



Department  
of Health

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# 2018 Quality Assurance Reporting Requirements

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## Technical Specifications Manual (2018 QARR/HEDIS® 2018)

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## I. Submission Requirements

### I. Submission Requirements

2018 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. The 2018 QARR incorporates measures from HEDIS® 2018. The major areas of performance included in the 2018 QARR are:

- 1) Effectiveness of Care
- 2) Access/Availability of Care
- 3) Experience of Care
- 4) Utilization and Risk Adjusted Utilization
- 5) Health Plan Descriptive Information
- 6) NYS-specific measures
  - Adolescent Preventive Care
  - Viral Load Suppression
  - Continuity of Care from Inpatient Detox to Lower Level of Care
  - Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care
  - Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
  - Use of Pharmacotherapy for Alcohol Abuse or Dependence
  - Maintaining/Improving Employment or Higher Education Status
  - Maintenance of Stable or Improved Housing Status
  - No or Reduced Criminal Justice Involvement
  - Potentially Preventable Mental Health Related Readmission Rate 30 Days
  - 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 2017 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2017 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 2017 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, 2017, (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 DFS prior to 2017 must report all QARR measures. Members with dental-only and catastrophic-only products are excluded when determining eligible membership for QARR.

## I. Submission Requirements

### Reporting Requirement Guidelines

- Table 1 lists, by product, the NYS-specific and HEDIS® 2018 measures required for submission.
- This manual describes in detail only the NYS-specific measures. Plans must purchase the HEDIS® 2018 Technical Specifications for descriptions of the required HEDIS® measures. Qualified Health Plans should follow all technical guidance outlined in the Quality Rating System (QRS) Reporting Requirements and Guidance on the CMS website.
- 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.
- Plans should always apply HEDIS® 2018 guidelines for each applicable product line when calculating continuous enrollment periods for NYS-specific measures.
- All submitted data must be audited by certified auditors from NCQA Licensed Organizations.
- Plans required to provide CAHPS data must use a NCQA-certified CAHPS vendor.
- All clarifications to the 2018 QARR will be distributed electronically to plan representatives and available on our web site [https://www.health.ny.gov/health\\_care/managed\\_care/plans/index.htm](https://www.health.ny.gov/health_care/managed_care/plans/index.htm) under the 'Health Plan Guidelines' section. All clarifications must be incorporated into the 2018 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 NYS residents 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 NYS and amend QARR processing in future cycles to limit out-of-state members.
- 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 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, 2018. 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, 2018. NYSDOH incorporates combined

## **I. Submission Requirements**

- 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® 2018 and QARR 2018 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- PPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is required.

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

- A plan intending to report their EPO population separately from their PPO population must contact the Quality Measurement and Evaluation Unit: [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov) by January 15, 2018.
- 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® 2018 and QARR 2018 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.
- NYS Specific Measures Summary-Level File is 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, 2018. NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- If plans are including their POS members with their HMO, POS is included in their commercial HMO rates. Follow HEDIS® 2018 instructions regarding commercial POS products.
- Commercial specifications should be followed for all required HEDIS® 2018 and QARR 2018 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.
- NYS Specific Measures Summary-Level File is required.

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

- PPO product data should be reported separately for all licensed organizations with sufficient enrollment, and plans should follow CMS guidance on reporting by product.
- Members who have any of the 'medical' benefit, as defined by HEDIS®, should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and is included in applicable measures.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. NYSDOH will only be collecting measures and numerators included in the

## I. Submission Requirements

- QRS Measure set.
- PPO plans must use an **HHS-approved survey vendor** and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is required.

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

- EPO product data should be reported separately for all licensed organizations with sufficient enrollment, and plans should follow CMS guidance on reporting by product.
- Members who have any of the 'medical' benefit, as defined by HEDIS®, should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and is included in applicable measures.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- EPO plans must use an **HHS-approved survey vendor** and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is 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 an **HHS-approved survey vendor** and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is 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 an **HHS-approved survey vendor** and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is 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® 2018 and QARR 2018 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** survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS Specific Measures Summary-Level File is required.



## I. Submission Requirements

### **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® 2018 and QARR 2018 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 optional.
- NYS Specific Measures Summary-Level File is required.

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

- Plans should follow Medicaid specifications in HEDIS® 2018 and QARR 2018 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.
- NYS Specific Measures Summary-Level File is required.

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

- Plans should follow Medicaid specifications in HEDIS® 2018 and QARR 2018 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.
- NYS Specific Measures Summary-Level File is required.

### **Medicare and Dual Eligible:**

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

## Measure Retirement

Retired:            Frequency of Ongoing Prenatal Care  
                         Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for  
                         Members on Digoxin

## New Measure Requirements

There are 10 new measures required for 2018 QARR:

- Use of Opioids at High Dosage
- Use of Opioids from Multiple Providers
- Continuity of Care from Inpatient Detox to Lower Level of Care
- Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care
- Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
- Use of Pharmacotherapy for Alcohol Abuse or Dependence
- Maintaining/Improving Employment or Higher Education Status
- Maintenance of Stable or Improved Housing Status
- No or Reduced Criminal Justice Involvement
- Potentially Preventable Mental Health Related Readmission Rate 30 Days



## I. Submission Requirements

### Use of Supplemental Databases

#### What are they?

Supplemental databases contain information about health care services members received that is gathered from sources other than claims and encounters. There are various sources of information described by HEDIS® 2018 (General Guideline 33 Volume 2, HEDIS® 2018) that provide direction on how 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?

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

The information captured from data sources must comply with HEDIS® 2018 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 (e.g., 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 IDSS is April 2018.

### Where to Submit QARR

- Submit the IDSS directly to NCQA.
- Electronically submit all additional files (no later than 11:59p.m. ET on June 15, 2018) to our External Quality Review Organization (EQRO) via a secure file transfer facility. Do not mail materials. Additional files include:
  - 1) Commercial CAHPS files
  - 2) QHP Enrollee Survey files
  - 3) Patient-Level-Detail files
  - 4) Live Birth files
  - 5) Medicaid optional enhancement files
- Coordinate FTP site arrangements with Paul Henfield of IPRO at [phenfield@ipro.org](mailto:phenfield@ipro.org).
- Any plan failing to submit the files by 11:59 p.m. ET on the date due will receive a Statement of Deficiency (SOD) for failure to comply with quality program requirements. For Medicaid plans, the compliance portion of the Quality Incentive is affected by Statements of Deficiency.

## I. Submission Requirements

### What to Send for QARR Submission

All submissions must be received electronically by 11:59 p.m. ET on June 15, 2018.

- 2018 IDSS file for all payers. IDSS files must be locked by auditor.
- CAHPS de-identified member-specific file for CPPO, CEPO, CHMO, EP
- 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 2018 QARR submission

- Interactive Data Submission System (IDSS): <https://my.ncqa.org/>
- Other required files: [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov)
- HEDIS® 2018 measures: Updates can be found on NCQA's web site: [www.ncqa.org](http://www.ncqa.org). Submit questions 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 must refer to HEDIS specifications when calculating HEDIS measures as part of QARR.  
All other questions: Quality Measurement and Evaluation Unit at [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov) or (518) 486-9012.
- The Health Insurance Marketplace Quality Rating System Measure Technical Specifications can be found on CMS web site: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Revised\\_QRS-2018-Measure-Tech-Specs\\_20170929\\_508.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Revised_QRS-2018-Measure-Tech-Specs_20170929_508.pdf)
- NYSDOH is not responsible for the interpretation of The Health Insurance Marketplace specifications or updating information. Plans must refer to CMS specifications when calculating the QRS measures as part of QARR.

## II. Reporting Requirements

### II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
<b>Effectiveness of Care</b>												
A	Adherence to Antipsychotic Medications for People with Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2018	●
H	Adolescent Preventive Care Measures	1	✓	✓	NR	NR	NR	✓	✓	NR	NYS 2018	●
H	Adult BMI Assessment		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Annual Monitoring for Patients on Persistent Medications		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Antidepressant Medication Management		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Appropriate Testing for Children with Pharyngitis		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A	Appropriate Treatment for Children with Upper Respiratory Infection		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
S	Aspirin Discussion and Use	4	NR	NR	NR	NR	NR	NR	NR	NR	CAHPS 5.0H	
A	Asthma Medication Ratio		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis		✓	✓	✓	✓	✓	✓	NR	✓	HEDIS 2018	●
A	Breast Cancer Screening		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●

<p><b>Method</b> A - admin, H - hybrid, S - survey, E - electronic</p> <p><b>Product lines</b>  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</p>	<p><b>Flag</b></p> <p>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 specifications.  8 = DOH calculated no plan reporting required.  9 = QHP only report numerators required by CMS.  10 = HbA1c Control &lt;7.0% is not required for QARR.</p>	<p><b>Shading</b> – Purple – Not required  Orange – New</p>
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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2018	●
A/H	Cervical Cancer Screening		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A/H	Childhood Immunization Status	9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A	Chlamydia Screening in Women	3	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A/H	Colorectal Cancer Screening	3,6	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
H	Comprehensive Diabetes Care	9, 10	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
H	Controlling High Blood Pressure		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Diabetes Monitoring for People with Diabetes and Schizophrenia		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications		NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Disease-Modifying Anti-Rheumatic Drugs for RA		✓	✓	✓	NR	NR	✓	NR	✓	HEDIS 2018	●
S	Flu Shots for Adults Ages 18 - 64	4	✓	✓	✓	✓	✓	✓	✓	✓	CAHPS 5.0H	

<p><b>Method</b> A - admin, H - hybrid, S - survey, E - electronic</p> <p><b>Product lines</b></p> <p>EPO - Exclusive Provider Organization</p> <p>PPO - Preferred Provider Organization</p> <p>HMO - Health Maintenance Organization</p> <p>POS - Point of Service</p> <p>PHSP - Prepaid Health Services Plan</p> <p>HIV SNP - HIV Special Needs Plan</p> <p>HARP - Health and Recovery Plan</p> <p>EP - Essential Plan</p>	<p><b>Flag</b></p> <p>1 = Use members in WCC for 12-17 stratum.</p> <p>2 = Enhanced for Medicaid; separate file needed.</p> <p>3 = Enhanced for Medicaid; file not needed.</p> <p>4 = DOH conducting Medicaid CAHPS.</p> <p>5 = Administrative method only for QARR.</p> <p>6 = Medicaid follow commercial specifications.</p> <p>7 = Commercial plans follow Medicaid specifications.</p> <p>8 = DOH calculated no plan reporting required.</p> <p>9 = QHP only report numerators required by CMS.</p> <p>10 = HbA1c Control &lt;7.0% is not required for QARR.</p>	<p><b>Shading</b> – Purple – Not required</p> <p>Orange – New</p>
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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Follow-Up After Emergency Department Visit for Mental Illness	2	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	2	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Follow-Up After Hospitalization for Mental Illness	2, 9	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Follow-Up Care for Children Prescribed ADHD Medication	2	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A/H	Immunizations for Adolescents	9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A/H	Lead Screening in Children	7	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
S	Medical Assistance with Smoking Cessation	4	✓	✓	✓	✓	✓	✓	✓	✓	CAHPS 5.0H	
A	Medication Management for People with Asthma	9	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Metabolic Monitoring for Children and Adolescents on Antipsychotics		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
A	Non-Recommended Cervical Cancer Screening in Adolescent Females		✓	✓	NR	NR	NR	✓	NR	NR	HEDIS 2018	●
A	Persistence of Beta-Blocker Treatment After a Heart Attack		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●

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<p><b>Method</b> A - admin, H - hybrid, S - survey, E - electronic</p> <p><b>Product lines</b></p> <p>EPO - Exclusive Provider Organization</p> <p>PPO - Preferred Provider Organization</p> <p>HMO - Health Maintenance Organization</p> <p>POS - Point of Service</p> <p>PHSP - Prepaid Health Services Plan</p> <p>HIV SNP - HIV Special Needs Plan</p> <p>HARP - Health and Recovery Plan</p> <p>EP - Essential Plan</p>	<p><b>Flag</b></p> <p>1 = Use members in WCC for 12-17 stratum.</p> <p>2 = Enhanced for Medicaid; separate file needed.</p> <p>3 = Enhanced for Medicaid; file not needed.</p> <p>4 = DOH conducting Medicaid CAHPS.</p> <p>5 = Administrative method only for QARR.</p> <p>6 = Medicaid follow commercial specifications.</p> <p>7 = Commercial plans follow Medicaid specifications.</p> <p>8 = DOH calculated no plan reporting required.</p> <p>9 = QHP only report numerators required by CMS.</p> <p>10 = HbA1c Control &lt;7.0% is not required for QARR.</p>	<p><b>Shading</b> – Purple – Not required</p> <p>Orange – New</p>
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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Pharmacotherapy Management of COPD Exacerbation		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Proportion of Days Covered		NR	NR	NR	✓	✓	NR	NR	NR	PQA 2018	●
A	Statin Therapy for Patients with Cardiovascular Disease		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Statin Therapy for Patients with Diabetes		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Use of Imaging Studies for Low Back Pain		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Use of Multiple Concurrent Antipsychotics in Children and Adolescents		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
A	Use of Opioids at High Dosage		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Use of Opioids From Multiple Providers		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Use of Spirometry Testing in The Assessment and Diagnosis of COPD		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Viral Load Suppression	8	NR	NR	NR	NR	NR	✓	✓	✓	NYS 2018	

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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
H	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
<b>Access / Availability of Care</b>												
A	Adult Access to Preventive/Ambulatory Care		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	●
A	Annual Dental Visit		NR	NR	NR	✓	✓	✓	NR	NR	HEDIS 2018	●
A	Continuity of Care from Inpatient Detox to Lower Level of Care		NR	NR	NR	NR	NR	NR	NR	✓	NYS 2018	●
A	Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care		NR	NR	NR	NR	NR	NR	NR	✓	NYS 2018	●
A	Children's Access to PCPs		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
A	Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence		NR	NR	NR	NR	NR	✓	✓	✓	NYS 2018	●

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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
H	Prenatal and Postpartum Care		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	●
A	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.		✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
A	Use of Pharmacotherapy for Alcohol Abuse or Dependence		NR	NR	NR	NR	NR	✓	✓	✓	NYS 2018	●
<b>Health Plan Descriptive Information</b>												
	Board Certification		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
	Enrollment by Product Line		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
<b>Cost of Care</b>												
	Relative Resource Use for People with Asthma		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
	Relative Resource Use for People with Cardiovascular Conditions		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
	Relative Resource Use for People with COPD		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
	Relative Resource Use for People with Diabetes		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
	Relative Resource Use for People with Hypertension		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
<b>Use of Services</b>												

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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Well-Child Visits in the First 15 Months of Life	5, 9	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	5	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2018	●
A	Adolescent Well-Care Visits	5	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2018	●
A	Ambulatory Care		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Frequency of Selected Procedures		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Bariatric Weight Loss Surgery		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Tonsillectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Hysterectomy, vaginal & abdominal		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Cholecystectomy, open & laparoscopic		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Back Surgery		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Percutaneous Coronary Intervention (PCI)		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	
A	Cardiac Catheterization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	
A	Coronary Artery Bypass Graft (CABG)		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	

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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Prostatectomy		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	
A	Mastectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Lumpectomy		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Identification of Alcohol and Other Drug Services		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	All Cause Readmission		✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2018	
A	Inpatient Utilization (General Hospital-Acute Care)		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Inpatient Hospital Utilization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	
A	Emergency Department Utilization		✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2018	
A	Mental Health Utilization		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Antibiotic Utilization		✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	
A	Standardized Healthcare-Associated Infection Ratio		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
<b>Experience of Care</b>												
S	CAHPS Health Plan Survey 5.0H, Adult Version	4	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2018	

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Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
S	CAHPS Health Plan Survey 5.0H, Child Version	4	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
S	QHP Enrollee Experience Survey		NR	NR	NR	✓	✓	NR	NR	NR	QRS 2018	De-identified member file
<b>Measures Collected Using Electronic Clinical Data Systems</b>												
E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
E	Depression Remission or Response for Adolescents and Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
E	Depression Screening and Follow-Up for Adolescents and Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
E	Unhealthy Alcohol Use Screening and Follow-up		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
E	Pneumococcal Vaccination Coverage for Older Adults		NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2018	
<b>NYS-Specific Prenatal Care Measures</b>												
A	Risk-Adjusted Low Birth Weight		These prenatal care measures will be calculated by the Office of								NYS 2018	

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## II. Reporting Requirements

Method	Measure	Flag	Product Lines								Specs	Patient-Level Detail
			Commercial			Qualified Health Plans		Medicaid				
			PPO/EPO	HMO/POS	EP	PPO/EPO	HMO/POS	HMO/PHSP	HIV SNP	HARP		
A	Prenatal Care in the First Trimester		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 2018	
A	Risk-Adjusted Primary Cesarean Section										NYS 2018	
A	Vaginal Births after Cesarean Section										NYS 2018	
<b>NYS-Specific Behavioral Health Measures</b>												
A	Maintaining/Improving Employment or Higher Education Status		These measures will be calculated and reported by New York State using the NYS Community Mental Health Eligibility Assessment. HARP members are required to be assessed for Behavioral Health Home and Community Based Services (BH HCBS) eligibility using the NYS Community Mental Health Eligibility Assessment at the time of enrollment and at least annually thereafter. This measure will be calculated by New York State using 3M Software and health plan submitted encounters.								NYS 2018	
A	Maintenance of Stable or Improved Housing Status										NYS 2018	
A	No or Reduced Criminal Justice Involvement										NYS 2018	
A	Potentially Preventable Mental Health Related Readmission Rate 30 Days										NYS 2018	

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## III. 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, HIVSNP, HARP, and EP QARR data, as applicable.
- All organizations must send a copy of the written agreement with an NCQA-licensed audit organization by December 1, 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, Commercial HMO, and EP 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, 2018). 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 (email to the Office of Quality and Patient Safety [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov) by July 17, 2018). The FAR must contain audit validation signatures.
- NYSDOH requires plans to submit data for all measures indicated in Table 1. Plans may not designate a measure as 'NR -- plan chose not to report this measure.'
- Plans may designate a measure "UN" (Unaudited) if reporting a measure that is not required to be audited. This result applies only to Board Certification measures.

## IV. Reporting Schedule

### 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 <b>all products</b> included in the audit.	Due: <b>December 1, 2017</b>  To: NYSDOH via email nysqarr@health.ny.gov	All products lines
<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, 2018 by 11:59 p.m. ET</b>  To: NCQA	All product lines
<b>Additional File Submission</b>		
Live Birth File (required for all product lines) Patient-Level Detail file (required for all product lines) Enhancement files (optional for MA, HIVSNP, and HARP)  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.	Due: <b>June 15, 2018 by 11:59 p.m. ET</b>  To: IPRO via FTP site	All product lines
<b>CAHPS Files</b>		
Commercial Survey – de-identified member-level files of CAHPS responses are required. Follow NCQA CAHPS file layout for file submission. CAHPS sample frames must be reviewed by auditor prior to CAHPS administration.  Insurers with Qualified Health Plans - de-identified member-level files of Enrollee Survey responses are required.	Due: <b>June 15, 2018 by 11:59 p.m. ET</b>  To: IPRO via FTP site	CPPO CHMO CEPO EP QPPO QEPO  QHMO QPOS
<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 17, 2018</b>  To: NYSDOH via email nysqarr@health.ny.gov	All product lines

NYSDOH requires all reporting entities to submit all components on June 15, 2018 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, 2018. Sufficient reasons for the extension request must be provided with the request and only those requests that have been approved will be acknowledged.

NYSDOH Quality Assurance Reporting Requirement Unit: nysqarr@health.ny.gov



## V. NYS-Specific Measures

### V. NYS-Specific Measures

#### Adolescent Preventive Care Measures (ADL)

##### CHANGES TO THE MEASURE:

- Removed ICD-9-CM Codes.
- Changed Administrative Specifications for Numerator 2: Deleted HCPCS Code G8930.
- Changed Administrative Specifications for Numerator 3: Deleted HCPCS Codes G0436, G0437.
- Clarified Medical Record Specifications for Numerator 1: Added that an HPV vaccination alone without any of the above-mentioned documentation, including assessment, will not be counted as numerator compliant.

##### DESCRIPTION

The percentage of adolescents ages 12-17 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
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 if all services occur within the measurement year and were provided by a PCP or OB/GYN practitioner. This applies to both administrative and medical record data.
- The health plan may include sick visits that occur within the measurement year.
- The health plan is encouraged to include all visits and records in this review, even if the visits were provided by a practitioner other than the one to which the member is assigned.

##### ELIGIBLE POPULATION

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

The eligible population for these measures will be derived from the systematic sample generated for Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) denominator from HEDIS® 2018, using the hybrid method. Adolescents in the denominator of the 12-17-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 should be generated using the WCC eligible population for ages 3-17 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 WCC should be generated from the entire eligible population of 3-17 years. It should not be limited to the 12-17 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

## V. NYS-Specific Measures

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 3-17.	1. Determine eligible population for WCC per HEDIS specification for ages 3-17.
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 12-17 age-group.	4. Determine members in the sample who are in the 12-17 age-group.
QARR-ADL	5. The members in the WCC sample in the 12-17 age-group become the denominator for the Adolescent Preventive Care measures.	5. The members in the WCC sample for the 12-17 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 are 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. 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, Acronyms, and Other Terms

- Notation that a specific 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' is not 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.

## V. NYS-Specific Measures

- 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 counted 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, would 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 specific 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-10-CM Diagnosis	CPT II Codes	HCPCS
Counseling for HIV	Z71.7		
Counseling for Other STIs	Z70.8		
Counseling of Oral and Other Contraceptives	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

**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 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”, “sexual abuse”
- Distribution of educational materials to the member pertaining to risk behaviors and preventive actions

## V. NYS-Specific Measures

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, HIV test alone, or HPV vaccination 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-10-CM Diagnosis	CPT II	HCPCS
Depression screening	None	1220F, 3085F, 3351F, 3352F, 3353F, 3354F, 3725F	G0444, G8431, G8510, G8511, S3005

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

#### Medical Record Specifications

The following are positive findings:

- Use of a standardized depression questionnaire (such as Beck’s Depression Inventory, Patient Health Questionnaire, Reynolds Adolescent Depression Screen, Mood and Feelings Questionnaire)
- Use of a checklist indicating that depression or affective and physical symptoms of depression were addressed (sad, down, hopeless or suicidal ideation, loss of interest, poor appetite, change in sleep pattern, and difficulty concentrating)
- Notation of the presence or absence of adolescent’s depressive symptoms (both affective and physical as listed above) during the measurement year
- Notation of findings from assessment of depression (e.g., “denies symptoms of depression”, “depression symptoms - none or risks noted”, “depression - yes or no”)
- Notation of counseling or referral for treatment of depression
- 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

## V. NYS-Specific Measures

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 (including e-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	
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
- 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

## V. NYS-Specific Measures

### 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-10-CM Diagnosis or Procedure	CPT	CPT II	HCPCS
Alcohol and/or drug assessment or screening		99408, 99409	3016F, 4290F	G0396, G0397, H0001, H0049
Alcohol and or Drug Use Counseling Services	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 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 or alcohol use
- Only one topic is needed for a positive numerator finding (e.g., 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
- Assessment or counseling or education about tobacco use only
- Assessment or counseling or education prior to or after the measurement year
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that substance use was addressed



## V. NYS-Specific Measures

### Viral Load Suppression

The Viral Load Suppression measure will be calculated by the AIDS Institute and the Office of Quality and Patient Safety using the NYSDOH HIV Surveillance System.

#### Calculation of Measures

Upon close of the measurement year (January 1, 2017 through December 31, 2017) NYSDOH 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, 2016. This algorithm captures HIV+ Medicaid recipients based on their HIV-related service utilization, including outpatient visits, laboratory testing, inpatient stays, 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 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.

#### 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.

#### Eligible Population:

<b>Product Line:</b>	Medicaid HMO/PHSP, Medicaid HIVSNP, Medicaid HARP
<b>Ages:</b>	2 years of age or older
<b>Continuous Enrollment:</b>	12 months' continuous enrollment for the measurement year. The allowable gap is no more than one month during the measurement year.
<b>Anchor Date:</b>	December 31 of the measurement year.
<b>HIV confirmation</b>	Confirmed HIV positive through a match with the HIV Surveillance System.

#### Denominator

The eligible population.

#### Numerator

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.



## V. NYS-Specific Measures

### Continuity of Care for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care

These measures focus on individuals engaged in treatment for alcohol and other drug dependence who are discharged to the community.

1. *Continuity of Care from Inpatient Detox to Lower Level of Care.* The percentage of inpatient detox discharges for members 13 years of age and older with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD treatment within 14 days of the discharge date.
2. *Continuity of Care from Inpatient Rehabilitation to Lower Level of Care.* The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date.

### Continuity of Care From Inpatient Detox To Lower Level of Care

The percentage of inpatient AOD detox discharges for members 13 years of age and older, who had a follow-up lower level AOD visit within 14 days of the discharge date.

#### Definitions

**Intake Period** January 1 - December 17 of the measurement year

**Direct Transfer** A **direct transfer** is when the discharge date from one inpatient detox setting and the admission date to a second inpatient detox setting are one calendar day apart or less. For example:

- An inpatient detox discharge on June 1, followed by an admission to another inpatient detox setting on June 1, is a direct transfer.
- An inpatient detox discharge on June 1, followed by an admission to an inpatient detox setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient detox setting on June 3, is not a direct transfer; these are two distinct inpatient detox stays.

Use the following method to identify admission to and discharges from inpatient detox settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify if the inpatient stay contains a detox code (Detoxification Value Set).
3. Identify if the inpatient stay includes a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
4. Identify the admission and discharge dates for the stay.

To combine direct transfers, keep the first admission date of the first admission and the discharge date of the last discharge date as one episode.

Treat transfers as separate discharges when the transfer is within the same institution or between institutions but to a different level of care (e.g., a transfer between detox and inpatient care).

Treat transfers as separate discharges when the transfer does not have a primary AOD diagnosis. A primary diagnosis of one of the following is required for transfer: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. (The same AOD diagnosis is not required for the original admission and transfer).

## V. NYS-Specific Measures

### Eligible Population

**Product Lines** HARP

**Ages** 13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate.

- 13-17 years
- 18+ years
- Total

**Continuous Enrollment** Date of discharge through 14 days after discharge

**Allowable Gap** No gaps in enrollment

**Anchor date** None

**Benefits** Medical and chemical dependency (inpatient and outpatient)

**Event/Diagnosis** An inpatient detox discharge during the Intake Period. Follow the steps below to identify the eligible population.

**Step 1** An acute or nonacute inpatient detox discharge with a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient detox discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify if the inpatient stay contains a detox code (Detoxification Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If a member has more than one inpatient detox discharge, identify all inpatient detox discharges between January 1 and December 17 of the measurement year with a clean period (see next step).

**Direct transfers:** See above definition (A primary diagnosis of one of the following is required for the transfer: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set).

**Step 2 Exclusions** Exclude detox discharges where the member was not discharged alive.

Exclude inpatient detox discharges followed by admission to a non-AOD acute or nonacute inpatient care setting on the date of the inpatient detox discharge or within 14 days of the inpatient detox discharge, regardless of principal diagnosis for the admission. To identify admission to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

**Step 3** If a member has more than one inpatient detox discharge in a 15-day period, include only the first inpatient detox discharge.

### Multiple Inpatient Detox Discharges in a 15-day Period

For example, if a member has an inpatient discharge date of January 1, then include the January 1 discharge date and do not include inpatient detox discharges with an admission date that occur on or between January 2 and January 15; then, if applicable, include the next inpatient detox discharge with an admission date on or after January 16. Identify discharges chronologically including only one per 15-day period.

## V. NYS-Specific Measures

**Step 4** Calculate continuous enrollment. Members must be continuously enrolled on the date of discharge through 14 days after the discharge date.

### Administrative Specification

**Denominator** The eligible population

**Numerator** A follow-up inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a primary diagnosis of AOD within 14 days after the inpatient detox discharge. Include visits that occur on the date of the inpatient detox discharge. Any of the following code combinations meet criteria:

- An inpatient admission **with** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Stand Alone Visits Set **with** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Do not count events that include detoxification or detoxification codes (Detoxification Value Set).

## V. NYS-Specific Measures

### Continuity of Care From Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment To Lower Level of Care

#### Description

The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse (AOD) or dependence treatment, who had a follow-up lower level AOD visit within 14 days of the discharge date.

#### Definitions

**Intake Period** January 1-December 17 of the measurement year

**Direct Transfer** A **direct transfer** is when the discharge date from one inpatient AOD treatment setting and the admission date to a second inpatient AOD treatment setting are one calendar day apart or less. For example:

- An inpatient AOD treatment discharge on June 1, followed by an admission to another inpatient AOD treatment setting on June 1, is a direct transfer.
- An inpatient AOD treatment discharge on June 1, followed by an admission to an inpatient AOD treatment setting on June 2, is a direct transfer.
- An inpatient AOD treatment discharge on June 1, followed by an admission to another inpatient AOD treatment setting on June 3, is not a direct transfer; these are two distinct inpatient AOD treatment stays.

Use the following method to identify admission to and discharges from inpatient AOD treatment settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify all inpatient stays with a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
3. Identify the admission and discharge dates for the stay.

To combine direct transfers, keep the admission date of the first admission and the discharge date of the last discharge date as one episode.

Treat transfers as separate discharges when the transfer is within the same institution or between institutions but to a different level of care (e.g., a transfer between inpatient and residential care).

Treat transfers as separate discharges when the transfer does not have a primary AOD diagnosis. A primary diagnosis of one of the following is required for transfer: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. (The same AOD diagnosis is not required for the original admission and transfer).

#### Eligible Population

**Product Lines** HARP

**Ages** 13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate.

- 13-17 years
- 18+ years
- Total

**Continuous Enrollment** Date of discharge through 14 days after discharge

## V. NYS-Specific Measures

**Allowable Gap** No gaps in enrollment

**Anchor Date** None

**Benefits** Medical and chemical dependency (inpatient and outpatient)

**Event/  
Diagnosis** An inpatient discharge for AOD during the Intake Period  
Follow the steps below to identify the eligible population.

**Step 1** An acute or nonacute inpatient AOD treatment discharge with a primary diagnosis of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient AOD treatment discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify if the inpatient stay contains an appropriate diagnosis code (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, or Other Drug Abuse and Dependence Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If a member has more than one inpatient AOD treatment discharge, identify all inpatient AOD treatment discharges between January 1 and December 17 of the measurement year.

Do not include inpatient stays that contain detoxification or detoxification codes (Detoxification Value Set).

**Direct transfers: See above definition (A primary diagnosis of one of the following is required for the transfer: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set).**

**Step 2  
Exclusions** Exclude inpatient AOD rehabilitation discharges where the member was not discharged alive.

Exclude inpatient AOD treatment discharges followed by admission to a non-AOD acute or nonacute inpatient care setting on the date of the inpatient AOD treatment discharge or within 14 days of the inpatient AOD treatment discharge, regardless of principal diagnosis for the admission. To identify admission to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

**Step 3 Multiple  
inpatient  
discharges in a  
15-day period**

If a member has more than one inpatient AOD treatment discharge in a 15-day period, include only the first inpatient discharge.

For example, if a member has an inpatient AOD treatment discharge date of January 1, then include the January 1 discharge date and do not include inpatient AOD treatment discharges with an admission date that occur on or between January 2 and January 15; then, if applicable, include the next inpatient AOD treatment discharge with an admission date on or after January 16. Identify discharges chronologically including only one per 15-day period.

**Step 4** Calculate continuous enrollment. Members must be continuously enrolled on the date of discharge through 14 days after the discharge date.

### Administrative Specification

## V. NYS-Specific Measures

**Denominator** The eligible population.

**Numerator** A follow-up outpatient visit, intensive outpatient encounter or partial hospitalization, with a primary diagnosis of AOD within 14 days after the inpatient AOD treatment discharge. Include visits that occur on the date of the inpatient AOD treatment discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Set **with** a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** with a primary diagnosis using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Do not count events that include detoxification or detoxification codes (Detoxification Value Set).

## V. NYS-Specific Measures

### Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence

#### Description

The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid dependence

#### Definitions

<b>Intake Period</b>	January 1- December 1 of the measurement year
<b>Index Episode</b>	The earliest visit with an opioid dependence disorder diagnosis
<b>IESD</b>	Index Episode Start Date. The earliest date of service during the Intake Period with a diagnosis of opioid dependence disorder
<b>Negative Diagnosis History</b>	A period of 60 days before the IESD when the member had no claims/encounters with a diagnosis of opioid dependence disorder  For inpatient stays use the date of admission to determine Negative Diagnosis History

#### Eligible Population

<b>Product Lines</b>	Medicaid, HIV SNP, HARP
<b>Ages</b>	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. <ul style="list-style-type: none"><li>• 13-17 years</li><li>• 18+ years</li><li>• Total</li></ul>
<b>Continuous Enrollment</b>	60 days prior to the IESD through 29 days (inclusive) after the IESD
<b>Allowable Gap</b>	No gaps in enrollment
<b>Anchor Date</b>	None
<b>Benefits.</b>	Medical, Chemical Dependency, and Pharmacy
<b>Event/ Diagnosis</b>	The earliest opioid abuse and dependence diagnosis during Intake Period. Follow the steps below to identify the eligible population.
<b>Step 1</b>	Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following: <ul style="list-style-type: none"><li>• An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>), Any of the following code combinations meet the criteria:<ul style="list-style-type: none"><li>– IET Stand Alone Visits Set <b>with</b> a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>),</li><li>– IET Visits Group 1 Value Set <b>with</b> IET POS Group 1 Value Set <b>and</b> with a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>),</li><li>– IET Visits Group 2 Value Set <b>with</b> IET POS Group 2 Value Set <b>and</b> with a diagnosis of opioid abuse or dependence (<u>Opioid Abuse and Dependence Value Set</u>),</li></ul></li></ul>



## V. NYS-Specific Measures

- An ED visit (ED Value Set) **with** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
- A detoxification visit (Detoxification Value Set) **with** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set),
- An acute or nonacute inpatient discharge with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set). To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.

For members with more than one episode of opioid abuse or dependence, use the first episode.

*For members, whose index episode was an ED visit that resulted in an inpatient stay, or other inpatient stay use the inpatient discharge as the IESD. An ED visit results in an inpatient stay When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.*

*For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer).*

### Step 2 Exclusions

Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) during the 60 days (2 months) before the IESD.

*For an inpatient stay, use the admission date to determine the Negative Diagnosis History.*

*For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. An ED visit results in an inpatient stay When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or one calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.*

*For direct transfers, use the first admission to determine the Negative Diagnosis History.*

### Step 3

Calculate continuous enrollment. Members must be continuously enrolled without any gaps, 60 days (2 months) before the IESD through 29 days after the IESD.

### Administrative Specification

#### Denominator

The eligible population.

#### Numerator

Initiation of pharmacotherapy treatment within 30 days of the Index Episode.

Any of the following will identify initiation of pharmacotherapy treatment for opioid abuse or dependence:

- A Medication Assisted Therapy Dispensing Event (Medication Assisted Treatment).
- Dispensed a prescription for Opioid Abuse or Dependence (MAT Opioid Abuse or Dependence Medications List).

*If the Index Episode was an inpatient admission, the 30-day period for the MAT begins on the day of discharge.*

## V. NYS-Specific Measures

### MAT for Opioid Abuse or Dependence

Description	Prescription
Opioid Dependence	<ul style="list-style-type: none"><li>• Buprenorphine HCL</li><li>• Naloxone HCL</li></ul>
Alcohol/Opioid Dependence	<ul style="list-style-type: none"><li>• Naltrexone HCL</li><li>• Naltrexone Microspheres</li></ul>

**Note:** NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2017.

## V. NYS-Specific Measures

### Use of Pharmacotherapy for Alcohol Abuse or Dependence

#### Description

The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.

#### Eligible Population

<b>Product Lines</b>	Medicaid, HIVSNP, HARP
<b>Ages</b>	13 years and older as of December 31, of the measurement year. Report two age stratifications and a total rate. <ul style="list-style-type: none"><li>• 13-17 years</li><li>• 18+ years</li><li>• Total</li></ul>
<b>Continuous Enrollment</b>	The measurement year
<b>Allowable Gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
<b>Anchor Date</b>	December 31 of the measurement year
<b>Benefits.</b>	Medical, Chemical Dependency, and Pharmacy
<b>Event/ Diagnosis</b>	Members with at least one alcohol use or dependence diagnosis ( <u>Alcohol Abuse or Dependence Value Set</u> ) during the measurement year.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	Number of individuals with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.  Any of the following will identify initiation of pharmacotherapy treatment for alcohol abuse or dependence: <ul style="list-style-type: none"><li>• Dispensed a prescription for Alcohol Abuse or Dependence (<u>MAT Alcohol Abuse or Dependence Medications List</u>) during the measurement year.</li></ul>

#### MAT for Alcohol Abuse or Dependence Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	<ul style="list-style-type: none"><li>• Disulfiram (oral)</li></ul>
Antagonist	<ul style="list-style-type: none"><li>• Naltrexone (oral and injectable)</li></ul>
Other	<ul style="list-style-type: none"><li>• Acamprosate (oral; delayed-release tablet)</li></ul>

**Note:** NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2017.

## V. NYS-Specific Measures

### Behavioral Health Measures

The following measures will be calculated by the Office of Mental Health and the Office of Quality and Patient Safety using the NYS Community Mental Health Assessment data.

1. *Maintaining/Improving Employment or Higher Education Status.* The percentage of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education at the second assessment point.
2. *Maintenance of Stable or Improved Housing Status.* The percentage of Community Mental Health (CMH) assessed members with maintenance of stable or improved housing status.
3. *No or Reduced Criminal Justice Involvement.* The percentage of Community Mental Health (CMH) assessed members with no or reduced criminal justice involvement.

#### Calculation

These measures will be calculated and reported by the Office of Mental Health and the Office of Quality and Patient Safety using the NYS Community Mental Health Eligibility Assessment. HARP members are required to be assessed for Behavioral Health Home and Community Based Services (BH HCBS) eligibility using the NYS Community Mental Health Eligibility Assessment at the time of enrollment and at least annually thereafter.

#### **Reporting Requirements**

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

### Maintaining/Improving Employment or Higher Education Status

#### **Description**

The percentage of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education at the second assessment point.

#### **Definitions**

<b>Intake Period</b>	The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.
<b>Screen One</b>	The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.
<b>Screen Two</b>	The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.
<b>Valid Screen</b>	The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

#### **CMH BH HCBS Eligibility Screen Items used in measure:**

##### **Employment Status**

1. Employed
2. Unemployed, seeking employment
3. Unemployed, not seeking employment

##### **Enrolled in Formal Education Program**

1. No
2. Part-time
3. Full-time

## V. NYS-Specific Measures

### Eligible Population

<b>Product Lines</b>	HARP
<b>Ages</b>	21 – 64 years old as of January 1, of the measurement year
<b>Continuous Enrollment</b>	Enrolled on the date of Screen One through the date of Screen Two
<b>Allowable Gap</b>	No more than one gap in enrollment of up to 30 days between Screen One and Screen Two
<b>Anchor Date</b>	The date of Screen Two
<b>Benefits</b>	Medical, Mental Health, and Chemical Dependency
<b>Event/ Diagnosis</b>	Follow the steps below to identify the eligible population.
<b>Step 1</b>	<ul style="list-style-type: none"><li>Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be 335-456 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria:<ul style="list-style-type: none"><li>Signed date is not missing AND</li><li>Completed assessment date is not missing AND</li><li>The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.</li></ul></li></ul>
<b>Step 2 Exclusions</b>	Exclude members where employment status <u>and</u> enrolled in formal education program are missing on Screen Two.

### Administration Specification

<b>Denominator</b>	The eligible population
<b>Numerator</b>	<p>The number of Community Mental Health (CMH) assessed members who were employed or enrolled in formal education on Screen Two.</p> <p>Members with the following answers to the questions listed below on Screen Two:</p> <p><b>Employment Status:</b></p> <ol style="list-style-type: none"><li>Employed</li></ol> <p><b>Formal Education Program:</b></p> <ol style="list-style-type: none"><li>Part-time</li><li>Full-time</li></ol>

## V. NYS-Specific Measures

### Maintenance of Stable or Improved Housing Status

#### Description

The percentage of Community Mental Health (CMH) assessed members with maintenance of stable or improved housing status.

#### Definitions

<b>Intake Period</b>	The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.
<b>Screen One</b>	The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.
<b>Screen Two</b>	The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.
<b>Valid Screen</b>	The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

#### CMH BH HCBS Eligibility Screen Items used in measure:

- Residential/Living status at time of assessment
1. Private home / apartment / rented room
  2. DOH Adult Home
  3. Homeless – shelter
  4. Homeless - street
  5. Mental Health supported/supportive housing (all types)
  6. OASAS/SUD community residence
  7. OCFS/ACS/DSS Community Residential Program (Family Foster Care Group Home, Therapeutic Foster Care)
  8. OPWDD community residence
  9. Long-term care facility (nursing home)
  10. Rehabilitation hospital/unit
  11. Hospice facility/palliative care unit
  12. Acute care hospital
  13. Correctional facility

#### Eligible Population

<b>Product Lines</b>	HARP
<b>Ages</b>	21 – 64 years old as of January 1, of the year prior to the measurement year
<b>Continuous Enrollment</b>	Enrolled on the date of Screen One through the date of Screen Two
<b>Allowable Gap</b>	No more than one gap in enrollment of up to 30 days between Screen One and Screen Two
<b>Anchor Date</b>	The date of Screen Two
<b>Benefits</b>	Medical, Mental Health, and Chemical Dependency
<b>Event/ Diagnosis</b>	Follow the steps below to identify the eligible population.

## V. NYS-Specific Measures

- Step 1**
- Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be between 335-456 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria:
    - Signed date is not missing AND
    - Completed assessment date is not missing AND
    - The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.

**Step 2 Exclusions** Exclude members where Residential/Living status at time of assessment is Missing or Other on Screen Two.

### Administrative Specifications

**Denominator** The eligible population

**Numerator** The number of Community Mental Health (CMH) assessed members of members with maintenance of stable or improved housing status.

Members with any of the following answers to the Residential/Living status at time of assessment question on Screen Two:

1. Private home / apartment / rented room
2. DOH Adult Home
3. Mental Health supported/supportive housing (all types)
4. OASAS/SUD community residence
5. OCFS/ACS/DSS Community Residential Program (Family Foster Care Group Home, Therapeutic Foster Care)
6. OPWDD community residence



## V. NYS-Specific Measures

### No or Reduced Criminal Justice Involvement

The percentage of Community Mental Health (CMH) assessed members with No or Reduced Criminal Justice Involvement.

#### Definitions

<b>Intake Period</b>	The 12-month window starting on January 1 of the year prior to the measurement year and ending on December 31 of the year prior to the measurement year.
<b>Screen One</b>	The first valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.
<b>Screen Two</b>	The most recent valid Community Mental Health BH HCBS Eligibility Screen in the measurement year.
<b>Valid Screen</b>	The screen is complete (neither signed date nor completed assessment date are missing), not a test record, and not a duplicate screen.

#### CMH BH HCBS Eligibility Screen Items used in measure:

##### Police Intervention – Arrested with charges

1. Never
2. More than 1 year ago
3. 31 days - 1 year ago
4. 8 - 30 days ago
5. 4 - 7 days ago
6. In last 3 days

#### Eligible Population

<b>Product Lines</b>	HARP
<b>Ages</b>	21 – 64 years old as of January 1, of the year prior to the measurement year
<b>Continuous Enrollment</b>	Enrolled on the date of Screen One through the date of Screen Two
<b>Allowable Gap</b>	No more than one gap in enrollment of up to 30 days between Screen One and Screen Two
<b>Anchor Date</b>	The date of Screen Two
<b>Benefits Event/ Diagnosis</b>	Medical, Mental Health, and Chemical Dependency Follow the steps below to identify the eligible population.
<b>Step 1</b>	<ul style="list-style-type: none"><li>• Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and at least one valid Community Mental Health BH HCBS Eligibility Screen in the year prior to the measurement year. The screens must be 335-456 days apart. A valid Community Mental Health BH HCBS Eligibility Screen must meet the following criteria:<ul style="list-style-type: none"><li>– Signed date is not missing AND</li><li>– Completed assessment date is not missing AND</li><li>– The screen is not a duplicate screen. Duplicate screens occur within 30 days of one another, have the same assessment reason, and are done by the same</li></ul></li></ul>

## V. NYS-Specific Measures

health home. When duplicate screens are found, the screen that has the more recent completed assessment date or signed date, and/or is more complete, and/or has few demographic item errors should be kept.

**Step 2 Exclusions** Exclude members where Police Intervention – Arrested with charges is Missing on Screen Two.

### Administrative Specification

**Denominator** The eligible population.

**Numerator** The number of Community Mental Health (CMH) assessed members who were never arrested with charges or were arrested with charges more than 1 year ago on Screen Two.

Members with any of the following answers to the Police Intervention – Arrested with charges question on Screen Two.

1. Never
2. More than 1 year ago

## V. NYS-Specific Measures

### Potentially Preventable Mental Health Related Readmission Rate 30 Days

The Potentially Preventable Mental Health Related Readmission measure will be calculated by the Office of Quality and Patient Safety.

#### Calculation of Measures

Upon close of the measurement year (January 1, 2017 through December 31, 2017), the following performance measure will be calculated by the Office of Quality and Patient Safety using health plan submitted encounter data and output from 3M™.

#### Reporting Requirements

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

#### Description

The percentage of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days.

#### Definitions

<b>Mental Health (MH) Related Admission</b>	An admission is considered MH Related when the 3M™ All Patient Refined Diagnosis Related Group (APR DRG) service line, derived mainly from the primary diagnosis and the severity of illness, is categorized as mental health. See the attached table for a list of APR DRG that are considered MH Related.
<b>Clinically-related</b>	Clinically-related is defined as a requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior hospital admission. These are not restricted to MH Related readmissions. A clinically-related readmission may have resulted from the process of care and treatment during the prior admission (e.g. readmission for a surgical wound infection) or from a lack of post admission follow up (lack of follow-up arrangements with a primary care physician) rather than from unrelated events that occurred after the prior admission (broken leg due to trauma) within a specified readmission time interval.
<b>Initial Admission (IA)</b>	The Initial Admission is a MH Related admission that is followed by a clinically related readmission within the readmission time interval. Subsequent readmissions relate back to the care rendered during or following the Initial Admission. The Initial Admission initiates a readmission chain.
<b>Readmission Chain</b>	A readmission chain is a sequence of admissions that are all clinically-related to the MH Related Initial Admission and occur within a specified readmission time interval. A readmission chain must contain an Initial Admission and at least one readmission.
<b>Only Admission (OA)</b>	An Only Admission is a MH Related admission for which there is neither a prior Initial Admission nor a clinically-related readmission within the readmission time interval and the individual was alive at discharge.
<b>At-Risk Admission</b>	An admission that has the potential for a readmission. Initial Admissions and Only Admissions are considered At Risk Admissions.
<b>Terminating a Readmission Chain</b>	Terminating a Readmission Chain prevents any subsequent readmissions from joining the Readmission Chain. Admissions that do not pass the exclusion criteria or are not clinically-related to the Initial Admission or occur outside of the specified readmission time interval or have a discharge status of transferred to an acute care hospital, left against medical advice or died, terminate a Readmission Chain.

## V. NYS-Specific Measures

### Eligible Population

<b>Product Lines</b>	HARP
<b>Ages</b>	21 – 64 years old as of the date of discharge
<b>Time Frame</b>	Discharges on or between January 1 – December 1 of the measurement year
<b>Allowable Gap</b>	No gaps in enrollment
<b>Anchor Date</b>	Date of discharge
<b>Benefits</b>	Medical, Mental Health (Inpatient and Outpatient).
<b>Event/ Diagnosis</b>	Identify all acute inpatient article 28 MH-related discharges on or between January 1 to December 1 of the measurement year.
<b>Step 2 Exclusions</b>	Exclude direct transfers and admissions where the patient died. Identify and exclude admissions related to complex medical conditions, non-events as listed in the following tables:

#### Readmission Exclusions (Specific to 3M™ Grouper Version 31)

- Admissions for immunocompromised or metastatic malignancy
- Neonatal or obstetrical admissions
- Multiple Trauma Admissions
- Admissions for burns
- Transplant admissions
- Planned readmissions
- Patient left against medical advice
- Data errors

#### Non-events (At Risk Admission Exclusions: Specific to 3M™ Grouper Version 31)

- Admissions to non-acute care facilities
- Admissions to an acute care hospital for patients assigned to the APR DRGs for rehabilitation, aftercare, and convalescence
- Same-day transfers to an acute care hospital for non-acute care (e.g., hospice care)
- Malignancies with a chemotherapy or radiotherapy procedure
- Selected hematological disorders
- Certain blood disorder/procedure combinations
- Certain planned chemotherapy, radiation procedure

**Step 3** Restrict to initial admissions and only admissions.

### Administrative Specifications

<b>Denominator</b>	At-risk admissions.
<b>Numerator</b>	The number of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days.

$$\text{PPR Formula*} = \frac{IA}{IA+OA}$$

\*Note: the IA and OA must be MH-related

## V. NYS-Specific Measures

### Table of MH Related APR DRG's

Acute Anxiety & Delirium States
Adjustment Disorders & Neuroses except Depressive Diagnoses
Bipolar Disorders
Depression except Major Depressive Disorder
Disorders of Personality & Impulse Control
Eating Disorders
Major Depressive Disorders & Other/unspecified Psychoses
Organic Mental Health Disturbances
Other Mental Health Disorders
Schizophrenia

## V. NYS-Specific Measures

### Prenatal Care Measures/Birth File

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 (10 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, 2017 through December 31, 2017) 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 considers 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, 2017 to December 31, 2017 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
- 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.)

## V. NYS-Specific Measures

- Hospital of Delivery (PFI)
- 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, 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.

**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 occurring during the period of January 1, 2017 to December 31, 2017. 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® 2018 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.



## V. NYS-Specific Measures

### 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., 2017).
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., 2017).
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.
Submission ID	90-94	Left Justified	Enter the NCQA five-digit submission ID
Product Line	97-98	Left Justified	1 = MA 2 = HIV SNP 3 = HARP 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10 = CEPO 11 = EP
Mother's Client ID Number (CIN)	99-106	For Medicaid: AA##### For CHP: 0##### or 5#####	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)

## V. NYS-Specific Measures

Element Name	Location	Coding	Notes
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:** New PFI INSTRUCTIONS

A list of current hospital PFI codes is available on the Health Data NY website:  
(<https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r/data>).

Please use the link to access the listing. On the main page, click "Filter" button, and under "Description is" filter, select all the check boxes except:

1. Adult Day Health Care Program-Offsite
2. Certified Home Health Agency
3. Hospice
4. Long Term Home Health Care Program
5. Residential Health Care Facility-SNF

After selecting the description of the facility type, click 'Export' button and download as 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 email the Quality Assurance Reporting Requirements Unit at [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov).

## VI. Patient-Level Detail File Submission

### VI. Patient-Level Detail and NYS Specific Measures Summary-Level File Submission

The Office of Quality and Patient Safety (OQPS) requires a Patient-Level Detail (PLD) file for all submissions. These files are used to: 1) validate summary-level data submitted by measure in the IDSS, 2) create composite measures, 3) enhance Medicaid, 4) monitor health disparities, and 5) conduct research and evaluation. NYSDOH requires a PLD file validation for all submissions. NYSDOH requires all plans to use the NYS PLD file and variables listed in the table below. For specific file formats, refer to the NYS Patient-Level Detail Specifications.

#### Patient-Level Detail

- Follow NCQA Specifications for those measures included in the NYS PLD file for each product, and follow the NYS Specifications for NYS-Specific measures included in the NYS PLD.
- Separate product level specific PLD files will submitted.
- The patient-level data must match the summary-level data for each measure in the NCQA IDSS.
- The NYS patient-level data will not match the summary-level data for hybrid measures.
- All fields in the NYS PLD file specifications are mandatory.
- Plans are required to submit PLD files for all measures applicable to the product line.

#### NYS Specific Measures Summary-Level Data

- Not all measures are captured in NCQA IDSS.
- NYS Specific Measures summary-level data will be collected as a separate file.

Measures included in the NYS Patient-Level Detail File for 2018 QARR:

	Measure Name	Specifications for Measures Included in the PLD	Optional Medicaid Enhancements
		NYS	
SAA	Adherence to Antipsychotic Medications for People with Schizophrenia	●	
ADL	Adolescent Preventive Care Measures	●	
ABA	Adult BMI Assessment	●	
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. Patient-Level Detail File Submission

	Measure Name	Specifications for Measures Included in the PLD	Optional Medicaid Enhancements
		NYS	
COL	Colorectal Cancer Screening	●	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	●	
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	●	
COD	Continuity of Care from Inpatient Detox to Lower Level of Care	●	
COR	Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care	●	
PPC	Prenatal and Postpartum Care	●	
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	●	

## VI. Patient-Level Detail File Submission

	Measure Name	Specifications for Measures Included in the PLD	Optional Medicaid Enhancements
		NYS	
W34	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	●	
AWC	Adolescent Well-Care Visits	●	
POD	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	●	
POA	Use of Pharmacotherapy for Alcohol Abuse or Dependence	●	

## VI. Patient-Level Detail File Submission

### 2018 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, 2018. 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.

Not all NYS Specific Measures are contained in the NCQA IDSS. A separate NYS Specific Measure Summary-level File (NYS File) will be required of those plans and products listed in the table below.

Product	Files	PLD Specifications
Commercial HMO	NYS File + NYS PLD	NYS Commercial
Commercial PPO	NYS File + NYS PLD	NYS Commercial
Commercial EPO	NYS File + NYS PLD	NYS Commercial
QHP HMO	NYS PLD	NYS QHP (Marketplace)
QHP POS	NYS PLD	NYS QHP (Marketplace)
QHP EPO	NYS PLD	NYS QHP (Marketplace)
QHP PPO	NYS PLD	NYS QHP (Marketplace)
Medicaid	NYS File + NYS PLD	NYS Medicaid
HIVSNP	NYS File + NYS PLD	NYS Medicaid
HARP	NYS File + NYS PLD	NYS Medicaid
EP	NYS File + NYS PLD	NYS Commercial

## VI. Patient-Level Detail File Submission

**NYS Specific Measures Summary-Level File:** Not all NYS Specific Measures are included in the IDSS. We are requiring summary-level data to be submitted as a fixed-width text file. All data should be populated using administrative results only, even if the final reported rate was calculated using the hybrid method.

### Hybrid Measures:

- The Eligible Population should reflect the summary eligible population (administrative method) and not the Final Sample Size (FSS). The numerator should reflect the summary of numerator events by administrative data in eligible population (before exclusions). The rate should reflect the current year's administrative rate (before exclusions).
- The patient-level data will not match the summary-level data (NYS Specific Measures Summary-Level File) for measures calculated using the hybrid method.
- If your plan reports COL or LCS using the administrative method then follow the instructions for administrative measures.

### Administrative Measures:

- The Eligible Population should reflect the summary eligible population. The numerator should reflect the summary of numerator events (Numerator events by administrative data and Numerator events by supplemental data) The rate should reflect the current year's reported rate.
- The patient-level data must match the summary-level data (NYS Specific Measures Summary-Level File) for each measure calculated using the administrative method.

### **Record Format for all Product lines**

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	44-49	Right justified
ADL Numerator 1- Sexual Activity	50-55	Right justified
ADL Numerator 2- Depression	56-61	Right justified
ADL Numerator 3- Tobacco Use	62-67	Right justified
ADL Numerator 4- Substance Use	68-73	Right justified
ADL Rate 1- Sexual Activity	74-78	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
ADL Rate 1- Depression	79-83	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
ADL Rate 1- Tobacco Use	84-88	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
ADL Rate 1- Substance Use	89-93	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)



## VI. Patient-Level Detail File Submission

Element	Location	Coding
COL Eligible Population	94-99	Right justified
COL Numerator	100-105	Right justified
COL Rate	106-110	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
LSC Eligible Population	111-116	Right justified
LSC Numerator	117-122	Right justified
LSC Rate	123-127	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
COD Eligible Population	128-133	Right justified
COD Numerator	134-139	Right justified
COD Rate	140-144	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
COR Eligible Population	145-150	Right justified
COR Numerator	151-156	Right justified
COR Rate	157-161	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
POD Eligible Population	162-167	Right justified
POD Numerator	168-173	Right justified
POD Rate	174-178	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)
POA Eligible Population	179-184	Right justified
POA Numerator	185-190	Right justified
POA Rate	191-195	must include 4 digits after decimal (e.g., .2018), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)

## VI. Patient-Level Detail 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 NYS 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 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.

### Hybrid Measures:

- The PLD file should only include the patient-level details from the hybrid method. The denominator and numerator results (Numerator events by administrative data, Numerator events by supplemental data and Numerator events by medical record data) should reflect those members used to calculate the hybrid reported rate.
- The patient-level data will not match the summary-level data (NYS Specific Measures Summary-Level File) for measures calculated using the hybrid method.
- If your plan reports COL or LCS using the administrative method then follow the instructions for administrative measures.

### Administrative Measures:

- The PLD file should include the patient-level details from the denominator and numerator results used to calculate the reported rate.
- The patient-level data must match the summary-level data (NYS Specific Measures Summary-Level File) for each measure calculated using the administrative method.

### Product Specific Reporting:

- Commercial Plans with approval from NCQA and NYSDOH to combine report their HMO and PPO membership should place these members in their CHMO product line.
- Commercial Plans with approval from NCQA and NYSDOH to combine report their EPO and PPO membership should place these members in their CPPO product line.

## ***VI. Patient-Level Detail File Submission***

- 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.

### **File Specifications**

See the attached excel file for the NYS PLD File Specifications.

### **Technical Assistance**

For Commercial, Medicaid, Marketplace PLD support, please submit questions to PCS at <https://my.ncqa.org/>.

For NYS PLD Support, please contact QARR Unit at (518) 486-9012 or [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov).

## VI. Patient-Level Detail File Submission

### 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**

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 following 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 CIN 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, for 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 to be considered a numerator “hit”: up to 7 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. In addition to the CIN, the files require 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> 1) 7-Day and 2) 30 Day	Submission ID	1-5	FUH.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	Discharge Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

- Follow-Up After Emergency Department Visit for Mental Illness:** There are two time periods in which a follow-up visit must have taken place to be considered a numerator “hit”: up to 7 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. In addition to the CIN, the files require 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> 1) 7-Day and 2) 30 Day	Submission ID	1-5	FUM.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	ED Visit Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

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

- 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 to be considered a numerator “hit”: up to 7 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. In addition to the CIN, the files require 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>	Submission ID	1-5	FUA.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0##### or 5#####	
	ED Visit Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

- 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® 2018 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 second 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).w

## 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>	Submission ID	1-5	Add.txt
	Product Line (1 = Medicaid 2 = HIV SNP 3 = HARP)	6	
	CIN (‘0’ fill the first position of this for CHP CINs)	7-14  For Medicaid – AA#####A For CHP – 0##### or 5#####	
	Included in Denominator 1? (1=Yes; 0=No)	15	
	Index Episode Start Date (YYYYMMDD)	16-23	
	Subsequent Visit Date1 (YYYYMMDD)	24-31	
	Indicator of Prescribing Provider for Visit Date1 (1=Yes; 0=No)	32	
	Indicator of Numerator Compliance for Initiation measure (1=Yes; 0=No)	33	
	Included in Denominator 2? (1=Yes; 0=No)	34	
	Subsequent Visit Date2 (YYYYMMDD)	35-42	
	Subsequent Visit Date3 (YYYYMMDD)	43-50	
	Indicator of Numerator Compliance for Continuation and Maintenance measure (1=Yes; 0=No)	51	

**Technical Assistance:** If you need clarification on these files, please contact the Quality Assurance Reporting Requirements Unit at [nysqarr@health.ny.gov](mailto:nysqarr@health.ny.gov).



## VIII. DRG Crosswalk

2018 QARR / HEDIS® 2018

### 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, 215-274, 280-316, 326-358, 368-395, 405-425, 432-446, 453-520, 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, 215-274, 326-358, 405-425, 453-520, 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