Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual

Measurement Year ~~1~~2

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DSRIP@HEALTH.NY.GOV

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I.Overview of Requirements

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~~that 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~~are available from the Independent Assessor organization. Domain 2~~ and~~, 3 and 4 measures ~~will be~~are 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

Reporting Requirements for Measures

~~Each PPS is~~In this document, there are two responsible parties noted for ~~submitting all required measures which are the responsibility of the PPS to report~~reporting requirements: 1) PPS – data reported by the ~~deadline. Results which are the responsibility of~~ PPS to the New York State Department of Health (NYS DOH~~) will be produced for each PPS by~~); and 2) NYS DOH – NYS DOH data sources used to calculate measures.

II. Methodology for Establishing Performance Goals, Annual Improvement Targets, and High Performance

Performance Goals

Performance goals are intended to reflect best performance expected in New York State and the performance goals are the same, consistently applied to all ~~PPSs~~PPS each year. The performance goal for each measure will not be changed throughout the DSRIP demonstration. CMS suggested using the top decile as a mechanism for establishing performance goals. For measures where the goal is to reduce an outcome or occurrence and a lower result is desirable, the lower decile is used, ~~while~~and for measures where the goal is to increase the occurrence and a higher result is desirable, the upper decile is used.

Several sources were considered for establishing goals. National data (NCQA's Quality Compass for Medicaid) top decile results were compared to NYS Medicaid managed care (MMC) results for 2013. The NYS MMC results exceeded the national data for the majority of the measures. The 2013 MMC data was used to calculate results for quality measures by zip code of the member's residence (excluding members with dual eligibility). Zip codes with less than 30 in the denominator or eligible population were excluded, and the 90th percentile was determined for the performance goal. Two quality measures had a small number of zip codes with 30 enrollees for the measure, therefore the top decile of health plan data was used for the performance goal. Efficiency measures (i.e., potentially

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preventable admissions, readmissions and emergency room visits) are population-based measures that have a skewed distribution when examined by zip code. For these measures, the performance goals were established by using all PPS baseline results, and reducing the best performing baseline result by 20%,% of the gap to the default goal, so that the performance goal will provide every PPS with a goal that moves beyond the best current performance.

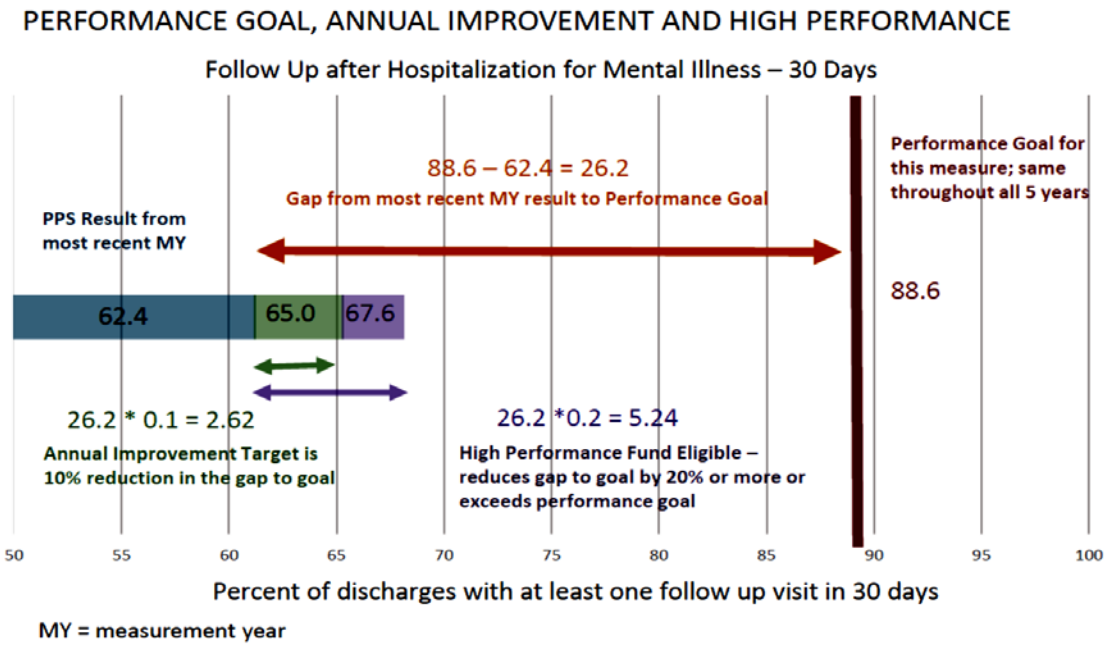
If data for the measure iswas not available for 2013, the performance goal was set to a default of 100%/0% for use in the first measurement year. The performance goals for these measures will be established have been reset using the first measurement year PPS results. Similarly,The performance goals were established with the same methodology as above by using PPS results from measurement year 1, and reducing the best performing baseline result by 20% of the gap to the goal. All performance goals that have not been set using MY 1 results will be established for measureswith PPS results from MY 2. Performance goals using dually eligible members beginning in measurement yearwill be established using results from MY 3.

If the measure specifications are changed to the degree that prior results are not comparable, CMS and NYS DOH have established a process for resetting performance goals. Details about the process are in section VIII.

Annual Improvement Targets (AITs)

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 measurement year (MY) result will be used to determine the gap between the PPS result and the measure's performance goal, and then 10% of that gap is added to the most current PPS result to set the annual improvement target for the current MY (baseline for Measurement Year 1 and so on). Each subsequent year will continue to be set with an improvement target using the most recent year's result. This will account for smaller gains/losses in subsequent years as performance improves toward the goal or measurement ceiling. If a PPS result for a MY meets or exceeds the performance goal, then the annual improvement target and the high performance target (where applicable) for the next MY will equal the PPS' most recent result. Information on how achievement values are determined using AIT and performance goals is contained in the Achievement Value Guide.

Figure 1.



As illustrated in Figure 1, the following example demonstrates the process for determining the annual improvement target (AIT):

Process Step: Determine AIT	**Description**	**Example**
Establish gap amount	Goal – PPS' result = gap	88.6 – 62.4 = 26.2
Calculate 10% of gap amount (increment)	Gap *.10 = increment	26.2 * .10 = 2.62
Set annual improvement target (AIT) by adding increment to PPS' result	Increment + PPS' result = AIT	2.62 + 62.4 = 65.02

In this example, the annual improvement target for the PPS would be 65.02%, and the PPS result would need to meet or exceed that value 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. Determining the AIT and high performance is explained below:

Process Step: Determine High Performance	**Description**	**Example**
Establish gap amount	Goal – PPS' result = gap	88.6 – 62.4 = 26.2
Calculate 10% of gap amount (increment)	Gap *.10 = increment	26.2 * .10 = 2.62
Set annual improvement target (AIT) by adding increment to PPS' result	Increment + PPS' result = AIT	2.62 + 62.4 = 65.02
Evaluate high performance (HP) using actual PPS performance for MY	(Increment*2) + PPS' result = HP OR higher than performance goal	5.24 + 62.4 = 67.64 OR PPS > 88.6

The PPS result for the most recent MY is used to determine the next MY's annual improvement target:

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Process Step: Determine next MY AIT	**Description**	**Example**
Establish gap amount	Goal – PPS' MY1 result = gap	88.6 – 62.4 = 26.2
Calculate 10% of gap amount (increment) MY2	Gap *.10 = increment for MY2	26.2 * .10 = 2.62
Set annual improvement target (AIT) by adding increment to PPS' result	Increment + PPS' MY1 result = AIT MY2	2.62 + 62.4 = 65.02
PPS result for MY2 is used for MY3 gap amount	Goal –MY2 PPS result = new gap for MY3	88.6 – 65.02 = 23.58
Calculate 10% of gap amount (increment) MY3	Gap *.10 = increment for MY3	23.58 * .10 = 2.36
Set annual improvement target (AIT) for MY3 by adding increment to PPS' result	Increment + PPS' result = AIT MY3	2.36 + 65.02 = 67.38

In this example, the MY2 annual improvement target was 65.02%. The PPS' result (65.02%) for MY2 met the AIT and MY2's result is then used to set ~~the next~~MY3's AIT of 67.38%.

High Performance Measures

Ten measures are part of the high performance funds. These measures relate to avoidable hospitalizations, behavioral health and cardiovascular disease with the latter markers aligning with the nationwide Million Hearts Initiative on cardiac outcomes, in order to tackle the leading cause of mortality in New York State.

The ten measures eligible for high performance are:

1. Potentially Preventable Emergency Room Visits (All Population)
2. Potentially Preventable Readmissions (All Population)
3. Potentially Preventable Emergency Room Visits (BH Population)
4. ~~Potentially Preventable Readmissions for SNF patients~~
4. Antipsychotic Use in Persons with Dementia (SNF Long Stay Residents) **NEW**
5. Follow-up after Hospitalization for Mental Illness
6. Antidepressant Medication Management
7. Diabetes Monitoring for People with Diabetes and Schizophrenia
8. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
9. Controlling High Blood Pressure
10. Medical Assistance with Smoking and Tobacco Use Cessation - Discussion of Cessation Strategies

A PPS can achieve high performance through two methods: 1) achieving a reduction in gap to goal by 20% or more in any annual measurement period year for a high performance eligible measure; or 2) meeting or exceeding the measure's performance goal for the measurement period year for a high performance eligible measure.

Pay for Reporting (P4R) Measures

In cases where the measure type is Pay for Reporting (P4R), performing provider systems can earn incentive payment for successfully reporting the measures the PPS is responsible for reporting to NYS DOH within the timeframes for each MY. Measures which are that NYS DOH has the responsibility of NYS DOH to report on reporting will be credited to the PPS in P4R situations.

Pay for Performance (P4P) Measures

In cases where the measure type is Pay for Performance (P4P), a PPS will receive achievement values for results that meet or exceed the annual improvement target. or exceed the performance goal. Improvement targets are determined based on a PPS' previous annual performance in the measure and will be calculated by NYS DOH using the methodology described previously in this section. Measure results with

If the denominator for a measure is less than 30 members or events in the denominator will not be included in, the calculation of the achievement value. Measure results with less than 30 members or events in the denominator will not be included in the calculation of the achievement value. Measure results will indicate data is considered too small to determine a statistically valid result; this is referred to as small cell size and. Measure results with small cell size are not used for determining the achievement value associated with for the measure will be subtracted from the total possible achievement value for the project. Prior to receiving the achievement value for the measure, PPSs PPS will need to have results for two consecutive years that are based on denominators greater than 30. For information about how these situations impact annual achievement value awards, see the Achievement Value Guide.

However, to provide PPS with as much information as possible, the results based on small cell size WILL be shared in PPS annual reports and used to create the AIT for the next measurement year so the PPS can understand current status.

III. Defining the Eligible Population for Performance Measurement

IMPORTANT NOTES:

1. The eligible population is ~~everyone~~comprised of all members attributed to the PPS who ~~qualifies~~qualify for the measure. The eligible population is NOT limited to people who have gone to providers or sites that are involved in project specific activities, or people residing in a specific county or area.

2. Calculation of measure results are member-centric, evaluating each member for meeting criteria for the measure. The member is then attributed to the PPS as of the measurement time frame, such as end of the measurement year. Member eligibility information is evaluated for the measurement window, such as 12 months irrespective of PPS attribution.

~~2.~~3. Members who are dually eligible (Medicare and Medicaid) will NOT be included in PPS measure results for claims-based measures for measurement years 1 and 2. Dually eligible members will be included in PPS results for measurement years 3 through 5. Results will be reported separately (non-duals/duals) for measures so that performance goals, increments and trends will not be reset for the PPS. Combined dual/non-dual results will also be calculated. Achievement values associated with measures with more than 5% of the denominator consisting of dually eligible members will be proportioned for the dual/non-dual results. ~~The readmission measure associated with project 3.a.v will be calculated with Minimum Data Set (MDS) and State Planning and Research Cooperative System (SPARCS) data and will include dually eligible residents in the skilled nursing facilities.~~

   Several measures currently include dual eligibles as the measure specifications do not require claim derived information. These measures include: Health Home enrollment measures (3 measures), Skilled Nursing Facility measures (Long-Stay Residents Depressive Symptoms and Antipsychotic Use for Persons with Dementia), and Hospital measures (ED for Uninsured and H-CAHPS). These measures will not be reported separately.

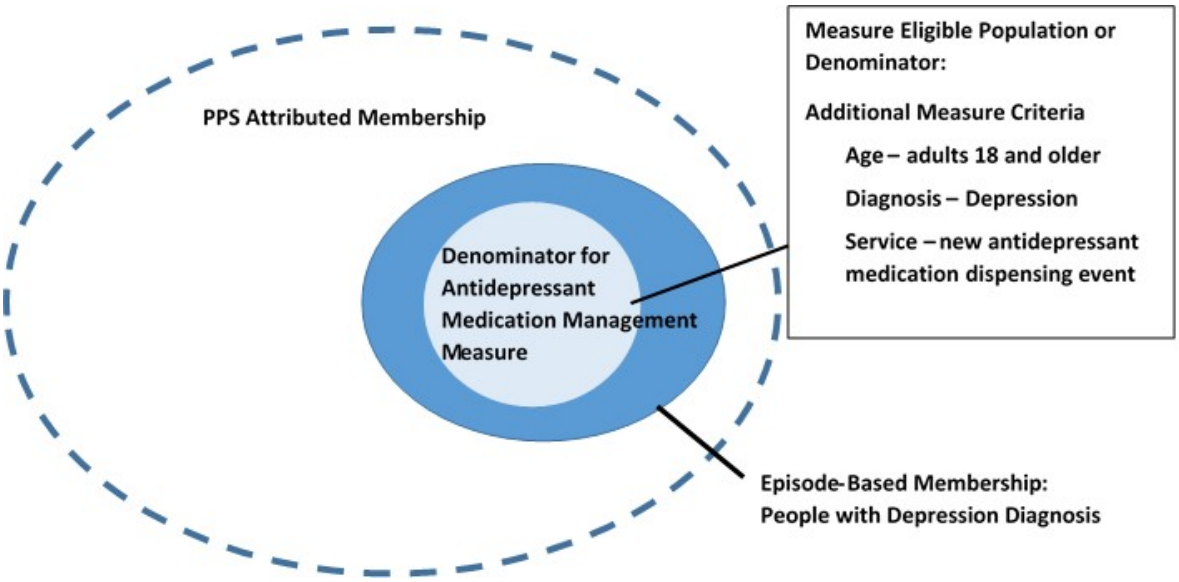
Measure Eligible Population

Members are attributed to a specific PPS for performance measurement based on the qualifying services the members used, their assigned PCP or area of residence. In addition to the member's attribution to a PPS, performance measures use specific criteria to determine eligibility for the 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 apply criteria such as age or diagnosis of a health condition to identify members in the eligible population. While some measures may apply to everyone in the PPS (population-based), others may capture a smaller group within the PPS membership that meet added measure specific criteria such as diagnosis of a health condition (episode-based).

For example, Figure 2 below shows how the PPS membership is narrowed to those with a diagnosis and then further to the measure's eligible population or denominator for an episode-based measure, *Antidepressant Medication Management*.

Figure 2. Denominator Illustration



IV. Baseline Results for Project Approval -Completed

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 the measures associated with a Domain 3 project ~~is~~was within 10 percentage points or 1.5 standard deviations to the performance goals, the project ~~will~~was not ~~be~~ approved. If baseline PPS data ~~is~~was not available (such as measures requiring medical record data or survey responses), the PPS baseline result ~~is~~was assumed to be 0% for the purposes of approving projects. For example if a project ~~has~~had seven associated measures, baseline PPS results ~~are~~were available for three of the measures and unavailable for four, the PPS would be approved as the majority of the measures (i.e. four of the seven) ~~are~~were not within 10 percentage points or 1.5 standard deviations.

~~As of January 2015 all PPSs passed the project approval test using available data. Upon the completion of additional metrics some PPSs may fail some projects after January 2015. In the event that a project fails approval for a PPS, the PPS can replace a failing project with a project of comparable value within Domain 3b – 3e. The PPS cannot select a new project with an index value that is lower than the previously selected project without consent from DOH. Also, the PPS will be expected to implement the new project in at least as many provider sites and in at least as fast the timeline (scale and speed) as the failing project. Lastly, the PPS will accept the original project score from the failing project.~~

~~REMINDER: PPS baseline performance for measures associated with behavioral health projects (3.a.i – 3.a.v) are not subject to performance goal review.~~

In January 2015 all PPS passed the project approval test using available data.

V. Measure Reporting Schedule

Each measurement periodyear 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 periodyear. Results for the measurement periodyear 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 MY award is in March of the year after the MY. 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 (see Section IX, XI and Appendix B). Measures are required to be reported each year and will not be allowed to be rotated. The PPS'PPS will gather and report this information by December of the reporting year.

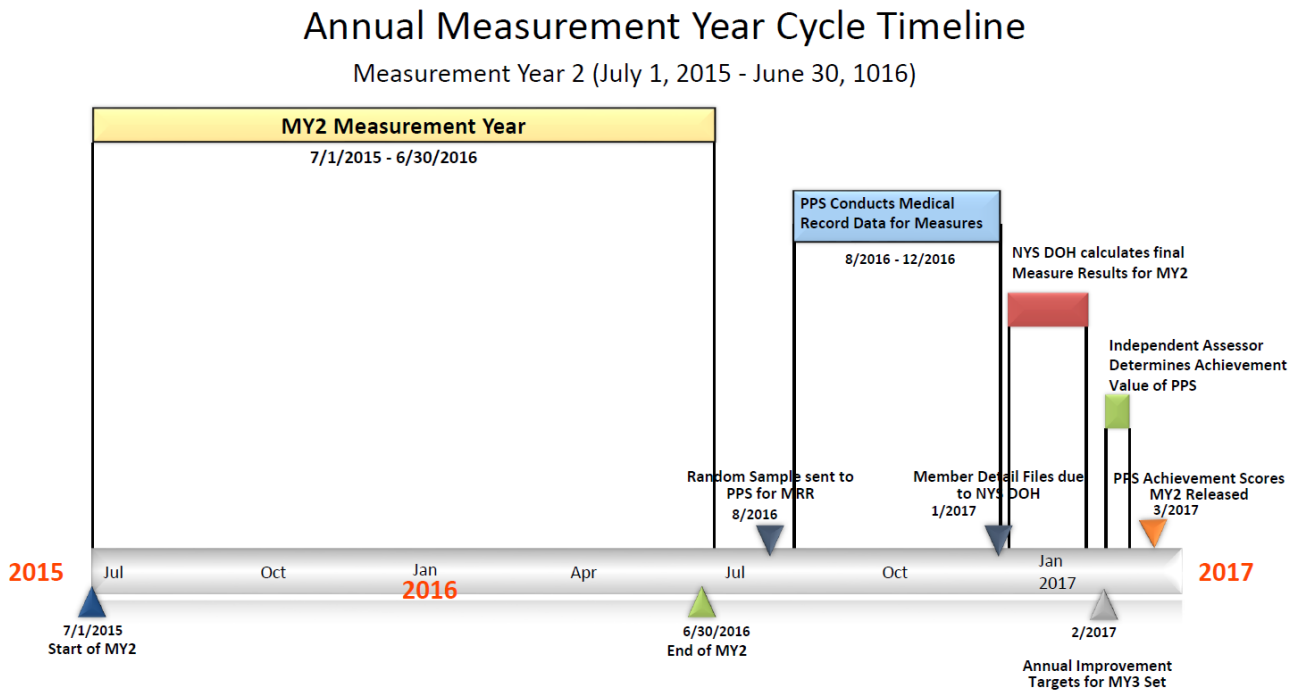
The following example provides the timeline for activities in eachthe measurement periodyear (Table 1). The example uses the first measurement period, but is the same timeframes for all subsequent periods. This is illustrated in Figure 3.

Table 1 – Annual Measurement Cycle

Annual Measurement Year Cycle	Time Frame
PPS baseline dataMY1 results, annual improvement targets released to PPSsPPS	June 2015May 2016
MY1MY2 Measurement PeriodYear Begins	July 1, 2014, 2015
MY1MY2 Measurement PeriodYear Ends	June 30, 2015 2016
MY2MY3 Measurement PeriodYear Begins	July 1, 2015 2016
NYS DOH sends samples for measures requiring medical record (MR) data for MY 1MY2	August 2015 2016
NYS DOH and vendor pullspull sample frame and administersadminister C&G CAHPS	August – November 2015December 2016
MR abstraction conducted, validated and Member Detail File created	August – November 2015December 2016
Completed Member Detail File sent to NYS DOH	December 2015January 2017
Medicaid claims for MY1MY2 frozen following January 2016 2017 refresh of December 2015 2016 claims and encounters load	January 2016 2017

NYS DOH calculates final results for ~~Measurement Year~~MY2, including PPS' Member Detail File information, C&G CAHPS, other non-claims based data	February ~~2016~~2017
Final ~~MY1~~MY2 results provided to Independent Assessor	February ~~2016~~2017
Annual improvement targets for ~~MY2~~MY3 for PPS calculated	February ~~2016~~2017
PPS MY2 results and MY3 annual improvement targets released to PPS	March 2017
Independent Assessor determines achievement value of ~~MY1~~MY2 measures and issues PPS reports	March ~~2016~~2017
~~MY2~~MY3 Measurement ~~Period~~Year Ends	June 30, ~~2016~~2017

Figure 3 – ~~Quality~~Annual Measurement ~~Annual~~Year Cycle Timeline



VI. Reporting Submission Process

Measures or reports indicated as 'PPS' for reporting responsibility will be provided by the PPS. For several of the measures in Domain 3, the reporting responsibility is shared between the PPS and NYS DOH. The PPS reporting will be done through a member detail file. The information from the PPS member detail file will be incorporated into the final result calculation by NYS DOH. Table 2 lists the PPS reporting requirements for each Domain. Several requirements are specific to projects.

Table 2 – Performing Provider Systems Reporting Responsibilities

Domain 1	Domain 1 Measures will be reported through the MAPP system DSRIP Implementation Plan tool. ~~PPSs~~PPS will report on progress towards and completion of organizational milestones as well as project requirements. ~~PPSs~~PPS will also report progress towards and achievement of project speed and scale commitments set forth in the application.
Domain 2	• PPS reported metrics will be collected per instructions from the Independent Assessor Project Specific PPS Requirements Patient Activation (Project 2.d.i) **TO BE REVISED PENDING CMS APPROVAL** • Patient Activation Measure ~~survey~~ – PPS will conduct the ~~survey~~assessment for the uninsured population and non- and low-utilizer population • C&G CAHPS Survey (3.0 version) – PPS will contract with a certified CAHPS vendor to conduct this survey annually for the uninsured population. The vendor will provide NYS DOH with a de-identified response set. (NOTE: This is separate from the NYS DOH sponsored C&G CAHPS for Medicaid members)
Domain 3	PPS and NYS DOH shared - NYS DOH prepares sample and calculates final results; PPS provides Member Detail File for the following measures: • Screening for Clinical Depression and Follow Up • Controlling High Blood Pressure • Comprehensive Diabetes Care • Viral Load Suppression • Prenatal/Postpartum Care • Frequency of Ongoing Prenatal Care (same sample as Prenatal/Postpartum Care) • Childhood Immunization • Lead Screening for Children (same sample as childhood immunization) Project Specific PPS Requirements Prenatal (Project 3.f.i) • Early Elective Delivery – Hospitals will ~~have to~~ review medical records for all inductions and cesarean sections that occur prior to the onset of labor between 36 0/7 and 38 6/7 weeks and ~~provide the hospital specific data for early elective delivery~~complete the New York State Perinatal Quality Collaborative (NYSPQC) Scheduled Delivery Forms for these deliveries Palliative Care (Project 3.g.i – 3.g.ii) **TO BE REVISED PENDING CMS APPROVAL** • ~~Community Project – PPS will conduct assessments for all members that are not enrolled in Managed Long Term Care (MLTC) plans or other waiver programs which are already conducting Uniform Assessment System (UAS-NY) assessments~~ • ~~Nursing Home Project – PPS will conduct assessments for all residents in the nursing home for each nursing home in the PPS network~~Community Project – Implementation of proposed measures and data requirements will be conducted during Measurement Year 3. For MY2, revised palliative care measures were under review by CMS. In order to acknowledge this, PPS can earn these AV based on the successful reporting of Domain 1 reporting requirements based on guidance issued in March 2016. • Nursing Home Project – Implementation of proposed measures and data requirements will be conducted during Measurement Year 3. For MY2, revised palliative care measures were under

	review by CMS. In order to acknowledge this, PPS can earn these AV based on the successful reporting of Domain 1 reporting requirements based on guidance issued in March 2016.
Domain 4	Domain 4 Measures are based on the NYS Prevention Agenda and will be calculated in accordance with NYS Prevention Agenda data source methodology located here. The measures will be calculated in alignment with PPS service areas where geographically-limited data is available. Measures will be reported against NYS Prevention Agenda benchmarks, but achievement is based on reporting of applicable measures.

~~VI.~~VII. *Resources for Technical Assistance*

Several resources are available for collecting data for measures required to be calculated by the PPS. All of the resources can be requested by sending an email to dsrip@health.ny.gov:

1. Measure specifications are available from the Measure Stewards for each measure. A number of measures are from the National Committee for Quality Assurance's HEDIS® (Volume 2) which is available for purchase. Some of the measure descriptions with some details are available on the National Quality Forum website (http://www.qualityforum.org/).
2. The Independent Assessor ~~is a resource for~~Performance Facilitators can provide technical assistance in collection and use of performance data.
3. The NYS DOH's Office of Quality and Patient Safety (OQPS) staff can provide technical assistance for specifications or file layout.
4. Technical specifications for all NYS-specific measures such as *Screening for Clinical Depression and Follow up* and *Viral Load Suppression* have been developed by OQPS (Appendix D~~ and E respectively).~~).
5. IPRO is available to help with any specification clarifications for medical record reviews.

~~VII.~~VIII. Measure Descriptions, Specifications, ~~Achievement Values~~and Performance Goals

Measure descriptions~~, specifications~~ and ~~achievement values~~information for Domain 1 measures are included in Table 3 and Table 4~~ for Domain 1 measures~~. Tables 5 and 6 contain information for the measures associated with Domains 2 and 3 respectively, including the projects associated with each measure. Table 7 contains the Prevention Agenda indicators associated with the Domain 4 Population-wide Strategy Implementation. Reporting responsibility is indicated for each measure. Measures identified as PPS' responsibility will be obtained from information provided by the PPS. For several Domain 3 measures, responsibility is shared between NYS DOH and the PPS. The PPS will provide medical record review information in the member detail file which NYS DOH will incorporate into the final result calculation. Measures indicated as NYS DOH's reporting responsibility will be calculated by NYS DOH and results will be provided to the PPS.

NYS DOH Measure Calculation Process

NYS DOH uses Medicaid claims and encounters as the basis for calculation of claims-based measures and identification of the eligible population for measures requiring medical record data. Programs used to calculate measure results have been developed using the measure steward specifications. Validation procedures for these programs included: review by external staff experienced in Healthcare Effectiveness Data and Information Set (HEDIS~~)~~®) source code review, replication of Medicaid managed care submitted data produced from certified HEDIS® software results, and comparison of all Medicaid results from previous years. Medicaid transaction data for the measurement ~~period~~year (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.

Measure specifications are updated annually and implemented in result calculations beginning in July of each measurement year. Prior to implementing the measure specification changes, impacts to measure results are tested to determine changes creating a significant impact to results, following procedures detailed in the *Measure Retirement and Specification Modifications* section below. Due to the timing of implementing new specifications, impact to measures may not be known at this time. Known changes are highlighted in the table below, but additional measures may be determined to have significant impact and require adjustments to performance goals and previous results (if applicable). Measures affected by significant impact will be communicated to PPS outside of this manual in an update document. Two measure proposals are pending CMS review and approval. Implementation of the prosed measures will be communicated to the PPS outside of this manual.

Highlight of Measure Changes

Measure	Change	Reason for Change	Impact for Achievement Value
Potentially Preventable Readmission for Skilled Nursing Facility	Replacement. Antipsychotic Use for Persons with	The low number of readmissions at individual SNFs involved with the project would make it	None. Performance Goal, MY0 baseline and MY1 results available for replacement measure.

	Dementia for Long Stay Residents	difficult to monitor the impact of interventions on readmissions.	Annual AV available all MYs.
Meaningful Use Certified Providers who conduct bidirectional exchange	Revision. The two aspects of bidirectional exchange will be captured separately 1. Make information available in SHIN-NY 2. Access information through the SHIN-NY	The criteria for determining bidirectional exchange have been clarified with Qualified Entities.	Each component will receive 0.5 AV. Remains P4R all 5 years. Note - MY2 results may not be able to be compared to previous years due to significant impact of changed specifications on results.
Helpful, Courteous and Respectful Office Staff	Removed.	Review of measure mapping indicated this measure was not applicable to Domain 2 projects.	Getting Timely Appointments, Care and Information AV increased from 0.5 to 1 for MY 2, 3, 4, and 5
PQI 13 – Angina without Procedure	Replacement. PQI 8 – Heart Failure	Retirement of PQI 13 by the measure steward Agency for Healthcare Research and Quality (AHRQ). PQI 8 is a cardiovascular related indicator and will be used as the replacement.	None. Reset of Performance Goal, MY0, MY1, and AIT for MY2 will be produced for use in MY2 results. Previous AV award unchanged. Annual AV available all MYs.
PQI 90 – Composite of PQIS	Revision. PQI 90 with PQI 13 removed	The retirement of PQI 13 by the measure steward will remove the indicator from the overall composite and impact trend.	None. Reset of Performance Goal, MY0, MY1, and AIT for MY2 will be produced for use in MY2 results. Previous AV award unchanged. Annual AV available all MYs.
Statin Therapy for Patients With Cardiovascular Disease	Addition. Cholesterol Management for Patients with Cardiovascular Disease was removed in MY1	The measure Statin Therapy for Patients with Cardiovascular Disease was introduced by NCQA to reflect current treatment guidelines.	Add AV to project. Performance Goal, MY1 result and AIT for MY2 will be calculated and introduced in MY2 results. Annual AV available MY2, MY3, MY4 and MY5.

Measure Retirement and Specification Modifications

The measures associated with the Domain 2 and 3 projects will be collected for all five years of the demonstration and specifications will be held consistent to the extent possible. Many of the measures used in DSRIP are currently used in CMS Medicaid quality core sets, as well as health plan reporting for Quality Assurance Reporting Requirements (QARR is NYS' version of HEDIS®), and the measure steward is often a national organization. Situations may arise when the measure stewards retire or alter measure specifications to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. To

align collection of data from all health care providers, the measure modifications may also be incorporated in DSRIP.

Objective

The objective is to maintain the achievement value awards for measures associated with projects throughout the DSRIP demonstration years. Measure definitions and specifications will be maintained consistently throughout the measurement years (2014-2019) to the greatest extent possible.

Guiding principles

Should the measure steward retire or modify the specifications, we may accept and incorporate retirement or modifications to keep DSRIP measures relevant and meaningful to providers working to improve the quality of care. To that end, the guiding principles for the incorporation in DSRIP measures are as follows:

1. Clinically relevant and meaningful quality measures reflecting recommended care and current health care practices; and
2. Alignment and consistent use of measure specifications for DSRIP and core sets used by other programs in NYS, such as QARR~~/HEDIS~~, health homes or provider programs (e.g. incentives or Patient Centered Medical Home initiatives).

Determining Use in DSRIP

~~The~~These two guiding principles are the key criteria for determining whether the retirement or modification will be incorporated into DSRIP. If clinical relevance is the reason for the recommended action by the measure steward, the modification will be incorporated into DSRIP. Clinically relevant, meaningful information will better engage providers in improvement activities by providing credible data for use in those activities. Improvement of care is facilitated by coordinated efforts among units of health care delivery (practices, health plans). Measure alignment between ~~PPSs~~PPS and other units facilitates coordination and comparability of results at various levels of health care delivery.

Process for Adjusting Performance Goals, Annual Improvement Targets and Achievement Values

Using the two guiding principles, decisions will be made regarding retirement or implementation of modifications. CMS will be notified of all decisions, including impact to performance goals, annual improvement targets and achievement values prior to the measurement year that the change is introduced.

When the decision is made to retire a measure or to implement a modification with a measure, the method of implementing the change and its impact to the performance goal (PG~~),~~) and annual improvement target (AIT) will be dependent on four factors:

- Necessity of implementation (clinical relevance and alignment concern)
- Availability of replacement measure for retired measure
- Ability to implement change in a stratified fashion
- Ability to compare results with modification to previous results or to re-calculate previous results with modification

Necessity – If the genesis for the retirement or modification is not due to clinical relevance and the measure is not used in other programs, the retirement or modification will not be implemented for DSRIP.

Availability of replacement measure for retired measure – If there is a standardized measure with similar focus available for replacement for the retired measure, the new measure will be introduced at the beginning of the next measurement year. The new measure will be associated with the same achievement value as the retired measure. See *Adjusting Performance Goals, Annual Improvement Targets and Achievement Values* below for details on how data sources affect the continuity of the total achievement values.

Stratified implementation – If the modification can be applied in a stratified manner, meaning that the portion of the result used in DSRIP remains unchanged, this portion will be used for the improvement evaluation for the PPS in determining the achievement value award.

Comparability to Previous results – Retirement of a measure would not allow comparability to previous results. A measure result with the modification will be considered to not affect comparability if the change in the result with the modification is less than 10 percent change from the previous results without the modification, or no significant impact. Significant impact is determined if revised specifications alter the previous year's overall results by more than a 10 percent change. The method to determine percent change is to:

- divide the previous result (pervious measurement year data with original specifications) by the new result (previous measurement year data if available or current measurement year data with revised specifications) and multiply the quotient by 100;
- then subtract 100 from the result for the percent change.

Percent Change = [(Previous Result/New Result)*100] – 100

Adjusting Performance Goals, Annual Improvement Targets and Achievement Values – If the previous year's result, compared to results with the changes implemented, ~~are~~is determined to have less than a 10 percent change, the performance goals, annual improvement targets and achievement values will not be affected in any manner.

If there is more than a 10 percent change or significant impact to the previous year's result compared to results with the changed implemented, the performance goals and annual improvement targets will be re-established. If the data is available to re-calculate the previous year's results with the modification, such as with claims-based measures, the revised result can be created using previous year's claims. This would allow no interruption of achievement value awards. Non-claims based measures would need to have data collection before the baseline data would be available. The first year's results with the revised measure will be considered the baseline and will be used to set the performance goal and the annual improvement target for the next measurement year. In the interim year, when the baseline data is being collected, the achievement value will be retained in the project as pay-for-reporting (P4R) award.

The decision process and any subsequent need for revising performance goals, annual improvement targets, and achievement values are described in two decision trees (Measure Retirement- Figure 4 and Measure Specification Modifications – Figure 5).

Annual achievement value (AV) awards are affected under two scenarios as shown in the two decision trees: in the case of measure retirement with no replacement and in the case of significant modification to non-

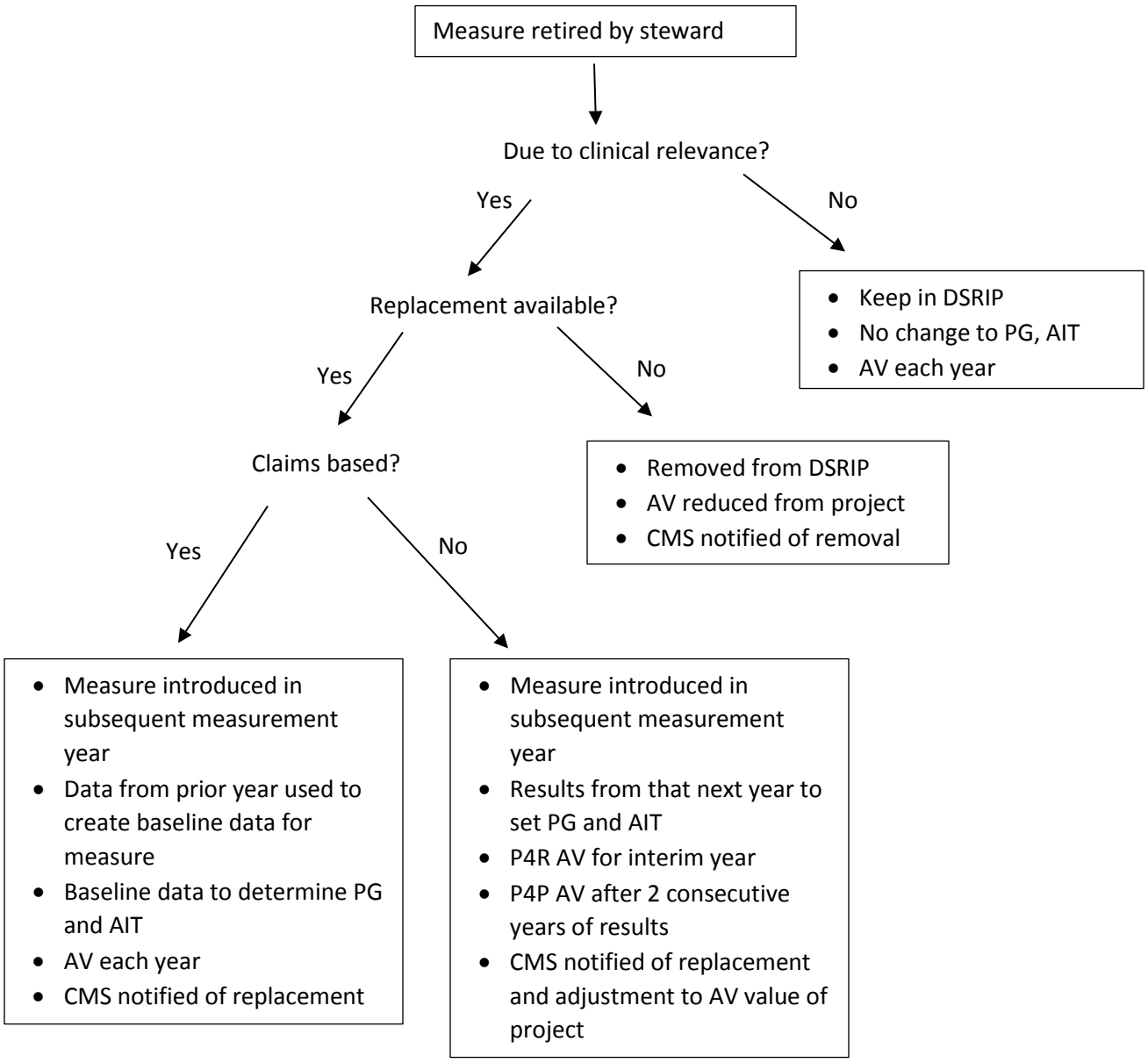
claims-based measures. Details regarding impact of available achievement values on annual payments are contained in the Achievement Value Guide).

If one of the measures is retired, the number of AVs will be reduced to a new AV amount, depending on the DSRIP year and the current status of the measure (whether the measure is currently pay-for-performance or reporting (P4R or P4P). This will reduce the number of AVs available in the measurement reporting period. If a measure in a given measurement year and status (P4P or P4R) is removed, the funding percent allocation for that performance period will be shifted to either P4R or P4P as required. For example, the following chart shows the number of currently-available AVs for project 3.a.i. If a P4P measure is retired in DY2, there will be 7 P4P AVs instead of 8 P4P AVs. The resulting AVs will be recalculated and communicated to PPSs.

		DSRIP YEAR				
Project	P4P/P4R	DY1	DY2	DY3	DY4	DY5
3.a.i	P4P	0	8 7	8 7	10 9	10 9
	P4R	10 9	2	2	2	2

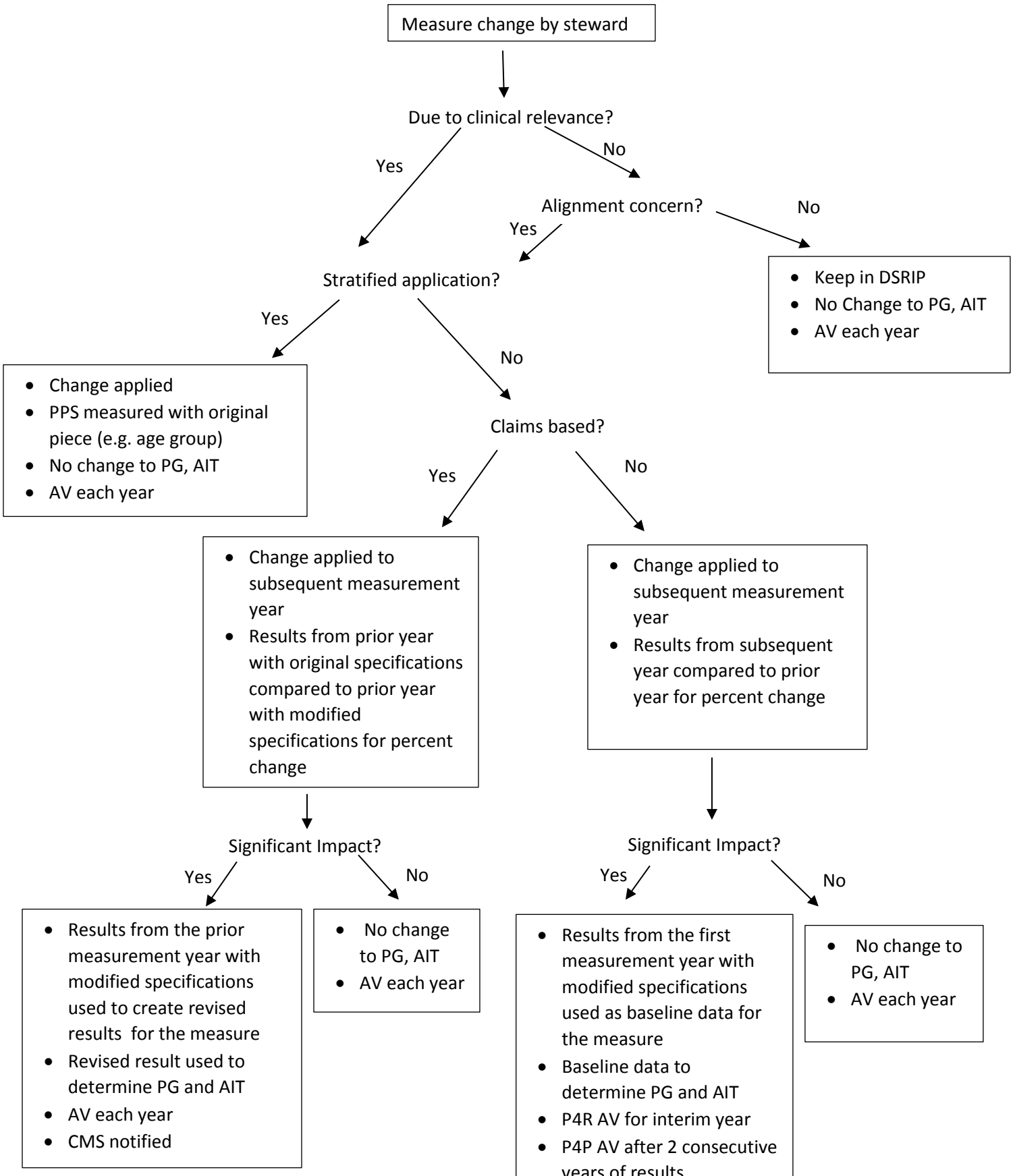
If a measure is a non-claims-based measure that requires two consecutive years of results, the AV will be retained but will be considered a P4R measure only in the interim year. For example, if one of the above non-claims-based measures is significantly modified in DY2, the measure will return to P4R until two consecutive years of measure results have expired.

Figure 4. Measure Retirement Decision Tree



PG = Performance Goal
AIT = Annual Improvement Target
AV = Achievement Value

Figure 5. Measure Specification Modification Decision Tree



PG = Performance Goal
AIT = Annual Improvement Target
AV = Achievement Value

Common Scenarios

To demonstrate the process, several examples are provided. The examples described in this section are not intended to be inclusive of every situation which may arise, but address scenarios most likely to occur. If a new scenario arises during DSRIP, CMS and the NYS DOH will collaborate on the appropriate process to address the new scenario.

Scenario 1 - Measure specifications altered for reasons other than clinical relevance AND no alignment concern because measure is not in use in other levels of health care delivery in New York, such as health plan (QARR), meaningful use and health homes.

> For example, a newer version of ~~CG~~ C&G CAHPS questionnaire is released with a modification in the response option schema for some questions. This could be done to echo new response options for other items in the survey version. The measure steward determines the modification is not based on validity of results and is not related to changes in clinical care recommendations.

Process decision: the original response option schema will be maintained to allow for consistent measurement. Maintaining measures specific to DSRIP will not introduce any confusion over the use of different measure versions within other levels of health care delivery.

Scenario 2 - Measure specifications altered for clinical relevance AND can be applied to DSRIP in a stratified fashion to allow consistent trending.

> For example, if the upper age limit for a DSRIP measure was changed from 64 to 75 years, the specification modification could be applied in a manner that the original measure specifications would be maintained for consistency in trending. The PPS results for the measure could be stratified by age allowing consistent trending for the age group through age 64. The change in the age limit does not indicate an issue with relevance to the population through age 64.

Process decision: the measure specifications will be applied in a manner that allows for stratification of results so that the original specifications will be maintained to allow for consistent trending for evaluation of improvement. Stratified results would be provided; for example results for the 65 to 75 year age group separately from the results for the other age group.

Scenario 3 - Measure specifications altered for clinical relevance AND cannot be applied to DSRIP in a fashion to allow consistent trending. Common examples are modifications to coding, medications, other technical adjustments, or criteria related to recommended clinical care or treatment guidelines.

> For example, measure specifications are modified to update new Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes which reflect recently added services relevant to the measure and allow more complete collection of the information.

Process decision: the modifications will be incorporated into the finalized version of the measure specification manual for the measurement year to allow for continued meaningful results of recommended quality care.

Scenario 4 - Measures which are retired by the measure steward because of changes in recommended quality care.

> For example, the *Cholesterol Management for Patients with Cardiovascular Conditions* has been retired by NCQA due to recommendation changes regarding the LDL-c control level.

Process decision: the retirement will be incorporated.

Glossary for Measure Components

The terminology below is included in components for measures described in the tables below or in performance measurement procedures.

Achievement Value: The achievement value associated with the measure which the PPS will earn if associated criteria are met.

Annual Improvement Target (AIT): The result the PPS needs to meet or exceed to attain the achievement value for the measure for the measurement year. The annual improvement target is established using the PPS' result from the previous measurement year. For example, the result for Measurement Year (MY) 1 is used to set the annual improvement target for MY 2 (see Section II).

Demonstration Year (DY): DYs are twelve month calendar year periods beginning on April 1st and ending on March 31st for all 5 of the demonstration years. For example, DY1 begins on April 1, 2015 and ends March 31, 2016. The DY is different from the measurement year (see below).

Denominator: The members of the eligible population who meet the measure's additional criteria (e.g. all adult patients with diabetes) and are included in the result calculation. Note: many measures include specific denominator inclusion and exclusion criteria.

High Performance Eligible: The indicator is displayed for measures which are eligible for high performance funds.

Measure Eligible Population: 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 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 (population-based), others may capture a smaller group within the PPS membership (episode-based). Population-based measures apply to the entire attributed PPS population over the measurement year. Episode-based measures are limited to only those members seen for that episode of care during the measurement year. Episode of care refers to all care provided over a measurement year 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). Institutional-based measures apply to all people within the institution, such as nursing home measures.

Measure Reporting Responsibility: The collection process for each measure will be identified as calculated by the NYS DOH, or will be the responsibility of the PPS to collect or report. Measures that incorporate medical record data collected by the PPS with claims and encounters are shared responsibility of the PPS and NYS DOH. This will be detailed in *Section IX* in medical record guidelines.

Measure Name: 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.

NQF Number: If the measure has a measure number from the National Quality Forum, whether currently endorsed or not, the number is included to facilitate access to more detailed specifications. Measures without an NQF number are listed as NA or Not Applicable.

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 are P4R throughout the entire demonstration period, while some measures also introduce a P4P achievement value in latter demonstration years (see tables 4 through 7).

Measure Achievement Value (AV): Several measures have more than one component. For such measures, the achievement value for the measure is proportioned among the components for a total AV of '1' for the measure. This allows each measure to weigh equally in the overall achievement for a project.

Measurement Year (MY): A twelve month period from July 1 of the previous year to June 30 of the current year.

Numerator: Description of criteria to determine compliance for the particular measure (e.g. all patients with an HbA1c test). Note: many measures include specific numerator inclusion and exclusion criteria.

Payment: The payment methodology for DYs is displayed.

Performance Goals (PG): Many of the measures in domain 2 and 3 will have performance goals established to represent the best performance expected in NYS. The goals are used in calculating the gap to goal for the annual improvement targets and high performance targets, if applicable. This methodology used for establishing performance goals is described in Section II.

Specification Version: The version of the specifications used for the measure results is indicated, where applicable. When there are changes to the measure specifications, there can be differences with the NQF version. The indicated version of the measure steward's specifications will be used.

Statewide Measure: The indicator is displayed for measures which are used to determine State performance for DSRIP. These measures are used to calculate state achievement of annual performance milestones in DY 3-5. The performance on these milestone can determine the amount of funding available to the program

Steward: Specifies the organization that maintains or administers the measure (e.g. National Committee for Quality Assurance (NCQA), Agency for Healthcare Research and Quality (AHRQ)). The measure steward should be referred to for detailed specifications. This manual provides high-level requirements for collection of the measures.

Calculation of Domain 1 Process Measures

Domain 1 measures are process measures and are based largely on milestone reporting and completion of milestones and project requirements, as well as measures specific to Health Homes in accordance with Attachment J. Domain 1 measures are broken into two categories: organizational measures and project measures. Domain 1 achievement values are assigned for each project for both organizational and project components.

Organizational measures include the following sections: Governance, Workforce Strategy, Financial Sustainability, and Cultural Competency and Health Literacy.

Project requirements are based on *Domain 1 DSRIP Project Requirements Milestones & Metrics* and are described in more detail in Appendix A.

Calculation of Achievement Values for Domain 1 metrics is described in Tables 3 and 4 below.

Calculation of Domain 4 Population Health Measures

Projects in Domain 4: *Population-wide Strategy Implementation* are aligned to the NYS Prevention Agenda and align with projects in Domain 3. Performing Provider Systems selected one or two projects from at least one of the four priority areas:

- Promote Mental Health and Prevent Substance Abuse;
- Prevent Chronic Disease;
- Prevent HIV/AIDS; and
- Promote Healthy Women, Infants and Children

The Prevention Agenda has established performance goals for each priority area and defined indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities. These performance goals will be utilized to report on performance of PPS Domain 4 projects (payment is based on reporting only). The ~~PPSs~~PPS are responsible for reporting on progress in implementing their selected strategies.

The New York State Prevention Agenda Dashboard allows for a visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It will serve as a key source for monitoring progress made around the state with regard to meeting the Prevention Agenda 2017 objectives. The state dashboard homepage displays a quick view of the most current data for New York State and the Prevention Agenda 2017 objectives, many of which are Domain 4 Pay for Reporting measures. The most current data are compared to data from previous time periods to assess the annual progress for each indicator. Specific data source methodology can be located here. Results of indicators are not specific to Medicaid and are not from the same time frame as the DSRIP measurement year. The most currently available data for some indicators may represent past years.

For each Prevention Agenda priority area and focus area, measurable targets have been identified with outcome goals. Achievement values for Domain 4 measures are based on Pay for Reporting only, but progress towards these Prevention Agenda benchmarks will be calculated and monitored for reporting purposes. When possible, Domain 4 measures will be calculated according to PPS service areas, depending on the availability of county-specific data.

Data Sources for Domain 4 Projects

Domain 4 measures rely on data sources such as those listed below. Each project measure will be tracked and published electronically in yearly reports for the State and counties (where county data is available) as a Prevention Agenda (PA) Tracking Indicator.

- Asthma Surveillance Data
- Baseline Data - State and County Tracking Indicators for the Priority Areas
- Cancer Registry
- Community Health Indicator Reports
- County Health Indicators by Race/Ethnicity (CHIRE)
- County/ZIP Code Perinatal Data Profile
- Expanded (County Level) Behavioral Risk Factor Surveillance System
- Health Data NY GOV
- Hospital-Acquired Infection Reporting System
- Leading Causes of Death in New York State
- Medicaid Redesign Team Health Disparities Work Group Data and Information
- New York State Prevention Agenda Tracking Indicator Dashboard
- Prevention Quality Indicators (PQI)
- Report on Managed Care Plans Performance in New York State
- Sexually Transmitted Diseases Data and Statistics
- The New York State Pregnancy Risk Assessment ~~monitoring~~Monitoring System (PRAMS)
- Vital Statistics (births, pregnancies, deaths)

Other External Data Sources

- America's Health Rankings
- Behavioral Risk Factor Surveillance System - National and State Prevalence Data
- Children in the States Factsheets (Children's Defense Fund)
- Chronic Disease Indicators - CDC
- County Health Rankings-Mobilizing Action Toward Community Health
- County Mental Health Profiles
- EpiQuery: NYC Interactive Health Data
- Governor's Traffic Safety Committee
- Health Indicator Sortable Stats
- Health, United States, 2012 - In Brief
- Healthy People 2010
- Healthy People 2020
- Kids Well-being Indicator Clearinghouse (KWIC)
- National Center for Health Statistics
- New York State Data Center
- NYS School Report Cards, NYS DOE
- Pregnancy Risk Assessment Monitoring System (PRAMS) - CDC Ponder
- Prevention Risk Indicator Services Monitoring System (OASAS)
- U.S. Bureau of Labor Statistics
- U.S. Census Bureau
- Youth Risk Behavior Survey (YRBS)

Table 3. Domain 1 Measures

Domain 1 Section	Metrics / Measurement Definition	AV Calculation Methodology
Organizational Measures		
Organizational – Governance	Finalize governance structure and sub-committee structure	One achievement value point *for each project* will be given for Governance based on demonstrated progress towards completion of milestones, completion of milestones by target dates specified by DOH or PPS, and ongoing reporting.*
	Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
	Finalize bylaws and policies or Committee Guidelines where applicable	
	Establish governance structure reporting and monitoring processes	
Organizational – Workforce Strategy	Workforce Strategy Budget Updates	One achievement value point *for each project* will be given for Workforce Strategy based on quarterly reporting, adherence to adjusted workforce spending commitments in each payment period ~~(or within reasonable threshold (90% of spending targets),~~, and sufficient explanation of any deviation from implementation plan projections. Workforce spending commitments have been adjusted according to the following: DY1: 80% of DY1 commitment DY2: 80% of total DY1 and DY2 commitment DY3: 85% of total DY1, DY2 and DY3 commitment DY4: 90% of total commitment *Note that these are subject to change in future DSRIP periods.*
	Workforce Staff Impact Analysis and Updates	
	New Hire Employment Analysis and Updates	
Organizational – Financial Sustainability	Finalize PPS finance structure, including reporting structure	One achievement value point *for each project* will be given for Financial Sustainability based on demonstrated progress towards completion of milestones, completion of milestones by target dates specified by DOH or PPS, and ongoing reporting.*
	Perform network financial health current state assessment and develop financial sustainability strategy to address key issues	
	Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
	Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy for the PPS and for facilitating network partner engagement with the MCOs	

Domain 1 Section	Metrics / Measurement Definition	AV Calculation Methodology
	Finalize a plan towards achieving ~~90~~80% value-based payments across network by year 5 ~~of~~which aligns with the ~~waiver at the latest~~CMS approved Value Based Payment Roadmap	
	~~Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation~~	
	~~Contract 50% of care costs through Level 1 VBPs, and ≥ 30% of these costs through Level 2 VBPs or higher~~	
	~~≥90% of total MCO PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and ≥ 35% of total costs captured in VBPs has to be in Level 2 VBPs or higher~~	
Cultural Competency and Health Literacy	Finalize cultural competency / health literacy strategy	One achievement value point *for each project* will be given for Cultural Competency / Health Literacy based on demonstrated progress towards completion of milestones, including completion of milestones by target dates specified by DOH or PPS, and ongoing reporting.*
	Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material)	
Project Measures		
Quarterly Progress Reports	See Appendix A and Domain 1 DSRIP Project Requirements Milestones & Metrics guide.	One achievement value point *for each project* will be given for demonstrated progress towards completion or achievement of project metrics, for reporting of providers completing project requirements where applicable, and for additional required project reporting ~~measures~~ such as ~~the~~project budget, flow of funds, and health home P4R measures ~~below~~.
Project Implementation Speed	Measure for evaluating performance against application commitments to speed of implementation of all project requirements.	One achievement value point following completion of project requirements by commitment date (see Appendix A for more details on completion of project requirements and applicable timeframes).
Project System Change Implementation (DY2)	Measure for evaluating completion of major project system transformation requirements (See Appendix A).	One achievement value point for completion of project requirements classified as "Project System Changes". See Appendix A for more details.
Patient Engagement Speed	Measure for evaluating performance against discounted application commitments to member engagement.	One achievement value point for engaging at least 80% of discounted active engagement commitments in DSRIP application for each payment period. ~~Definition~~Definitions of active ~~management will be~~engagement have been published under a separate protocol document to the DSRIP Website.

[*]Progress will be demonstrated through quarterly reporting. Independent Assessor will make final determination regarding whether or not PPS has achieved organizational milestones or demonstrated satisfactory progress towards completion.

Table 4. Additional Domain 1 Health Home Measures

Measure Name	Numerator Description	Denominator Description	Performance Goal	Achievement Value	Reporting Responsibility	Payment: DY 1 through 5
Health Home assigned/referred members in outreach or enrollment	Number of referred and assigned HH eligible members with at least one outreach or enrollment segment during the measurement year	Total number of referred and assigned HH eligible members in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home members who were in outreach/enrollment -who were enrolled during the measurement year	Number of HH members with at least one enrollment segment in the Health Home Tracking System during the measurement year	Total number HH eligible members with at least one outreach or enrollment segment of in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R
Health Home enrolled members with a care plan during the measurement year	Number HH with a care plan update indicated in any of the four quarters of the measurement year	Total number HH eligible members with at least one segment of enrollment in the Health Home Tracking System during the measurement year	NA – Pay for Reporting measure only	Reporting on this measure is required in order to earn project Quarterly Progress Report AV	NYS DOH	P4R

Table 5. Domain 2 Measures

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
Domain 2 – System Transformation										
Potentially ~~Avoidable~~Preventable Emergency Room Visits ±	3M	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people (excludes those born during the measurement year) as of June 30 of measurement year	6.10 per 100 Medicaid enrollees *High Perf Elig # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Potentially ~~Avoidable~~Preventable Readmissions ±	3M	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge)	Number of people as of June 30 of the measurement year	180.66 per 100,000 Medicaid Enrollees *High Perf Elig # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
PQI 90 – Composite of all measures ±	AHRQ ~~4.4~~5.0.3	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of admissions which were in the numerator of one of the adult prevention quality indicators	Number of people 18 years and older as of June 30 of measurement year	~~321.05~~TBD per 100,000 Medicaid Enrollees # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
PDI 90– Composite of all measures ±	AHRQ ~~4.4~~5.0.3	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of admissions which were in the numerator of one of the pediatric prevention quality indicators	Number of people 6 to 17 years as of June 30 of measurement year	41.37 per 100,000 Medicaid Enrollees # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement	~~NA~~NYS-specific	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Dollars paid by MCO under value based arrangements	Total Dollars paid by MCOs	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R
~~Percent of eligible providers meeting~~ Meaningful Use ~~criteria,~~Certified Providers who have a participating ~~agreements with qualified entities (RHIOs)~~ agreement	~~NA~~NYS-specific	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of eligible providers meeting meaningful use criteria, who have at least one participating agreement with a qualified entity (~~RHIO~~QE)	Number of eligible providers meeting meaningful use criteria in the PPS network	NA – Pay for Reporting measure only # SW measure	0.5	NYS DOH	P4R	P4R
~~Percent of eligible providers meeting~~ Meaningful Use ~~criteria~~Certified Providers who ~~are able to participate in~~conduct bidirectional exchange	~~NA~~NYS-specific	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of eligible providers meeting meaningful use criteria, ~~are able to participate in bidirectional exchange~~ who both 1) make data available and 2) access	Number of eligible providers meeting meaningful use criteria in the PPS network	NA – Pay for Reporting measure only # SW measure	0.5	NYS DOH	P4R	P4R

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
				data using SHIN-NY with a QE						
Percent of PCP providers meeting PCMH (NCQA) or ~~Advance~~Advanced Primary Care (SHIP) standards	NA	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of PCP providers meeting PCMH Standards (all levels and any standard year) or ~~Advance~~Advanced Primary Care Standards	Number of PCP providers in the PPS network	NA – Pay for Reporting measure only # SW measure	1	NYS DOH	P4R	P4R
Primary Care - Usual Source of Care ~~– Q2~~	1351a_C&G CAHPS Adult Primary Care (version 3.0, Q2)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Percent of Reponses 'Yes'	All Responses	92.5% ~~100%^~~ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Primary Care – Length of Relationship ~~– Q3~~	1351a_C&G CAHPS Adult Primary Care (version 3.0, Q3)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Percent of Responses at least '1 year' or longer	All Responses	86.5% ~~100%^~~ # SW measure	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Adult Access to Preventive or Ambulatory Care – 20 to 44 years	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 20 to 44 as of June 30 of the measurement year	91.1% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
Adult Access to Preventive or Ambulatory Care – 45 to 64 years	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 45 to 64 as of June 30 of the measurement year	94.4% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Adult Access to Preventive or Ambulatory Care – 65 and older	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of adults who had an ambulatory or preventive care visit during the measurement year	Number of adults ages 65 and older as of June 30 of the measurement year	94.4% # SW measure	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children's Access to Primary Care – 12 to 24 months	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement ~~period~~year	Number of children ages 12 to 24 months as of June 30 of the measurement year	100.0% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children's Access to Primary Care – 25 months to 6 years	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement ~~period~~year	Number of children ages 25 months to 6 years as of June 30 of the measurement year	98.4% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
Children's Access to Primary Care – 7 to 11 years	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement ~~period~~year or year prior	Number of children ages 7 to 11 years as of June 30 of the measurement year	100.0% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Children's Access to Primary Care – 12 to 19 years	HEDIS ~~2015®~~ 2016	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number of children who had a visit with a primary care provider during the measurement ~~period~~year or year prior	Number of children ages 12 to 19 years as of June 30 of the measurement year	98.8% # SW measure	0.25 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Getting Timely Appointments, Care and information ~~(Q6, 8, and 10)~~	1351a_C&G CAHPS Adult Primary Care (version 3.0, Q6, 8 and 10)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number responses 'Usually' or 'Always' got appt for urgent care or routine care as soon as needed~~-~~, and got answers the same day if called during the day	Number who answered they called for appointments or called for information	~~100%^~~ 92.5% # SW measure	~~0.5~~1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
~~Helpful, Courteous, and Respectful Office Staff (Q21 and 22)~~	~~1351a_C&G CAHPS Adult Primary Care (version 3.0)~~	~~NA~~	~~2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii~~	~~Number responses 'Usually' or 'Always' that clerks and receptionists were helpful and courteous and respectful~~	~~All responses~~	~~100%^ # SW measure~~	~~0.5 if annual improvement target or performance goal met or exceeded~~	~~NYS DOH~~	~~P4R~~	~~P4P~~

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
Medicaid Spending on ER and Inpatient Services ±	NYS-specific	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Total spending on ER and IP services	Per member per month of members attributed to the PPS as of June of the measurement year	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R
Medicaid spending on Primary Care and community based behavioral health care	NYS-specific	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Total spending on Primary Care and Community Behavioral Health care as defined by MMCOR categories	Per member per month of members attributed to the PPS as of June of the measurement year	NA – Pay for Reporting measure only	1	NYS DOH	P4R	P4R
H-CAHPS – Care Transition ~~Metrics (Q23, 24,~~ CMS Data Set H_COMP_7_SA and ~~25)~~H_COMP_7_A	H-CAHPS V9.0 (Q23, 24, and 25)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Average of hospital specific results for the Care Transition composite using Strongly Agree and Agree responses	Hospitals with H-CAHPS participating in the PPS network	~~100%^~~97.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Care Coordination ~~(Q13, 17 and 20)~~	1351a_C&G CAHPS Adult Primary Care (version 3.0, Q13, 17 and 20)	NA	2.a.i – 2.a.v, 2.b.i – 2.b.ix, 2.c.i – 2.c.ii	Number responses 'Usually' or 'Always' that provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines	All responses	~~100%^~~ 91.9% # SW measure	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
~~PAM Level~~PAM Measure Proposal Pending CMS approval PAM Score	~~NA~~Insignia - NYS Modifications	NA	2.d.i	~~Interval measure of % of members of total with Level 3 or 4 on PAM~~NA	~~Baseline measure of % of members of total with Level 3 or 4 on PAM~~NA	~~Ratio greater than 1~~Performance based on difference between mean score of individual cohorts (cohorts determined by DY) between successive measurement years.	~~1 if ratio greater than 1~~From 0.25 up to 1 AV depending on mean cohort increase over previous measurement year	PPS	P4R	P4P
~~Use~~Non-use of primary and preventive care services~~ Percent of attributed 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)~~ ±	~~NA~~NYS-specific	NA	2.d.i	The percentage of~~ NU and LU~~ Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code~~.~~ in the measurement year	~~Baseline~~The percentage of~~ NU and LU~~ Medicaid members who do not have at least one claim with a preventive services CPT or equivalent code~~.~~ in the baseline measurement year	Ratio lower than 1	1 if ratio lower than 1	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2	Payment: DY 3, 4 and 5
ED use by uninsured ±	~~NA~~NYS-specific with SPARCS	NA	2.d.i	~~Annual measure of number~~The percentage of ED visits ~~for~~which are self-pay ~~per 100 ED visits~~ payer typology only for all hospitals in the PPS network in the measurement year	~~Baseline measure of number~~The percentage of ED visits for self-pay ~~per 100 ED visits~~payer typology only for all hospitals in the PPS network in the baseline measurement year	Ratio ~~less~~lower than 1	1 if ratio ~~less~~lower than 1	NYS DOH	P4R	P4P
C&G CAHPS by PPS for uninsured	1351a_C&G CAHPS Adult Primary Care (version 3.0)	NA	2.d.i	Using the C&G CAHPS Survey, ~~Annual measure of four~~three composite measures~~.~~ and one rating measure: 1) Getting timely appointments, care, and information 2) How well providers (or doctors) communicate with patients 3) Helpful, courteous, and respectful office staff 4) Patients' rating of the provider (or doctor)	~~Using the C&G CAHPS Survey, three composite measures and one rating measure:~~ ~~1) Getting timely appointments, care, and information~~ ~~2) How well providers (or doctors) communicate with patients~~ ~~3) Helpful, courteous, and respectful office staff~~ ~~4) Patients' rating of the provider (or doctor)~~ 250 (or more) completed survey responses	NA – Pay for reporting only	~~0.25 for each composite/ rating result~~1 if completed survey volume is 250 or higher	PPS	P4R	P4R

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Table 6. Domain 3 Measures

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Domain 3 - Clinical Improvement Projects										
Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) ±	3M	NA	3.a.i – 3.a.iv	Number of preventable emergency room visits as defined by revenue and CPT codes	Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year	35.29 per 100 Medicaid enrollees with Behavioral Health Qualifying Service *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Antidepressant Medication Management – Effective Acute Phase Treatment	HEDIS ~~2015~~® 2016	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication during the entire 12-week acute treatment phase	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication	60.0% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Antidepressant Medication Management – Effective Continuation Phase Treatment	HEDIS ~~2015~~® 2016	0105	3.a.i – 3.a.iv	Number of people who remained on antidepressant medication for at least six months	Number of people 18 and older who were diagnosed with depression and treated with an	43.5% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
					antidepressant medication					
Diabetes Monitoring for People with Diabetes and Schizophrenia	HEDIS ~~2015®~~ 2016	1934	3.a.i – 3.a.iv	Number of people who had both an LDL-C test and an HbA1c test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and diabetes	89.8% *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Diabetes Screening for People with Schizophrenia or Bipolar Disease who are Using Antipsychotic Medication	HEDIS ~~2015®~~ 2016	1932	3.a.i – 3.a.iv	Number of people who had a diabetes screening test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication	89.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	HEDIS ~~2015®~~ 2016	1933	3.a.i – 3.a.iv	Number of people who had an LDL-C test during the measurement year	Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease	92.2% (health plan data) *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase	HEDIS ~~2015®~~ 2016	0108	3.a.i – 3.a.iv	Number of children who had one follow-up visit with a practitioner within the 30 days after starting the medication	Number of children, ages 6 to 12 years, who were newly prescribed ADHD medication	72.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Follow-up care for Children Prescribed ADHD	HEDIS ~~2015®~~ 2016	0108	3.a.i – 3.a.iv	Number of children who, in addition to the	Number of children, ages 6 to 12 years,	78.7% (health plan data)	0.5 if annual improvement	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Medications – Continuation Phase				visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended	who were newly prescribed ADHD medication and remained on the medication for 7 months		target or performance goal met or exceeded			
Follow-up after hospitalization for Mental Illness – within 7 days	HEDIS ~~2015~~® 2016	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge	Number of discharges between the start of the measurement ~~period~~year to 30 days before the end of the measurement ~~period~~year for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders	74.2% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Follow-up after hospitalization for Mental Illness – within 30 days	HEDIS ~~2015~~® 2016	0576	3.a.i – 3.a.iv	Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 30 days of discharge	Number of discharges between the start of the measurement ~~period~~year to 30 days before the end of the measurement ~~period~~year for patients ages 6 years and older, who were hospitalized for	88.2% *High Perf Elig	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
					treatment of selected mental health disorders					
Screening for Clinical Depression and follow-up	NYS ~~DOH~~ specific	NA	3.a.i – 3.a.iv	Number of people screened for clinical depression using a standardized depression screening tool, and if positive, with follow up within 30 days	Number of people with a qualifying outpatient visit who are age 18 and older	~~100%~~^56.2%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Adherence to Antipsychotic Medications for People with Schizophrenia	HEDIS ~~2015®~~ 2016	1879	3.a.i – 3.a.iv	Number of people who remained on an antipsychotic medication for at least 80% of their treatment period	Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications ~~-~~during the measurement year	76.5%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Initiation of Alcohol and Other Drug Dependence Treatment (1 visit within 14 days)	HEDIS ~~2015®~~ 2016	0004	3.a.i – 3.a.iv	Number of people who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	57.1%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Engagement of Alcohol and Other Drug Dependence Treatment (Initiation and 2 visits within 44 days)	HEDIS ~~2015®~~ 2016	0004	3.a.i – 3.a.iv	Number of people who initiated treatment AND who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Number of people age 13 and older with a new episode of alcohol or other drug (AOD) dependence	28.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
~~Potentially Preventable Readmissions for SNF patients ±~~Antipsychotic Use for Persons with Dementia ±	~~3M, using SPARCS and~~ Pharmacy Quality Alliance MDS ~~data~~3.0	NA	3.a.v	Number of ~~at risk admissions followed by a clinically related readmission within 30 days of discharge for~~ long stay ~~nursing home~~ residents ~~(greater than 100 days)~~with dementia who are persistently receiving an antipsychotic medication without evidence of a psychotic disorder or related condition	~~Number of at risk admissions (excludes malignancies, trauma, burns, obstetrical, newborn, left against advice and transfers)~~Number of days for long stay residents (101+ days) with two consecutive assessments and who have an active diagnosis of Alzheimer or dementia OR cognitive impairment. Persons with evidence of psychotic disorder or related condition are excluded	~~5.7~~6.9% *High Perf Elig	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Percent of Long Stay Residents who have Depressive Symptoms ±	MDS 3.0 Measure #0690	NA	3.a.v	Residents with an assessment with either 1) the resident	Long stay residents (101+ days) with an assessment	0.~~15~~16%	1 if annual improvement target or	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				expressing little interest or pleasure, or feeling down or depressed or hopeless in half or more of the days over the last 2 weeks and a resident interview total severity score indicates the presence of depression; OR 2) staff assess resident demonstrates little interest or pleasure, or feeling down or depressed or hopeless in half or more of the days over the last 2 weeks and a staff assessment interview total severity score indicates the presence of depression			performance goal met or exceeded			
Prevention Quality Indicator # 7 (Hypertension) ±	AHRQ ~~4.4~~5.0.3	0276	3.b.i – 3.b.ii	Number of admissions with a principal diagnosis of hypertension	Number of people 18 years and older as of June 30 of measurement year	12.32 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Prevention Quality Indicator # ~~13 (Angina without~~	AHRQ ~~4.4~~5.0.3	~~0282~~ 0277	3.b.i – 3.b.ii	Number of admissions with a principal	Number of people 18 years and older as of	~~2.75~~TBD per 100,000	1 if annual improvement	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
~~procedure~~8 (Heart Failure) ±				diagnosis of ~~angina without a cardiac procedure~~heart failure	June 30 of measurement year	Medicaid Enrollees	target or performance goal met or exceeded			
~~Cholesterol Management~~Statin Therapy for Patients with ~~CV Conditions retired. NYS DOH may introduce a cholesterol management measure in future~~Cardiovascular Disease –Received Statin Therapy	~~TBD~~HEDIS® 2016	~~TBD~~	3.b.i – 3.b.ii	Number of people who were dispensed at least one high or moderate-intensity statin medication	Number of males age 21 to 75 or females age 40 to 75 who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease in both the measurement year and year prior	100%^	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Statin Therapy for Patients with Cardiovascular Disease –Statin Adherence 80%	HEDIS® 2016		3.b.i – 3.b.ii	Number of people who achieved a proportion of days covered of 80% for the treatment period	Number of males age 21 to 75 or females age 40 to 75 who have had an MI, CABG or PCI in the year prior or a diagnosis of ischemic vascular disease in both the measurement year and year prior	100%^	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Controlling High Blood Pressure	HEDIS ~~2015~~® 2016	0018	3.b.i – 3.b.ii, 3.h.i	Number of people whose blood pressure was adequately controlled as follows:	Number of people, ages 18 to 85 years, who have hypertension	73.3% (2012 Data) *High Perf Elig	1 if annual improvement target or performance	PPS and NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
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Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				• below 140/90 if ages 18-59; • below 140/90 for ages 60 to 85 with diabetes diagnosis; or • below 150/90 ages 60 to 85 without a diagnosis of diabetes			goal met or exceeded			
Aspirin Use	~~HEDIS 2015~~HEDIS® 2016 (Volume 3 using CAHPS data)	NA	3.b.i – 3.b.ii	Number of respondents who are currently taking aspirin daily or every other day	Number of respondents who are men, ages 46 to 65 years, with at least one cardiovascular risk factor; men, ages 66 to 79 years, regardless of risk factors; and women, ages 56 to 79 years, with at least two cardiovascular risk factors	~~100%^~~62.9%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Discussion of Risks and Benefits of Aspirin Use	~~HEDIS 2015~~HEDIS® 2016 (Volume 3 using CAHPS data)	NA	3.b.i – 3.b.ii	Number of respondents who discussed the risks and benefits of using aspirin with a doctor or health provider	Number of respondents who are men, ages 46 to 79 years, and women, ages 56 to 79 years	~~100%^~~67.3%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit	~~HEDIS 2015~~HEDIS® 2016 (Volume 3 using CAHPS data)	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses 'Sometimes', 'Usually' or 'Always' were advised to quit	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	~~100%^~~95.6%	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Medication	~~HEDIS 2015~~HEDIS® 2016 (Volume 3 using CAHPS data)	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses 'Sometimes', 'Usually' or 'Always' discussed cessation medications	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	~~100%^~~83.9%	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Medical Assistance with Smoking and Tobacco Use Cessation – Discussed Cessation Strategies	~~HEDIS 2015~~ HEDIS® 2016 (Volume 3 using CAHPS data)	0027	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.e.i, 3.h.i	Number of responses 'Sometimes', 'Usually' or 'Always' discussed cessation methods or strategies	Number of respondents, ages 18 years and older, who smoke or use tobacco some days or every day	~~100%^~~ 75.3% *High Perf Elig	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Flu Shots for Adults Ages 18 – 64	~~HEDIS 2015~~ HEDIS® 2016 (Volume 3	0039	3.b.i – 3.b.ii, 3.c.i – 3.c.ii, 3.h.i	Number of respondents who have had a flu shot	Number of respondents, ages 18 to 64 years	~~100%^~~63.4%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
	using CAHPS data)									
Health Literacy ~~(QHL13)~~ – Instructions Easy to Understand	2357a_ C&G CAHPS Adult Supplement (QHL13)	NA	3.b.i – 3.b.ii, 3.c.i – 3.c.ii	Number of responses 'Usually' or 'Always' that instructions for caring for condition were easy to understand	Number of respondents who answered they saw provider for an illness or condition and were given instructions	~~100%^~~98.8%	~~0.33~~1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Health Literacy – Describing How to Follow Instructions ~~(QHL14)~~	2357a_ C&G CAHPS Adult Supplement (QHL14)	NA	3.b.i – 3.b.ii, 3.c.i – 3.c.ii	Number of responses 'Usually' or 'Always' that provider asked patient to describe how the instruction would be followed	Number of respondents who answered they saw provider for an illness or condition and were given instructions	~~100%^~~89.7%	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Health Literacy – Explained What to do if Illness Got Worse ~~(QHL16)~~	2357a_ C&G CAHPS Adult Supplement (QHL16)	NA	3.b.i – 3.b.ii, 3.c.i – 3.c.ii	Number of responses 'Usually' or 'Always' that provider explained what to do if illness/condition got worse or came back	Number of respondents who answered they saw provider for an illness or condition	~~100%^~~94.1%	0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Prevention Quality Indicator # 1 (DM Short term complication) ±	AHRQ ~~4.4~~5.0.3	0272	3.c.i – 3.c.ii	Number of admissions with a principal diagnosis of diabetes with short-term complications (ketoacidosis,	Number of people 18 years and older as of June 30 of measurement year	8.23 per 100,000 Medicaid Enrollees	~~1if~~0.33 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				hyperosmolarity, or coma)						
Comprehensive Diabetes screening – All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	HEDIS ~~2015®~~ 2016	0055, 0062, 0057	3.c.i – 3.c.ii, 3.h.i	Number of people who received at least one of each of the following tests: HbA1c test, ~~,~~ diabetes eye exam, and medical attention for nephropathy	Number of people ages 18 to 75 with diabetes	64.6%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ~~-~~±	HEDIS ~~2015®~~ 2016	0059	3.c.i – 3.c.ii, 3.h.i	Number of people whose most recent HbA1c level indicated poor control (>9.0 percent), was missing or did not have a HbA1c test	Number of people ages 18 to 75 with diabetes	23.2%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Prevention Quality Indicator # 15 Younger Adult Asthma ±	AHRQ ~~4.4~~5.0.3	0283	3.d.i – 3.d.iii	Number of admissions with a principal diagnosis of asthma	Number of people ages 18 to 39 as of June 30 of the measurement year	13.56 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Pediatric Quality Indicator # 14 Pediatric Asthma ±	AHRQ ~~4.4~~5.0.3	0728	3.d.i – 3.d.iii	Number of admissions with a principal diagnosis of asthma	Number of people ages 2 to 17 as of June 30 of the measurement year	42.55 per 100,000 Medicaid Enrollees	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Asthma Medication Ratio (5 – 64 Years)	HEDIS ~~2015®~~ 2016	1800	3.d.i – 3.d.iii	Number of people with a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	Number of people, ages 5 to 64 years, who were identified as having persistent asthma	76.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Medication Management for People with Asthma (5 – 64 Years) – 50% of Treatment Days Covered	HEDIS ~~2015®~~ 2016	1799	3.d.i – 3.d.iii	Number of people who filled prescriptions for asthma controller medications during at least 50% of their treatment period	Number of people, ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication	68.6%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Medication Management for People with Asthma (5 – 64 Years) – 75% of Treatment Days Covered	HEDIS ~~2015®~~ 2016	1799	3.d.i – 3.d.iii	Number of people who filled prescriptions for asthma controller medications during at least 75% of their treatment period	Number of people, ages 5 to 64 years, who were identified as having persistent asthma, and who received at least one controller medication	44.9%	0.5 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
HIV/AIDS Comprehensive Care : Engaged in Care	~~QARR 2015~~NYS-specific	NA	3.e.i	Number of people who had two visits for primary care or HIV related care with at least one visit during each half of the past year	Number of people living with HIV/AIDS, ages 2 years and older	91.8%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
HIV/AIDS Comprehensive Care : Viral Load Monitoring	~~QARR 2015~~NYS-specific	NA	3.e.i	Number of people who had two viral load tests performed with at least	Number of people living with HIV/AIDS, ages 2 years and older	82.7%	1 if annual improvement target or	NYS DOH	P4P	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				one test during each half of the past year			performance goal met or exceeded			
HIV/AIDS Comprehensive Care : Syphilis Screening	~~QARR 2015~~NYS-specific	NA	3.e.i	Number of people who were screened for syphilis in the past year	Number of people living with HIV/AIDS, ages 19 years and older	85.4%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Cervical Cancer Screening	HEDIS ~~2015~~® 2016	0032	3.e.i	Number of women who had cervical cytology performed every 3 years or women, ages 30 to 64 years, who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	Number of women, ages 24 to 64 years	83.9%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Chlamydia Screening (16 – 24 Years)	HEDIS ~~2015~~® 2016	0033	3.e.i	Number of women who had at least one test for Chlamydia during the measurement year	Number of sexually active women, ages 16 to 24	80.0%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Viral Load Suppression	NYS ~~DOH~~-specific	NA	3.e.i	Number of people whose most recent viral load result was below 200 copies	Number of people living with HIV/AIDS	~~100%~~^69.0%	1 if annual improvement target or performance	PPS and NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
							goal met or exceeded			
Prevention Quality Indicator # 9 Low Birth Weight ±	AHRQ ~~4.4~~5.0.3	0278	3.f.i	Number of low birth weight (< 2,500 grams) newborn admissions	Number of members born during the measurement year	28.80 per 1,000 newborns	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4P	P4P
Prenatal and Postpartum Care—Timeliness of Prenatal Care	HEDIS ~~2015~~® 2016	1517	3.f.i	Number of women who had a prenatal care visit in their first trimester or within 42 days of enrollment in Medicaid	Number of women who gave birth in the last year	93.9%	0.5 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Prenatal and Postpartum Care—Postpartum Visits	HEDIS ~~2015~~® 2016	1517	3.f.i	Number of women who had a postpartum care visit between 21 and 56 days after they gave birth	Number of women who gave birth in the last year	81.6%	0.5 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Frequency of Ongoing Prenatal Care (81% or more)	HEDIS ~~2015~~® 2016	1391	3.f.i	Number of women who received 81 percent or more of the expected number of prenatal care visits, adjusted for gestational age and month the member enrolled in Medicaid	Number of women who gave birth in the last year	81.4%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
Well Care Visits in the first 15 months (5 or more Visits)	HEDIS ~~2015®~~ 2016	1392	3.f.i	Number of children who had five or more well-child visits with a primary care provider in their first 15 months of life	Number of children turning 15 months in the measurement ~~period~~year	93.3%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P
Childhood Immunization Status (Combination 3 – 4313314)	HEDIS ~~2015®~~ 2016	0038	3.f.i	Number of children who were fully immunized (4 ~~Diphtheria~~Diptheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, 1 Varicella, and 4 pneumococca1)	Number of children turning age 2 in the measurement ~~period~~year	88.4%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Lead Screening for Children	HEDIS ~~2015®~~ 2016	NA	3.f.i	Number of children who had their blood tested for lead poisoning at least once by their 2nd birthday	Number of children turning age 2 in the measurement ~~period~~year	95.3%	1 if annual improvement target or performance goal met or exceeded	PPS and NYS DOH	P4R	P4P
Early Elective Deliveries (All inductions and cesarean sections that occur prior to onset of labor, occurring at or after 36 0/7 weeks and before 38 6/7 weeks gestation without documentation of listed maternal or fetal reason) ±	NYS Perinatal Quality Collaborative	NA	3.f.i	Number of scheduled deliveries (i.e. All inductions and cesarean sections that occur prior to onset of labor) occurring at or after 36 0/7 weeks and before 38 6/7 weeks gestation without documentation	Number of scheduled deliveries (i.e. All inductions and cesarean sections that occur prior to onset of labor) occurring at or after 36 0/7 weeks and before 38 6/7	NA – Pay for Reporting measure only	1	PPS	P4R	P4R

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				of listed maternal or fetal reason						
~~Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain~~Palliative Care Proposal Pending CMS approval MY2 Palliative Care Proxy Measure	~~UAS-NY~~NA	NA	3.g.i – 3.g.ii	~~Number of people whose current assessment indicates the same or better response to pain than prior assessment~~Successful reporting of Domain 1 reporting requirements based on guidance issued in March 2016	~~Number of people with a valid response for the question in both assessment periods~~NA	~~100%^~~NA	1 if ~~annual improvement target or performance goal~~reporting requirements met~~ or exceeded~~	~~NYS DOH~~PPS	P4R	P4P
~~Risk-Adjusted percentage of members who had severe or more intense daily pain ±~~	~~UAS-NY~~	~~NA~~	~~3.g.i – 3.g.ii~~	~~Number of people with an assessment response indicating pain in the last three days and a pain intensity response of severe or worse~~	~~Number of people with valid responses for the questions~~	~~0.0% (unadjusted)~~	~~1 if annual improvement target or performance goal met or exceeded~~	~~NYS DOH~~	~~P4R~~	~~P4P~~
~~Risk-adjusted percentage of members whose pain was not controlled ±~~	~~UAS-NY~~	~~NA~~	~~3.g.i – 3.g.ii~~	~~Number of people with an assessment response indicating pain and a pain control response indicating not controlled~~	~~Number of people with valid responses for the questions~~	~~0.0% (unadjusted)~~	~~1 if annual improvement target or performance goal met or exceeded~~	~~NYS DOH~~	~~P4R~~	~~P4P~~
~~Advanced Directives – Talked about Appointing for Health Decisions~~	~~UAS-NY~~	~~NA~~	~~3.g.i – 3.g.ii~~	~~Number of people with a response of yes or no to one or more of the following three: legal guardian, health care~~	~~Number of people with an assessment~~	~~100%~~	~~1 if annual improvement target or performance~~	~~NYS DOH~~	~~P4R~~	~~P4P~~

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Measure Name	Steward and Specification Version	NQF #	Projects Associated with Measure	Numerator Description	Denominator Description	Performance Goal *High Performance eligible #Statewide measure	Achievement Value	Reporting Responsibility	Payment: DY 2 and 3	Payment: DY 4 and 5
				~~proxy or family member responsible~~			~~goal met or exceeded~~			
~~Depressive feelings - percentage of members who experienced some depression feeling ±~~	~~UAS-NY~~	~~NA~~	~~3.g.i – 3.g.ii~~	~~Number of people who respond that they experienced some feelings related to depression~~	~~Number of people with an assessment~~	~~0.0%~~	~~1 if annual improvement target or performance goal met or exceeded~~	~~NYS DOH~~	~~P4R~~	~~P4P~~
Annual Monitoring for Patients on Persistent Medications – ACE/ARB	HEDIS ~~2015®~~ 2016	NA	3.h.i	Number of people who had at least one blood test for potassium and a monitoring test for kidney function in the measurement year	Number of people, ages 18 and older, who received at least a 180-day supply of ACE inhibitors and/or ARBs	95.4%	1 if annual improvement target or performance goal met or exceeded	NYS DOH	P4R	P4P

± A lower rate is desirable.
* High Performance Eligible measure
# Statewide measure
^ Performance Goal is a system default and will be changed following Measurement Year 2 results.

Table 7. Domain 4 Measures

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
Percentage of premature death (before age 65 years)	NYS DOH Vital Statistics	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Number of people who died before age 65 in the measurement period	Number of deaths in the measurement period	Pay for Reporting measure only	NYS DOH	P4R
Percentage of premature death (before age 65 years) – Ratio of Black non-Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Percentage of Black non-Hispanics who died before age 65	Percentage of White non-Hispanics who died before age 65	Pay for Reporting measure only	NYS DOH	P4R
Percentage of premature death (before age 65 years) – Ratio of Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Percentage of Hispanics who died before age 65	Percentage of White non-Hispanics who died before age 65	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Number of preventable hospitalizations for people age 18 or older	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Black non-Hispanics to White non-Hispanics	SPARCS	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Rate of preventable hospitalizations for Black non-Hispanics age 18 or older	Rate of preventable hospitalizations for White non-Hispanics age 18 or older	Pay for Reporting measure only	NYS DOH	P4R

~~± A lower rate is desirable.~~
~~* High Performance Eligible measure~~
~~# Statewide measure~~
~~^ Performance Goal is a system default and will be changed following Measurement Year 1 results.~~

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years – Ratio of Hispanics to White non-Hispanics	SPARCS	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Rate of preventable hospitalizations for Hispanics age 18 or older	Rate of preventable hospitalizations for White non-Hispanics age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Percentage of adults with health insurance - Aged 18-64 years	US Census	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Number of respondents age 18-64 who reported that they had health insurance coverage	Number of people age 18-64	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	~~BRFSS~~eBRFSS	4.a.i – 4.a.iii, 4.b.i – 4.b.ii, 4.c.i – 4.c.iv, 4.d.i	Number of respondents age 18 or older who reported that they had a regular health care provider	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	~~BRFSS~~eBRFSS	4.a.i – 4.a.iii	Number of respondents age 18 or older who reported experiencing poor mental health for 14 or more days in the last month	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted percentage of adult binge drinking during the past month	~~BRFSS~~eBRFSS	4.a.i – 4.a.iii	Number of respondents age 18 or older who reported binge drinking on one or more occasions in the past 30 days. Binge drinking is defined as men having 5 or more drinks or women having 4 or more drinks on one occasion.	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted suicide death rate per 100,000	NYS DOH Vital Statistics	4.a.i – 4.a.iii	Number of deaths of people age 18 or older with an ICD-10 primary cause of death code: X60-X84 or Y87.0	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Percentage of adults who are obese	~~BRFSS~~eBRFSS	4.b.i – 4.b.ii	Number of respondents 18 or older who are obese. Obesity is defined as having a body mass index (BMI) of 30.0 or greater.	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Percentage of children and adolescents who are obese	~~BRFSS~~NYS excluding NYC: -	4.b.i – 4.b.ii	Number of public school children who are obese. Obesity is defined as weight category greater than or equal to 95th	Number of public school children	Pay for Reporting measure only	NYS DOH	P4R

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
	Student Weight Status Category Reporting; NYC – Fitnessgram		percentile. Counties outside NYC: Grades K-12th; NYC counties: Grades K-8th.				
Percentage of cigarette smoking among adults	BRFSSeBRFSS	4.b.i – 4.b.ii	Number of people age 18 or older who report currently smoking cigarettes	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years	BRFSSeBRFSS	4.b.i – 4.b.ii	Number of respondents age 50-75 years who received a colorectal cancer screening exam (used a blood stool test at home in the past year; and/or, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years; and/or, had a colonoscopy in the past 10 years)	Number of people age 50-75	Pay for Reporting measure only	NYS DOH	P4R
Asthma emergency department visit rate per 10,000	SPARCS	4.b.i – 4.b.ii	Number of emergency department visits with primary diagnosis ICD-9CM code 493	Number of people	Pay for Reporting measure only	NYS DOH	P4R
Asthma emergency department visit rate per 10,000 - Aged 0-4 years	SPARCS	4.b.i – 4.b.ii	Number of emergency department visits with primary diagnosis ICD-9CM code 493 aged 0-4 years	Number of children aged 0-4 years	Pay for Reporting measure only	NYS DOH	P4R
Age-adjusted heart attack hospitalization rate per 10,000	SPARCS	4.b.i – 4.b.ii	Number of inpatient hospitalizations with a principal diagnosis ICD-9CM code 410	Number of people	Pay for Reporting measure only	NYS DOH	P4R
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	SPARCS	4.b.i – 4.b.ii	Number of inpatient hospitalizations for children age 6-17 years with a principal diagnosis ICD-9CM code: 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033	Number of children age 6-17 years	Pay for Reporting measure only	NYS DOH	P4R

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
Rate of hospitalizations for short-term complications of diabetes per 10,000 – Aged 18+ years	SPARCS	4.b.i – 4.b.ii	Number of inpatient hospitalizations for adults age 18 years or older with a principal diagnosis ICD-9CM code: 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033	Number of people age 18 or older	Pay for Reporting measure only	NYS DOH	P4R
Newly diagnosed HIV case rate per 100,000	NYS HIV Surveillance System	4.c.i, – 4.c.ii, 4.c.iv	Number of people newly diagnosed with HIV, regardless of concurrent or subsequent AIDS diagnosis	Number of people	Pay for Reporting measure only	NYS DOH	P4R
Newly diagnosed HIV case rate per 100,000—Difference in rates (Black and White) of new HIV diagnoses	NYS HIV Surveillance System	4.c.i, – 4.c.ii, 4.c.iv	Rate of Black non-Hispanics newly diagnosed with HIV, regardless of concurrent or subsequent AIDS diagnosis	Rate of White non-Hispanics newly diagnosed with HIV, regardless of concurrent or subsequent AIDS diagnosis	Pay for Reporting measure only	NYS DOH	P4R
Newly diagnosed HIV case rate per 100,000—Difference in rates (Hispanic and White) of new HIV diagnoses	NYS HIV Surveillance System	4.c.i, – 4.c.ii, 4.c.iv	Rate of Hispanics newly diagnosed with HIV, regardless of concurrent or subsequent AIDS diagnosis	Rate of White non-Hispanics newly diagnosed with HIV, regardless of concurrent or subsequent AIDS diagnosis	Pay for Reporting measure only	NYS DOH	P4R
Gonorrhea case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	4.c.iii, – 4.c.iv	Number of women age 15-44 diagnosed with gonorrhea	Number of women age 15-44	Pay for Reporting measure only	NYS DOH	P4R
Gonorrhea case rate per 100,000 men - Aged 15-44 years	NYS STD Surveillance System	4.c.iii, – 4.c.iv	Number of men age 15-44 diagnosed with gonorrhea	Number of men age 15-44	Pay for Reporting measure only	NYS DOH	P4R
Chlamydia case rate per 100,000 women - Aged 15-44 years	NYS STD Surveillance System	4.c.iii, – 4.c.iv	Number of women age 15-44 diagnosed with Chlamydia	Number of women age 15-44	Pay for Reporting measure only	NYS DOH	P4R
Primary and secondary syphilis case rate per 100,000 males	NYS STD Surveillance System	4.c.iii, – 4.c.iv	Number of men diagnosed with primary or secondary syphilis	Number of men	Pay for Reporting measure only	NYS DOH	P4R
Primary and secondary syphilis case rate per 100,000 females	NYS STD Surveillance System	4.c.iii, – 4.c.iv	Number of women diagnosed with primary or secondary syphilis	Number of women	Pay for Reporting measure only	NYS DOH	P4R

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
Percentage of preterm births	NYS DOH Vital Statistics	4.d.i	Number of infants born at less than 37 weeks gestation among infants with known gestational age	Number of births within the measurement period	Pay for Reporting measure only	NYS DOH	P4R
Percentage of preterm births – Ratio of Black non-Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Percentage of preterm births for Black non-Hispanics	Percentage of preterm births for White-non Hispanics	Pay for Reporting measure only	NYS DOH	P4R
Percentage of preterm births – Ratio of Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Percentage of preterm births for Hispanics	Percentage of preterm births for White-non Hispanics	Pay for Reporting measure only	NYS DOH	P4R
Percentage of preterm births – Ratio of Medicaid births to non-Medicaid births	NYS DOH Vital Statistics	4.d.i	Percentage of preterm births whose primary payer is Medicaid	Percentage of preterm births whose primary payer is non-Medicaid	Pay for Reporting measure only	NYS DOH	P4R
Percentage of infants exclusively breastfed in the hospital	NYS DOH Vital Statistics	4.d.i	Number of infants exclusively fed breast milk in the hospital	Number of births within the measurement period	Pay for Reporting measure only	NYS DOH	P4R
Percentage of infants exclusively breastfed in the hospital – Ratio of Black non-Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Percentage of Black non-Hispanic infants exclusively fed breast milk in the hospital	Percentage of White non-Hispanic infants exclusively fed breast milk in the hospital	Pay for Reporting measure only	NYS DOH	P4R
Percentage of infants exclusively breastfed in the hospital – Ratio of Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Percentage of Hispanic infants exclusively fed breast milk in the hospital	Percentage of White non-Hispanic infants exclusively fed breast milk in the hospital	Pay for Reporting measure only	NYS DOH	P4R
Percentage of infants exclusively breastfed in the hospital – Ratio of Medicaid births to non-Medicaid births	NYS DOH Vital Statistics	4.d.i	Percentage of infants exclusively fed breast milk in the hospital for births whose primary payer is Medicaid	Percentage of infants exclusively fed breast milk in the hospital for births whose primary payer is non-Medicaid	Pay for Reporting measure only	NYS DOH	P4R
Maternal mortality rate per 100,000 births	NYS DOH Vital Statistics	4.d.i	Number of deaths to women from any causes related to or aggravated by pregnancy or its management that occurred while pregnant or within 42	Number of births within the measurement period	Pay for Reporting measure only	NYS DOH	P4R

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
			days of termination of pregnancy (ICD-10 codes O00-95, O98-O99, and A34 (obstetrical tetanus))				
Percentage of children with any kind of health insurance - Aged under 19 years	US Census ~~Bureau, Small Area Health Insurance Estimates~~	4.d.i	Number of children aged under 19 years with any kind of health insurance coverage in the past 12 months	Number of children aged under 19 years	Pay for Reporting measure only	NYS DOH	P4R
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	NYS DOH Vital Statistics	4.d.i	Number of pregnancies (the sum of the number of live births, induced terminations of pregnancies, and all fetal deaths) in adolescent females aged 15-17 years	Number of females aged 15-17 years	Pay for Reporting measure only	NYS DOH	P4R
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years – Ratio of Black non-Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Rate of pregnancies in Black non-Hispanic adolescent females aged 15-17 years	Rate of pregnancies in White non-Hispanic adolescent females aged 15-17 years	Pay for Reporting measure only	NYS DOH	P4R
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years—Ratio of Hispanics to White non-Hispanics	NYS DOH Vital Statistics	4.d.i	Rate of pregnancies in Hispanic adolescent females aged 15-17 years	Rate of pregnancies in White non-Hispanic adolescent females aged 15-17 years	Pay for Reporting measure only	NYS DOH	P4R
Percentage of unintended pregnancy among live births	~~Pregnancy Risk Assessment Monitoring System~~NYS DOH Vital Statistics	4.d.i	Number of unintended pregnancies (current pregnancy indicated as 'Wanted Later' or 'Wanted Never') among live births	Number of live births	Pay for Reporting measure only	NYS DOH	P4R
Percentage of unintended pregnancy among live births –	~~Pregnancy Risk Assessment~~	4.d.i	Percentage of unintended pregnancies among Black non-Hispanic females	Percentage of unintended pregnancies among White non-Hispanic females	Pay for Reporting measure only	NYS DOH	P4R

Measure Name	Data Source	Projects Associated with Measure	Numerator Description	Denominator Description	Achievement Value	Reporting Responsibility	Payment: DY 2 through 5
Ratio of Black non-Hispanics to White non-Hispanics	~~Monitoring System~~NYS DOH Vital Statistics						
Percentage of unintended pregnancy among live births—Ratio of Hispanics to White non-Hispanics	~~Pregnancy Risk Assessment Monitoring System~~NYS DOH Vital Statistics	4.d.i	Percentage of unintended pregnancies among Hispanic females	Percentage of unintended pregnancies among White non-Hispanic females	Pay for Reporting measure only	NYS DOH	P4R
Percentage of unintended pregnancy among live births—Ratio of Medicaid births to non-Medicaid births	~~Pregnancy Risk Assessment Monitoring System~~NYS DOH Vital Statistics	4.d.i	Percentage of unintended pregnancies for births whose primary payer is Medicaid	Percentage of unintended pregnancies for births whose primary payer is non-Medicaid	Pay for Reporting measure only	NYS DOH	P4R
Percentage of women with health coverage - Aged 18-64 years	US Census ~~Bureau, Small Area Health Insurance Estimates~~	4.d.i	Number of female respondents aged 18-64 who reported that they had health insurance coverage	Number of females aged 18-64	Pay for Reporting measure only	NYS DOH	P4R
Percentage of live births that occur within 24 months of a previous pregnancy	NYS DOH Vital Statistics	4.d.i	Number of live births that occur within 24 months of a previous pregnancy	Number of live births	Pay for Reporting measure only	NYS DOH	P4R

~~VIII.~~IX. Random Sample, Medical Record Review Guidelines, and Early Elective Delivery Data Collection

Medical record chart/ Electronic Health Record Collection Steps

These guidelines apply to the following measures:

- Screening for Clinical Depression and Follow Up
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Viral Load Suppression
- Prenatal/Postpartum care
- Frequency of Ongoing Prenatal Care (same sample as Prenatal/Postpartum Care)
- Childhood Immunization
- Lead Screening for Children (same sample as Childhood Immunization)

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 based on the technical specifications for each measure (e.g continuous enrollment, age or diagnosis).

Step 2: ~~NYSDOH~~NYS DOH will draw a systematic random sample (n = ~~411~~453) using a random index number after sorting the eligible population for each PPS. The random sample will include an oversample of 10% (~~411 + 41.1 = 452.1 – rounds to 453).~~453 + 46 = 499). Members will be identified as being included in the sample or being in the oversample. Members in the sample cannot be removed from the sample unless they meet an exclusion criteria for the measure. Members who are excluded from the measure, as defined by the specifications, will be excluded from the sample and the first member in the oversample will be brought into the sample, and so forth for each exclusion. Oversample members not included in the sample remain in the oversample. Every member in the sample and oversample will be accounted for in the member detail files returned to NYS DOH. (See Appendix B)

Step 3: The random sample, including the oversample, will be sent to the Medical record review (MRR) vendors using a secure file transfer mechanism. ~~Two~~In addition to the sample, multiple files will be sent to the MRR vendor for each measure. ~~One file contains~~These files contain member information such as Medicaid eligibility ~~information (~~segments, PPS Identifier, Medicaid Client Identification Number, first and last name, and numerator information from administrative data~~) and one file containing~~. Additional files linking the member to services provided include information about the provider and visit/service information ~~(~~such as dates of visits/services, National Provider Identifier(s) (NPI) of the provider(s) associated with visits or services, and other measure specific requirements~~, such as~~ (i.e. HbA1C tests, or date of delivery).

Step 4: The MRR vendors will use abstraction tools and will develop training materials for review staff. The tool and materials must be approved by the licensed audit organization contracted by the Independent Assessor.

~~Step 5: The~~Step 5: Using the files as well as additional data sources, such as Qualified Entities (RHIOs) and health plans, the PPS and vendor will develop the record chases, using developed logic, to identify the practices and locations where records exist for the members that can be used in the medical record review.

Step 6: The PPS staff and MRR vendors are responsible for working with the providers to retrieve the required information from the medical records (paper or electronic). ~~PPSs will collaborate with the MRR vendors in the retrieval efforts. The~~ The PPS and vendors will coordinate the record retrieval and materials. Information is abstracted from records using trained medical record review staff. The abstracted information will be entered in the abstraction tool. ~~If medical record information determines that the member did not qualify for the measure per specifications, the member can be excluded and substituted with a different member contained in the oversample. The denominator status for the member excluded and the member pulled from the oversample will be reflected in the member detail file. (See Appendix B)~~If the medical record does not contain information for care provided in the measurement year, other medical records, if available, are pursued for review. Members cannot be excluded from the sample because no records are located. Each measure contains information about required and optional exclusions. Members meeting the measure criteria for exclusion can be removed from the sample and a member from the oversample will be moved into the sample. The PPS will receive additional administrative data from the State regarding claims or encounters for the measurement year that should be included in the chase logic for members who remain numerator non-compliant.

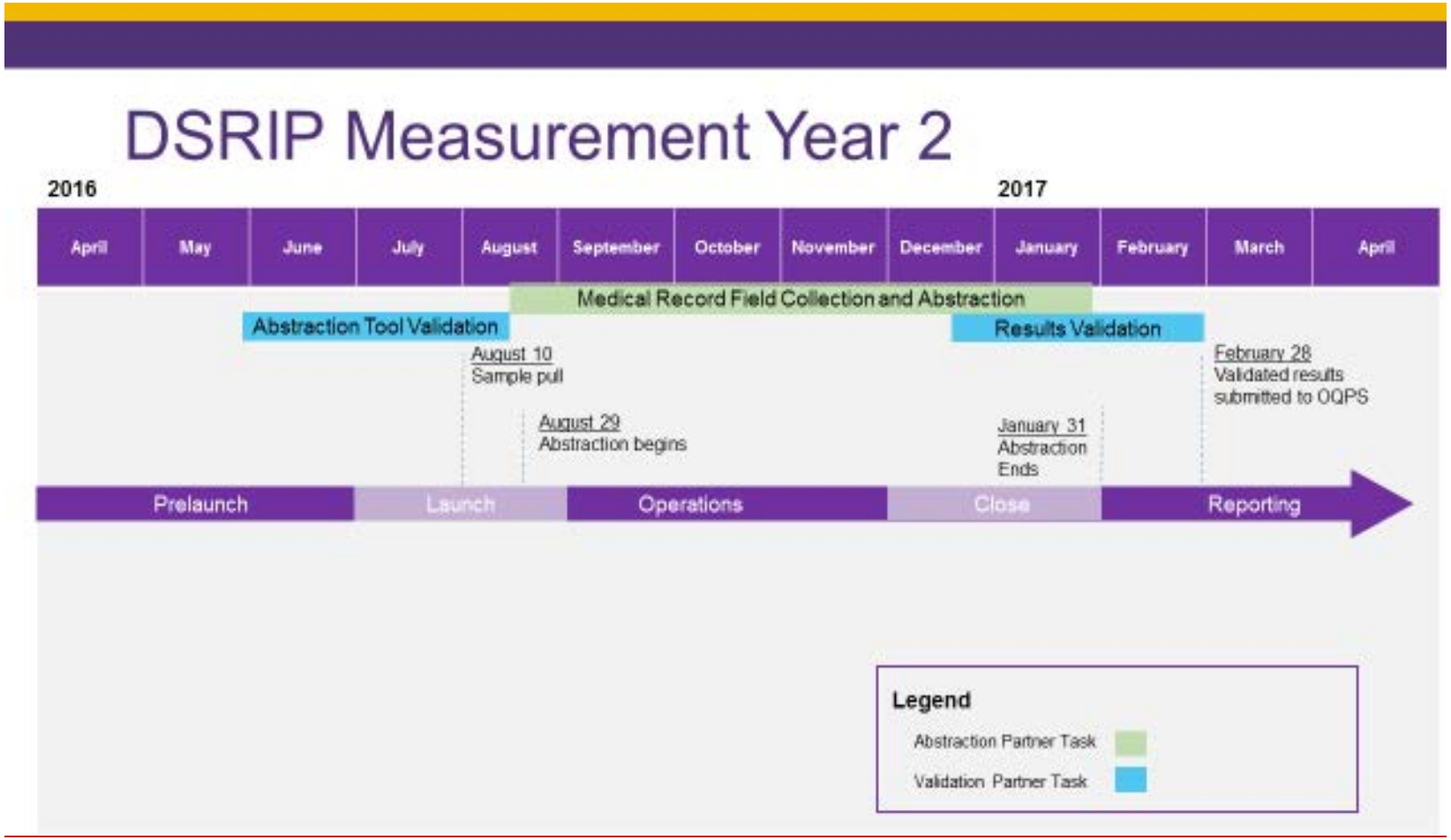
Step ~~6:~~7: In early December, the PPS and vendor will prepare a list of numerator compliant members for each measure by PPS. The licensed audit organization will ~~review~~determine a random sample and request a set of ~~medical~~ records ~~(n = 30) per measure~~ from ~~MRR vendor (or review units for vendors) to~~the PPS and vendor to use in validation. The licensed audit organization will conduct a medical record review validation~~.~~ for the sample of medical records (n = 30) per measure. If the validation process determines numerator-compliance findings to be invalid, the data will be invalidated and not incorporated into the PPS's final result for that measure. Results from the licensed audit organization's findings for each measure will be sent from the licensed audit organization to NYS DOH at the end of January.

Step ~~7~~8: The PPS or MRR vendors will extract the abstracted data, determine numerator and denominator status for each member in the sample file and complete the member detail file.

Step ~~8~~9: The PPS and MRR vendors will submit the completed member detail file to NYS DOH via a secure file transfer mechanism. Member attribution to the PPS will be reconciled. The

information in the file, and the validation findings, will be incorporated with administrative data to calculate the PPS final result for the measure for the measurement ~~period.~~

year.


DSRIP Measurement Year 2
2016
2017
April
May
June
July
August
September
October
November
December
January
February
March
April
Medical Record Field Collection and Abstraction
Abstraction Tool Validation
Results Validation
August 10
Sample pull
August 29
Abstraction begins
January 31
Abstraction
Ends
February 28
Validated results
submitted to OQPS
Prelaunch
Launch
Operations
Close
Reporting
Legend
Abstraction Partner Task
Validation Partner Task

Reporting for Early Elective Delivery (Project 3.f.i)

Birthing hospitals associated with a PPS ~~who have~~that has chosen project 3.f.i. will be required to review medical records for all inductions and cesarean sections that occur prior to onset of labor occurring at or after 36 0/7 weeks and before 38 6/7 weeks gestation during the time period of July 1 of the year prior through June 30 of the current year. Information collected for each qualifying delivery will be submitted to the NYS Perinatal Quality Collaborative by December 1 of the current year.

Step 1: The hospital will review all medical records for inductions and cesarean sections that occur prior to onset of labor occurring at or after 36 0/7 weeks and before 38 6/7 weeks gestation. Information about each qualifying delivery will be recorded on the appropriate form and submitted using the steps below.

Step 2: Trained medical record review staff should abstract information using the Scheduled Delivery Form for all scheduled deliveries with the relevant gestational age that occur within the measurement ~~period~~year (See Appendix C). If a hospital has zero inductions and cesarean sections that occur prior to onset of labor occurring at or after 36 0/7 weeks and before 38 6/7 weeks gestation ~~they~~, the hospital will be required to complete an aggregate data log indicating there were zero scheduled deliveries for that time period.

Step 3: The completed forms will be submitted through the NYS DOH Health Commerce System (HCS) using the application called the *NYS Perinatal Quality Collaborative (NYSPQC) Scheduled Delivery Form System*. Each hospital will need to have a designated person with an HCS account and proper roles assigned to access this secure system. For questions about getting an HCS account, or locating who in your organization may have an already existing account, please e-mail NYSPQC@health.state.ny.us.

Step 4: The information submitted will be used to calculate the PPS's final result for the measure for the measurement ~~period~~year. For each PPS calculation, hospital-specific results will be aggregated and averaged across all birthing hospitals within each PPS network. If a hospital participates with more than one PPS, the hospital does not need to enter information more than once. The same hospital-specific data will be used for each PPS network in which the hospital participates.

~~IX.~~X. 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.

~~X.~~XI. Member Detail File Requirements and Layout

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

~~XI.~~XII. Final Result Calculation

For measures requiring medical record data, NYS DOH will incorporate information from the member detail file with the administrative data for the measurement year to calculate the PPS' final results for the measurement year. Measures calculated by NYS DOH will be produced in ~~January~~February following the measurement year after the January refresh of the December encounter and claims data are loaded in the Medicaid data system. This allows a six month run out of claims and encounters prior to calculating measure results.

~~XII.~~XIII. Data to Performing Provider Systems and Independent Assessor

NYS DOH will aggregate all results and provide information to the Independent Assessor. The Independent Assessor will determine whether annual improvement targets and high performance levels (where applicable) were attained. ~~PPSs~~PPS will receive reports containing final measure results, achievement value attainment, and high performance attainment for the completed measurement year, as well as annual improvement targets and high performance levels for the next measurement year.

Appendix A – Domain 1 Project Milestones and Metrics

Domain 1 Project Milestones & Metrics are based largely on investments in training and recruiting personnel, identifying project leadership, and developing clinical protocols that will strengthen the PPS' ability to successfully meet DSRIP project goals. Additionally, the project requirements include specific provider-level commitments to increase the availability of NCQA-certified PCPs, invest in HIT, and fully establish the project programs (medical villages, Ambulatory ~~ICS~~ICUS, etc.). Each requirement's milestone and associated metrics are detailed. These requirements also comprise of the completion time period in addition to the unit level of reporting, both which are discussed in further detail below.

Completion of project requirements falls into three key timeframes:

1) **System Transformation Changes Due by DY2**
Based upon the work plan section in Attachment I (NY DSRIP Program Funding and Mechanics Protocol), no more than the first two years will be utilized to implement major system changes related to the project. For example, project requirements within this category include developing clinical protocols, training for care coordinators, identifying key project personnel, performing population health management activities, and using EHRs or other technical platforms to track actively engaged patients.

2) **Requirements Requiring Completion by DY3**
A number of project requirements detail prescribed end dates within their description. Two of these project requirements are safety net providers actively sharing medical records with RHIO/SHIN-NY by the end of DY3 and PCPs achieving NCQA 2014 Level 3 PCMH certification by the end of DY3.

3) **Completion Adhering to Speed and Scale Commitments**
The due dates for these project requirements are at the discretion of the PPS and should be consistent with commitments made in the speed and scale sections of the approved application. Example requirements include: implementing open access scheduling, deploying a provider notification/secure messaging system, and converting outdated or unneeded hospital capacity.

Completion of project requirements is also delineated by the unit level of reporting:

1) **Project-Unit Level Reporting**
These are Domain 1 requirements reported at the project-wide level and demonstrating the PPS' overall project performance and success. Some of these requirements are performing population health management activities, developing a comprehensive care plan for each patient, establishing partnerships between primary care providers and participating Health Homes, and developing educational materials consistent with cultural and linguistic needs of the population.

2) **Provider-Unit Level Reporting**
These are Domain 1 requirements for which performance and success must be demonstrated and reported at the individual provider/practice site level. *Note:* Applicable provider types, by which reporting will be demarcated, refer to the classifications each PPS selected along with speed and scale submissions.

Appendix B – Performing Provider System Member Detail File Layout

The information from the medical record review will be used to determine denominator and numerator status for each member in the sample for the PPS. Members may be involved in more than one measure, and all of the measure information for that member will be in the single row. Files will be completed using the following file layout and formats in the table below. All rows will be the same length. Zero fill all columns that are not applicable to the member, such as measures not associated with the PPS' projects.

Members identified as 1 through ~~411~~453 in the sample file are considered to be the denominator for the measure and those identified from ~~412~~454 through ~~453~~499 are considered the oversample. For the member detail file, those who were in the denominator should be reflected with a value '1'. If a member meets exclusion criteria for the measure, the member's denominator status will be '8' indicating exclusion. The first member in the oversample will then be pulled into the denominator. All members from the oversample who are not included in the denominator will be indicated as '9' in the denominator column. If the sample has less than ~~411~~453 members and some are excluded, the final denominator will be less than ~~411~~453. Most numerator status columns for the measure will also be indicated as '1' if the ~~member's~~member is numerator compliant for the measure or '0' if numerator non-compliant. Two measures use a count of events in the numerator fields, so there may be more values than '1' and '0' in those columns.

MY2 File Layout Changes – Three additional numerator columns for 'Screening for Clinical Depression and Follow Up Plan' have been incorporated into the file layout due to revised measure technical specifications. These have been inserted in columns 13, 14 and 15. All ensuing columns have been renumbered accordingly.

Column Placement	Name	Direction	Allowed Values
Column 1-~~8~~2	PPS ~~MMIS~~ ID	Enter the PPS' ~~eight~~two digit numeric ~~MMIS~~PPS ID.	~~#########~~#
Column ~~9–16~~3-10	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~~year. For example, CINs for ~~2015~~2016 should be used. • For Medicaid, use the 8 digit alpha-numeric CIN.	AA#####A
Column ~~17~~11	Denominator for Screening for Clinical Depression ~~Screening~~and Follow Up	Enter a '1' if this member is in the denominator of the Screening for Clinical Depression ~~Screening~~ and Follow Up measure, '0' if the member is not in the denominator of this measure ~~or if the information is missing~~. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample

Column Placement	Name	Direction	Allowed Values
Column ~~18~~12	Numerator component 1 for Screening for Clinical Depression ~~Screening~~and Negative Result	Enter a '1' if this member is in the numerator component 1 of the Screening for Clinical Depression ~~Screening~~ and Follow Up measure, '0' if the member is not in the numerator component 1 or the information is missing.	1 = Yes 0 = No
Column 13	Numerator component 2 for Screening for Clinical Depression and Follow Up	Enter a '1' if this member is in the numerator component 2 of the Screening for Clinical Depression and Follow Up measure, '0' if the member is not in the numerator component 2 or the information is missing.	1 = Yes 0 = No
Column 14	Numerator component 3 for Screening for Clinical Depression and Follow Up	Enter a '1' if this member is in the numerator component 3 of the Screening for Clinical Depression and Follow Up measure, '0' if the member is not in the numerator component 3 or the information is missing.	1 = Yes 0 = No
Column 15	Numerator component 4 for Screening for Clinical Depression and Follow Up	Enter a '1' if this member is in the numerator component 4 of the Screening for Clinical Depression and Follow Up measure, '0' if the member is not in the numerator component 4 or the information is missing.	1 = Yes 0 = No
Column ~~19~~16	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. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample
Column ~~20~~17	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 ~~21~~18	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. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample
Column ~~22~~19	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 ~~23~~20	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~~),~~ as well as HbA1c ≥ 9.0%), '0' if the member is not in the numerator or if the member's ~~information is missing for all numerators of CDC (such as the member's record could not be located).~~HbA1c ≤ 9.0%.	1 = Yes 0 = No
Column ~~24~~21	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 ~~25~~22	Numerator 4 for CDC – Medical Attention for Nephropathy	Enter a '1' if this member is in the numerator of the CDC Medical Attention for Nephropathy measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column ~~26~~23	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.~~. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample
Column ~~27~~24	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
~~Column28~~Column 25	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. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	0 – 2 8 = Exclusion 9 = Oversample
Column ~~29~~26	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 ~~30~~27	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 ~~31~~28	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. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	0 – 2 8 = Exclusion 9 = Oversample
Column ~~32~~29	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 ~~33~~30	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 ~~34~~31	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 ~~35~~32	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 ~~36~~33	Numerator 5 for FPC (81% or more)	Enter the number of times this member is in the numerator of the Frequency of Ongoing Prenatal Care 81% or more measure, '0' if the member is not in the numerator or the information is missing.	0 – 2

Column Placement	Name	Direction	Allowed Values
Column ~~37~~34	Denominator for Childhood Immunization (CIS)	Enter a '1' if this member is in the denominator of the CIS measure, '0' if the member is not in the denominator of this measure. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample
Column ~~38~~35	Numerator 1 for CIS – Four DTaP	Enter the number of times this member has a vaccination meeting HEDIS® specifications for DTaP in numerator of the CIS– Four DTaP measure. Enter '0' if this member did not receive any DTaP vaccinations meeting HEDIS® specifications.	0-9
Column ~~39~~36	Numerator 2 for CIS – Three IPV	Enter the number of times this member has a vaccination meeting HEDIS® specifications for IPV in numerator of the CIS – Three IPV measure. Enter '0' if this member did not receive any IPV vaccinations meeting HEDIS® specifications.	0-9
Column ~~40~~37	Numerator 3 for CIS – One MMR	Enter the number of times this member has a vaccination meeting HEDIS® specifications for MMR in numerator of the CIS– One MMR measure. Enter '0' if this member did not receive any MMR vaccinations meeting HEDIS® specifications. Enter '1' if the member has a history of illness or seropositive result.	0-9
Column ~~41~~38	Numerator 4 for CIS – Three HiB	Enter the number of times this member has a vaccination meeting HEDIS® specifications for HiB in numerator of the CIS – Three HiB measure. Enter '0' if this member did not receive any HiB vaccinations meeting HEDIS® specifications.	0-9
Column ~~42~~39	Numerator 5 for CIS – Three Hepatitis B	Enter the number of times this member has a vaccination meeting HEDIS® specifications for Hepatitis B in numerator of the CIS – Three Hepatitis B measure. Enter '0' if this member did not receive any Hepatitis B vaccinations meeting HEDIS® specifications. Enter '3' if the member has a history of illness or seropositive result.	0-9
Column ~~43~~40	Numerator 6 for CIS – One VZV	Enter the number of times this member has a vaccination meeting HEDIS® specifications for VZV in numerator of the CIS – One VZV measure. Enter '0' if this member did not receive any VZV vaccinations meeting HEDIS® specifications. Enter '1' if the member has a history of illness or seropositive result.	0-9
Column ~~44~~41	Numerator 7 for CIS – Four Pneumococcal Conjugate	Enter the number of times this member has a vaccination meeting HEDIS® specifications for Pneumococcal Conjugate in numerator of the CIS – Four Pneumococcal Conjugate measure. Enter '0' if this member did not receive any Pneumococcal Conjugate vaccinations meeting HEDIS® specifications.	0-9
Column ~~45~~42	Denominator for Lead Screening for Children	Enter a '1' if this member is in the denominator of the Lead Screening for Children measure, '0' if the member is not in the denominator of this measure. If the member was excluded from the denominator, enter '8'. If the member remained in the oversample and is not in the final denominator, enter '9'.	1 = Yes 0 = No 8 = Exclusion 9 = Oversample
Column ~~46~~43	Numerator for Lead Screening for Children	Enter a '1' if this member is in the numerator of the Lead Screening for Children measure, '0' if the member is not in the numerator or the information is missing.	1 = Yes 0 = No

Appendix C - New York State Perinatal Quality Collaborative (NYSPQC) Scheduled Delivery Form (Project 3.f.i)

New York State Perinatal Quality Collaborative – Scheduled Delivery Form
Scheduled is defined as all inductions and cesarean sections prior to onset of labor between 36 0/7 and 38 6/7 weeks gestational age

A. Patient Demographics

1.Permanent Facility Identifier(PFI):	2. Facility Name:	3a. Sequence Number:	3b. System ID:
4. Admit Date (Month and Year): mm/yyyy	_____/ _____(mm/yyyy)	5. Maternal Age: _____years	[1]Medical Record Number:

Delivery Type				6. NOTES:
7. Vaginal:	Spontaneous ☐	Operative ☐		
8. Cesarean:	Primary ☐	Repeat ☐		
9. Induced Labor:	Yes ☐	No ☐		
10. Patient ethnicity:	Hispanic ☐	Non-Hispanic ☐	Ethnicity Unknown ☐	
11. Patient race:	White ☐ Asian ☐	Black or African American ☐ Native Hawaiian/ Other Pacific Islander ☐	American Indian/ Alaskan Native ☐ Some Other Race ☐	Race Unknown ☐
12. Primary Insurer:	Medicaid ☐	Uninsured ☐	Private ☐	Other ☐

B. Clinical Data

13. Final Gestational Age at Delivery:	____weeks ____days
14. Was gestational age documented in the chart?	☐Yes ☐ No
15. Was gestational age of less than 39 weeks confirmed by one of the following? • First or second trimester ultrasound < 20 weeks • Fetal heart tones documented for 30 weeks by Doppler ultrasonography • 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result	☐Yes ☐ No
16. Was fetal lung maturity documented by amniocentesis?	☐Yes ☐ No
17. For inductions, was the Bishop Score of cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother?	☐Score ≥8 primigravida, ≥6 multigravida ☐ Determined, did not meet criteria ☐ Not measured or cannot be calculated

Patient Counseling (18b and 18c are only required for RPCs participating in the OB Prenatal Education Project)

18a. Was there documentation in the medical record that the maternal and fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks were discussed with the mother?	☐Yes ☐ No
18b. Was there documentation in the medical record of the mother's preferred language? If yes, please specify the language.	☐Yes, _____ ☐ No
18c. Was patient education provided in the mother's preferred language?	☐Yes ☐ No

Reason for Scheduled Delivery

19. Was there documentation in the medical or prenatal record of the primary reason for scheduled delivery?	☐Yes ☐ No

Which of the following was the PRIMARY reason documented in the medical records for a scheduled delivery between 36 0/7 and 38 6/7 weeks gestation? (Reasons can be maternal, fetal, psychosocial)
SELECT ONLY ONE (AND SPECIFY BELOW AS NEEDED)

20. Maternal Reasons for Scheduled Delivery ***SELECT ONLY ONE ***

Premature rupture of membranes	☐	Prepregnancy hypertension	☐	Hematological condition(specify in #23 below)	☐
Prolonged rupture of membranes	☐	Gestational diabetes	☐	Active genital herpes infection	☐
Chorioamnionitis	☐	Diabetes(Type I/II)	☐	Prior myomectomy	☐
Placental abruption	☐	Heart disease (specify in #23 below)	☐	Prior vertical or "T" incision c-section	☐
Placenta previa/Vasa previa	☐	Liver disease(specify in #23 below)	☐	History of poor pregnancy outcomes(specify in #23 below)	☐
Gestational hypertension	☐	Renal disease(specify in #23 below)	☐	History of fast labor (<3 hrs) and distant from hospital	☐
Preeclampsia/Eclampsia	☐	Pulmonary disease(specify in #23 below)	☐	HIV	☐
Placenta Accreta	☐	Other (specify in #23 below)	☐		

NYSPQC Scheduled Delivery Form [1]Medical Record # and initials for site use only-will not be sent to NYSDOH Revision Date: 6-30-2014

New York State Perinatal Quality Collaborative – Scheduled Delivery Form
Scheduled is defined as all inductions and cesarean sections prior to onset of labor between 36 0/7 and 38 6/7 weeks gestational age

				3. Sequence Number (from front of form):	
21. Fetal Reasons for Scheduled Delivery ***SELECT ONLY ONE IF NO MATERNAL REASON SPECIFIED***					
Oligohydramnios	☐	Intrauterine growth restriction (< 5th percentile for gestational age)	☐	Fetal demise	☐
Macrosomia–Sono EFW>5,000 gms	☐	Abnormal fetal testing (by NST, BPP, or continuous wave Doppler)	☐	Mono-Di Twins	☐
Major fetal anomaly	☐	Alloimmunization/fetal hydrops	☐	Other (specify in #23 below)	☐
22. Psychosocial Reasons for Scheduled Delivery ***SELECT ONLY ONE IF NO MATERNAL OR FETAL REASON SPECIFIED***					
Psychosocial stress (e.g., domestic violence, no social support, working long hrs. upright)	☐	Patient request – "Elective"	☐	Convenience of patient/doctor (includes scheduling difficulties)	☐
				Other (specify in #23 below)	☐
23.Specify (narrative as directed above)					
24a. When 'Other' is selected as the Maternal or Fetal reason, was the reason for scheduled delivery reviewed by a designated reviewer or panel? ☐Yes ☐ No ☐ Review Pending			Results of scheduled delivery review from Q24a: 24b. Medically indicated based on review? ☐Yes ☐No		
24c. If the answer to question 24a. is "Yes", please explain decision based on review					
Infant Outcome					
25. Plurality – please enter the number of infants delivered: |_____|					
26. Was any infant(s) admitted to the Neonatal Intensive Care Unit (NICU) for more than 4 hours?				☐Yes ☐ No	
27. If 'Yes': Number of days in NICU (Baby #1)				|__|__|__|	
28. If 'Yes': Number of days in NICU (Baby #2)				|__|__|__|	
29. If 'Yes': Number of days in NICU (Baby #3)				|__|__|__|	
C. Data collection, entry and verification					
30. Initials of individual *completing* this form:			[1]Initials of obstetrician:		
D. Optional Data Collection (for site use only)					
31. Optional Field for Data Collection(#1)					
32. Optional Field for Data Collection(#2)					
33. Optional Field for Data Collection(#3)					
34. Optional Field for Data Collection(#4)					
35. Optional Field for Data Collection(#5)					

NYSPQC Scheduled Delivery Form [1]Medical Record # and initials for site use only-will not be sent to NYSDOH Revision Date: 6-30-2014

Appendix D –~~Screening for Clinical Depression and Follow Up Technical Specifications~~ New York State-Specific Measures

Screening for Clinical Depression and Follow Up Plan

Changes for MY 2 specifications

- Clarification added regarding determining the standardized screening score or result
- Additional exclusion codes and categories were added
- Numerator components added to provide additional information about opportunities to improve care

Description:

Percentage of Medicaid enrollees age 18 and older who were screened for clinical depression using a standardized depression screening tool, and if a positive screen, received appropriate follow-up care. The intention of the measure is to capture early identification and intervention for persons with positive scores on screening tools within the context of routine preventive care visits.

Definitions:

Screening	Completion of a standardized, validated clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition. This measure looks for screening with a standardized tool being conducted in the practitioner's office during preventive care or evaluation and management visits.
Adult Standardized Screening tool (Ages 18 and older)	An assessment tool that has been normalized and validated for the adult population (e.g. Patient Health Questionnaire [PHQ-9], Beck Depression inventory [BDI or BDI-II], Mood Feeling Questionnaire [MFQ], Center for Epidemiologic Studies Depression Scale [CES-D], Depression Scale [DEPS], Duke Anxiety-Depression Scale [DADS], Geriatric Depression Scale [GDS], Hopkins Symptom Checklist [HSCL], Zung Self-Rating Depression Scale [SDS], Cornell Scale Screening ~~and~~, PRIME MD-PHQ-2, and Edinburgh Postnatal Depression Scale [EPDS]). Assessment tools may be named or a complete tool may be embedded in the medical record and not named.
Depression screen scoring	Standardized depression screening tools do not diagnose depression, but rather indicate whether or not there is a need for more detailed follow-up by a clinician. Standardized depression screening tools are typically scored, and the scoring includes established cut points for depression based on established sensitivity, specificity and positive and negative predictive values of the scores for detecting depression. Established scoring cut points for the most commonly used screens in primary care (PHQ) are detailed in Medical Record Specifications below.
Follow Up Plan	Documentation of follow up must include one or more of the following in the 30~~-~~-day period following the initial positive screen (inclusive of the screening visit date): • Recommended or prescribed antidepressant medication;

- Recommended or made referral or follow up visit with behavioral health provider;
- Recommended or scheduled follow up outpatient visit with any provider, including the PCP or other provider administering the original screen, for further assessment within 30 days of the positive screen;
- Further assessment on the same day of the positive screen which includes documentation of additional depression assessment indicating no depression (such as positive score from ~~PHQ2~~PHQ-2 with a negative ~~PHQ9~~PHQ-9 or documented negative findings after further evaluation);
- Referral to emergency department for crisis services on the same day of the positive screen; or
- Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.

Intake Period July 1 of the prior year through June 1 of the measurement year.

DSRIP Measurement Year July 1 of the prior year through June 30 of the current year. For example, measurement year ~~1~~2 is July 1, ~~2014~~2015 to June 30, ~~2015~~2016.

Eligible Population:

Product Line: Medicaid

Ages: 18 years or older as of July 1 of the measurement year. Report two age stratifications and a total result.

- 18 - 64 years
- 65 years and older
- Total

Continuous Enrollment: Continuous enrollment in Medicaid for the measurement year. The allowable gap is no more than one month during the measurement year.

Anchor Date: June 30 of the measurement year.

Event diagnosis Members who had a qualifying outpatient visit during the intake period (listed in table CDF-A)

CDF-A: Qualifying outpatient visits

Coding System	Qualifying Codes
CPT	96150, 96151, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
HCPCS	G0402, G0438, G0439, G0444

Denominator

A systematic sample drawn from the eligible population.

Required Denominator Exclusions

~~Remove members with~~ (listed in table CDF-B~~):~~)

Remove members with

- ~~a~~ : A diagnosis of ~~Major Depression~~a depressive disorder in the year prior to the measurement year or prior to the date of the first standardized screen in the measurement year. If there is no standardized screen in the measurement year, remove any member with a diagnosis at any time in the measurement year.
- ~~a~~A diagnosis of Bipolar disorder in the year prior to the measurement year or prior to the date of the first standardized screen in the measurement year. If there is no standardized screen in the measurement year, remove any member with a diagnosis at any time in the measurement year.
- A diagnosis of severe intellectual disability or dementia in the year prior or during the measurement year.

CDF-B: Diagnoses codes for exclusions

Diagnosis	ICD-9-CM Codes	ICD-10-CM Codes
~~Depression~~Depressive disorders	296.20-296.25, 296.30-296.35, 298.0, 300.4, 311	F32.0-F32.4, F32.9, F33.1-F33.41, F33.9, F34.0-F34.1, F34.8-F34.9
Bipolar ~~Disorder~~disorder I or II	296.00-296.05, 296.10-296.15, 296.40-296.45, 296.50-296.55, 296.60-296.65, 296.7	F30.10-F30.13, F30.2, F30.3, F30.8, F30.9, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.77, F31.81, F31.89, F31.9
Severe/profound intellectual disability	318.1-318.2	F72-F73
Vascular dementia with behavioral problems	290.40	F01.51
Dementia in other diseases classified elsewhere with behavioral disturbance	294.11	F02.81

Numerator

Members who were screened for clinical depression with a standardized tool in the measurement year and if positive, had appropriate follow up care within 30 days (inclusive) of the positive result.

Administrative Specifications

HCPCS Code	Description
G8431	Screening for clinical depression is documented as positive and follow up plan is documented
G8510	Screening for clinical depression is documented as negative; a follow up plan is not required

NOTE: Use of HCPCS codes in administrative data will need to be verified by the PPS to ensure the use of this code by a provider is associated with a standardized depression screening tool and follow up plan as

indicated. ~~If~~As providers are encouraged to use the HCPCS codes to allow monitoring of improvement in administrative data, the PPS needs to ensure the coding is associated with the standardized tools, with scoring and follow up documentation if indicated.

Medical Record Specifications

Required Denominator Exclusions

Remove members with medical record documentation of:

- Any history of bipolar disorder or of a depressive disorder prior to the date of the first standardized screen in the measurement year. If there is no standardized screen in the measurement year, remove any member with a diagnosis of bipolar disorder or depressive disorder at any time in the measurement year. Diagnoses of depressive disorders include major depressive disorder (MDD), persistent depressive disorder (dysthymia), or unspecified depressive disorder.
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. Examples include members with delirium or severe cognitive impairment.

Numerator

The following steps are used to determine numerator component compliance~~:~~ and will be used in the calculation of numerator events:

Step 1 Review all qualifying visits within the intake period to determine if a standardized depression screen was conducted. This may involve records from more than one provider.

Step 2 Identify all of the members with a standardized screening tool documented during the intake period. If a member has more than one visit with a standardized screen during the intake period, use the result from the first date. Members with one or more completed standardized screening tools are compliant for numerator component 1.

Step 3 For all the members with a documented screening, determine the result of the screening. Identify members whose result is negative by: 1) Clinician documentation that screening results are negative, or, if there is no clinician documentation of screening results; 2) Negative screening score using the cut point criteria specified for the ~~screening~~ tool. ~~(e.g.~~Members who screen negative are compliant for numerator component 2.

Negative screens for PHQ tools:

- PHQ-9: A member with a PHQ-9 score ~~is~~ < 5 is considered to have screened negative for depression~~).~~.
- PHQ-2 with numeric scale: A member with a PHQ-2 score < 3 when a scored PHQ-2 instrument is used is considered to have screened negative for depression.
- PHQ-2 without a numeric scale: A member who answers “no” to both of the two questions is considered to have screened negative for depression.

Step 4 For all the members with a documented screening, determine the result of the screening. Identify members whose result is positive by: 1) Clinician documentation that screening results are positive, or, if there is no clinician documentation of screening results; 2) Positive screening score using the cut point criteria specified for the ~~screening~~ tool. ~~(e.g.~~Members who screen positive are compliant for numerator component 3.

Positive screens for PHQ tools:

- PHQ-9: A member with a PHQ-9 score ~~is~~ ≥ 5 is considered to have screened positive for depression~~).~~.
- PHQ-2 with numerical scale: A member with a PHQ-2 Score ≥ 3 when a scored PHQ-2 instrument is used is considered to have screened positive for depression.
- PHQ-2 without numerical scale: A member who answers "yes" to either of the two questions is considered to have screened positive for depression.

Step 5 For all of the members from Step 4, count members for whom follow-up care was provided within 30 days (inclusive) of the date of the positive screen. Members who have documented follow up plans are compliant for numerator component 4.

Follow up documentation must include one or more of the following within 30 days following the positive screen:

- Recommended or prescribed antidepressant medication;
- Recommended or made referral or follow up visit with behavioral health provider;
- Recommended or scheduled follow up outpatient visit with any provider, including the PCP or other provider administering the original screen, for further assessment within 30 days of the positive screen;
- Further assessment on the same day of the positive screen which includes documentation of additional depression assessment indicating no depression (such as positive score from ~~PHQ2~~PHQ-2 with a negative ~~PHQ9~~PHQ-9 or documented negative findings after further evaluation);
- Referral to emergency department for crisis services on the same day of the positive screen; or
- Arrangement for inpatient admission for mental health diagnosis on the same day as the positive screen.

Step 6 Sum the total of the members ~~identified in Step 3~~ compliant with ~~a~~numerator component 1 AND 2 (screened negative ~~screening result~~) and ~~members who received appropriate~~with numerator component 1 AND 3 AND 4 (screened positive with documented follow-up ~~from Step 5~~plan) for the total numerator events.

~~Screening for Clinical Depression Flow chart~~

Numerator Events = Screened negative (members compliant with both Numerator components 1 and 2) + Screened positive with documented follow up plan (members compliant with Numerator components 1, 3 and 4)

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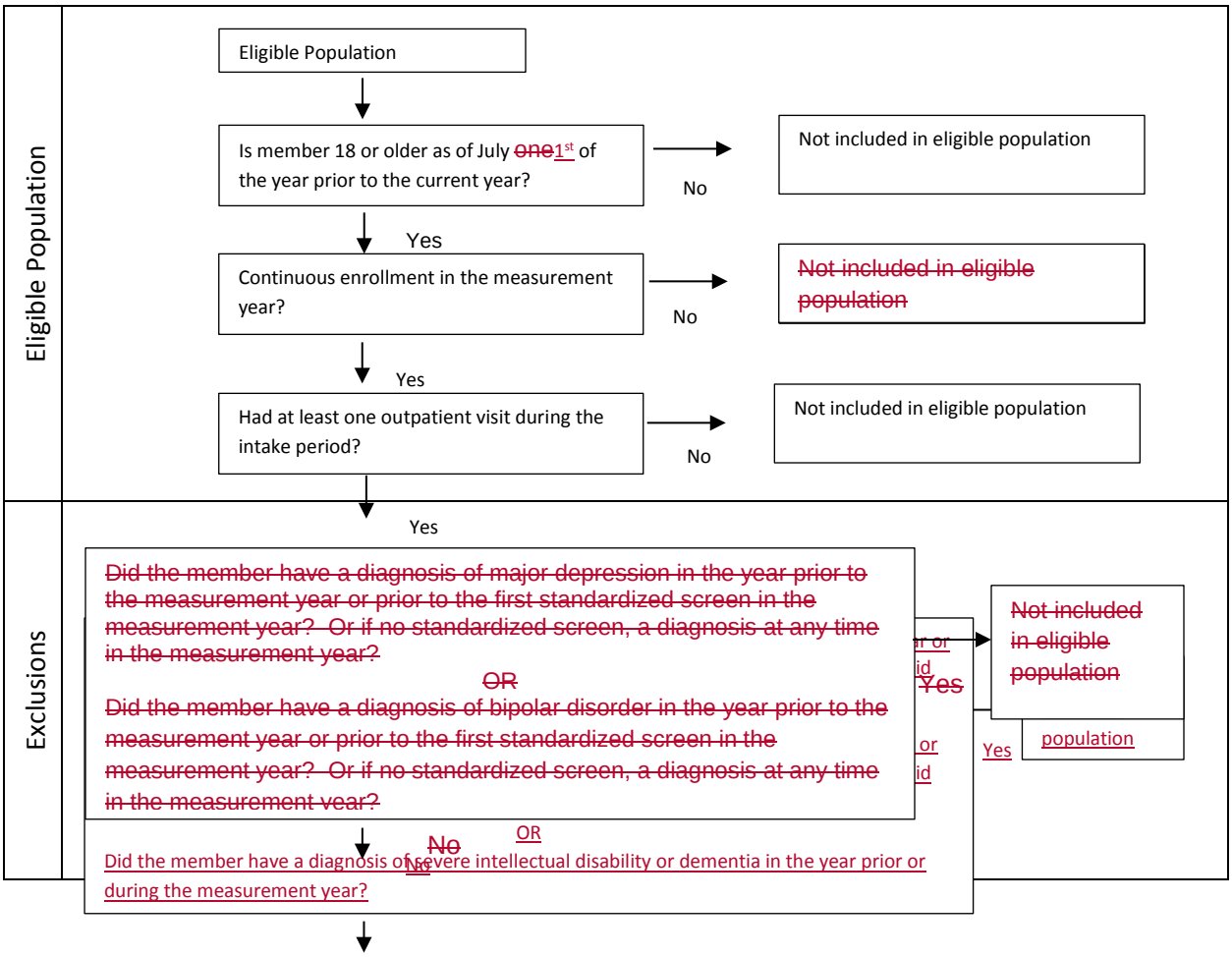
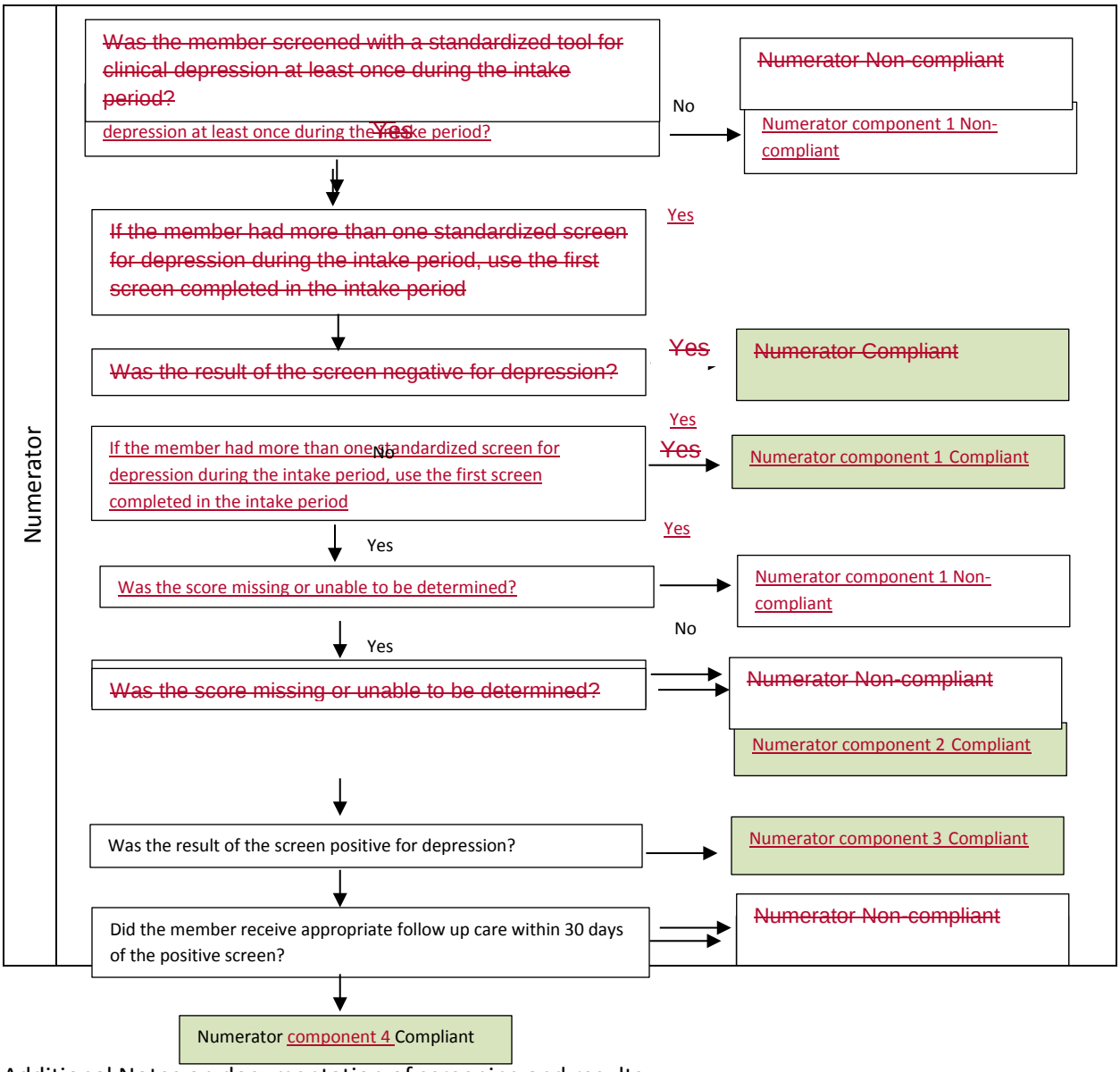
Screening for Clinical Depression and Follow Up flow chart





Additional Notes on documentation of screening and results:

Use of standardized tools embedded in forms or electronic medical records –

If all of the questions and response categories from a standardized screening tool are used within medical records that allow the same consistency of creating a score for determining positive and negative results, the information would be acceptable evidence of numerator compliance whether the name of the tool is present or not. The key requirements for numerator compliance are:

- All questions from a standardized tool are included
- Same standardized tool response options are available
- Documented score or finding of negative or positive screen
- Follow up plan documented if positive

Example: ~~PHQ2~~PHQ-2 questions, with responses, score or finding, and follow up if indicated = numerator compliant

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

"Score 5; Positive screen, Referral and appointment made with Capital Psychiatric Clinic on XX/XX/XXXX" (within 30 days of the positive screen).

Use of Summary of Findings from Standardized tools –

Documentation that indicates a standardized tool was used for screening for clinical depression with a score, and if the score indicates a positive screen, the follow up plan is documented.

Example: Standardized tool completed, with score or finding and follow up if indicated = numerator compliant

"~~PHQ2~~PHQ-2 ~~assessment completed, negative screen. No follow up indicated~~"

Use of Summary of Findings from Symptom Queries –

Documentation about findings from queries or discussion without specific questions ~~or scores~~from a standardized tool or score is ~~not~~NOT numerator compliant.

Example: No indication of tool, or finding, or general query statements = numerator non-compliant

"depression screening negative" or "depression screen done" or "denies depression"

~~Appendix E – Viral Load Suppression Technical Specifications~~

Viral Load Suppression

Description:
The percentage of Medicaid enrollees who qualified through at least one method as living with HIV/AIDS during the year prior to the measurement year who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Definitions:

HIV Viral Load	The HIV viral load is the number of copies of the human immunodeficiency virus (HIV) in the blood or bodily fluid.
HIV Viral Load Test	The HIV viral load test measures the number of HIV copies in a milliliter of blood.
DSRIP Measurement Year	July 1 of the prior year through June 30 of the current year. For example, measurement year 1 is July 1, 2014 to June 30, 2015.

Eligible Population:

Product Line:	Medicaid
Ages:	All members of the eligible population ages 2 and older as of June 30 of the measurement year.
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:	June 30 of the measurement year.
Index Episode Event:	Identify members as having HIV or AIDS who met at least one of the following criteria during the year prior to the measurement year with at least one of the 4 methods listed below:
Method 1	At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of HIV (HIV Value Set) or an inpatient DRG for HIV during the year prior to the measurement year (Table HIV-A)

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

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

Method 2 At least one outpatient visit (Ambulatory Visits Value Set/ Table HIV-C), with a primary or secondary diagnosis indicating HIV/AIDS (HIV Value Set/ Table HIV-B).

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

Description	ICD-9-CM Diagnosis	ICD-10-CM Diagnosis
HIV/AIDS	042, V08	B20, Z21

Table HIV-C: Codes to Identify Outpatient and ED Visits

Description	CPT	HCPCS	UB Revenue	ICD-9-CM Diagnosis	ICD-10-CM Diagnosis
Outpatient Visit	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, ~~G0402, G0402, G0438, G0438, G0439, G0439~~	G0402, G0402, G0438, G0438, G0439, G0439	051x, 0520-0523, 0526-0529, 0982, 0983	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9
ED Visit	99281, 99282, 99283, 99284, 99285		450, 451, 452		

Method 3 At least one ED Visit (ED Value Set/ Table HIV-C), with a primary or secondary diagnosis indicating HIV/AIDS (HIV Value Set/ Table HIV-B).

Method 4 At least one dispensing event for ARV medications (Table HIV-D) during the year prior to the measurement year AND without a primary or secondary diagnosis of Hepatitis B or HTLV-1 (Table HIV-E) in any setting (Acute Inpatient Value Set, Ambulatory Visits Value Set, Table HIV-A, and Table HIV-C). Members identified as having HIV/AIDS because of at least one dispensing event, where Truvada (Tenofovir disoproxil fumarate + emtricitabine or TDF/FTC) or Stribild was dispensed, must also have at least one diagnosis of HIV/AIDS (HIV Value Set / Table HIV-B) during the year prior to the measurement year. A dispensing event is one prescription of an amount lasting 30 days or less. To convert dispensing events for prescriptions longer than 30 days, divide the ~~days~~days' supply by 30 and round down~~;~~.

Table HIV-D: An excel file with NDC Codes to Identify Antiretroviral Medications ~~are~~is available at: http://www.health.ny.gov/health_care/managed_care/plans/index.htm

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

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

HTLV 1	079.51	B97.33

Denominator

A systematic sample drawn from the eligible population.

Denominator Required Exclusions

Medical record Any member found to be HIV negative during the measurement year or the year prior.

- Evidence for determining HIV negative status include: negative ~~HIV RNA PCR, HIV RNA bDNA, and HIV RNA NASBA test result~~diagnostic test results such as HIV Antibody test results or HIV rapid test results, documentation in the medical record of HIV negative status, or provider attestation of HIV negative status for the member. Statements such as "rule out HIV," "possible HIV", "questionable HIV" are not sufficient to confirm the diagnosis if such statements are the only notations of HIV in the medical record.
- Evidence must be dated for the measurement year or year prior. If the documentation is for the year prior, there must not be any further documentation of HIV positive status after the negative notation. For example, a member with a negative HIV test in the year prior must have the documentation for the measurement year reviewed for indication of no more recent HIV test or status. Documentation of the negative HIV status must be before June 30 of the measurement year.
- Attestations may be obtained from providers after the measurement year as long as the document specifies the member's HIV negative status for the measurement year. Attestations from providers must be from the providers associated with the member's health care. Obtaining attestations from all involved providers is necessary to ensure that the appropriate providers associated with the diagnosis are the ones attesting to the HIV negative status.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year.

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.

Medical Record Specifications

Numerator The following steps are used to determine numerator compliance:

Step 1 Review all medical record documentation for visits during the measurement year to determine dates of viral load testing.

Step 2 If there is more than one viral load test during the measurement year, determine the most recent viral load test in the measurement year.

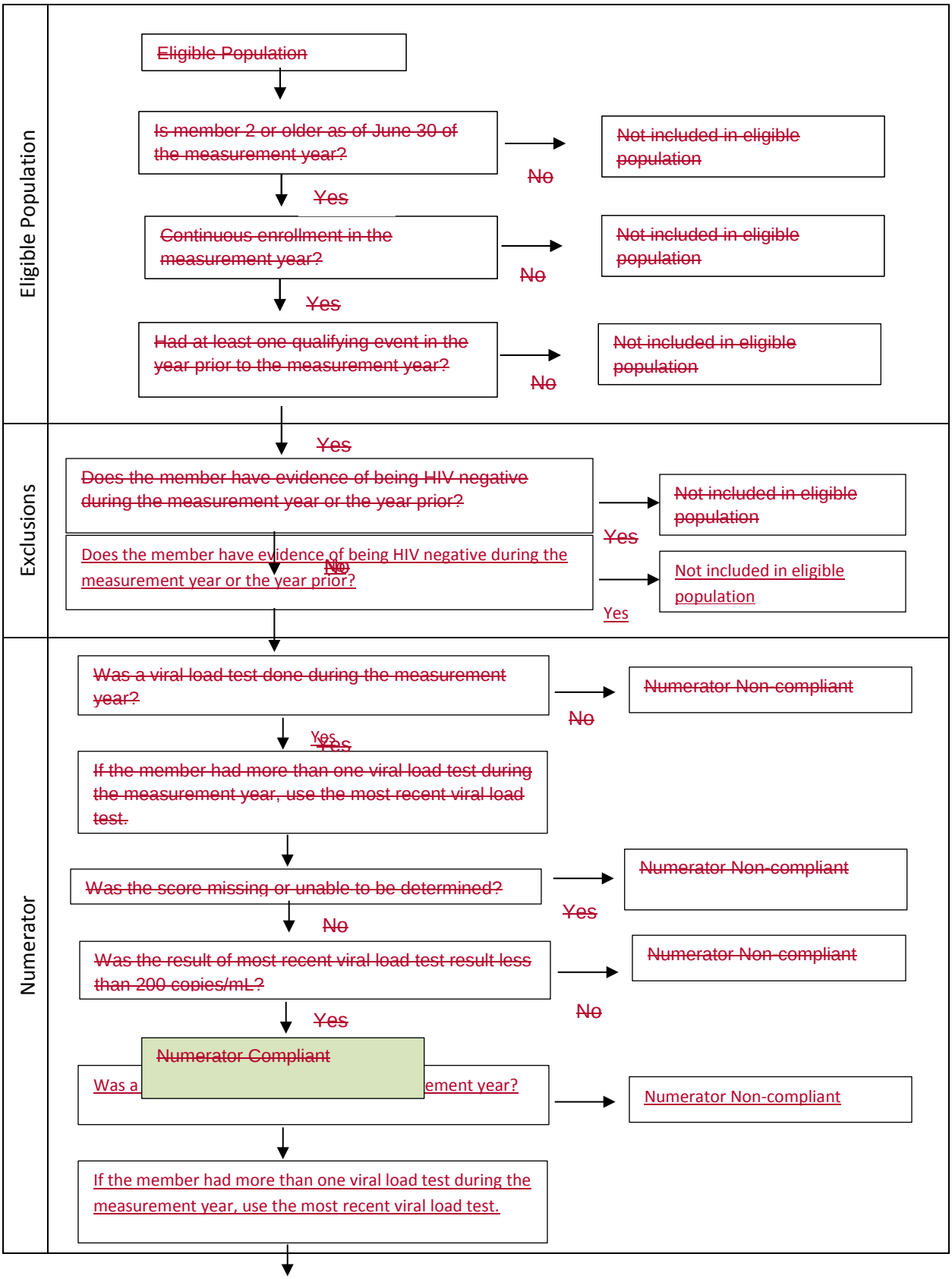
Step 3 Determine the viral load level from the most recent viral load test during the measurement year. Results for particular assays may need to be converted to determine if the result equates to below 200 copies/mL (such as log-10 results).

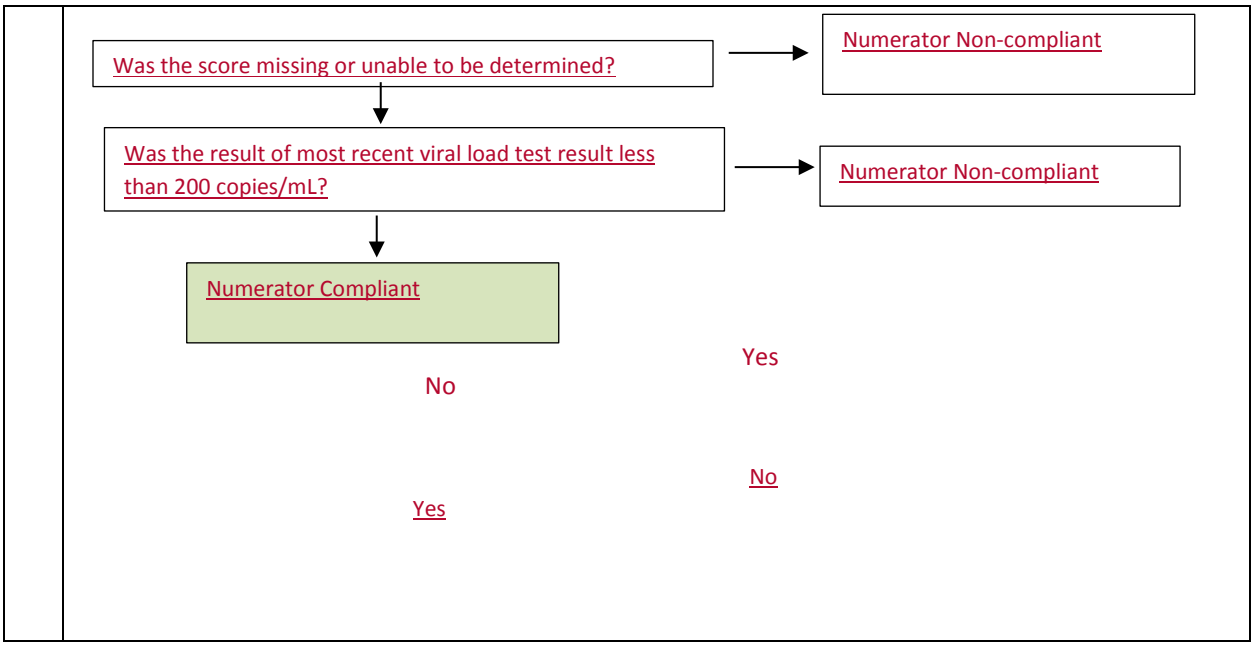
- Test results indicating viral load levels of less than 200 copies/mL; or
- Documentation of levels less than 200 copies/mL with the test date.

Step 4 Sum the total of members identified in Step 3 for the total numerator events.

NOTE Members without a viral load test during the measurement year or missing the result for the most recent test in the measurement year are numerator non-compliant.

~~Viral Load Suppression Flow Chart~~


Eligible Population
Eligible Population
Is member 2 or older as of June 30 of the measurement year?
No
Not included in eligible population
Yes
Continuous enrollment in the measurement year?
No
Not included in eligible population
Yes
Had at least one qualifying event in the year prior to the measurement year?
No
Not included in eligible population
Yes
Exclusions
Does the member have evidence of being HIV negative during the measurement year or the year prior?
Yes
Not included in eligible population
Does the member have evidence of being HIV negative during the measurement year or the year prior?
No
Yes
Not included in eligible population
Numerator
Was a viral load test done during the measurement year?
No
Numerator Non-compliant
Yes
If the member had more than one viral load test during the measurement year, use the most recent viral load test.
Was the score missing or unable to be determined?
Yes
Numerator Non-compliant
No
Was the result of most recent viral load test result less than 200 copies/mL?
No
Numerator Non-compliant
Yes
Numerator Compliant
Was a ement year?
Numerator Non-compliant
If the member had more than one viral load test during the measurement year, use the most recent viral load test.



Viral Load Suppression flow chart

Emergency Department Use By the Uninsured ±

Description:
The percentage of emergency department visits during the measurement year for individuals who are uninsured at the time of the visits.

Purpose: Increasing health insurance coverage among those who are uninsured can increase access to medical care, improve one's health status, and reduce the burden of medical costs on the patient. [1]

Data Source: New York State SPARCS Outpatient file

Eligible Population: Patients with emergency department visits at hospitals (Article 28) participating in a Performing Provider System (PPS) network

Denominator Description: Emergency department visits that do not result in an inpatient admission

Denominator Exclusions: Emergency department visits for out of state residents are excluded

Numerator Description: The emergency department visits among individuals with self-pay revenue codes (i.e., 0450, 0451, 0452, 0456, 0459) in all payer typology fields

Numerator Exclusions: not applicable

± A lower rate is desirable.

[1] Healthy People.gov (see https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services)

Meaningful Use Certified Providers who have a Participating Agreement; and Meaningful Use Certified Providers Who Conduct Bidirectional Exchange (two measures)

Description:
The percentage of Meaningful Use certified providers who are identified in the measurement year data file as having:

Participating Agreement - a participating agreement with at least one Qualified Entity (RHIO)

Bidirectional Exchange – evidence they conduct bidirectional exchange using the Statewide Health Information Network for New York (SHIN-NY)* with at least one Qualified Entity (or RHIO).

Purpose:
Increasing the number of eligible providers who participate with Qualified Entities and adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology improves the quality, safety, and efficiency of care while reducing disparities; promotes public and population health; improves care coordination; and promotes the privacy and security of patient information.

Data Source: Data files submitted by the Qualified Entities in New York State

Eligible Population: Providers who are participating in a Performing Provider System (PPS) who are Meaningful Use certified (able to use electronic health record technology)

Participating Agreement

Denominator Description: Number of providers who are Meaningful Use certified who are participating in a PPS

Denominator Exclusions: Providers who are not Meaningful Use certified

Numerator Description: Number of providers who have signed a participation agreement with at least one Qualified Entity

Numerator Exclusions: not applicable

Bidirectional Exchange

Denominator Description: Number of providers who are Meaningful Use certified who are participating in a PPS

Denominator Exclusions: Providers who are not Meaningful Use certified

Numerator Description: Number of providers who conduct bidirectional exchange by meeting both criteria: 1) make data available and 2) access data using the Statewide Health Information Network for New York (SHIN-NY) with at least one Qualified Entity

Numerator Exclusions: not applicable

* The SHIN-NY is a "network of networks" that links New York's eight regional Qualified Entities (QEs) throughout the state. Each Qualified Entity (or RHIO – Regional Health Information Organization) operates its own network that collects electronic health records from participating providers.

Primary Care Providers Meeting Patient Centered Medical Home or Advanced Primary Care Standards

Description:
The percentage of primary care providers meeting Patient Centered Medical Home (PCMH) (NCQA) or Advanced Primary Care Standards (as developed under the NYS Health Innovation Plan (SHIP)) during the measurement year.

Purpose:
Patient centered medical home and advanced primary care are promising models for transforming the organization and delivery of high quality primary care for all Medicaid members. Increasing the implementation of PCMH and advanced primary care has many benefits including, but not limited to, better coordinated and personalized care, improved access to medical care, improved health outcomes, especially for patients who have chronic conditions, increased provider satisfaction and efficient, cost-effective care.

Data Source: Provider Network Data System (PNDS), NCQA PCMH Certification File, and APC status file (as developed under SHIP)

Eligible Population: Primary care providers participating in a PPS network

Denominator Description: The number of primary care providers in the PPS network

Denominator Exclusions: Large medical groups or clinics that are categorized by an organizational National Provider Identifier (NPI)

Numerator Description: The number of primary care providers meeting patient centered medical home or advanced primary care standards *using any level and any standard year*

Numerator Exclusions: not applicable

Non-use of Primary and Preventive Care Services ±

Description:
The percentage of attributed members with no evidence of primary care or preventive care services in the measurement year.

Purpose:
Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. [2]

Data Source: Medicaid Data warehouse

Eligible Population: The attributed population in the measurement year

Denominator Description: All PPS attributed members as of June 30th of the measurement year, who meet continuous enrollment and age criteria for the Adult Access to Preventive or Ambulatory care and Children's Access to Primary Care measure specifications

Denominator Exclusions: Members eligible for Medicaid and Medicare (dual) at any time in the measurement year

Numerator Description: The percentage of attributed members who do not have at least one service with a preventive services CPT or equivalent code in the measurement year

Numerator Exclusions: not applicable

± A lower rate is desirable.

[1] Healthy People.gov (see https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services)

Medicaid Spending on Emergency Room and Inpatient Services ±

Description:
Total Medicaid spending on emergency room (ER) and inpatient (IP) services during the measurement year per PPS attributed member per month.

Purpose:
The Affordable Care Act [3] is working to improve quality and lower health care costs. The sources of inefficiency that are leading to increasing health care costs include payment for emergency room and inpatient care, and a lack of focus on disease prevention and engaging patients in primary care.

Data Source: Medicaid Data Warehouse

Eligible Population: All attributed members in the measurement year

Denominator Description: Total months enrolled in Medicaid (Member Months) for members attributed to the PPS as of June 30th of the measurement year

Denominator Exclusions: Members eligible for Medicaid and Medicare (dual) at any time in the measurement year.

Numerator Description: Total Medicaid amount paid for ER and IP services in the measurement year for the PPS attributed members

Numerator Exclusions: not applicable

± A lower rate is desirable.

[2] Key Features of the Affordable Care Act (see http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca/index.html#)

Medicaid Spending on Primary Care and Community Based Behavioral Health Care

Description:
Total spending on primary care (PC) and community behavioral health care (CBHC) during the measurement year per PPS attributed member per month.

Purpose:
The Affordable Care Act [3] is working to improve quality and lower health care costs. Important to this effort are primary care providers, and the integration of physical health and behavioral health services.

Data Source: Medicaid Data Warehouse

Eligible Population: All attributed members in the measurement year

Denominator Description: Total time enrolled in Medicaid (Member Months) for members attributed to the PPS as of June 30th of the measurement year

Denominator Exclusions: Members eligible for Medicaid and Medicare (dual) at any time in the measurement year

Numerator Description: Total paid amount for PC and CBHC services in the measurement year for the PPS attributed members

Numerator Exclusions: not applicable

[2] Key Features of the Affordable Care Act (see http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca/index.html#)

Other NYS-Specific Measures:

- Medicaid Provider Reimbursement with Methods other than Fee-for-Service (FFS) – in development and will be shared when final.

- PAM Level – measure specifications are pending CMS approval and detailed guidance will be shared once final.

- HIV/AIDS Comprehensive Care: Engaged in Care, Viral Load Monitoring and Syphilis Screening – See 2016 QARR Technical specifications manual at http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2016/docs/qarr_specifications_manual.pdf.

- Palliative Care Measures - measure specifications are pending CMS approval and will be shared once final. Palliative care measures will be implemented in MY3. For MY2, revised palliative care measures were under review by CMS. In order to acknowledge this, PPS can earn these AV based on the successful reporting of Domain 1 reporting requirements based on guidance issued in March 2016.