2017 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.

## ***I. Submission Requirements***

- PPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.

### **Commercial EPO (CEPO):**

- If a plan intends to report their EPO population separately from their PPO population they must contact the Quality Measurement and Evaluation Unit at [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov) by January 15, 2017.
- 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® 2017 and QARR 2017 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.
- Patient-Level-Detail 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 NYSDOH by March 3, 2017. NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- If plans are including their POS members with their HMO, that POS is included in their commercial HMO rates. Follow HEDIS® 2017 instructions regarding commercial point-of-service products.
- Commercial specifications should be followed for all required HEDIS® 2017 and QARR 2017 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.
- Patient-Level-Detail files are required.

### **Qualified Health Plan PPO (QPPPO):**

- 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. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- PPO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail 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

## ***I. Submission Requirements***

- 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. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- EPO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail 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. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- HMO plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail 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. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- POS plans must use a certified CAHPS vendor and have their Enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.

### **Essential Plans:**

- EP product data should be reported separately for all licensed organizations with sufficient enrollment unless there is approval from NYSDOH.
- 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® 2017 and QARR 2017 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.
- EP plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail 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 with 'Medicaid' results on the IDSS.
- Patient-Level-Detail 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 should follow Medicaid specifications in HEDIS® 2017 and QARR 2017 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.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are



## **I. Submission Requirements**

optional.

### **Medicaid HIV Special Needs Plans (HIVSNP):**

- Plans should follow Medicaid specifications in HEDIS® 2017 and QARR 2017 NYS-specific measures. If a required measure has only commercial specifications, HIVSNP organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are optional

### **Health and Recovery Plan (HARP):**

- Plans should follow Medicaid specifications in HEDIS® 2017 and QARR 2017 NYS-specific measures. If a required measure has only commercial specifications, HARP organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are optional.

### **Medicare and Dual Eligibles:**

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

## **Measure Retirement**

Retired: Human Papillomavirus Vaccine for Female Adolescents.  
Comprehensive Care for Persons Living with HIV/AIDS

## **New Measure Requirements**

There are two new measures required for 2017 QARR:

- Follow-Up After Emergency Department Visit for Mental Illness.
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence.

## **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® 2017 (General Guideline 39, Volume 2, HEDIS® 2017) 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. NYSDOH 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.

## **I. Submission Requirements**

The information captured from data sources must comply with HEDIS® 2017 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.

### **NYSDOH Reporting Requirements**

NCQA 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 supplemental numerator events in the Interactive Data Submission System (IDSS) is required. NYSDOH does not require the reporting of supplemental numerator events for NYS-Specific measures.

### **How to Submit QARR**

All plans must submit QARR data on the National Committee for Quality Assurance (NCQA) Interactive Data Submission System (IDSS). Estimated distribution date for the 2017 IDSS is April 2017.

### **Where to Submit QARR**

- The IDSS will be submitted directly to NCQA.
- ~~IDSS data extract (.csv) will be submitted to IPRO for QHP plans only.~~
- All additional files will be sent electronically to our External Quality Review Organization (EQRO) via a secure file transfer facility. No materials will be mailed. Additional files including: 1) commercial CAHPS files, 3) QHP Enrollee Survey files 4) Patient-Level-Detail files, 5) Live Birth files, and 6) Medicaid optional enhancement files, (all due no later than 11:59p.m. ET on June 15, 2017) 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](mailto:phenfield@ipro.org).
- Any plan which fails to submit the files by 11:59 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 11:59 p.m. ET on June 15, 2017.**

- ☒ 2017 IDSS file for all payers. IDSS files must be locked by auditor.
- ☒ ~~2017 IDSS extract (.csv) files for all QEPO, QPPO, QHMO, QPOS.~~
- ☒ CAHPS de-identified member-specific file for CPPO, CEPO, CHMO
- ☒ Enrollee Survey de-identified member-specific file for QEPO, QPPO, QHMO, QPOS
- ☒ Patient-Level-Detail file for all products (Includes NYS Specific Measures)
- ☒ Optional enhancement files for MA, HIVSNP, and HARP
- ☒ Prenatal Care Live Birth files for all payers

### **Questions concerning the 2017 QARR submission**

- Interactive Data Submission System (IDSS): <https://my.ncqa.org/>
- Other required files: [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov)
- HEDIS® 2017 measures: Updates can be found on NCQA's web site: [www.ncqa.org](http://www.ncqa.org). Questions can be submitted to NCQA's Policy Support System at the web site. NYSDOH 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.



## ***I. Submission Requirements***

All other questions: Quality Measurement and Evaluation Unit of NYSDOH at [nysgarr@health.ny.gov](mailto:nysgarr@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/2017\\_QRS-Measure\\_Technical\\_Specifications.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/2017_QRS-Measure_Technical_Specifications.pdf)
- NYSDOH 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: 2017 QARR/HEDIS®2017 - Table of Required Measures**

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				Required for products required to report the measure
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
Effectiveness of Care												
A	Adherence to Antipsychotic Medications for People with Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2017	●
H	Adolescent Preventive Care Measures	1	✓	✓	NR	NR	NR	✓	✓	NR	NYS 2017	●
H	Adult BMI Assessment		✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Annual Monitoring for Patients on Persistent Medications		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Antidepressant Medication Management		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Appropriate Testing for Children with Pharyngitis		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Appropriate Treatment for Children with Upper Respiratory Infection		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
S	Aspirin Discussion and Use	4	✓	✓	NR	✓	✓	NR	NR	NR	CAHPS 5.0H	
A	Asthma Medication Ratio		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis		✓	✓	✓	✓	✓	✓	NR	✓	HEDIS 2017	●
A	Breast Cancer Screening		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2017	●

**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  
HARP- Health and Recovery Plan  
EP- Essential 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.  
8 = DOH calculated no plan reporting required.  
9 = QHP only report numerators required by CMS.  
10 = HbA1c Control <7.0% is not required for QARR

**Shading –** Purple – Not required

Orange – New

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			Commercial			Qualified Health Plans		Medicaid				Required for products required to report the measure
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A/H	Cervical Cancer Screening		✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
A/H	Childhood Immunization Status	9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Chlamydia Screening in Women	3	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A/H	Colorectal Cancer Screening	3,6	✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
H	Comprehensive Diabetes Care	9, 10	✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
H	Controlling High Blood Pressure		✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Diabetes Monitoring for People with Diabetes and Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Disease-Modifying Anti-Rheumatic Drugs for RA		✓	✓	✓	NR	NR	✓	NR	✓	HEDIS 2017	●
S	Flu Shots for Adults Ages 18 - 64	4	✓	✓	NR	✓	✓	NR	NR	NR	CAHPS 5.0H	
A	Follow-Up After Emergency Department Visit for Mental Illness	2	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	2	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●

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**Shading –** Purple – Not required

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**Table 1: 2017 QARR/HEDIS®2017 - Table of Required Measures**

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				Required for products required to report the measure
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Follow-Up After Hospitalization for Mental Illness	2, 9	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Follow-Up Care for Children Prescribed ADHD Medication	2	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
A/H	Immunizations for Adolescents	9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
A/H	Lead Screening in Children	7	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
S	Medical Assistance with Smoking Cessation	4	✓	✓	NR	✓	✓	NR	NR	NR	CAHPS 5.0H	
A	Medication Management for People with Asthma	9	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Metabolic Monitoring for Children and Adolescents on Antipsychotics		✓	✓	NR	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Non-Recommended Cervical Cancer Screening in Adolescent Females		✓	✓	NR	NR	NR	✓	NR	✓	HEDIS 2017	●
A	Persistence of Beta-Blocker Treatment After a Heart Attack		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Pharmacotherapy Management of COPD Exacerbation		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Proportion of Days Covered		NR	NR	NR	✓	✓	NR	NR	NR	PQA 2017	●
A	Statin Therapy for Patients With Cardiovascular Disease		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●

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**Product lines**

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**Shading** – Purple – Not required

Orange – New

## II. Reporting Requirements

✓: Required measure  
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**Table 1: 2017 QARR/HEDIS®2017 - Table of Required Measures**

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			Commercial			Qualified Health Plans		Medicaid				Required for products required to report the measure
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Statin Therapy for Patients With Diabetes		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Use of Imaging Studies for Low Back Pain		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●
A	Use of Multiple Concurrent Antipsychotics in Children and Adolescents		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
A	Use of Spirometry Testing in The Assessment and Diagnosis of COPD		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Viral Load Suppression	8	NR	NR	NR	NR	NR	✓	✓	✓	NYS 2017	
H	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
<b>Access / Availability of Care</b>												
A	Adult Access to Preventive/Ambulatory Care		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	●
A	Annual Dental Visit		NR	NR	NR	✓	✓	✓	NR	NR	HEDIS 2017	●
A	Children's Access to PCPs		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
A	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2017	●

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			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
H	Prenatal and Postpartum Care		✓	✓	✓	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
Health Plan Descriptive Information												
Board Certification			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
Enrollment by Product Line			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
Cost of Care												
Relative Resource Use for People with Asthma			NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
Relative Resource Use for People with Cardiovascular Conditions			NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
Relative Resource Use for People with COPD			NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
Relative Resource Use for People with Diabetes			NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
Relative Resource Use for People with Hypertension			NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
Use of Services												
A	Well-Child Visits in the First 15 Months of Life	5, 9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●

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			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	5	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2017	●
A	Adolescent Well-Care Visits	5	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
A	Ambulatory Care		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
H	Frequency of Ongoing Prenatal Care		NR	NR	NR	NR	NR	✓	✓	NR	HEDIS 2017	●
A	Bariatric Weight Loss Surgery		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Tonsillectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Hysterectomy, vaginal & abdominal		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Cholecystectomy, open & laparoscopic		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Back Surgery		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Percutaneous Coronary Intervention (PCI)		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Cardiac Catheterization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Coronary Artery Bypass Graft (CABG)		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Prostatectomy		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Mastectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Lumpectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	

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			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Identification of Alcohol and Other Drug Services		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	All Cause Readmission		✓	✓	✓	✓	✓	NR	NR	NR	HEDIS 2017	
A	Inpatient Utilization (General Hospital-Acute Care)		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Inpatient Hospital Utilization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Emergency Department Utilization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2017	
A	Mental Health Utilization		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Antibiotic Utilization		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2017	
A	Standardized Healthcare-Associated Infection Ratio		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
<b>Experience of Care</b>												
S	CAHPS Health Plan Survey 5.0H, Adult Version	4	✓	✓	NR	NR	NR	NR	NR	NR	HEDIS 2017	De-identified member file
S	CAHPS Health Plan Survey 5.0H, Child Version	4	NR	NR	NR	NR	NR	✓	NR	NR	HEDIS 2017	De-identified member file
S	QHP Enrollee Experience Survey		NR	NR	NR	✓	✓	NR	NR	NR	QRS 2017	De-identified member file

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			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
Measures Collected Using Electronic Clinical Data Systems												
E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
E	Depression Remission or Response for Adolescents and Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2017	
NYS-Specific Prenatal Care Measures												
A	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. Commercial EPO/PPO, HMO/POS, Qualified Health Plans PPO/EPO, HMO/POS, Medicaid HMO/PHSP, Medicaid HIV SNP, HARP and EP are required to submit live birth files.								NYS 2017	
A	Prenatal Care in the First Trimester										NYS 2017	
A	Risk-Adjusted Primary Cesarean Section										NYS 2017	
A	Vaginal Births after Cesarean Section										NYS 2017	

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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, HIV SNP, HARP, and EP QARR data, as applicable.
- All organizations must send a copy of the written agreement with an NCQA-licensed audit organization by March 3, 2017. The copy can be sent via email to:  
Quality Measurement Unit  
Office of Quality and Patient Safety  
Email: [nysqarr@health.ny.gov](mailto: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 IDSS to their auditor along with the Medicaid enhancement files, Patient-level Detail files, and live birth files prior to the June 15 deadline (recommended by June 8, 2017). Auditors should check for accuracy and that the specified variables in the PLD files and the IDSS 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 28, 2017 via email to [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov)). The FAR must contain audit validation signatures.
- NYSDOH 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
<b>NCQA Licensed Audit Organization</b>		
Copy of written agreement with a NCQA licensed organization that indicates all products included in the audit.	Due: <b>March 3, 2017</b>  To: NYSDOH via email nysqarr@health.ny.gov	<ul style="list-style-type: none"> <li>All products lines</li> </ul>
<b>QARR Submission</b>		
Interactive Data Submission System (IDSS) Submitted  It is encouraged that plans send a version of the IDSS to their auditor one week 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: <b>June 15, 2017 by 11:59 p.m. ET</b>  To: NCQA	<ul style="list-style-type: none"> <li>All product lines</li> </ul>
<b>Additional File Submission</b>		
<ol style="list-style-type: none"> <li>1. Live Birth File (required for all product lines)</li> <li>2. Patient-Level Detail file (required for all product lines)</li> <li>3. Enhancement files (optional for MA, HIVSNP, and HARP)</li> </ol> <p>It is encouraged that plans send a version of the files to their auditor one week 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: <b>June 15, 2017 by 11:59 p.m. ET</b>  To: IPRO via FTP site	<ul style="list-style-type: none"> <li>All product lines</li> </ul>
<b>CAHPS Files</b>		
<p>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.</p> <p>Insurers with Qualified Health Plans- de-identified member-level files of Enrollee Survey responses are required.</p>	Due: <b>June 15, 2017 by 11:59 p.m. ET</b>  To: IPRO via FTP site	<ul style="list-style-type: none"> <li>CPPO</li> <li>CHMO</li> <li>CEPO</li> <li>QPPO</li> <li>QEPO</li> <li>QHMO</li> <li>QPOS</li> </ul>
<b>Final Audit Reports</b>		
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: <b>July 29, 2017</b>  To: NYSDOH via email nysqarr@health.ny.gov	<ul style="list-style-type: none"> <li>All product lines</li> </ul>

NYSDOH requires all reporting entities to submit all components on June 15, 2017 11:59 p.m. ET. Organizations who do not submit the IDSS 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, 2017. Sufficient reasons for the extension request must be provided with the request and only those requests that have been approved will be acknowledged.

## VI. Member-Level File Submission

### ADOLESCENT PREVENTIVE CARE MEASURES (ADL) CPPO, CEPO, CHMO, MA, HIVSNP, HARP, and EP

#### CHANGES TO THE MEASURE:

Added ICD-10-CM Diagnosis code added to Counseling for Other STIs

Clarified Medical Record Specifications for Numerator 2: Diagnosis of depression during the measurement year was removed.

Clarified Medical Record Specifications for Numerator 3: Notations about current or past behavior was changed to Notations of assessment of current or past behavior.

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#### 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.

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#### ELIGIBLE POPULATION

Product lines: Commercial PPO, Commercial EPO, Commercial HMO/POS, Medicaid HMO/PHSP (including Child Health Plus), HIV SNP, HARP, and EP.

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® 2017, 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 (ADL) 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 ADL measures.
- For plans using an administrative method to collect the WCC measure, the eligible population for the ADL 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 ADL measures. The sample for



## VI. Member-Level File Submission

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 ADL 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 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-ADL	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. <b>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.</b>

### 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 NYSDOH if they are determined to be under-reported by NYSDOH even if the auditor determined the result to be reportable.

### MEDICAL RECORD SPECIFICATIONS

#### Use of Questionnaires and Acronyms/Other Terms

## VI. Member-Level File Submission

- 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 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	Z70.8		
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, Z30.015, Z30.016, Z30.017, Z30.018, Z30.019, Z30.02, Z30.09		
Screening for high risk sexual behavior		Z72.5, Z72.51, Z72.52, Z72.53, Z70.0, Z70.1, Z70.2, Z70.3, Z70.9	4293F	G0445
<b>NOTE:</b> 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				

## VI. Member-Level File Submission

The following are positive findings:

- 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

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”)

## VI. Member-Level File Submission

- Notation of counseling or referral for treatment of depression
- 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:

- 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

**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:

- Notations of assessment of 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

## VI. Member-Level File Submission

- Distribution of educational materials to the member, pertaining to tobacco use
- Notation of “anticipatory guidance” for tobacco use
- Notation of discussion of exposure to secondhand smoke

The following are NOT positive findings:

- No assessment 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

### 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:

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

The following are NOT positive findings:

- Assessment 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

## ***VI. Member-Level File Submission***

- 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



## ***VI. Member-Level File Submission***

### **Viral Load Suppression MA, HIVSNP, and HARP**

The following performance measure will be calculated by the AIDS Institute and the Office of Quality and Patient Safety using the New York State Department of Health (NYSDOH) HIV Surveillance System.

#### **CALCULATION OF MEASURES**

Upon close of the measurement year (January 1, 2016 through December 31, 2016) DOH staff will apply an algorithm to identify Medicaid recipients who are potentially HIV-positive using claims and encounters from January 1, 2012 through December 31, 2015. This algorithm captures HIV+ Medicaid recipients on the basis of their HIV-related service utilization, including outpatient visits, laboratory testing, inpatient stays, and filling prescriptions for antiretroviral medications and HIV Special Needs Plans enrollment. DOH staff will then employ a multistage matching algorithm to link information on potentially HIV-positive members to the HIV Surveillance System.

The HIV Surveillance System provides information on the Viral load suppression levels for all matched cases. NYS Public Health law requires the electronic reporting to the NYSDOH any laboratory test, tests or series of tests approved for the diagnosis or periodic monitoring of HIV infection. This includes reactive initial HIV immunoassay results, all results (e.g. positive, negative, indeterminate) from supplemental HIV immunoassays (HIV-1/2 antibody differentiation assay, HIV-1 Western blot, HIV-2 Western blot or HIV-1 Immunofluorescent assay), all HIV nucleic acid (RNA or DNA) detection test results (qualitative and quantitative; detectable and undetectable), CD4 lymphocyte counts and percentages, positive HIV detection tests (culture, antigen), and HIV genotypic resistance testing.

#### **REPORTING REQUIREMENTS**

There are no reporting requirements for plans for this measure to the Office of Quality and Patient Safety.

## VI. Member-Level File Submission

### Viral Load Suppression MA, HIVSNP, HARP

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**Description:**

The percentage of Medicaid enrollees confirmed HIV-positive who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

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**Eligible Population:**

**Product Line:** Medicaid HMO/PHSP, Medicaid HIVSNP, Medicaid HARP

**Ages:** 2 years of age or older

**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.

**HIV confirmation** Confirmed HIV positive through a match with the HIV Surveillance System.

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**Denominator**

The eligible population.

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**Numerator**

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The number of Medicaid enrollees in the denominator with a HIV viral load less than 200 copies/mL for the most recent HIV viral load test during the measurement year.

## **VI. Member-Level File Submission**

### **PRENATAL CARE MEASURES/BIRTH FILE**

**CPPO, CEPO, CHMO, QPPO, QEPO, QHMO, QPOS, MA, HIVSNP, HARP, and EP**

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, 2016 through December 31, 2016) 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, 2016 to December 31, 2016 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
- Mother's Resident Zip Code at Time of Delivery

## VI. Member-Level File Submission

- 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.

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

## VI. Member-Level File Submission

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

### 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, 2016 to December 31, 2016. The mothers must be continuously enrolled with the primary payer at least 43 days prior to the delivery up to 56 days after delivery, with no gaps in enrollment. 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® 2017 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. <b>List mother more than once in the case of multiple births.</b>
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., 2016)
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., 2016)
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

## VI. Member-Level File Submission

Element Name	Location	Coding	Notes
			<b>3= HARP</b> 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10= CEPO <b>11= EP</b>
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, HIVSNP, HARP, 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, HIVSNP, HARP, 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, HIVSNP, HARP, or EP
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

### Patient-Level Detail and Optional Enhancements File Submissions

The Office of Quality and Patient Safety (OQPS) requires a Patient-Level Detail (PLD) file for all submissions. These files are used in a number of ways: 1) validation of summary-level data submitted by measure in the IDSS, 2) composite measure creation, 3) Medicaid enhancements, 4) monitoring health disparities, and 4) research and evaluation. NCQA requires a PLD file validation for all submissions. NYSDOH is requiring all plans to use the NCQA PLD file and append additional PLD for NYS Specific measures and variables listed in the table below. For specific file formats, refer to the NCQA Patient-Level Detail Specifications, and the NYS Patient-Level Detail Specifications.

#### Patient-Level Detail

- Follow NCQA Specifications for those measures included in the NCQA PLD file for each product and follow the NYS Specifications for those measures included in the NYS PLD.
- Separate product level specific PLD files will submitted.
- NYS PLD measures should be appended to the end of the NCQA PLD file columns.
- The patient-level data must match the summary-level data for each measure.
- All fields in the NCQA and NYS PLD file specifications are mandatory.
- Plans are required to submit these PLD files for all measures applicable to the product line.

Measures included in the Patient-Level Detail File for 2017 QARR:

	Measure Name	Specifications for Measures Included in the PLD		Optional Medicaid Enhancements
		NCQA	NYS	
SAA	Adherence to Antipsychotic Medications for People with Schizophrenia	●		
ADL	Adolescent Preventive Care Measures		●	
ABA	Adult BMI Assessment	●		
MPM	Annual Monitoring for Patients on Persistent Medications	●		
AMM	Antidepressant Medication Management	●		
CWP	Appropriate Testing for Children with Pharyngitis	●		
URI	Appropriate Treatment for Children with Upper Respiratory Infection	●		
AMR	Asthma Medication Ratio	●		
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	●		
BCS	Breast Cancer Screening	●		
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	●		
CCS	Cervical Cancer Screening	●		
CIS	Childhood Immunization Status	●		
CHL	Chlamydia Screening in Women	●		Member level file

## VI. Member-Level File Submission

COL	Colorectal Cancer Screening	●	● MA Only	Member level file
CDC	Comprehensive Diabetes Care	●		
CBP	Controlling High Blood Pressure	●		
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	●		
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	●		
ART	Disease-Modifying Anti-Rheumatic Drugs for RA	●		
FUM	Follow-Up After Emergency Department Visit for Mental Illness			Enhancement file
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence			Enhancement file
FUH	Follow-Up After Hospitalization for Mental Illness	●		Enhancement file
ADD	Follow-Up Care for Children Prescribed ADHD Medication	●		Enhancement file
IMA	Immunizations for Adolescents	●		
LSC	Lead Screening in Children	●	● Comm Only	
MMA	Medication Management for People with Asthma	●		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	●		
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	●		
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	●		
PCE	Pharmacotherapy Management of COPD Exacerbation	●		
PDC	Proportion of Days Covered	●		
SPC	Statin Therapy for Patients With Cardiovascular Disease	●		
SPD	Statin Therapy for Patients With Diabetes	●		
LBP	Use of Imaging Studies for Low Back Pain	●		
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	●		
SPR	Use of Spirometry Testing in The Assessment and Diagnosis of COPD	●		
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	●		
AAP	Adult Access to Preventive/Ambulatory Care	●		
ADV	Annual Dental Visit	●		
CAP	Children's Access to PCPs	●		
IET	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	●		
PPC	Prenatal and Postpartum Care	●		
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	●		
W15	Well-Child Visits in the First 15 Months of Life	●		
W34	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	●		
AWC	Adolescent Well-Care Visits	●		
FPC	Frequency of Ongoing Prenatal Care	●		

## VI. Member-Level File Submission

### 2017 NYS Patient-Level Detail 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 PLD measures for 2017 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 PLD files are due on June 15, 2017. The file should be named PLDF\_SubID\_MMDDYYYY\_Version

Example: PLDF\_12345\_11132015\_v1

Each product should submit a separate PLD file. For example, if your health plan has a Commercial HMO, Commercial PPO, Medicaid, HARP, and EP product they should be submitting five separate PLD, one for each product. Please use the specifications listed for each product in the table below.

Product	Files	PLD Specifications
Commercial HMO	Header record + NCQA PLD + NYS PLD	NCQA Commercial and NYS Commercial
Commercial PPO	Header record + NCQA PLD + NYS PLD	NCQA Commercial and NYS Commercial
Commercial EPO	Header record + NCQA PLD + NYS PLD	NCQA Commercial and NYS Commercial
QHP HMO	Header record + NCQA PLD + NYS PLD	NCQA Marketplace and NYS QHP (Marketplace)
QHP POS	Header record + NCQA PLD + NYS PLD	NCQA Marketplace and NYS QHP (Marketplace)
QHP EPO	Header record + NCQA PLD + NYS PLD	NCQA Marketplace and NYS QHP (Marketplace)
QHP PPO	Header record + NCQA PLD + NYS PLD	NCQA Marketplace and NYS QHP (Marketplace)
Medicaid	Header record + NCQA PLD + NYS PLD	NCQA Medicaid and NYS Medicaid
HIVSNP	Header record + NCQA PLD + NYS PLD	NCQA Medicaid and NYS Medicaid
HARP	Header record + NCQA PLD + NYS PLD	NCQA Medicaid and NYS Medicaid
EP	Header record + NCQA PLD + NYS PLD	NCQA Commercial and NYS Commercial

## VI. Member-Level File Submission

**Header Record:** To be submitted as a fixed-width text file 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, HIVSNP, HARP, or EP
Submission ID	39-43	Right justified
ADL Eligible Population	44-48	Right justified
ADL Exclusions	49-54	Right justified
ADL Numerator 1- Sexual Activity	55-59	Right justified
ADL Numerator 2- Depression	60-64	Right justified
ADL Numerator 3- Tobacco Use	65-69	Right justified
ADL Numerator 4- Substance Use	70-74	Right justified
ADL Rate 1- Sexual Activity	75-79	Right justified
ADL Rate 1- Depression	80-84	Right justified
ADL Rate 1- Tobacco Use	85-89	Right justified
ADL Rate 1- Substance Use	90-94	Right justified
COL Eligible Population	95-99	Right justified
COL Exclusions	100-104	Right justified
COL Numerator	105-109	Right justified
COL Rate	110-114	Right justified
LSC Eligible Population	115-119	Right justified
LSC Exclusions	120-124	Right justified
LSC Numerator	125-129	Right justified
LSC Rate	130-134	Right justified

## VI. Member-Level File Submission

### NYS Patient-Level Detail File Notes:

Include one row for every member who was enrolled in the product and who meets criteria for one or more of the specified measures for the measurement year.

#### Members to Exclude:

- Exclude members who are not in any eligible population of any measure in the product line specific PLD.

#### Audit Designations:

- Measures with an audit designation of NR, BR or Failed Audit are recorded in the patient-level file as “0.” Each member should show “0” in the numerator and denominator fields for any measure with these designations.

#### Member ID:

- The Member ID on the NCQA PLD file format should be the Client Identification Number (CIN) for Medicaid members (including HIV/SNP and HARP Members). **If the Medicaid/CHP CIN is invalid, the member will not be eligible for enhancement, if applicable.**
- The member information for the NYS PLD should be on the same row as the NCQA PLD.
- The Member ID for Marketplace enrolled Child Health Plus (CHP) members should be the Member Policy number assigned by the Marketplace to send to KIDS as the Member ID in the PLD file (8 digits beginning with 5).
- For CHP members, health plans are to use the 8-digit Member Policy number, beginning with a 5, for encounter reporting of Marketplace enrolled members and for the Member ID in the PLD file for QARR reporting.
- For CHP members, health plans are to use the KIDS assigned 8-digit number for non-marketplace enrolled members for encounter reporting and for the Member ID in the PLD file for QARR.
- Members enrolled in different product lines (Medicaid, CHP) at different times during the measurement year or year prior should report the member ID 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 for the Member ID in the PLD file

#### Product Specific Reporting:

- 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.
- Measures that are not applicable to the member should be zero-filled.
- Commercial Products should report Lead Cancer Screening in their NYS Specific PLD.
- Medicaid Products should report Colorectal Cancer Screening in their NYS Specific PLD.
- Column start and column end fields will be updated following the release of the NCQA PLD specifications (Anticipated November 1, 2016). The details for each specific product will begin at the end of NCQA's PLD and the final fix width will be determined when NCQA releases the final specifications.

### Technical Assistance

Commercial, Medicaid, Marketplace PLD Support

Submit questions to PCS at <https://my.ncqa.org/>

NYS PLD Support

Contact QARR Unit at 518-486-9012 or [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov)

## VI. Member-Level File Submission

### Commercial NYS PLD File Specifications

Measure	Column Length	Column Start	Column End	Field	Specification
ADL	1	250	250	Denominator for Adolescent Preventive Care (ADL)	Enter: '1' if this member is in the denominator '0' if this member is not in the denominator
ADL	1	251	251	Numerator 1 for Adolescent Preventive Care – Sexual Activity	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	252	252	Numerator 2 for Adolescent Preventive Care – Depression	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	253	253	Numerator 3 for Adolescent Preventive Care – Tobacco Use	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	254	254	Numerator 4 for Adolescent Preventive Care – Substance Use	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
LSC	1	255	255	Denominator for Lead Screening in Children (LSC)	Enter: '1' if this member is in the denominator '0' if this member is not in the denominator
LSC	1	256	256	Numerator for Lead Screening in Children (LSC)	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
General Info	2	257	258	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

## VI. Member-Level File Submission

Measure	Column Length	Column Start	Column End	Field	Specification
					05 = 18-19 yrs 06 = 20-24 yrs 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
General Info	1	259	259	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
General Info	1	260	260	Ethnicity	Enter the Member's ethnicity: 1=Hispanic 2=Non-Hispanic 9=Unknown 0=Declined
General Info	1	261	261	Language Spoken	Enter the member's spoken language: 1=English 2=Non-English 9=Unknown 0=Declined
General Info	3	262	264	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 999 = Unknown



## VI. Member-Level File Submission

Measure	Column Length	Column Start	Column End	Field	Specification
General Info	3	265	267	Indirect Race Estimate - White	Enter the indirectly estimated probability of the member's race being White as a percentage of 100
General Info	3	268	270	Indirect Race Estimate -Black	Enter the indirectly estimated probability of the member's race being Black as a percentage of 100
General Info	3	271	273	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
General Info	3	274	276	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
General Info	3	277	279	Indirect Race Estimate -Other	Enter the indirectly estimated probability of the member's race being Other as a percentage of 100
General Info	3	280	282	Indirect Race Estimate -Hispanic	Enter the indirectly estimated probability of the member's ethnicity being Hispanic as a percentage of 100

## VI. Member-Level File Submission

### Medicaid NYS PLD File Specifications

Measure	Column Length	Column Start	Column End	Field	Specification
ADL	1	271	271	Denominator for Adolescent Preventive Care (ADL)	Enter: '1' if this member is in the denominator '0' if this member is not in the denominator
ADL	1	272	272	Numerator 1 for Adolescent Preventive Care – Sexual Activity	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	273	273	Numerator 2 for Adolescent Preventive Care – Depression	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	274	274	Numerator 3 for Adolescent Preventive Care – Tobacco Use	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
ADL	1	275	275	Numerator 4 for Adolescent Preventive Care – Substance Use	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing
COL	1	276	276	Denominator for Colorectal Cancer Screening (COL)	Enter: '1' if this member is in the denominator '0' if this member is not in the denominator
COL	1	277	277	Numerator for Colorectal Cancer Screening (COL)	Enter: '1' if this member is in the numerator '0' if this member is not in the numerator OR the information for this member is missing

## VI. Member-Level File Submission

### QHP (Marketplace) NYS PLD File Specifications

Measure	Column Length	Column Start	Column End	Field	Specification
General Info	2	165	166	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 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
General Info	1	167	167	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
General Info	1	168	168	Ethnicity	Enter the Member's ethnicity: 1=Hispanic 2=Non-Hispanic 9=Unknown 0=Declined
General Info	1	169	169	Language Spoken	Enter the member's spoken language: 1=English 2=Non-English

## VI. Member-Level File Submission

Measure	Column Length	Column Start	Column End	Field	Specification
					9=Unknown 0=Declined
General Info	3	170	172	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 999 = Unknown
General Info	3	173	175	Indirect Race Estimate - White	Enter the indirectly estimated probability of the member's race being White as a percentage of 100
General Info	3	176	178	Indirect Race Estimate -Black	Enter the indirectly estimated probability of the member's race being Black as a percentage of 100
General Info	3	179	181	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
General Info	3	182	184	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
General Info	3	185	187	Indirect Race Estimate -Other	Enter the indirectly estimated probability of the member's race being Other as a percentage of 100
General Info	3	188	190	Indirect Race Estimate -Hispanic	Enter the indirectly estimated probability of the member's ethnicity being Hispanic as a percentage of 100
General Info	1	191	191	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
General Info	1	192	192	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

## VI. Member-Level File Submission

Measure	Column Length	Column Start	Column End	Field	Specification
					the Marketplace, '4' if the member enrolled in the Small Business outside the Marketplace, and '9' if unknown.

### FIPS County Codes

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, HIVSNP, and HARP

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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, Follow-Up After Emergency Department Visit for Mental Illness, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, and Follow Up Care for Children Prescribed ADHD Medication). Enhancement files for four of the six 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.
- All emergency department visits included in the denominator for the Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence 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.
- 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 Patient-level detail 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 IDSS. 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
<b>Follow-Up After Hospitalization for Mental Illness:</b> <b>1) 7-Day and</b> <b>2) 30 Day</b>	OMC Plan ID	1-7	FUH.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	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 After Emergency Department Visit 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 emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these visits with admissions to a State Operated Psychiatric Facility. Any visit 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 visits 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 visit 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 IDSS. The files require elements in addition to the CIN. The files will include: the visit 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 visit, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

Measure	Data Elements	Fields	File Name
<b>Follow-Up After Emergency Department Visit for Mental Illness:</b> <b>1) 7-Day and</b> <b>2) 30 Day</b>	OMC Plan ID	1-7	FUM.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	8	
	CIN	9-16 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	ED Visit Date (YYYYMMDD)	17-24	
	7-Day Follow-up Visit Date (YYYYMMDD)	25-32	
	30-Day Follow-up Visit Date (YYYYMMDD)	33-40	

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence:** 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 emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these visits with admissions to a State Operated Psychiatric Facility. Any visit 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 visits 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 visit 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 IDSS. The files require elements in addition to the CIN. The files will include: the visit 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 visit, 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.
- NYS DOH email:      Quality Assurance Reporting Requirements Unit  
nysqarr@health.ny.gov



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

numerator “hit”; up to seven days after emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these visits with admissions to a State Operated Psychiatric Facility. Any visit 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 visits 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 visit 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 IDSS. The files require elements in addition to the CIN. The files will include: the visit 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 visit, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

Measure	Data Elements	Fields	File Name
<b>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence: 1) 7-Day and 2) 30 Day</b>	OMC Plan ID	1-7	FUA.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	8	
	CIN	9-16 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	ED Visit 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® 2017 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 2<sup>nd</sup> 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
	OMC Plan ID	1-7	Add.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	8	

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

Measure	Data Elements	Fields	File Name
<b>Follow-Up Care for Children Prescribed ADHD Medication:</b> <b>1.) Initiation Phase</b>  <b>2.) Continuation and Maintenance Phase</b>	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	
	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

### 2017 QARR / HEDIS® 2017

#### 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