NEW YORK STATE | Department of Health

2020 Quality Assurance Reporting Requirements

Technical Specifications Manual (2020 QARR/HEDIS® 2020)

New York State Department of Health
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I. Submission Requirements

2020 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 2020 QARR incorporates measures from HEDIS 2020.

Areas of performance included in the 2020 QARR:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data
- NYS-specific measures

Organizations Required to Report

Article 44 licenses

- Medicaid and Commercial Managed Care plans (HMO/PHSP, HIVSNP) certified by the New York State Department of Health (NYSDOH) prior to 2019 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2019 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 for information on reporting requirements to the NYSDOH.

Article 32 Article 42 Article 43 Article 47 licenses

- Preferred Provider Organizations/Exclusive Provider Organizations (PPO/EPO) licensed by the New York State Department of Financial Services (DFS) prior to 2019 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, 2019, (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

- Qualified Health Plans (QHP) licensed by DFS prior to 2019 must report all QARR measures. Members with dental-only and catastrophic-only products are **excluded** when determining eligible membership for QARR.

Reporting Requirement Guidelines

- Table 1 – QARR List of Required Measures lists by product the NYS-specific and HEDIS 2020 measures required for submission.
- This manual describes in detail **only** the NYS-specific measures. Plans must purchase the HEDIS 2020 Technical Specifications for descriptions of the required HEDIS measures. Qualified Health

I. Submission Requirements

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 Exchange data collection unit as per CMS for QARR reporting.
- Plans should always apply HEDIS 2020 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 an NCQA-certified CAHPS vendor.
- All clarifications to the 2020 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 under the Health Plan Guidelines section. All clarifications must be incorporated into the 2020 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 the Table 1 – QARR List of Required Measures, 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 guidelines for members with dual enrollment in Commercial/Medicaid.
- NYS-specific measures will be reported using the NYS-Specific Patient-Level Detail file. NYS-specific measures will not be reported via NCQA IDSS.
- 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.

I. Submission Requirements

Specific Instructions for Commercial, Medicaid, and Qualified Health Plan Product Lines of Business:

Commercial PPO (CPPO):

- PPO product data should be reported separately for all licensed organizations meeting the enrollment threshold 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, 2020. 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, 2020. 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 2020 and QARR 2020 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 by January 15, 2020.
- 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 2020 and QARR 2020 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 meeting the enrollment threshold 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, 2020. 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 2020 instructions regarding commercial POS products.
- Commercial specifications should be followed for all required HEDIS 2020 and QARR 2020 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.

Commercial Off-Exchange Product
- Off-Exchange products must include this membership in the commercial product line.
- Plans without a Commercial product should contact NYSQARR@health.ny.gov for further guidance.

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

Qualified Health Plan EPO (QEPO):
- EPO product data should be reported separately for all licensed organizations meeting the enrollment threshold, 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.

Qualified Health Plan HMO (QHMO):
- HMO product data should be reported separately for all licensed organizations meeting the enrollment threshold, 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.

Qualified Health Plan POS (QPOS):
- POS product data should be reported separately for all licensed organizations meeting the enrollment threshold, 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.

Essential Plans (EP):
- EP product data should be reported separately for all licensed organizations meeting the enrollment threshold.
- 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 2020 and QARR 2020 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.

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 2020 and QARR 2020 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 2020 and QARR 2020 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.

Medicaid Health and Recovery Plan (HARP):
- Plans should follow Medicaid specifications in HEDIS 2020 and QARR 2020 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.

I. Submission Requirements

- NYS-Specific Measures Summary-Level File is required.

Medicare and Dual Eligible:
- Plans should **NOT** submit Medicare information.

What's New in the 2020 NYS Technical Specifications?

- NYSDOH will freeze the NYS QARR Technical Specifications on December 15, 2019. Clarifications issued after that date will not affect coding or program changes.

NYS-Specific Measure Retirement

- 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

NYS-Specific New Measure Requirements

- Percentage of Members Assessed for Home and Community Based Services Eligibility

NYS-Measure Trending

- NYS will not trend the following measures:
  - Controlling High Blood Pressure (CBP)
  - Follow-up After Emergency Department Visit for Mental Illness (FUM)
  - Follow-Up After Hospitalization for Mental Illness (FUH)
  - Identification of Alcohol and Other Drug Services (IAD)
  - Use of Opioids at High Dosage (HDO)

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. See HEDIS 2020 (General Guidelines Volume 2, HEDIS 2020) for 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
3) members in hospice and members who have died
4) 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 clinical conditions that may change over time, to correct billing information, and for measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and for excluding deceased members.

The information captured from data sources must comply with HEDIS 2020 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.

I. Submission Requirements

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 2020.

Where to Submit QARR

- Submit the IDSS directly to NCQA.
- Electronically submit all additional files to our External Quality Review Organization (EQRO) via a secure file transfer facility (see Reporting Schedule for dates). 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 Lisa Balistreri of IPRO at ebalistreri@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**.

What to Send for QARR Submission

The following submissions must be received electronically by 11:59 p.m. ET on June 15, 2020.

☑ 2020 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

The following submission must be received electronically by 11:59 p.m. ET on August 1, 2020
☑ Live Birth files for all payers

Questions Concerning the 2020 QARR Submission

- Interactive Data Submission System (IDSS): https://my.ncqa.org/
- Other required files: nysqarr@health.ny.gov
- HEDIS 2020 measures: Updates can be found on NCQA's web site: 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.
- The Health Insurance Exchange Quality Rating System Measure Technical Specifications can be found on CMS web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Rating-System/About-the-QRS.html NYSDOH is not responsible for the interpretation of The Health Insurance Exchange specifications or updating information. Plans must refer to CMS specifications when calculating the QRS measures as part of QARR.
- All other questions: Quality Measurement and Evaluation Unit at nysqarr@health.ny.gov or (518) 486-9012.

II. Table 1 – QARR List of Required Measures

QARR Method	Measure	Flag	Alpha Name	Product Lines								Specs	Patient-Level Detail
				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
				Effectiveness of Care									
A	Adherence to Antipsychotic Medications for Individuals with Schizophrenia		SAA	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A/H	Adolescent Preventive Care	1	ADL	✓	✓	NR	NR	NR	✓	✓	NR	NYS 2020	●
A/H	Adult BMI Assessment		ABA	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Antidepressant Medication Management		AMM	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Appropriate Testing for Pharyngitis		CWP	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Appropriate Treatment for Upper Respiratory Infection		URI	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Asthma Medication Ratio		AMR	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis		AAB	✓	✓	✓	✓	✓	✓	NR	✓	HEDIS 2020	●
A	Breast Cancer Screening		BCS	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia		SMC	NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2020	●
A/H	Cervical Cancer Screening		CCS	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●

Method A - admin, H - hybrid, S - survey, E - electronic

Product lines
EPO - Exclusive Provider Organization
PPO - Preferred Provider Organization
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POS - Point of Service
PHSP - Prepaid Health Services Plan
HIVSNP - HIV Special Needs Plan
HARP - Health and Recovery Plan
EP - Essential Plan

Flag
1 = Use members in WCC for 12-17 stratum.
2 = Enhanced for Medicaid; separate file needed.
3 = Enhanced for Medicaid; file not needed.
4 = DOH conducts Medicaid/HARP/HIVSNP 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.
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10 = HbA1c Control <7.0% is not required for QARR.

Shading – Purple– Not required
Orange – New

II. Reporting Requirements

QARR Method	Measure	Flag	Alpha Name	Product Lines								Specs	Patient-Level Detail
				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
A/H	Childhood Immunization Status	9	CIS	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2020	●
A	Chlamydia Screening in Women	3	CHL	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A/H	Colorectal Cancer Screening	3,6	COL	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A/H	Comprehensive Diabetes Care	9, 10	CDC	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A/H	Controlling High Blood Pressure		CBP	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Diabetes Monitoring for People with Diabetes and Schizophrenia		SMD	NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		SSD	NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2020	●
S	Flu Vaccinations for Adults Ages 18 - 64	4	FVA	✓	✓	✓	✓	✓	✓	✓	✓	CAHPS 5.0H	
A	Follow-Up After High-Intensity Care for Substance Use Disorder	2	FUI	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Follow-Up After Emergency Department Visit for Mental Illness	2	FUM	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	2	FUA	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Follow-Up After Hospitalization for Mental Illness	2, 9	FUH	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●

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				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
A	Follow-Up Care for Children Prescribed ADHD Medication	2	ADD	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●
A/H	Immunizations for Adolescents	9	IMA	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2020	●
A	International Normalized Ratio Monitoring for Individuals on Warfarin		INR	NR	NR	NR	✓	✓	NR	NR	NR	QRS	●
A/H	Lead Screening in Children	7	LSC	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●
S	Medical Assistance with Smoking and Tobacco Use Cessation	4	MSC	✓	✓	✓	✓	✓	✓	✓	✓	CAHPS 5.0H	
A	Medication Management for People with Asthma	9	MMA	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Metabolic Monitoring for Children and Adolescents on Antipsychotics		APM	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●
A	Non-Recommended Cervical Cancer Screening in Adolescent Females		NCS	✓	✓	NR	NR	NR	✓	NR	NR	HEDIS 2020	●
A	Persistence of Beta-Blocker Treatment After a Heart Attack		PBH	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Pharmacotherapy for Opioid Use Disorder		POD	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Pharmacotherapy Management of COPD Exacerbation		PCE	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Proportion of Days Covered		PDC	NR	NR	NR	✓	✓	NR	NR	NR	PQA	●

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A	Risk of Continued Opioid Use		COU	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Statin Therapy for Patients with Cardiovascular Disease		SPC	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Statin Therapy for Patients with Diabetes		SPD	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Use of Imaging Studies for Low Back Pain		LBP	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Use of Opioids at High Dosage		HDO	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Use of Opioids From Multiple Providers		UOP	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Use of Spirometry Testing in The Assessment and Diagnosis of COPD		SPR	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Viral Load Suppression	8	VLS	NR	NR	NR	NR	NR	✓	✓	✓	NYS 2020	
A/H	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		WCC	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2020	●
				Access / Availability of Care									
A	Adults' Access to Preventive/Ambulatory Health Services		AAP	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	●
A	Annual Dental Visit		ADV	NR	NR	NR	✓	✓	✓	NR	NR	HEDIS 2020	●
A	Children and Adolescents' Access to Primary Care Practitioners		CAP	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●

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II. Reporting Requirements

QARR Method	Measure	Flag	Alpha Name	Product Lines								Specs	Patient-Level Detail
				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
A	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment		IET	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence		POD-N	NR	NR	NR	NR	NR	✓	✓	✓	NYS 2020	●
A/H	Prenatal and Postpartum Care		PPC	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	●
A	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		APP	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●
A	Use of Pharmacotherapy for Alcohol Abuse or Dependence		POA	NR	NR	NR	NR	NR	✓	✓	✓	NYS 2020	●
				Health Plan Descriptive Information									
Board Certification			BCR	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
Enrollment by Product Line			ENP	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
				Use of Services									
A	Acute Hospital Utilization		AHU	✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	
A	Adolescent Well-Care Visits	5	AWC	✓	✓	NR	NR	NR	✓	✓	NR	HEDIS 2020	●
A	Ambulatory Care		AMB	NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2020	
A	Antibiotic Utilization		ABX	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Emergency Department Utilization		EDU	✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	

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				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
A	Frequency of Selected Procedures		FSP	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Bariatric Weight Loss Surgery			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Tonsillectomy			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Hysterectomy, Vaginal & Abdominal			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Cholecystectomy, Open & Laparoscopic			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Back Surgery			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Percutaneous Coronary Intervention (PCI)			✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	
A	Cardiac Catheterization			✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	
A	Coronary Artery Bypass Graft (CABG)			✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	
A	Prostatectomy			✓	✓	✓	NR	NR	NR	NR	NR	HEDIS 2020	
A	Mastectomy			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Lumpectomy			✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Identification of Alcohol and Other Drug Services		IAD	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Inpatient Utilization–General Hospital/Acute Care		IPU	NR	NR	NR	NR	NR	✓	✓	✓	HEDIS 2020	
A	Mental Health Utilization		MPT	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
A	Plan All-Cause Readmission		PCR	✓	✓	✓	✓	✓	✓	✓	✓	HEDIS 2020	

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				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				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	W15	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2020	●
A	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	5	W34	✓	✓	NR	✓	✓	✓	✓	NR	HEDIS 2020	●
				Experience of Care									
S	CAHPS Health Plan Survey 5.0H Adult Version	4	CPA	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
S	CAHPS Health Plan Survey 5.0H Child Version		CPC	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
S	QHP Enrollee Experience Survey			NR	NR	NR	✓	✓	NR	NR	NR	QRS 2020	De-identified member file
				Measures Collected Using Electronic Clinical Data Systems									
E	Breast Cancer Screening		BCS-E	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
E	Colorectal Cancer Screening	6	COL-E	✓	✓	✓	NR	NR	✓	✓	✓	HEDIS 2020	
E	Follow-Up Care for Children Prescribed ADHD Medication		ADD-E	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Adult Immunization Status		AIS	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Depression Remission or Response for Adolescents and Adults		DRR	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	

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				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
E	Depression Screening and Follow-Up for Adolescents and Adults		DSF	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Prenatal Depression Screening and Follow-Up		PND	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Postpartum Depression Screening and Follow-Up		PDS	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Prenatal Immunization Status		PRS	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Unhealthy Alcohol Use Screening and Follow-up		ASF	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		DMS	NR	NR	NR	NR	NR	NR	NR	NR	HEDIS 2020	
				NYS-Specific Prenatal Care Measures									
A	Risk-Adjusted Low Birth Weight			These prenatal care measures will be calculated by the Office of Quality and Patient Safety using the birth data submitted by plans and the Department's Vital Statistics Birth File. Commercial EPO/PPO, HMO/POS, Qualified Health Plans PPO/EPO, HMO/POS, Medicaid HMO/PHSP, Medicaid HIV								NYS 2020	
A	Prenatal Care in the First Trimester											NYS 2020	
A	Risk-Adjusted Primary C-Section											NYS 2020	
A	Vaginal Births after C-Section											NYS 2020	

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				Commercial			Qualified Health Plans		Medicaid				All products required to report measure
				PPO/ EPO	HMO/ POS	EP	PPO/ EPO	HMO/ POS	HMO/ PHSP	HIV SNP	HARP		
				SNP, HARP and EP are required to submit live birth files.									
				NYS-Specific Behavioral Health Measures									
A	Employed, Seeking Employment, or Enrolled in a Formal Education Program	8		These measures will be calculated and reported by New York State using the NYS Community Mental Health Eligibility Assessment for HARP members only. 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.								NYS 2020	
A	Stable Housing Status	8										NYS 2020	
A	No Arrests in Past Year	8										NYS 2020	
A	Completion of Home and Community Based Services Annual Needs Assessment	8										NYS2020	
A	Potentially Preventable Mental Health Related Readmission Rate 30 Days	8		This measure will be calculated by New York State using 3M Software and health plan submitted encounter for HARP Members only.								NYS 2020	
				NYS-Specific AHRQ Quality Indicators™									
A	PDI 90 Pediatric Quality Overall Composite	8		These measures will be calculated by the Office of Quality and Patient Safety using Health Plan submitted encounters for Medicaid Managed Care (HMO/PHSP) members only.								AHRQ v2018	
A	PQI 90 Prevention Quality Overall Composite	8										AHRQ v2018	

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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 3, 2019. The copy can be sent in PDF format via email to:

  QARR Unit
  Office of Quality and Patient Safety
  Email: 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, 2020). 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 nysqarr@health.ny.gov by July 15, 2020). The FAR must contain audit validation signatures.
- NYSDOH requires plans to submit data for all measures indicated in Table 1 – QARR List of Required Measures. 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

	Due Date and Destination	Organizations	
NCQA Licensed Audit Organization			
Copy of written agreement with a NCQA licensed organization that indicates **all products** included in the audit.	**December 3, 2019** **To: NYSDOH via email nysqarr@health.ny.gov**	All products lines	
QARR Submission			
Interactive Data Submission System (IDSS) Submission 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.	**June 15, 2020 by 11:59 p.m. ET** To: NCQA	All product lines	
Additional File Submission			
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.	**June 15, 2020 by 11:59 p.m. ET** To: IPRO via FTP site	All product lines	
Live Birth File (required for all product lines)	**August 1, 2020 by 11:59 p.m. ET** To: IPRO via FTP site	All product lines	
CAHPS Files			
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.	**June 15, 2020 by 11:59 p.m. ET** To: IPRO via FTP site	CPPO CHMO CEPO EP QPPO QEPO	QHMO QPOS
Final Audit Reports			
A copy of the Final Audit Report, including findings, corrective actions, and measure-specific results with signatures is required. Final Audit Report submissions are required to include the specified information for all supplemental database use.	**July 15, 2020** To: **NYSDOH via email nysqarr@health.ny.gov**	All product lines	

NYSDOH requires all reporting entities to submit all components per above schedule. Organizations who do not submit the IDSS by the submission deadline will be given a Statement of Deficiency (SOD) 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, 2020. Reasons for the extension request must be provided with the request, and only those requests that have been approved will be acknowledged.

NYSDOH QARR Unit: nysqarr@health.ny.gov

V. NYS-Specific Measures

Adolescent Preventive Care

Summary of changes to QARR 2020

- Revised eligible population language for clarity.
- Counseling Related to Sexual Activity Table
  - Removed code Z70.8 from the Counseling for Other STIs row
  - Added codes Z90.3 and Z70.9 to the Counseling for Other STIs row
- Depression Screening Table
  - Removed Active Depression Diagnosis row
  - Added code G9717 to Depression Screening row
- Alcohol and Substance use Counseling Table
  - Added code T1006 to the Alcohol and or Drug Use Counseling Services row
  - Added codes H0020 and J2315 to the Drug Use Treatment Medication row

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), HIVSNP.

The eligible population for these measures is comprised of the same members included in the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) eligible population referenced in HEDIS 2020 in the 12-17-year-old age range, before exclusions. Adolescents in the denominator of the 12-17-year-old cohort of the WCC measure, after the systematic sample is pulled, 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 denominator of the ADL measures.

V. NYS-Specific 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 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 Sample 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. **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 ADL denominator.**

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 sexual 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.

V. NYS-Specific Measures

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.
- 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 Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety 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	Z70.3, Z70.9		
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 or Counseling 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
Documentation of Sexual Activity			G9818

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

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	Z13.31	1220F, 3085F, 3351F, 3352F, 3353F, 3354F, 3725F	G0444, G8431, G8510, G8511, G9717, S3005
Antidepressant Pharmacotherapy		4063F, 4064F	

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

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	G9275, G9276, G9459, G9902, G9903, G9904, G9906
Tobacco Cessation Counseling or Services	Z71.6	99406, 99407	4000F, 4001F, 4004F	G9458, G9907, G9909
Tobacco Cessation Classes				S9453
Smoking Cessation Medication				S4990, S4991, S4995

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

V. NYS-Specific Measures

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

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, G0442, G9518, G9622, G9623, H0001, H0049
Alcohol and or Drug Use Counseling Services	Z71.41 Z71.51		4306F, 4320F	G0443, G9621, H0005, H0006, H0007, H0022, H0047, H0050, T1006, T1007
Drug Use Treatment Medication				H0020, J2315, J0570, J0571, J0572, J0573, J0574, J0575, S0109

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.

V. NYS-Specific Measures

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 • Notation of prescription for drug use treatment medication • 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, 2019 through December 31, 2019) 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, 2018. 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:

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

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.

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V. NYS-Specific Measures

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

Summary of changes to QARR 2020

These measures are removed from the 2020 Quality Assurance Reporting Requirements:

Continuity of Care from Inpatient Detox to Lower Level of Care
Continuity of Care from Inpatient Rehabilitation to Lower Level of Care

V. NYS-Specific Measures

Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence

Summary of changes to QARR 2020

- NYS changed the measure alpha name from POD to POD-N.

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

Intake Period	January 1 - December 1 of the measurement year
Index Episode	The earliest visit with an opioid dependence disorder diagnosis.
IESD	Index Episode Start Date. The earliest date of service during the Intake Period with a diagnosis of opioid dependence disorder.
Negative Diagnosis History	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

Product Lines	Medicaid, HIVSNP, HARP
Ages	18 years and older as of December 31 of the measurement year
Continuous Enrollment	60 days prior to the IESD through 29 days (inclusive) after the IESD
Allowable Gap	No gaps in enrollment
Anchor Date	None
Benefits	Medical, Chemical Dependency, and Pharmacy
Event/ Diagnosis	The earliest opioid abuse and dependence diagnosis during Intake Period. Follow the steps below to identify the eligible population.

Step 1	Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:
	
	• An outpatient visit, intensive outpatient visit, or partial hospitalization with a diagnosis of opioid abuse or dependence (NYS Opioid Value Set). Any of the following code combinations meet the criteria:
	  ◦ HEDIS IET Stand Alone Visits Set ***with*** a diagnosis of opioid abuse or dependence (NYS Opioid Value Set).
	  ◦ HEDIS IET Visits Group 1 Value Set ***with*** HEDIS IET POS Group 1 Value Set ***and*** with a diagnosis of opioid abuse or dependence (NYS Opioid Value Set).
	  ◦ HEDIS IET Visits Group 2 Value Set ***with*** HEDIS IET POS Group 2 Value Set ***and*** with a diagnosis of opioid abuse or dependence (NYS Opioid Value Set).
	• An ED visit (HEDIS ED Value Set) ***with*** a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).
	• A detoxification visit (HEDIS Detoxification Value Set) ***with*** a diagnosis of opioid abuse or dependence (NYS Opioid Value Set).

	• An acute or nonacute inpatient discharge with a diagnosis of opioid abuse or dependence (NYS Opioid Value Set). To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (HEDIS Inpatient Stay Value Set). 2. Identify the discharge date for the stay. *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. Refer to General Guideline 44 for new instructions. *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 an index visit with a diagnosis of opioid abuse or dependence (NYS Opioid 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. *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. For members with more than one episode of opioid abuse or dependence, use the first episode.

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 AOD Medication Treatment Value Set). • Dispensed a prescription for Opioid Abuse or Dependence (Opioid Use Disorder Treatment Medications List). *If the Index Episode was an inpatient admission,* the 30-day period for the MAT begins on the day of discharge. **Opioid Use Disorder Treatment Medications**

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

V. NYS-Specific Measures

	Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2019.

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

Product Lines	Medicaid, HIVSNP, HARP
Ages	18 years and older as of December 31 of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	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).
Anchor Date	December 31 of the measurement year
Benefits	Medical, Chemical Dependency, and Pharmacy
Event/ Diagnosis	Members with at least one alcohol use or dependence diagnosis (NYS Alcohol Value Set) during the measurement year.

Administrative Specification

Denominator	The eligible population
Numerator	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: • Dispensed a prescription for Alcohol Abuse or Dependence (Alcohol Use Disorder Treatment Medications List) during the measurement year.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2019.

V. NYS-Specific Measures

Behavioral Health Measures

Summary of Changes to QARR 2020

- Added new behavioral health measure:
  - Completion of Home and Community Based Services Annual Needs Assessment
- Updated Measure Names
- Updated Definitions, Eligible Population, and Administration Specification language

The following three NYS-Specific behavioral health 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.

Employed, Seeking Employment, or Enrolled in a Formal Education Program

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

Stable Housing Status

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

No Arrests in Past Year

The percentage of Community Mental Health (CMH) assessed members with no arrests in the past year.

Completion of Home and Community Based Services Needs Assessment

The percentage of members enrolled in a HARP with a complete Home and Community Based Services annual needs assessment during the measurement year.

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.

The fourth NYS-Specific behavioral health measure will be calculated by the Office of Quality and Patient Safety.

Potentially Preventable Mental Health Related Readmission Rate 30 Days.

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

Calculation

Upon close of the measurement year (January 1, 2019 through December 31, 2019), 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 these measures to the Office of Quality and Patient Safety.

V. NYS-Specific Measures

Employed, Seeking Employment, or Enrolled in a Formal Education Program

Description
The percentage of Community Mental Health (CMH) assessed members who were employed, seeking employment, or enrolled in formal education program.

Definitions

Intake Period	January 1 through December 31 of the measurement year.
Screen	The last valid Community Mental Health Behavioral Health Home and Community Based Services (CMH BH HCBS) Eligibility Screen in the intake period.
Valid Screen	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

Eligible Population

Product Lines	HARP
Ages	21 – 64 years old at the time of screening.
Continuous Enrollment	Enrolled in the same HARP for at least 6 months prior to the latest screen date in the measurement year.
Allowable Gap	No more than one gap in enrollment of up to 30 days in the 6 months prior to the latest screen date in the measurement year.
Anchor Date	The latest screen date of the measurement year.
Benefits	Medical, Mental Health, and Chemical Dependency
Event/ Diagnosis	Follow the steps below to identify the eligible population.
Step 1	Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and select the screen with the latest assessment date.
Step 2 Exclusions	Exclude members where employment status and enrolled in formal education program are missing.

Administration Specification

Denominator	The eligible population

V. NYS-Specific Measures

Numerator	Criteria for inclusion: Employment status: • Employed, or • Unemployed, seeking employment Enrolled in a formal education program: • Part-time, or • Full-time

V. NYS-Specific Measures

Stable Housing Status

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

Definitions

Intake Period	January 1 through December 31 of the measurement year.
Screen One	The last valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.
Valid Screen	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 the 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 14. Other 15. SUD residential program 16. SUD permanent supportive housing

Eligible Population

Product Lines	HARP
Ages	21 – 64 years old at the time of screening.
Continuous Enrollment	Enrolled in the same HARP for at least 6 months prior to the latest screen date in the measurement year.
Allowable Gap	No more than one gap in enrollment of up to 30 days in the 6 months prior to the latest screen date in the measurement year.
Anchor Date	The latest screen date of the measurement year.
Benefits	Medical, Mental Health, and Chemical Dependency
Event/ Diagnosis	Follow the steps below to identify the eligible population.
Step 1	Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and select the screen with the latest assessment date.

V. NYS-Specific Measures

Step 2 Exclusions	Exclude members with the following values for RESIDENTIAL/LIVING STATUS AT TIME OF ASSESSMENT: • DOH adult home • Long-term care facility (nursing home) • Rehabilitation hospital/unit • Hospice facility/palliative care unit • Acute care hospital • Correctional facility • Other • Missing

Administrative Specifications

Denominator	The eligible population
Numerator	The number of Community Mental Health (CMH) assessed members with stable housing status. Criteria for inclusion in the numerator is shown below: Residential/Living status at time of assessment: • Private home / apartment / rented room • Mental Health supported/supportive housing (all types) • OASAS/SUD community residence • OCFS/ACS/DSS Community Residential Program (Family Foster Care Group Home, Therapeutic Foster Care) • OPWDD community residence • SUD residential program • SUD permanent supportive housing

V. NYS-Specific Measures

No Arrests in the Past Year

Description

The percentage of Community Mental Health (CMH) assessed members with no arrests in the past year.

Definitions

Intake Period	January 1 through December 31 of the measurement year.
Screen	The last valid Community Mental Health Behavioral Health Home and Community Based Services (BH HCBS) Eligibility Screen in the intake period.
Valid Screen	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

Product Lines	HARP
Ages	21 – 64 years old at the time of screening.
Continuous Enrollment	Enrolled in the same HARP for at least 6 months prior to the latest screen date in the measurement year.
Allowable Gap	No more than one gap in enrollment of up to 30 days in the 6 months prior to the latest screen date in the measurement year.
Anchor Date	The latest screen date of the measurement year.
Benefits	Medical, Mental Health, and Chemical Dependency
Event/ Diagnosis	Follow the steps below to identify the eligible population.
Step 1	Identify members with at least one valid Community Mental Health BH HCBS Eligibility Screen during the measurement year and select the screen with the latest assessment date.
Step 2 Exclusions	Exclude members where Police Intervention – Arrested with charges is missing.

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 at time of assessment. Criteria for inclusion: Arrested with charges:

	• Never • 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 Measure

Upon close of the measurement year (January 1, 2019 through December 31, 2019), 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

Mental Health (MH) Related Admission	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.
Clinically-related	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.
Initial Admission (IA)	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.
Readmission Chain	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.
Only Admission (OA)	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.
At-Risk Admission	An admission that has the potential for a readmission. Initial Admissions and Only Admissions are considered At Risk Admissions.
Terminating a Readmission Chain	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.

Eligible Population

Product Lines	HARP
Ages	21 – 64 years old as of the date of discharge
Time Frame	Discharges on or between January 1 – December 1 of the measurement year

V. NYS-Specific Measures

Allowable Gap	No gaps in enrollment
Anchor Date	Date of discharge
Continuous Enrollment	3 months prior to the index admission, at the time of admission, and 1-month post discharge
Benefits	Medical, Mental Health (Inpatient and Outpatient).
Event/ Diagnosis	Identify all acute inpatient article 28 MH-related discharges on or between January 1 to December 1 of the measurement year.
Step 2 Exclusions	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

Denominator	At-risk admissions.
Numerator	The number of at-risk admissions for Mental Health that result in a clinically related readmission within 30 days. PPR Formula*: $\frac{IA}{IA+OA}$ *Note: the IA and OA must be MH-related

V. NYS-Specific Measures

Completion of Home and Community Based Services Annual Needs Assessment

Description
The percentage of members enrolled in a HARP who had an HCBS annual needs assessment completed during the measurement year.

Definitions

Intake Period	January 1 to December 31 of the measurement year.
HCBS Annual Needs Assessment	The HCBS annual needs assessment for HARP members will be conducted using the Community Mental Health Behavioral Health (BH) HCBS Eligibility Screen instrument.
Valid Screen	The Community Mental Health BH HCBS Eligibility Screen is complete (neither signed date nor completed assessment date are missing) and not a test record.

Eligible Population

Product Lines	HARP
Ages	21 – 64 years old at the time of screening. Age is calculated as of December 31 of the measurement year.
Continuous Enrollment	Enrolled in the same HARP plan for at least 6 months of the measurement year.
Allowable Gap	No more than one gap in enrollment of up to 30 days during the 6-month continuous enrollment period.
Anchor Date	December 31 of the measurement year.
Benefits	Medical, Mental Health, and Chemical Dependency

Administration Specification

Denominator	The eligible population
Numerator	Criteria for inclusion: • Screen Assessment Date: ○ Between January 1 to December 31 of the measurement year. • The date the assessment was signed is not missing.

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
Other Mental Health Disorders
Schizophrenia

V. NYS-Specific Measures

Prenatal Care Measures/Birth File

Summary of Changes to QARR 2020

- Updated the Record Format for all Product lines, Element Name language for the Number of Enrollment Days Prior to Delivery. New language reads as follows:
  - "The number of days the mother was enrolled in the plan during the 10-month period immediately prior to delivery. Cannot be a negative number. The number of days should not include the delivery date and should not include gap days.
- Removed the following fields:
  - Most Recent Enrollment Date
  - Most Recent Disenrollment Date
- Updated location fields
- Updated instructions for PFI

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, 2019 through December 31, 2019) 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.

V. NYS-Specific Measures

Reporting Requirements
Plans are to report all live births that occurred during the period of January 1, 2019 to December 31, 2019 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.)
- Hospital of Delivery (PFI)
- Mother's Date of Admission
- Number of Enrollment Days Prior to Delivery
- 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 1-80.
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 1-80.
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 1-80.
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 1-80.
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 1-80.
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 1-80.
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 1-80.
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 1-96. 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 1-96.
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 1-96.
EP: Submit one file containing EP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

V. NYS-Specific Measures

Eligible Group

- The eligible group will include all deliveries resulting in live births occurring during the period of January 1, 2019 to December 31, 2019.
- Use the delivery date to determine the product to assign to the member.
- Identify the women who had at least one live birth during the measurement period for whom the plan is the primary payer at the time of delivery.
- Include all deliveries where the member was enrolled with the plan on the date of delivery.
- Mothers with more than one birth during the measurement year or with multiple live births will be listed in the file more than once.

Record Format for all Product lines

Element Name	Location	Coding	Notes
Mother's Last Name	1-20	Left Justified	No numeric entries. **List mother more than once in the case of multiple births.**
Mother's First Name	21-35	Left Justified	Do not include middle initial or punctuation
Mother's Date of Birth	36-43	DDMMYYYY	Year must include four digits (e.g., 1985).
Mother's Resident Zip Code at Time of Delivery	44-48	Right Justified	No blanks, use 99999 if unknown.
Date of Delivery	49-56	DDMMYYYY	Year must include four digits (e.g., 2019).
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. *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.
Mother's Date of Admission	62-69	DDMMYYYY	Year must include four digits (e.g., 2019).
Number of Enrollment Days Prior to Delivery	70-73	Right Justified	The number of days the mother was enrolled in the plan during the 10-month period immediately prior to delivery. Cannot be a negative number. The number of days should not include the delivery date and should not include gap days.
Submission ID	74-78	Left Justified	Enter the NCQA five-digit submission ID
Product Line	79-80	Left Justified	1 = MA 2 = HIVSNP 3= HARP 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10=CEPO 11= EP
Mother's Client ID Number (CIN)	81-88	For Medicaid: AA#####A For CHP: 0####### or 5#######	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)
Baby's Client ID Number* (CIN)	89-96	For Medicaid: AA#####A For CHP:	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)

V. NYS-Specific Measures

Element Name	Location	Coding	Notes
		0####### or 5#######	

Live Birth Files that are missing greater than 10% of the Baby Client ID Number will not be accepted. If you are not able to reach the following thresholds, contact NYSQARR@health.ny.gov.

- **90% - threshold for Medicaid/HIVSNP**
- **75% - threshold for HARP**

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 that list the following Description:

1. Hospital
2. Primary Care Hospital- Critical Access Hospital

After selecting the description of the facility type, click 'Export' button and download as a a csv file with all available PFI information.

Header Record: To be submitted in standard ASCII format as the first row on the live birth 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, QHP_PPO, QHP_EPO, QHP_HMO, QHP_POS, MEDICAID, HIVSNP, HARP, EP Left justified
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.

V. NYS-Specific Measures

AHRQ Quality Indicators™

The Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) quantify hospital admissions that most likely could have been avoided through high-quality outpatient care. The two AHRQ Quality Indicators™ included in QARR reporting are PDI 90 Pediatric Quality Overall Composite and PQI 90 Prevention Quality Overall Composite.

Reporting Requirements
There are no reporting requirements for plans for this measure. These measures are calculated by the Office of Quality and Patient Safety.

PDI 90 Pediatric Quality Overall Composite

Description:
Pediatric Quality Indicators (PDI) overall composite per 100,000 enrollees, ages 6 to 17 years. Includes admissions for one of the following conditions: asthma, diabetes with short-term complications, gastroenteritis, or urinary tract infection.

Eligible Population:

Product Line	Medicaid HMO/PHSP
Ages	6 – 17 years old as of the beginning of the measurement year
Time Frame	Measurement year
Allowable Gap	No gaps in enrollment
Anchor Date	Date of admission
Continuous Enrollment	4 months continuous enrollment.
Benefits	Medical
Event/ Diagnosis	Identify all acute inpatient discharges on or between January 1 to December 31 of the measurement year.
Exclusions	Members who were dually enrolled in Medicaid and Medicare at any point in the measurement year. For a full list of inclusion and exclusion criteria see the Technical Specifications from AHRQ; https://www.qualityindicators.ahrq.gov/Archive/PDI_TechSpec_ICD10_v2018.aspx

Denominator	The eligible population
Numerator	Discharges, for patients ages 6 to 17 years, that meet the inclusion and exclusion rules for the numerator in any of the following PDIs: • PDI 14 Asthma Admission Rate • PDI 15 Diabetes Short-Term Complications Admission Rate • PDI 16 Gastroenteritis Admission Rate

	• PDI 18 Urinary Tract Infection Admission Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PDIs are counted only once in the composite numerator.
Rate Calculation	Observed and risk adjusted rates per 100,000 enrollees were calculated for each plan for each of the two measures. The measures were risk adjusted by the patient's age group, gender, race/ethnicity, Medicaid aid category, and the enrollee's Clinical Risk Group (CRG) status from the previous year.

PQI 90 Prevention Quality Overall Composite

Description:

Prevention Quality Indicators (PQI) overall composite per 100,000 enrollees, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection.

Eligible Population:

Product Line	Medicaid HMO/PHSP
Ages	18 years old as of the beginning of the measurement year
Time Frame	Measurement year
Allowable Gap	No gaps in enrollment
Anchor Date	Date of admission
Continuous Enrollment	4 months continuous enrollment
Benefits	Medical
Event/ Diagnosis	Identify all acute inpatient discharges on or between January 1 to December 31 of the measurement year.
Exclusions	Members who were dually enrolled in Medicaid and Medicare at any point in the measurement year. For a full list of inclusion and exclusion criteria see the Technical Specifications from AHRQ; https://www.qualityindicators.ahrq.gov/Archive/PQI_TechSpec_ICD10_v2018.aspx

Denominator	The eligible population
Numerator	Discharges, for patients ages 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs: • PQI #1 Diabetes Short-Term Complications Admission Rate • PQI #3 Diabetes Long-Term Complications Admission Rate

	• PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate • PQI #7 Hypertension Admission Rate • PQI #8 Heart Failure Admission Rate • PQI #10 Dehydration Admission Rate • PQI #11 Bacterial Pneumonia Admission Rate • PQI #12 Urinary Tract Infection Admission Rate • PQI #14 Uncontrolled Diabetes Admission Rate • PQI #15 Asthma in Younger Adults Admission Rate • PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.
Rate Calculation	Observed and risk adjusted rates per 100,000 enrollees were calculated for each plan for each of the two measures. The measures were risk adjusted by the patient's age group, gender, race/ethnicity, Medicaid aid category, and the enrollee's Clinical Risk Group (CRG) status from the previous year.

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

Summary of Changes to QARR 2020

- Added COL-E to Summary-Level File Table
- Added the following measures for inclusion in the PLD file:
  - Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)
  - Pharmacotherapy for Opioid Use Disorder (POD)
- Updated alpha name for Initiation of Pharmacotherapy upon New Episode of Opioid Dependence (POD-N)
- Added clarification for Member ID instructions for Commercial and Marketplace health plans

The Office of Quality and Patient Safety (OQPS) requires a Patient-Level Detail (PLD) file for all submissions. PLD files are used for the following purposes:

1) validate summary-level data submitted by measure in the IDSS
2) create composite measures
3) enhance Medicaid
4) monitor health disparities
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. Follow the NYS Specifications for NYS-Specific measures included in the NYS PLD.
- Submit separate product-level-specific PLD files.
- The patient-level data must match the plan reported data 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

- NYS-Specific Measures are not captured in NCQA IDSS.
- NYS-Specific Measures summary-level data will be collected as a separate file.
- The administrative method is required for NYS to collect the eligible population.

Measures included in the NYS Patient-Level Detail File for 2020 QARR:

	Measure Name	Specifications for Measures Included in the PLD NYS	Source for Medicaid Enhancements (See Section VII)
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	●	
ADL	Adolescent Preventive Care	●	
AWC	Adolescent Well-Care Visits	●	
AAP	Adults' Access to Preventive/Ambulatory Health Services	●	
ABA	Adult BMI Assessment	●	
ADV	Annual Dental Visit	●	
AMM	Antidepressant Medication Management	●	
CWP	Appropriate Testing for Pharyngitis	●	
URI	Appropriate Treatment for Upper Respiratory Infection	●	
AMR	Asthma Medication Ratio	●	
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	●	
BCS	Breast Cancer Screening	●	
SMC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	●	
CCS	Cervical Cancer Screening	●	
CIS	Childhood Immunization Status	●	
CAP	Children and Adolescents' Access to Primary Care Practitioners	●	
CHL	Chlamydia Screening in Women	●	NYS PLD File
COL	Colorectal Cancer Screening	●	NYS PLD 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	●	
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	●	Enhancement file
FUM	Follow-Up After Emergency Department Visit for Mental Illness	●	Enhancement file
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder	●	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	●	
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	●	
INR	International Normalized Ratio Monitoring for Individuals on Warfarin	●	

VI. Patient-Level Detail File Submission

	Measure Name	Specifications for Measures Included in the PLD NYS	Source for Medicaid Enhancements (See Section VII)
POD-N	Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	●	
POD	Pharmacotherapy for Opioid Use Disorder	●	
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	●	
PPC	Prenatal and Postpartum Care	●	
PDC	Proportion of Days Covered	●	
SPC	Statin Therapy for Patients with Cardiovascular Disease	●	
SPD	Statin Therapy for Patients with Diabetes	●	
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	●	
LBP	Use of Imaging Studies for Low Back Pain	●	
HDO	Use of Opioids at High Dosage	●	
UOP	Use of Opioids from Multiple Providers	●	
POA	Use of Pharmacotherapy for Alcohol Abuse or Dependence	●	
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	●	
W15	Well-Child Visits in the First 15 Months of Life	●	
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year	●	

VI. Patient-Level Detail File Submission

2020 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 2019 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, 2020. 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 submit five separate PLD files--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 Summary File + NYS PLD	NYS Commercial
Commercial PPO	NYS Summary File + NYS PLD	NYS Commercial
Commercial EPO	NYS Summary File + NYS PLD	NYS Commercial
QHP HMO	NYS PLD	NYS QHP (Exchange)
QHP POS	NYS PLD	NYS QHP (Exchange)
QHP EPO	NYS PLD	NYS QHP (Exchange)
QHP PPO	NYS PLD	NYS QHP (Exchange)
Medicaid	NYS Summary File + NYS PLD	NYS Medicaid
HIVSNP	NYS Summary File + NYS PLD	NYS Medicaid
HARP	NYS Summary File + NYS PLD	NYS Medicaid
EP	NYS Summary File + NYS PLD	NYS Commercial

Note

"0" fill those measures not applicable to product. See Table 1 – QARR List of Required Measures.

VI. Patient-Level Detail File Submission

NYS-Specific Measures Summary-Level File: Not all NYS-Specific Measures are included in the IDSS. We require summary-level data 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, using only the 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 LSC 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	Data Elements
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified	
Product Line	21-38	CPPO, CEPO, CHMO, MEDICAID, HIVSNP, HARP, or EP, QHP_HMO, QHP_POS, QHP_PPO, QHP_EPO	
Submission ID	39-43	Right justified	
ADL Eligible Population	44-49	Right justified	
ADL Numerator 1 Sexual Activity	50-55	Right justified	Number of numerator events by administrative data in eligible population (before exclusions)
ADL Rate 1-Sexual Activity	56-60	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions)
ADL Numerator 2 Depression	61-66		Number of numerator events by administrative data in eligible population (before exclusions)
ADL Rate 2-Depression	67-71	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions)
ADL Numerator 3 Tobacco Use	72-77		Number of numerator events by administrative data in eligible population (before exclusions)
ADL Rate 3-Tobacco Use	78-82	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must	Current year's administrative rate (before exclusions)

Element	Location	Coding	Data Elements
		include 3 digits after decimal (e.g., 1.000)	
ADL Numerator 4 Substance Use	83-88		Number of numerator events by administrative data in eligible population (before exclusions)
ADL Rate 4-Substance Use	89-93	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions)
COL Eligible Population	94-99	Right justified	
COL Numerator	100-105	Right justified	Number of numerator events by administrative data in eligible population (before exclusions)
COL Rate	106-110	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions)
LSC Eligible Population	111-116	Right justified	Eligible population (before optional exclusions)
LSC Numerator	117-122	Right justified	Number of numerator events by administrative data in eligible population (before exclusions)
LSC Rate	123-127	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions)
POD-N Eligible Population	128-133	Right justified	
POD-N Numerator	134-139	Right justified	Numerator events by administrative data
POD-N Rate	140-144	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Reported rate
POA Eligible Population	145-150	Right justified	
POA Numerator	151-156	Right justified	Numerator events by administrative data
POA Rate	157-161	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Reported rate
COL-E Initial Population	162-167	Right justified	Number of Initial Population summed over data sources
COL-E Denominator	168-173	Right justified	Number of denominator events summed over data sources
COL-E Numerator	174-179	Right justified	Number of numerator events summed over data sources

Element	Location	Coding	Data Elements
COL-E Rate	180-185	Must include 4 digits after decimal (e.g., .2019), 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.
- Only include member months for those members included in any measure specified in the PLD.
- Enrollment by Product Line is not a measure in the PLD. Use the member months contribution this member adds according to the Enrollment by Product Line measure. If the member is only in Enrollment by Product Line measure, they would not be included in the 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 Exchange enrolled Child Health Plus (CHP) members should be the Member Policy number assigned by the Exchange 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 Exchange 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-Exchange 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.
- For Commercial plans, Member ID should be the health plan's internal, individual member identifier for QARR PLD reporting. Do not report the member's family identifier, and do not report the identifier used in HEDIS.
- For MarketPlace plans, the Member ID should be the member's NYS-issued HIXNY Member ID for QARR PLD reporting.

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 LSC using the administrative method, then follow the instructions for administrative measures.

VI. Patient-Level Detail File Submission

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.
- Measures that are not applicable to the member should be zero-filled.
- Commercial Products should report Lead Screening in Children in their NYS-Specific PLD.
- Medicaid Products should report Colorectal Cancer Screening in their NYS-Specific PLD.

File Specifications

See NYS PLD File Specifications located at:
https://www.health.ny.gov/health_care/managed_care/plans/index.htm

Technical Assistance

For Commercial, Medicaid, Exchange 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.

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		UKNOWN/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 in Women
- Colorectal Cancer Screening
- Follow-Up after Hospitalization for Mental Illness*****
- Follow-Up after High-Intensity Care for Substance Use Disorder*
- Follow-Up After Emergency Department Visit for Mental Illness*****
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*****
- Follow-Up Care for Children Prescribed ADHD Medication*****

*****Enhancement files for these 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 Abuse or 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 for 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 in Women 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

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

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.

Measure	Data Elements	Fields	File Name
Follow-Up After Hospitalization for Mental Illness: 1) 7-Day and 2) 30-Day	Submission ID	1-5	FUH.txt
	Product Line (1 = Medicaid 2 = HIVSNP 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
Follow-Up After Emergency	Submission ID	1-5	FUM.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	

Measure	Data Elements	Fields	File Name
Department Visit for Mental Illness: **1) 7-Day and** **2) 30-Day**	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 After High-Intensity Care for Substance Use Disorder

There are two time period in which a follow-up visit must have taken place to be considered a number "hit": within 7 days after the visit or discharge, and within 30 days after the visit or discharge for which the member received follow-up for substance use disorder.

Measure	Data Elements	Fields	File Name
Follow-Up After High-Intensity Care for Substance Use Disorder **1) 7-Day and** **2) 30-Day**	Submission ID	1-5	FUI.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0####### or 5#######	
	Episode 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 Alcohol and Other Drug Abuse or 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
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: 1) 7-Day and 2) 30-Day	Submission ID	1-5	FUA.txt
	Product Line (1 = Medicaid 2 = HIVSNP 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 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 IDSS. Please note that, per HEDIS 2020 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).

Measure	Data Elements	Fields	File Name
Follow-Up Care for Children Prescribed ADHD Medication: **1) Initiation Phase** **2) Continuation and Maintenance Phase**	Submission ID	1-5	Add.txt
	Product Line (1 = Medicaid 2 = HIVSNP 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.

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

2020 QARR / HEDIS® 2020

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, 174-177, 180-182, 190-194, 196-201, 203-207, 220-229, 240-249, 251-254, 260-264, 279-284, 301-305, 308-310, 312-317, 320-322, 340-344, 346-347, 349, 351, 361-364, 380-385, 401, 403-405, 420-425, 440-447, 461-463, 465-466, 468-470, 480-484, 500-501, 510-514, 517-519, 530-532, 540-542, 544-546, 560-561, 563-566, 650-651, 660-663, 680-681, 690-692, 694-696, 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, 174-177, 180-182, 191-192, 220-229, 260-264, 301-305, 308-310, 312-317, 320-322, 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, 461-463, 465-466, 468-470, 500-501, 530-532, 660-663, 690-692, 694-696, 720-724, 811-813, 815-816, 843-844, 861-863, 890, 892-894, 930