DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) -

MEASURE SPECIFICATION AND REPORTING MANUAL

DRAFT

Office of Quality and Patient Safety

NEW YORK STATE DEPARTMENT OF HEALTH

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I. Reporting Requirements for Performing Provider Systems and Performance Targets

Throughout the five demonstration years, Performing Provider Systems (PPS) will report on progress and milestones and be evaluated using specific quality measures associated with their projects. This section describes the domains and the methodology for establishing goals and annual improvement increments which will be used to determine performance attainment in each demonstration year.

Domains

All DSRIP measures are organized into 4 Domains. The lead partner for each PPS will be required to report measures for all four domains as specified in the project plan. The project requirement details for Domain 1 and Domain 4 measures will be forthcoming from the Independent Assessor organization. Domain 2 and 3 measures will be described in this measure specification and reporting manual.

Domain 1 – Overall Project Progress

Domain 2 – System Transformation

Domain 3 – Clinical Improvement

Domain 4 – Population-wide

Glossary for Measure Components

The terminology below are included in components for measures described in Table 1 Required Measures.

Annual Improvement Target: The result the PPS needs to meet or exceed to attain the achievement value for the measure for the demonstration year. The annual improvement target is established using the PPS' result from the most recent demonstration year. For example, result for Demonstration Year (DY) 1 is used to set the annual improvement target for DY 2.

Goals (where relevant): Many of the measures in domain 2 and 3 will have goals established using high performance thresholds (such as 90th percentile) where possible. The goals are used as guidelines for measure performance and to incorporate into the calculation of achievement targets. This calculation is discussed further in the subsequent section on Performance Goals.

Demonstration Year: A twelve month period for the DSRIP program demonstration.

Denominator: The total eligible population that meets the measures additional criteria (e.g. all adult patients with diabetes). Note: many measures include specific denominator inclusion and exclusion criteria.

Measure Attribution: Measures are developed to capture the population which is recommended for a particular service, called the eligible population. To define the eligible population, measures often have more criteria such as age or diagnosis of a health condition to be included in the eligible population. While some measures may apply to everyone in the PPS (patient-based), others may capture a smaller group within the PPS membership (episode-based). Patient-based measures apply to the entire attributed PPS population over the measurement period. Episode-based measures are limited to only those members seen for that episode of care within the PPS network during the measurement period. Episode of care refers to all care provided over a DY measurement period for a specific condition (e.g. Diabetes - all diabetes care received in a defined time period for those members; HIV- all HIV care received in a defined time period for those members). Intuitional-based measures apply to results all people within the institution, such as nursing home measures.

Measure Data Source: The collection process for each measure will be identified as calculated by the NYSDOH, or the responsibility of the PPS to collect through appropriate means as detailed in method (e.g. medical record).

Measure Name or Description: The measure name or description is a brief statement of the measure. This will be used in the specifications, reporting templates and PPS reports containing results of the measures.

Measure Steward: Specifies the organization that endorses or stewards the measure (e.g. National Committee for Quality Assurance, Agency for Health Care Research and Quality). The measure steward should be referred to for detailed specifications. This manual provides high level requirements for collection of the measures.

Method: Specifies information sources in which data specific to the measure can be obtained (e.g. administrative data, survey, electronic health records). There are four basic methods involved in DSRIP reporting (PPS report, claims, medical record/EMR, and survey). PPS report describes data that comes from the PPS at the specified intervals. Claims describes use of Medicaid billing data. Medical record data will incorporate information abstracted from medical record data that will be incorporated with claims for the result calculation. Survey will use member responses for satisfaction measures.

Measure Status for DSRIP Payment: Pay for Performance (P4P) or Pay for Reporting (P4R). This designation specifies how the measure will be used for the purpose of DSRIP payment. Some measures will remain P4R throughout the entire DY project period, while some measures begin as P4R in DY 1-2, but transition to P4P in DY 3-5. Details on the improvement methodology used for will be described in more detail in the Annual Improvement Targets section.

Numerator: Description of eligible cases for the particular measure (e.g. all patients with an HbA1c > 9.0%). Note: many measures include specific numerator inclusion and exclusion criteria.

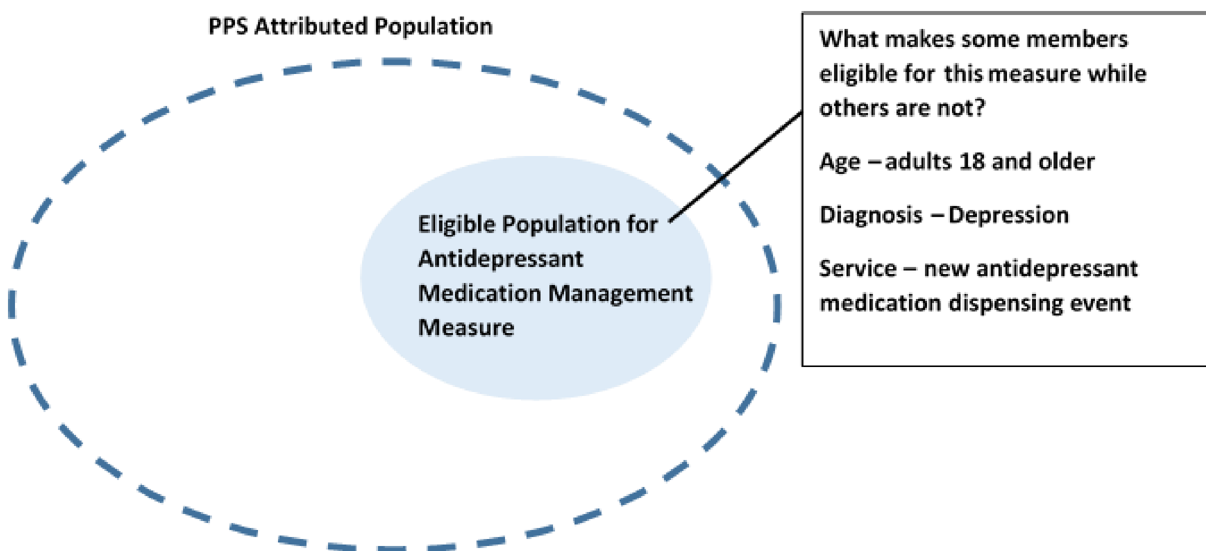
Result: The performance measure result calculated using the data source indicated for the measure for the demonstration year. The PPS result is the value used to determine whether the annual improvement target was attained or if a high performance level was achieved.

Performance Measurement

Members are attributed to a specific PPS for valuation or the ongoing view of 'membership' based on the services used by providers in the PPS. For measurement attribution, additional criteria are applied to the membership to determine eligibility for each specific measure.

Measures are developed to capture the population for which a particular service is recommended; this is called the eligible population. To define the eligible population, measures often have criteria such as age or diagnosis of a health condition to be included in the eligible population. While some measures may apply to everyone in the PPS (patient-based), others may capture a smaller group within the PPS membership (episode-based).

For example, the illustration below shows how the eligible population for an episode-based measure, *Antidepressant Medication Management*, involves a smaller portion of the PPS membership.



Performance Goals

Performance goals will be established for Domain 3 measures. Performance goals will be based on the top decile performance of zip codes for Medicaid recipients in NYS for each measure where data is available. Top decile targets in national data (NCQA's Quality Compass for Medicaid) demonstrated higher performance in NYS zip code data than national Medicaid. For measures where the goal is to reduce an occurrence and a lower result is desirable, the lower decile is used, while measures where the goal is to increase the occurrence and a higher result is desirable, use the upper decile. The performance goal is set using most current data available (largely 2013 measurement year) and will not be changed throughout the DSRIP demonstration.

Specifically, with the exception of behavioral health Domain 3 measures (3.a.i – 3.a.v), if the Performing provider system's performance on the 2012 and 2013 data for the majority of any chosen Domain 3 metric set is within 10 percentage points or 1.5 standard deviations to the performance goals, the project would not be approved. Performance Goals are included in Appendix A. The goals will be finalized for all measures where data is available in November 2014.

Pay for Performance (P4P) Measures

In cases where the measure type is Pay for Performance (P4P), PPS' will receive incentive payments for demonstrating improvements in results that meet or exceed the annual improvement target. Achievement targets are determined based on a PPS' most recent annual performance in the measure and will be calculated by NYS DOH (or Independent Assessor) using the methodology described below.

Annual improvement targets for measures for a PPS will be established using the methodology of reducing the gap to the goal by 10%. The most current PPS result (baseline for DY1 and so on) will be used to determine the gap between the PPS result and the measure's goal, and then 10% of that gap is added to the most current PPS result to set the annual improvement target for the current DY. Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling

For example – A measure has goal of 90% and the PPS' most recent result is 52%.

Process Step	Description	Example
Establish gap amount	Goal – PPS' result = gap	90 – 52 = 38
Establish improvement increment from gap	Gap *.10 = improvement increment	38 * .10 = 3.8
Establish annual improvement target by adding increment to PPS' result	Increment + PPS' result = improvement target	3.8 + 52 = 55.8

The annual improvement target for the PPS' current DY would be 55.8% or higher to get the achievement value for payment for P4P measures. If the PPS' result demonstrated a 20% reduction in the gap, and the measure is eligible for high performance funds, the PPS would receive additional payment.

Process Step	Description	Example
Establish gap amount	Goal – PPS' result = gap	90 – 52 = 38
Establish improvement increment from gap	Gap *.10 = improvement increment	38 * .10 = 3.8
Establish annual improvement target by adding increment to PPS' result	Increment + PPS' result = improvement target	3.8 + 52 = 55.8
Actual PPS performance for DY evaluated for achievement and high performance	Final PPS calculated result for the measure exceeds target and reduces gap by 20%	PPS result 60% (8 point gain of 38 point gap is 23%)

The PPS result for the DY is then used to determine the next DY's annual improvement target.

Process Step	Description	Example
Establish gap amount	Goal – PPS' result = gap	90 – 52 = 38
Establish improvement increment from gap	Gap *.10 = improvement increment	38 * .10 = 3.8
Establish annual improvement target by adding increment to PPS' result	Increment + PPS' result = improvement target	3.8 + 52 = 55.8
PPS result for DY is used for next annual improvement target	Goal – most current DY PPS result = new gap	90 – 60 = 30
Establish improvement increment from gap	Gap *.10 = improvement increment	30 * .10 = 3.0
Establish annual improvement target by adding increment to PPS' result	Increment + PPS' result = improvement target	3.0 + 60 = 63

In this example, the first DY annual improvement target was 55.8%. The PPS' result (60%) for the DY exceeded the target and this most recent result is then used to set the next annual improvement target of 63%.

High Performance Measures

Ten measures are part of the high performance funds (indicated on Table of Required Measures). PPS' that achieve reduction in gap to goal by 20% or more in any annual measurement period for a high performance eligible measure, will achieve additional funds for that measurement period award. Also, PPS' that meet or exceed the measure's performance goal (see section above) will achieve additional funds for each measurement period where the PPS result for the measurement period equals or exceeds the performance goal for the measure.

Pay for Reporting (P4R) Measures

In cases where the measure type is Pay for Reporting (P4R), providers can earn incentive payment for successfully reporting the measures to specifications to NYS DOH per the measure reporting timeframes for each DY.

Reporting Requirements for Measures

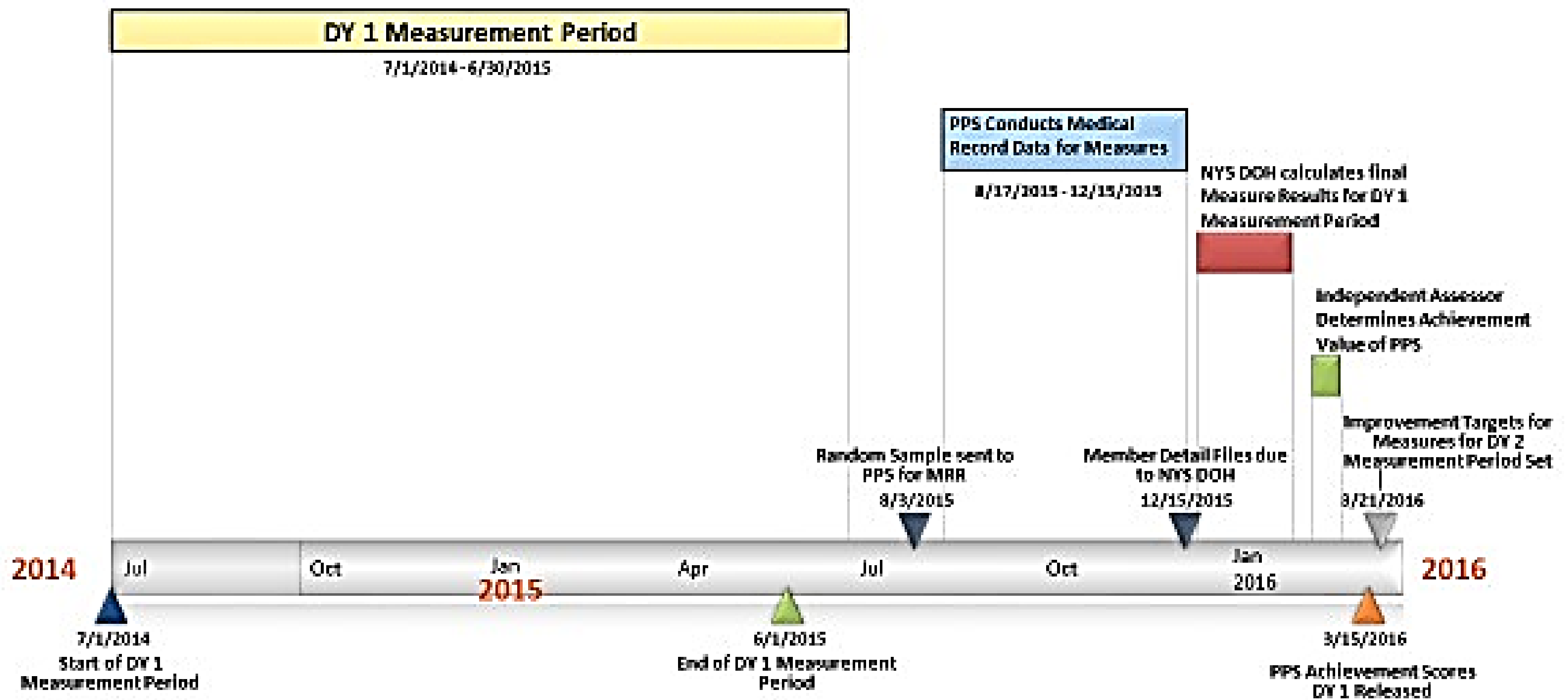
Each PPS is responsible for submitting all required measures which are the responsibility of the PPS to produce by the deadline.

II. Measure Reporting Schedule

Each measurement period will encompass twelve months, from July 1 of the year prior to June 30 of the reporting year. The reason for using a mid-year time period is to allow for a claim lag of six months so data will be as complete as possible when the PPS performance is calculated for the measurement period. Results for the measurement period will be finalized in January of the following year to allow for six month run out of billing data. The DSRIP time frame for providing results to the Independent Assessor to make determinations of the DY award is in March of the year after the DY. Measures which require information from medical records or other data sources will be collected from the PPS'. NYS DOH will provide the PPS with information about the eligible members, the required data elements and formats, and the file submission process. Measures are required to be reported each year and will not be allowed to be rotated. The PPS' will gather and report this information by December of the reporting year.

The following example provides the timeline for activities in each measurement period. The example uses the first measurement period, but is the same for all subsequent periods. This is illustrated in the figure on the following page.

Annual Measurement Year Cycle	**Time Frame**
DY1 Measurement Year Begins	July 1 , 2014
DY1 Measurement Year Ends	June 30, 2015
DY2 Measurement Year Begins	July 1, 2015
NYS DOH sends samples for measures requiring medical record data	August 2015
NYS DOH and vendor pull sample frame and administer C&G CAHPS	August – November 2015
PPS conducts medical record abstraction and completes Member Detail File	August – November 2015
Completed MDF sent to NYS DOH	December 2015
Medicaid claims for DY1 frozen following January 2016 refresh of December 2015 claims and encounters load	January 2016
NYS DOH calculates final results for Measurement Year, including PPS' MDF information and C&G CAHPS	February 2016
Final DY1 Measurement Year results shared with PPS' and Independent Assessor	February 2016
PPS determines annual improvement target for DY2	February 2016
Independent Assessor determines achievement value of DY1 measures	March 2016
DY2 Measurement Year Ends	June 30, 2016


Quality Measurement Annual Cycle Timeline
Example DY 1
Measurement Period DY 1 July 1, 2014- June 30, 2015
DY 1 Measurement Period
7/1/2014-6/30/2015
PPS Conducts Medical Record Data for Measures
8/17/2015 - 12/15/2015
NYS DOH calculates final Measure Results for DY 1 Measurement Period
Independent Assessor Determines Achievement Value of PPS
Improvement Targets for Measures for DY 2 Measurement Period Set
3/21/2016
Random Sample sent to PPS for MRR
8/3/2015
Member Detail Files due to NYS DOH
12/15/2015
2014
Jul
Oct
Jan
2015
Apr
Jul
Oct
Jan
2016
2016
7/1/2014
Start of DY 1 Measurement Period
6/1/2015
End of DY 1 Measurement Period
3/15/2016
PPS Achievement Scores DY 1 Released

III. *Reporting Submission Process*

In the tables of required metrics for each domain, the data source for each metric will be indicated. Data source for metrics which are indicated as 'NYS DOH' will be responsibility of the Department. Metrics indicated as 'PPS' will be provided by the PPS. For several of the metrics in Domain 3, the PPS reporting will be done with a member detail file. The information in the PPS member detail file (PPS-MDF) will be incorporated into the final result calculation by DOH.

Domain 1	Per instructions from the Independent Assessor
Domain 2	• NYS DOH calculated; results from NYS DOH sponsored Clinician and Group (C&G) CAHPS • PPS sponsored C&G CAHPS will provide de-identified response set from vendor • PPS reported metrics will be collected per instructions from the Independent Assessor
Domain 3	DOH calculated; PPS-MDF for the following measures: • Screening for Clinical Depression and Follow Up • Cholesterol Management for Patients with CV Conditions • Controlling High Blood Pressure • Comprehensive Diabetes Care • Viral Load Suppression • Prenatal/Postpartum care • Frequency of Ongoing Prenatal Care • Elective Delivery
Domain 4	Per instructions from the Independent Assessor

IV. *Resources for Technical Assistance*

Several resources are available for collecting data for measures required to be calculated by the PPS:

1. Measure specifications are available from National Quality Forum or the Measure Stewards for each measure. Several measures are from the National Committee for Quality Assurance's HEDIS (Volume 2) which is available for purchase.
2. Independent Assessor is a resource for technical assistance in collection and use of performance data.
3. Office of Quality and Patient Safety (OQPS) staff for technical assistance in specifications or file layout.
4. Specifications for *Clinical Depression Screening* and *Viral Load Suppression* are being reviewed by OQPS. Any specification clarifications for medical record review that are developed will be shared with PPS when available.

V. Table of Required Measures

Domain 1– Overall Project Progress Metrics						
	Measure Name	**High Performance Measure (*Statewide Metric)**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**
1. Core Domain 1 Metrics						
Semi-Annual Reports						
	Per Independent Assessor and contract requirements		Independent Assessor	PPS	P4R	P4R
Approval of DSRIP Plan (DY 1 only)						
	Per Independent Assessor and contract requirements		Independent Assessor	PPS	NA	NA
Workforce milestones						
	Percent Complete of System's preapproved Workforce Plan Number of health care workers retrained/redeployed vs. # eligible based on system service changes		NYS DOH	PPS	P4R	P4R
	Net change in number of new MDs hired – PCP; specialty		NYS DOH	PPS	P4R	P4R
	Net change in number of new mid-levels providers hired (RPA, NP, NM)		NYS DOH	PPS	P4R	P4R
	Net change in number of other mid-level providers hired		NYS DOH	PPS	P4R	P4R
System Integration milestones						
	Percent complete of preapproved system integration plan in the PPS project plan		NYS DOH	PPS	P4R	P4R
	For HH population, % in O/E; % in Active Care Management; % with Care Plan		NYS DOH	NYS DOH	P4R	P4R

Domain 2 – System Transformation Metrics						
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**
A. Create Integrated Delivery System (Required)						
Potentially Avoidable Services						
Claims	Potentially Avoidable Emergency Room Visits ±	Yes*	3M	NYS DOH	P4R	P4P
Claims	Potentially Avoidable Readmissions ±	Yes*	3M	NYS DOH	P4R	P4P
Claims	PQI Suite – Composite of all measures ±	*	AHRQ	NYS DOH	P4R	P4P
Claims	PDI Suite – Composite of all measures ±	*	AHRQ	NYS DOH	P4R	P4P
	Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement		NYS DOH	PPS	P4R	P4R
System Integration						
	Percent of Eligible Providers with participating agreements with RHIO's; meeting MU Criteria and able to participate in bidirectional exchange	*	NYS DOH	PPS	P4R	P4R
Primary Care						
	Percent of PCP meeting PCMH (NCQA)/ Advance Primary Care (SHIP)	*	NYS DOH	PPS	P4R	P4R
Survey	CAHPS Measures including usual source of care Patient Loyalty (Is doctor/clinic named the place you usually go for care? How long have you gone to this doctor/clinic for care?)	*	AHRQ	NYS DOH	P4R	P4P
Access to Care						
Claims	HEDIS Access/Availability of Care; Use of Services	*	NCQA	NYS DOH	P4R	P4P
Survey	CAHPS Measures: • Getting Care Quickly • Getting Care Needed • Access to Information • After Hours Wait Time	*	AHRQ	NYS DOH	P4R	P4P
Medicaid Spending for Projects Defined Population on a PMPM Basis						
Claims	Medicaid spending on ER and Inpatient Services ±		NYS DOH	NYS DOH	P4R	P4R

Domain 2 – System Transformation Metrics						
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**
Claims	Medicaid spending on PC and community based behavioral health care		NYS DOH	NYS DOH	P4R	P4R
B. Implementation of care coordination and transitional care programs						
Care Transitions						
Survey	H-CAHPS – Care Transition Metrics		CMS	PPS	P4R	P4P
Survey	CAHPS Measures – Care Coordination with provider up-to-date about care received from other providers	*	AHRQ	NYS DOH	P4R	P4P
C. Connecting Settings						
Performing Provider Systems will be required to meet all of the above metrics for A and B.						
D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations						
Assessment	Interval Change in Patient Activation Measure® (PAM®) – Distribution of member scores on PAM®. From this the percentage of members measured at Level 3 or 4 on the PAM® utilizing at least 13 item version. (Done separately for each population – UI and NU/LU using a convenience sample of all qualifying recipients accessing care from identified hot spots during a 3 month period)		Insignia Health	PPS	P4R	P4P
Claims	Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)		NYS DOH	NYS DOH	P4R	P4P
Claims	Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year. (Uninsured only)		NYS DOH	NYS DOH	P4R	P4P
Survey	C&G CAHPS of uninsured population using a certified CAHPS vendor. PPS must use the questionnaire developed by the NYS DOH in the survey. PPS will provide file of uninsured with a qualifying visit in previous six months to CAHPS vendor. CAHPS vendor will submit a de-identified response file to DOH for calculation of results.		AHRQ	PPS	P4R	P4P

* Indicates measure is included in Statewide improvement targets for continued funding from CMS.

± A lower result is desirable.

Domain 3 – Clinical Improvement Metrics							
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**	**Member Detail File Required**
A. Behavioral Health (Required) – All behavioral health projects will use the same metrics except for SNF programs implementing the BIPNH project. These providers will include the additional behavioral health measures below in A-2.							
Claims	PPV (for persons with BH diagnosis) ±	Yes	3M	NYS DOH	P4P	P4P	
Claims	Antidepressant Medication Management	Yes	NCQA	NYS DOH	P4P	P4P	
Claims	Diabetes Monitoring for People with Diabetes and Schizophrenia	Yes	NCQA	NYS DOH	P4P	P4P	
Claims	Diabetes Screening for People with Schizophrenia./BPD Using Antipsychotic Medication		NCQA	NYS DOH	P4P	P4P	
Claims	Cardiovascular Monitoring for People with CVD and Schizophrenia	Yes	NCQA	NYS DOH	P4P	P4P	
Claims	Follow-up care for Children Prescribed ADHD Medications		NCQA	NYS DOH	P4P	P4P	
Claims	Follow-up after hospitalization for Mental Illness	Yes	NCQA	NYS DOH	P4P	P4P	
Claims	Screening for Clinical Depression and follow-up		CMS	PPS	P4R	P4P	Yes
Claims	Adherence to Antipsychotic Medications for People with Schizophrenia		NCQA	NYS DOH	P4P	P4P	
Claims	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		NCQA	NYS DOH	P4P	P4P	
A – 2. Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project							
Claims	PPR for SNF patients ±	Yes	3M	NYS DOH	P4P	P4P	
MDS	Percent of Long Stay Residents who have Depressive Symptoms ±		CMS	NYS DOH	P4P	P4P	
B. Cardiovascular Disease							
Claims	PQI # 7 (HTN) ±		AHRQ	NYS DOH	P4P	P4P	
Claims	PQI # 13 (Angina without procedure) ±		AHRQ	NYS DOH	P4P	P4P	

Domain 3 – Clinical Improvement Metrics								
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**	**Member Detail File Required**
Claims/ Medical Record	Cholesterol Management for Patients with CV Conditions		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Controlling High Blood Pressure	Yes	NCQA	PPS	P4R	P4P	Yes
Survey	Aspirin Discussion and Use		NCQA	NYS DOH	P4R	P4P	
Survey	Medical Assistance with Smoking Cessation	Yes	NCQA	NYS DOH	P4R	P4P	
Survey	Flu Shots for Adults Ages 18 – 64		NCQA	NYS DOH	P4R	P4P	
Survey	Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse		AHRQ	NYS DOH	P4R	P4P	
C. Diabetes Mellitus							
Claims	PQI # 1 (DM Short term complication) ±		AHRQ	NYS DOH	P4R	P4P	
Claims/ Medical Record	Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Comprehensive diabetes care - LDL-c control (<100mg/dL)		NCQA	PPS	P4R	P4P	Yes

Domain 3 – Clinical Improvement Metrics							
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**	**Member Detail File Required**
Survey	Medical Assistance with Smoking Cessation	Yes	NCQA	NYS DOH	P4R	P4P	
Survey	Flu Shots for Adults Ages 18 – 64		NCQA	NYS DOH	P4R	P4P	
Survey	Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse		AHRQ	NYS DOH	P4R	P4P	
D. Asthma							
Claims	PQI # 15 Younger Adult Asthma ±		AHRQ	NYS DOH	P4P	P4P	
Claims	PDI # 14 Pediatric Asthma ±		AHRQ	NYS DOH	P4P	P4P	
Claims	Asthma Medication Ratio		NCQA	NYS DOH	P4P	P4P	
Claims	Medication Management for People with Asthma (5 – 64 Years)		NCQA	NYS DOH	P4P	P4P	
E. HIV/AIDS							
Claims	HIV/AIDS Comprehensive Care : Engaged in Care		NYS	NYS DOH	P4P	P4P	
Claims	HIV/AIDS Comprehensive Care : Viral Load Monitoring		NYS	NYS DOH	P4P	P4P	
Claims	HIV/AIDS Comprehensive Care : Syphilis Screening		NYS	NYS DOH	P4P	P4P	
Claims	Cervical Cancer Screening		NCQA	NYS DOH	P4R	P4P	
Claims	Chlamydia Screening		NCQA	NYS DOH	P4P	P4P	
Survey	Medical Assistance with Smoking Cessation		NCQA	NYS DOH	P4R	P4P	
Claims/ Medical Record	Viral Load Suppression		HRSA	PPS	P4R	P4P	Yes
F. Perinatal Care							
Claims	PQI # 9 Low Birth Weight ±		AHRQ	NYS DOH	P4P	P4P	

Method	Measure Name	High Performance Measure	Measure Steward	Data Source	DSRIP Year 2 Pay for Reporting/ Performance	DSRIP Year 3-5 Pay for Reporting/ Performance	Member Detail File Required
Domain 3 – Clinical Improvement Metrics							
Claims/ Medical Record	Prenatal and Postpartum Care—Timeliness and Postpartum Visits		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Frequency of Ongoing Prenatal Care (81% or more)		NCQA	PPS	P4R	P4P	Yes
Claims	Well Care Visits in the first 15 months		NCQA	NYS DOH	P4R	P4P	
Claims/ Imm. Registry	Childhood Immunization Status		NCQA	PPS	P4R	P4P	
Claims/ Imm. Registry	Lead Screening in Children		NCQA	PPS	P4R	P4P	
Claims/ Medical Records	PC-01 Early Elective Deliveries ±		Joint Commis-sion	PPS	P4R	P4R	Yes
G. Palliative Care – All projects will use the same metric set							
UAS-NY	Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain.		NYS	NYS DOH	P4R	P4P	
UAS-NY	Risk-Adjusted percentage of members who had severe or more intense daily pain ±		NYS	NYS DOH	P4R	P4P	
UAS-NY	Risk-adjusted percentage of members whose pain was not controlled ±		NYS	NYS DOH	P4R	P4P	
UAS-NY	Advanced Directives – Talked about Appointing for Health Decisions		NYS	NYS DOH	P4R	P4P	
UAS-NY	Depressive feelings - percentage of members who experienced some depression feeling ±		NYS	NYS DOH	P4R	P4P	
H. Renal Care							

Domain 3 – Clinical Improvement Metrics							
Method	**Measure Name**	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**	**Member Detail File Required**
Claims/ Medical Record	Comprehensive Diabetes screening - All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy)		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±		NCQA	PPS	P4R	P4P	Yes
Claims/ Medical Record	Comprehensive diabetes care - LDL-c control (<100mg/dL)		NCQA	PPS	P4R	P4P	Yes
Claims	Annual Monitoring for Patients on Persistent Medications – ACE/ARB		NCQA	NYS DOH	P4R	P4P	
Claims/ Medical Record	Controlling High Blood Pressure		NCQA	PPS	P4R	P4P	Yes
Survey	Flu vaccine 18-64		NCQA	NYS DOH	P4R	P4P	
Survey	Medical Assistance with Smoking and Tobacco Use Cessation		NCQA	NYS DOH	P4R	P4P	

± A lower result is desirable.

Domain 4– Population Health Project Metrics					
Measure Name	**High Performance Measure**	**Measure Steward**	**Data Source**	**DSRIP Year 2 Pay for Reporting/ Performance**	**DSRIP Year 3-5 Pay for Reporting/ Performance**
Semi-Annual Reports					
Population Health Projector Projects Implementation milestones	No	Independent Assessor	PPS	P4R	P4R

VI. Random Sample and Medical Record review guidelines

Medical record Chart/ Electronic Health Record Collection Steps

Step 1: NYS DOH will run the measure's eligible population for the PPS attributed members. The measure's eligible population is further defined by any measure-specific criteria of the (such as continuous enrollment, age or diagnosis) the technical specifications for each measure.

Step 2: Using the PPS's eligible population for the measure, NYSDOH will draw a systematic random sample using a random index number. The random sample will include an oversample of 10%.

Step 3: The random sample, including the oversample, will be sent to each PPS using a secure file transfer mechanism. A file containing the following will be sent to each PPS: Medicaid Client Identification, last and first name, NPI(s) of the provider(s) associated with the visit or event qualifying the member, and date of most recent visit seen for care.

Step 4: The PPS is then responsible for working with those providers to retrieve the required information from the medical records (paper or electronic). Information can be abstracted from records using medical record review staff. The abstracted information will be entered in a data collection tool which will be approved by the Independent Assessor. If a medical record determines the member did not qualify for the measure, the member can be substituted a member from the oversample. The Independent requires that each PPS maintain back up for each medical record abstract for confirmation upon annual PPS review.

Step 5: The PPS will submit the completed member detail file to NYSDOH via a secure file transfer mechanism. The information in the file will be incorporated with administrative data from the Medicaid transaction system to calculate the PPS final result for the measure for the measurement period.

VII. Aggregate Data reporting

Several measures will be reported by the PPS in aggregate, such as workforce milestones in Domain 1. The PPS will provide aggregated data to the Independent Assessor at the required intervals. Instructions about the file variables and mechanism for reporting data will be forthcoming from the Independent Assessor.

VIII. Member detail file requirements and layout

Each PPS will submit the member detail file to NYS DOH via a secure file transfer by the December 15 deadline for each demonstration year. Information which contains invalid Client Identification Numbers or values in the denominator on numerator fields will not be used. See Appendix B for the file layout and column value definitions.

IX. Final Result Calculation

NYS DOH uses Medicaid transaction data as the basis for calculation of claims based measures and identifying the eligible population for measures requiring medical record data. The programs used to calculate these data have been reviewed and validated by appropriate external entities. Medicaid transaction data for the measurement period (July 1 of previous year to June 30 of current year) will be considered finalized with the inclusion of the current year December billing information in the transaction systems, allowing a six-month run out of claims data. Information from the member detail file will be incorporated with the final administrative data for the measurement year to calculate the PPS results for the measurement year.

X. Data to PPS and Independent Assessor

PPS final results for each measure for the measurement period will be provided to the Independent Assessor. The Independent Assessor will determine whether annual improvement target and high performance level (where applicable) were attained. In addition the Independent Assessor will determine the annual improvement target for each measure for the next measurement period and provide results and reports to the PPS.

Appendix A – Performance Goals for Domain 3 Metrics

Performance Goals have been established for the measures in Domain 3 using 2013 New York State performance of the 90th percentile of all Medicaid managed care results by zip code; one measure used Medicaid managed care health plan data due to low volume by zip code. Using Medicaid managed care data for 2013, results were calculated by zip code of the residence of members. Zip codes with less than 30 in the denominators or eligible populations are excluded, and then the 90th percentile is determined for the performance goal. Several measures are new and the performance goal will be determined using results from Demonstration Year 1. Several measures have tentative performance goals established from 2012 data and will be finalized with 2013 data as soon as it is available.

Domain 3 – Clinical Improvement Metrics	
Measure Name	**Performance Goal**
A. Behavioral Health	
Potentially Preventable Emergency Department Visits (for persons with BH diagnosis) ±	TBD
Antidepressant Medication Management – Effective Acute Phase Treatment	61.8%
Antidepressant Medication Management – Effective Continuation Phase Treatment	45.1%
Diabetes Monitoring for People with Diabetes and Schizophrenia	85.5%
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	86.7%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	92.2% (health plan data)
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase	73.5%
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase	65.6%
Follow-up after hospitalization for Mental Illness – within 7 days	78.1%
Follow-up after hospitalization for Mental Illness – within 30 days	88.6%
Screening for Clinical Depression and follow-up	TBD
Adherence to Antipsychotic Medications for People with Schizophrenia	78.1%
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	TBD

Performance Goals for behavioral health will not be used to determine whether a PPS is approved to select a project as behavioral health projects are required for each PPS.

Domain 3 – Clinical Improvement Metrics	
Measure Name	**Performance Goal**
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	TBD
Potentially Preventable Readmissions for SNF patients ±	TBD
Percent of Long Stay Residents who have Depressive Symptoms	0.16%
B. Cardiovascular Disease	
Prevention Quality Indicator # 7 (HTN) ±	0.00 (2012 Data)
PQI # 13 (Angina without procedure) ±	0.00 (2012 Data)
Cholesterol Management for Patients with CV Conditions – LDL-C Testing	95.8%
Cholesterol Management for Patients with CV Conditions – LDL-C > 100 mg/dL	62.5%
Controlling High Blood Pressure	73.3% (2012 Data)
Aspirin Use	TBD
Discussion of Risks and Benefits of Aspirin Use	TBD
Medical Assistance with Smoking Cessation – Advised to Quit	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Medication	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Strategies	TBD
Flu Shots for Adults Ages 18 – 64	TBD
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	TBD
C. Diabetes Mellitus	
Prevention Quality Indicator # 1 (DM Short term complication) ±	0.00 (2012 Data)
Comprehensive Diabetes screening – All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy monitor)	61.2%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	24.0%
Comprehensive diabetes care - LDL-c control (<100mg/dL)	54.8%
Medical Assistance with Smoking Cessation – Advised to Quit	TBD

Domain 3 – Clinical Improvement Metrics	
Measure Name	**Performance Goal**
Medical Assistance with Smoking Cessation – Discussed Cessation Medication	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Strategies	TBD
Flu Shots for Adults Ages 18 – 64	TBD
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	TBD
D. Asthma	
Prevention Quality Indicator # 15 Younger Adult Asthma ±	0.00 (2012 Data)
Pediatric Quality Indicator # 14 Pediatric Asthma ±	0.00 (2012 Data)
Asthma Medication Ratio (5 – 64 Years)	78.6%
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered	76.9%
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered	51.2%
E. HIV/AIDS	
HIV/AIDS Comprehensive Care : Engaged in Care	90.7%
HIV/AIDS Comprehensive Care : Viral Load Monitoring	82.7%
HIV/AIDS Comprehensive Care : Syphilis Screening	83.1%
Cervical Cancer Screening	75.6%
Chlamydia Screening (16 – 24 Years)	78.7%
Medical Assistance with Smoking Cessation – Advised to Quit	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Medication	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Strategies	TBD
Viral Load Suppression	TBD
F. Perinatal Care	
Prevention Quality Indicator # 9 Low Birth Weight ±	TBD
Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.9%

Domain 3 – Clinical Improvement Metrics	
Measure Name	**Performance Goal**
Prenatal and Postpartum Care—Postpartum Visits	81.6%
Frequency of Ongoing Prenatal Care (81% or more)	81.4%
Well Care Visits in the first 15 months (5 or more Visits)	92.9%
Childhood Immunization Status (Combination 3 – 4313314)	88.9%
Lead Screening in Children	97.8%
PC-01 Early Elective Deliveries ±	TBD
G. Palliative Care	
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain	TBD
Risk-Adjusted percentage of members who had severe or more intense daily pain ±	0.0% (unadjusted)
Risk-adjusted percentage of members whose pain was not controlled ±	0.0% (unadjusted)
Advanced Directives – Talked about Appointing for Health Decisions	100%
Depressive feelings - percentage of members who experienced some depression feeling ±	0.0%
H. Renal Care	
Comprehensive Diabetes screening - All Four Tests (HbA1c, lipid profile, dilated eye exam, nephropathy)	61.2%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ±	24.0%
Comprehensive diabetes care - LDL-c control (<100mg/dL)	54.8%
Annual Monitoring for Patients on Persistent Medications – ACE/ARB	95.1%
Controlling High Blood Pressure	73.3% (2012 Data)
Flu Shots for Adults Ages 18 – 64	TBD
Medical Assistance with Smoking Cessation – Advised to Quit	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Medication	TBD
Medical Assistance with Smoking Cessation – Discussed Cessation Strategies	TBD

Appendix B – Member Detail File Layout

Column Placement	Name	Direction	Allowed Values
Column 1-8	PPS MMIS ID	Enter the PPS' eight digit numeric MMIS ID.	########
Column 9–16	CIN	A member's client identification number. The field should be continuous without any spaces or hyphens. The field is alpha- numeric and should be treated as a text field. This field is mandatory – do not leave it blank! • The CIN entered in this field should be for the CIN for the measurement period. For example, CINs for 2015 should be used. • For Medicaid, use the 8 digit alpha-numeric CIN.	AA#####A
Column 17	Denominator for Clinical Depression Screening	Enter a '1' if this member is in the denominator of the Clinical Depression Screening measure, '0' if the member is not in the denominator of this measure or if the information is missing.	1 = Yes 0 = No
Column 18	Numerator for Clinical Depression Screening	Enter a '1' if this member is in the numerator of the Clinical Depression Screening measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 19	Denominator for Cholesterol Management for Cardiovascular Conditions (CMC)	Enter a '1' if this member is in the denominator of the CMC measures, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No
Column 20	Numerator 1 for CMC – LDL-C Screen	Enter a '1' if this member is in the numerator of the CMC LDL-C Screen measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 21	Numerator 2 for CMC – LDL-C Control (<100 mg/dL)	Enter a '1' if this member is in the numerator of the CMC LDL-C Control measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 22	Denominator for Controlling High Blood Pressure (CBP)	Enter a '1' if this member is in the denominator of the CBP measure, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No
Column 23	Numerator for Controlling High Blood Pressure (CBP)	Enter a '1' if this member is in the numerator of the CBP measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 24	Denominator for Comprehensive Diabetes Care (CDC)	Enter a '1' if this member is in the denominator of the CDC measures, '0' if the member is not in the denominator of this measure.	1 = Yes 0 = No
Column 25	Numerator 1 for CDC – HbA1c Test	Enter a '1' if this member is in the numerator of the CDC HbA1c Test measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 26	Numerator 2 for CDC – HbA1c Poor Control (>9%)	Enter a '1' if this member is in the numerator of the CDC HbA1c Poor Control measure (which includes no test performed and test result missing from the record), '0' if the	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
		member is not in the numerator or if the member's information is missing for all numerators of CDC (such as the member's record could not be located).	
Column 27	Numerator 3 for CDC – Eye Exam	Enter a '1' if this member is in the numerator of the CDC Eye Exam measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 28	Numerator 4 for CDC – LDL-C Screen	Enter a '1' if this member is in the numerator of the CDC LDL-C Screen measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 29	Numerator 5 for CDC – LDL-C Control (<100 mg/dL)	Enter a '1' if this member is in the numerator of the CDC LDL-C Control measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 30	Numerator 6 for CDC – Nephropathy Monitor	Enter a '1' if this member is in the numerator of the CDC Nephropathy Monitor measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 31	Denominator for Viral Load Suppression	Enter a '1' if this member is in the denominator of the Viral Load Suppression measure, '0' if the member is not in the denominator of this measure or if the information is missing.	1 = Yes 0 = No
Column 32	Numerator for Viral Load Suppression	Enter a '1' if this member is in the numerator of the Viral Load Suppression measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 33	Denominator for Prenatal and Postpartum Care (PPC)	Enter the number of times this member is in the denominator of the Prenatal and Postpartum Care measures, '0' if the member is not in the denominator of this measure.	0 - 2
Column 34	Numerator 1 for PPC – Timeliness of Prenatal Care	Enter the number of times this member is in numerator of PPC – Timeliness of Prenatal Care measure, '0' if the member is not in the numerator or the information is missing.	0 - 2
Column 35	Numerator 2 for PPC – Postpartum Care	Enter the number of times this member is in the numerator of PPC – Postpartum Care measure, '0' if the member is not in the numerator or the information is missing.	0 - 2
Column 36	Denominator for Frequency of Ongoing Prenatal Care (FPC)	Enter the number of times this member is in the denominator of the Frequency of Ongoing Prenatal Care measure, '0' if the member is not in the denominator of this measure.	0 - 2
Column 37	Numerator 1 for FPC (<21%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care <21% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2

Column Placement	Name	Direction	Allowed Values
Column 38	Numerator 2 for FPC (21% to 40%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 21% to 40% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2
Column 39	Numerator 3 FPC (41% to 60%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 41% to 60% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2
Column 40	Numerator 4 for FPC (61% to 80%)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 61% to 80% measure, '0' if the member is not in the numerator or the information is missing.	0 - 2
Column 41	Numerator 5 for FPC (81% or more)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 81% or more measure, '0' if the member is not in the numerator or the information is missing.	0 - 2