NEW YORK STATE | Department of Health

2023 Quality Assurance Reporting Requirements

Technical Specifications Manual (2023 QARR/HEDIS® 2023)

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I. Submission Requirements

2023 Quality Assurance Reporting Requirements (QARR) consists of measures from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), Center for Medicare and Medicaid Services (CMS) QRS Technical Specifications, Oregon Health Sciences University (OSHU), and New York State-specific measures. The 2023 QARR incorporates measures from HEDIS 2023.

Areas of performance included in the 2023 QARR:

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

Organizations Required to Report

Article 44 licenses

- Medicaid and Commercial Managed Care plans (HMO/PHSP, HIVSNP) certified by the New York State Department of Health (NYSDOH) **prior** to 2022 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria.
- Plans certified during 2023 are required to submit **enrollment by product line** and any other measures where members meet HEDIS eligibility criteria.
- Managed Long-Term Care Medicaid Advantage Plus plans (MAPs) are **not** required to report QARR to NYSDOH.

Article 32
Article 42
Article 43
Article 47
licenses

- Preferred Provider Organizations/Exclusive Provider Organizations (PPO/EPO) licensed by the New York State Department of Financial Services (DFS) prior to 2022 must report all QARR measures **if there are more than 30,000 members residing in** New York State in PPO/EPO products as of December 31, 2023, for MY 2023 (unless the insurer is also a QHP, then follow guidance from CMS on minimum threshold). Members **with dental-only, vision-only, catastrophic-only, and student coverage-only products are excluded** when determining eligible membership for QARR.

Article 1113(a) licenses

- Qualified Health Plans (QHP) licensed by DFS **prior** to 2022 must report all QARR measures. Members **with dental-only and catastrophic-only products are excluded** when determining eligible membership for QARR.

I. Submission Requirements

Reporting Requirement Guidelines

- QARR List of Required Measures (Table 1) lists by product the measures required for submission.
- This manual describes in detail **only** the NYS-specific measures. Plans must purchase the HEDIS 2023 Technical Specifications for Health Plans for specifications of the required HEDIS measures. Qualified Health Plans should follow all technical guidance outlined in the Quality Rating System (QRS) Reporting Requirements and Guidance on the CMS website.
- Insurers offering a QHP should follow CMS guidance on the combination of both individual and Small Business Health Options Program (SHOP) members in the same Exchange data collection unit as per CMS for QARR reporting.
- Plans should always apply HEDIS 2023 guidelines for each applicable product line when calculating continuous enrollment periods for NYS-specific measures.
- All submitted data must be audited by certified auditors from NCQA Licensed Organizations.
- Plans required to provide CAHPS data must use an NCQA-certified CAHPS vendor.
- All clarifications to the 2023 QARR will be distributed electronically to plan representatives and available on our web site https://www.health.ny.gov/health_care/managed_care/plans/index.htm under the Health Plan Guidelines section. All clarifications must be incorporated into the 2023 QARR specifications.
- Plans must report required measures **for which there is an eligible population**. Plans **may not** elect to suppress reporting or designate a measure as "NR – plan chose not to report."
- **We prefer that only data for NYS residents be included in QARR and CAHPS measures**. In situations where commercial organizations are unable to remove out-of-state residents due to inclusion of contractual groups in their QARR process, the out-of-state members may be included. However, commercial plans should limit this to contracts originating in NYS and amend QARR processing in future cycles to limit out-of-state members.
- Collection Method: If a measure is denoted as Hybrid (H) **only** in the QARR List of Required Measures (Table 1), all plans **must use hybrid method** for collection **for all numerator non-compliant members**. Results calculated with administrative collection only for these measures will be invalidated by NYSDOH if they are determined to be under-reported, even if the auditor determined the result to be reportable. If a measure is denoted as Administrative or Hybrid (A/H), NYSDOH will accept the administrative collection and reporting of these measures, unless the rate deviates significantly from the statewide average or last year's rate.
- For all NYS-specific measures, follow NCQA general guidelines for members with dual enrollment in Commercial/Medicaid.
- NYS-specific measures **will be reported using the NYS-Specific Patient-Level Detail file**. NYS-specific measures will not be reported via NCQA IDSS.

I. Submission Requirements

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

Commercial PPO (CPPO)

- PPO product data should be reported separately for all licensed organizations meeting the enrollment threshold unless there is agreement from NCQA authorizing the combining of PPO and HMO/POS data or the combining of PPO and EPO data.
- NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- NYSDOH incorporates combined PPO/EPO submissions with PPO data tables.
- Members who have any of the 'medical' benefit, as defined by HEDIS, should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and is included in applicable measures.
- Commercial specifications should be followed for all required HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- PPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS-Specific Measures Summary-Level File is required.

Commercial EPO (CEPO)

- NYSDOH incorporates combined PPO/EPO submissions with PPO data tables.
- Members who have any of the 'medical' benefit, as defined by HEDIS, should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and is included in applicable measures.
- Commercial specifications should be followed for all required HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- EPO plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS-Specific Measures Summary-Level File is required.

Commercial HMO/POS (CHMO)

- HMO/POS product data should be reported separately for all licensed organizations meeting the enrollment threshold unless there is agreement from NCQA authorizing the combining of PPO or EPO and HMO/POS data.
- NYSDOH incorporates combined PPO/HMO submissions with HMO data tables.
- If plans are including their POS members with their HMO, POS is included in their commercial HMO rates. Follow HEDIS 2023 instructions regarding commercial POS products.
- Commercial specifications should be followed for all required HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- HMO/POS plans must use a certified CAHPS vendor and have their CAHPS sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS-Specific Measures Summary-Level File is required.

I. Submission Requirements

Commercial Off-Exchange Product

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

Qualified Health Plan PPO (QPPO)

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

Qualified Health Plan PPO (QEPO)

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

Qualified Health Plan HMO (QHMO)

- HMO product data should be reported separately for all licensed organizations meeting the enrollment threshold, and plans should follow CMS guidance on reporting by product.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- HMO plans must use an HHS-approved survey vendor and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.

Qualified Health Plan POS (QPOS)

- POS product data should be reported separately for all licensed organizations meeting the enrollment threshold, and plans should follow CMS guidance on reporting by product.
- Quality Rating System (QRS) Measure Technical Specifications should be followed for all required measures. NYSDOH will only be collecting measures and numerators included in the QRS Measure set.
- POS plans must use an HHS-approved survey vendor and have their enrollee survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.

I. Submission Requirements

Essential Plans (EP)

- EP product data should be reported separately for all licensed organizations meeting the enrollment threshold.
- Members who have any of the 'medical' benefit, as defined by HEDIS, should be included in the required measures. If the member has either outpatient or inpatient benefit coverage, the member is considered to have a 'medical' benefit and is included in applicable measures.
- Commercial specifications should be followed for all required HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only Medicaid specifications, commercial organizations should continue to use the commercial instructions for calculating the continuous enrollment portion of the measure.
- EP plans must use a certified CAHPS vendor and have their CAHPS survey sample frame reviewed and approved by their auditor.
- Patient-Level-Detail files are required.
- NYS-Specific Measures Summary-Level File is required.

Child Health Plus (CHP)

- Plans with both CHP and Medicaid products will combine members for the two products for measure calculation and reporting. Information will be included with 'Medicaid' results on the IDSS.

Medicaid HMO/PHSP (MA)

- Plans with both CHP and Medicaid products will combine members for the two products for measure calculation and reporting. Information will be included in 'Medicaid' results. CHP members will be included in all measures where the members meet eligibility criteria.
- Plans should follow Medicaid specifications in HEDIS 2023 and QARR 2023 NYS-specific measures for the required measures. If a required measure has only commercial specifications, Medicaid organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are optional.
- NYS-Specific Measures Summary-Level File is required.

Medicaid HIV Special Needs Plans (HIVSNP)

- Plans should follow Medicaid specifications in HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only commercial specifications, HIVSNP organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are optional.
- NYS-Specific Measures Summary-Level File is required.

Medicaid Health and Recovery Plan (HARP)

- Plans should follow Medicaid specifications in HEDIS 2023 and QARR 2023 NYS-specific measures. If a required measure has only commercial specifications, HARP organizations should continue to use the Medicaid instructions for calculating continuous enrollment.
- Patient-Level-Detail files are required. The fee-for-service (FFS) enhancement files are optional.
- NYS-Specific Measures Summary-Level File is required.

Medicare and Dual Eligible

- Plans should NOT submit information for enrollees with Medicare coverage.

I. Submission Requirements

What's New in the 2023 NYS Technical Specifications?

In MY2022, HEDIS introduced race and ethnicity stratification for five HEDIS measures, in MY2023 HEDIS added an additional eight measures to the required NCQA reporting requirements. They are also noted in QARR MY2023 reporting requirements. If a member qualifies for the denominator of a measure that requires race and ethnicity reporting to NCQA, then the patient level detail file that includes that member should have the member's race and ethnicity and the method used to identify the race and ethnicity (direct or indirect).

- Optional reporting of Asian American and Pacific Islander subgroups in the patient level detail file.
- More specific language choices other than English for the patient level detail file.
- NYSDOH will freeze the NYS QARR Technical Specifications on November 1, 2023. Clarifications issued after that date will not affect coding or program changes.

NYS-Specific Measure Retired or Removed

- None

NYS-Specific Measure Name Changed/Updated

- Use of Pharmacotherapy for Alcohol Use or Dependence (POA)

Non - NYS-Specific Measure Retired or Removed

- Annual Dental Visit (ADV)
- Appropriate Testing for Pharyngitis (CWP) (QHP Product Line ONLY, retired by QRS)
- Breast Cancer Screening (BCS)[1] – non-electronic reporting
- Flu Vaccinations for Adults Ages 18–64 (FVA)
- Frequency of Selected Procedures (FSP)

New HEDIS Measures Added to NYS QARR List of Required Measures

- Cervical Cancer Screening (CCS-E)[2]
- Oral Evaluation, Dental Services (OED)
- Social Need Screening and Intervention (SNS-E)
- Topical Fluoride for Children (TFC)

New NCQA Race and Ethnicity Stratified Measures added for MY2023

- Adult Immunization Status (AIS-E)
- Asthma Medication Ratio (AMR)
- Breast Cancer Screening (BCS-E)
- Follow-Up After Emergency Department Visit for Substance Use (FUA)
- Immunizations for Adolescents (IMA) (IMA-E)
- Initiation and Engagement of Substance Use Disorder Treatment (IET)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Well-Child Visits in the First 30 Months of Life (W30)

[1] Only the BCS-E measure will be reported
[2] E indicates Electronic Clinical Data Systems (ECDS) reporting method.

I. Submission Requirements

Use of Supplemental Databases

What are they?
Supplemental databases contain information about health care services members received that is gathered from sources other than claims and encounters. See HEDIS 2023 (General Guidelines Volume 2, HEDIS 2023) for direction on how the data may be used in the calculation of measures, and how the information will be processed and validated with proof-of-service documents from the legal health record.

The types of files, data sources, and collection processes dictate how the data must be captured, managed, and verified in order to incorporate information from the database into HEDIS/QARR reporting. NYSDOH is not adding or changing any of the HEDIS guidelines regarding the use of supplemental databases.

How are supplemental databases used by health plans?
As directed in HEDIS guidelines, health plans are permitted to use supplemental databases to capture information on services and events used for:

1) numerator compliance
2) optional exclusions
3) members in hospice and members who have died
4) eligible population required exclusions not related to the timing of the denominator event or diagnosis.

Supplemental databases should not be used to determine denominator events, to capture for clinical conditions that may change over time, to correct billing information, and for measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and for excluding deceased members.

The information captured from data sources must comply with HEDIS 2023 guidelines for timing, file type, data elements, collection processes, and procedures for maintaining systems and data integrity. All supplemental databases must be approved by the organization's auditor for inclusion in rate calculation. Plans are encouraged to contact auditors and seek approval of processes as early as possible to ensure information is allowed for HEDIS/QARR reporting.

NYSDOH Reporting Requirements
NCQA added a data element to collect numerator events by supplemental data to all Effectiveness of Care (EOC) measures and Utilization measures similar to EOC measures. The reporting of supplemental numerator events in the Interactive Data Submission System (IDSS) is required. NYSDOH does not require the reporting of supplemental numerator events for NYS-specific measures.

How to Submit QARR

All plans must submit QARR data on the National Committee for Quality Assurance (NCQA) Interactive Data Submission System (IDSS). Estimated distribution date for the IDSS for MY 2023 is March 2024.

Where to Submit QARR

- Submit the IDSS directly to NCQA.
- **Electronically submit all additional files to our External Quality Review Organization (EQRO) via a secure file transfer facility (see Reporting Schedule for dates).** Do not mail materials. Additional files include:

1) Commercial CAHPS files
2) QHP Enrollee Survey files
3) Patient-Level-Detail files
4) Live Birth files
5) Medicaid Optional Enhancement files

- Coordinate FTP site arrangements with Jeff Worden of IPRO at jworden@ipro.org.

- **Any plan failing to submit the files by 5:00 p.m. ET on the date due will receive a Statement of Deficiency (SOD) for failure to comply with quality program requirements. For Medicaid plans, the compliance portion of the Quality Incentive is affected by Statements of Deficiency for QARR reporting**.

What to Send for QARR Submission

QARR Submission Required File	*Files must be submitted electronically by 5:00 p.m. ET on the date indicated*
	MY 2023 Data Due Date
IDSS file for all payers – IDSS files must be locked by auditor	**June 28, 2024**
CAHPS de-identified member-specific file for CPPO, CEPO, CHMO, EP	**June 14, 2024**
Enrollee Survey de-identified member-specific file for QEPO, QPPO, QHMO, QPOS	**June 28, 2024**
Patient-Level-Detail file for all products (includes NYS-specific measures)	**June 28, 2024**
Optional enhancement files for MA, HIVSNP, and HARP	**June 28, 2024**
Live Birth files for all payers	**August 2, 2024**

Questions Concerning the 2023 QARR Submission

- Interactive Data Submission System (IDSS): https://my.ncqa.org/
- Other required files: nysqarr@health.ny.gov
- HEDIS 2023 measures: Updates can be found on NCQA's web site: www.ncqa.org. Submit questions to NCQA's Policy Support System at the web site. NYSDOH is not responsible for the interpretation of HEDIS specifications or updating HEDIS information. Plans must refer to HEDIS specifications when calculating HEDIS measures as part of QARR.
- The Health Insurance Exchange Quality Rating System Measure Technical Specifications can be found on CMS web site: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Quality-Rating-System/About-the-QRS.html NYSDOH is not responsible for the interpretation of The Health Insurance Exchange specifications or updating information. Plans must refer to CMS specifications when calculating the QRS measures as part of QARR.
- All other questions: Bureau of Quality of Measurement and Evaluation (BQME), Quality Assurance Reporting Requirements (QARR) Unit at nysqarr@health.ny.gov.

II. Table 1. QARR List of Required Measures

Table 1. QARR List of Required Measures

Table 1: QARR List of Required Measures, is no longer contained within the QARR Technical Specification Manual. It is now a stand-alone document that has been posted to the NYSDOH Managed Care website under the Quality Assurance Reporting Requirements (QARR), 2023 tabs.

III. Audit Requirements

- All organizations must contract with an NCQA-licensed audit organization for an audit of their Commercial PPO, Commercial EPO, Commercial HMO, Qualified Health Plan PPO Qualified Health Plan EPO, Qualified Health Plan HMO, Qualified Health Plan POS, Medicaid, HIVSNP, HARP, and EP QARR data, as applicable.
- Annually, all organizations must send a copy of the written agreement with an NCQA-licensed audit organization by **December 1, 2023.** The copy can be sent in PDF format via email to:

  BQME, QARR Unit
  Office of Quality and Patient Safety
  Email: nysqarr@health.ny.gov

- Commercial PPO, Commercial EPO, Commercial HMO, and EP health plans must use a certified CAHPS vendor for the CAHPS survey and have the sample frame reviewed and approved by their auditor.
- Insurers offering a Qualified Health Plan PPO, Qualified Health Plan EPO, Qualified Health Plan HMO, and Qualified Health Plan POS must use a certified CAHPS vendor for the enrollee survey and have the sample frame reviewed and approved by their auditor.
- It is recommended that health plans provide a draft version of the IDSS to their auditor along with the Medicaid enhancement files, Patient-level Detail files, and live birth files prior to the June 28 deadline (recommended by June 14 for each reporting year)). Auditors should check for accuracy and that the specified variables in the PLD files and the IDSS reconcile.
- Annually, A copy of the Final Audit Report (FAR), including identified problems, corrective actions, and measure-specific results must be submitted to the BQME, QARR Unit in the Office of Quality and Patient Safety upon receipt from your auditor (email to nysqarr@health.ny.gov **by July 29, 2024**). The FAR must contain audit validation signatures.
- NYSDOH requires plans to submit data for all measures indicated in the QARR List of Required Measures (Table 1). Plans may not designate a measure as 'NR -- plan chose not to report this measure.'
- Plans may designate a measure "UN" (Unaudited) if reporting a measure that is not required to be audited. This result applies only to Board Certification measures.

Audit File Requirements	2023 Due Date
Copy of written agreement with an NCQA licensed organization that indicates **all products** included in the audit.	**December 1, 2023**
A copy of the Final Audit Report, including findings, corrective actions, and measure-specifi results with signatures is required. Final Audit Report submissions are required to include the specified information for all supplemental databas use.	**July 29, 2024**

IV. Reporting Schedule

Deliverable	MY2023 Due Date / Destination	MY2023 Products
Copy of written agreement with an NCQA licensed organization that indicates **all products** included in the audit.	December 1, 2023 Email: NYSDOH nysqarr@health.ny.gov	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS
Interactive Data Submission System (IDSS) Submission It is encouraged that plans send a version of the IDSS to their auditor one week prior to the submission deadline. This review may pick up issues that can be corrected prior to submission and will help plans make the submission deadline.	June 28, 2024, by 11:59 p.m. ET To: NCQA	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS
Patient-Level Detail file (required for the indicated product lines). **Enhancement files** (optional for MA, HIVSNP, and HARP) Plans are encouraged to send a version of the files to their auditor one week prior to the submission deadline. This review may pick up issues that can be corrected prior to submission and will help plans make the submission deadline.	June 28, 2024, by 11:59 p.m. ET To: jworden@ipro.org	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS
Live Birth File (required for indicated product lines).	August 2, 2024, by 11:59 p.m. ET To: jworden@ipro.org	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS

IV. Reporting Schedule

Deliverable	MY2023 Due Date / Destination	MY2023 Products
Commercial Survey – de-identified member-level files of CAHPS responses are required. Follow NCQA CAHPS file layout for file submission. CAHPS sample frames must be reviewed by auditor prior to CAHPS administration. Insurers with Qualified Health Plans - de-identified member-level files of Enrollee Survey responses are required.	June 14, 2024, by 11:59 p.m. ET To: jworden@ipro.org	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS
A copy of the Final Audit Report, including findings, corrective actions, and measure-specific results with signatures is required. Final Audit Report submissions are required to include the specified information for all supplemental database use.	July 29, 2024 Email: NYSDOH nysqarr@health.ny.gov	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS

NYSDOH requires all reporting entities to submit all components per the above schedule. Organizations that do not submit the IDSS by the submission deadline will be given a Statement of Deficiency (SOD) for failure to meet program requirements for performance data reporting. Plans unable to meet the deadline submission may request an extension for submission **prior** to IDSS due date. Reasons for the extension request must be provided with the request, and only those requests that have been approved will be acknowledged. Questions/Extension Requests to: **BQME, QARR Unit: nysqarr@health.ny.gov**

V. NYS-Specific Measures

COVID-19 Immunization Status (CVS)

Measure Name: COVID-19 Immunization Status (Primary Series and Booster)

Description: Percentage of members aged 6 months and older who have received the primary series of the COVID-19 vaccine. Percentage of members aged 5 years and older who have received the primary series of the COVID-19 vaccine ***and*** a booster.

Eligible Population:

Applicable Product Line	**Commercial** (PPO/EPO, HMO/POS, EP), (PPO/EPO, HMO/POS), **Medicaid** (HMO/PHSP, HIV SNP, HARP).
Ages	Members who were at least 6 months old as of **January 1, 2023**. Report four age stratifications and a total: • 6 months – 4 years. • 5-11 years. • 12-17 years. • 18-64 years. • Total. The total is the sum of the age stratifications. **Reporting of age stratification is based on the member's age as of January 1, 2023**.
Time Frame	Measurement Year 2023 (January 1, 2023 – December 31, 2023).
Continuous Enrollment	Continuously enrolled for the entire measurement year (MY2023).
Allowable Gap	No more than one gap in continuous enrollment of up to 30 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	Enrolled on December 31, 2023.
Exclusions	Members who were dually enrolled in Medicaid and Medicare at any point in the measurement year.

Administrative Specification: The administrative method uses transaction data or other administrative data to calculate the measure (e.g., claims, encounters, or vaccine registry data).

Denominator	**Denominators**: ***Denominator 1*** - The eligible population. ***Denominator 2*** - Members aged 5 years and older ***and*** who have received the primary series of the COVID-19 vaccine (compliant with numerator 1).

V. NYS-Specific Measures

Numerator	**Numerators:** ***Numerator 1 - Fully Vaccinated****:* • Members age 5-64 in the denominator who received either one dose of the Janssen COVID-19 Vaccine or two doses of the Moderna, Pfizer, AstraZeneca, or Novavax COVID-19 Vaccine any time on or between December 1, 2020 - December 31, 2023. • Members age 6 months – 4 years in the denominator who have received three doses of the Pfizer vaccine any time on or between December 1, 2020 – December 31, 2023, or two doses of the Moderna vaccine any time on or between December 1, 2020 – December 31, 2023. Both the first dose and the second dose are required for Moderna, Pfizer, or Novavax as identified by the presence of applicable Vaccine Procedural Codes (CPT), CVX codes, or the National Drug Codes (NDC) in combination with Vaccine Administration Codes ***or*** unique dates of service during the measurement period. **Please note**, the list of CPT, CVX, Vaccine Administration, and NDC codes (table 1 below) was based on guidance from the American Medical Association (AMA). Please reference the full updated list of codes at the time of measurement calculation at the following website: *https://www.ama-assn.org/system/files/covid-19-immunizations-appendix-q-table.pdf*. We acknowledge this list is fluid and health plans and vendors may work to identify and verify additional NDC codes that were active during the measurement period but are not listed in the table below. • An NDC code that is not in the table below can be mapped if its generic name (or brand name), strength/dose and route match those of a code in the table below and the code was active during the measurement period. • NDC codes that identify immunizations can be mapped to codes in value sets that identify immunizations. Additionally, the CPT, CVX, and NDC codes can be used interchangeably, and an immunization can be defined by a combination of applicable CPT codes, CVX codes, and Vaccine Administration codes or by a combination of NDC10/NDC11 and Vaccine Administration Codes (see Table 3 – scenario 5 below for example). • Unique dates of service can be used in place of the Vaccine Administration Code if Vaccine Administration Codes are not consistently available. • Vaccine Administration codes without a CPT, CVX, ***OR*** NDC code do not contribute to compliance. ***Numerator 1 Vaccination Dates of Service:*** • For recipients of a two-dose vaccine (Pfizer, Moderna, Novavax), the date of service for the second dose must be within eight weeks (56) days of the service date of the first dose. The service date of the first dose serves as day 1. • For example, a first dose with a date of service of January 1, 2022 (day 1) would have to be accompanied by a second dose with a service date on or before February 25, 2022 (day 56). If the second dose is after day 56, the second dose is not numerator compliant. • For recipients of a one-dose vaccine (Janssen), only one dose is required to be considered numerator compliant. Please see Table 2 below for example scenarios.

For members aged 4 years or younger during the vaccination that require three doses of the Pfizer vaccine, the third dose must be at least eight weeks (56) days ***after*** the date of the second dose.

For children who transition from a younger (age 4) to older age group (age 5) between vaccination doses:

- Use the member's age *at the time of their first received dose* to determine the number of required doses to be numerator compliant.
- For example, a child that is 4 years or younger old at the time of their first dose would need two additional doses to be considered numerator complaint. This member would be reported in the 6-month to 4-year age band because they were 4 years old on January 1, 2023.

Combination of vaccine manufacturers:

- Using a combination of vaccine manufacturers between doses is acceptable to determine numerator compliance. For example, a member who received a first dose of Pfizer and a second dose of Moderna would be considered numerator compliant.
- Based on CDC guidance, for children aged 4 and younger that received a combination of vaccine manufacturers (Pfizer and Moderna), the member must receive a total of three doses to be considered numerator compliant. The third dose can be either Pfizer or Moderna to be considered numerator complaint.
- For example, if a 4-year-old member received Pfizer for the first dose, Moderna for the second dose, and did not receive a third dose, the member is not numerator complaint.

Please see Table 3 below for example vaccination scenarios and numerator compliance.

Table 1: COVID-19 Vaccination Codes – Primary Series (as of October 2022)
Please reference the following source for the full list of updated codes:
https://www.ama-assn.org/system/files/covid-19-immunizations-appendix-q-table.pdf

Vaccine CPT Code	Vaccine Administration Code(s)	Patient Age	Manufacturer	Vaccine Name(s)	NDC 10/NDC11 Product ID	CVX Code
91300	0001A (1st Dose) 0002A (2nd Dose)	12 years and older	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine / Comirnaty	59267-1000-1 59267-1000-01	208
91305	0051A (1st Dose) 0052A (2nd Dose)	12 years and older	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1025-1 59267-1025-01	217
91307	0071A (1st Dose) 0072A (2nd Dose)	5 years through 11 years	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1055-1 59267-1055-01	218

91308	0081A (1st Dose) 0082A (2nd Dose) 0083A (3rd Dose)	6 months through 4 years	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-0078-1 59267-0078-01 59267-0078-4 59267-0078-04	219
91301	0011A (1st Dose) 0012A (2nd Dose)	12 years and older	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	207
91311	0111A (1st Dose) 0112A (2nd Dose)	6 months through 5 years	Moderna, Inc	ModernaCOVID-19 Vaccine	80777-279-05 80777-0279-05	228
91309	0091A (1st Dose) 0092A (2nd Dose)	6 years through 11 years	Moderna, Inc	Moderna COVID-19 Vaccine	80777-275-05 80777-0275-05	221
91303	0031A (Single Dose)	18 years and older	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	212
91304	0041A (1st Dose) 0042A (2nd Dose)	18 years and older	Novavax, Inc	Novavax COVID-19 Vaccine	80631-100-01 80631-1000-01	211
91302	0021A (1st Dose) 0022A (2nd Dose)	18 years and older	AstraZeneca, Plc	AstraZeneca COVID-19 Vaccine	0310-1222-10 00310-1222-10	NA

***Numerator 2 - Fully Vaccinated with Booster*:**

- Members in the denominator who received either one dose of the Janssen COVID-19 Vaccine or two doses of the Moderna, Pfizer, or Novavax COVID-19 Vaccine any time on or between December 1, 2020 - December 31, 2023, ***and*** a booster dose of either the Janssen, Moderna, or Pfizer Vaccine.
- **Note**: members aged 6 months – 4 years, based on the member age on January 1, 2023, are ***not*** included in the denominator for numerator 2. The NYS MY2023 Patient-Level Detail (PLD) File Specifications do not include numerator or denominator columns for this age group for numerator 2.

Numerator 2 Vaccination Dates of Service:

- Vaccine booster recipients must meet the criteria listed above for numerator 1 **AND** the date of service for the booster dose must be at least 60 days following the service date of the dose that made the recipient compliant for numerator 1. The service date of the numerator 1 compliant dose serves as day 1.
- For example, a numerator 1 complaint dose with a date of service of July 1, 2021 (day 1) would have to be accompanied by a booster dose with a service date on or after August 29, 2021 (day 60) to be compliant for numerator 2.

Please see Table 3 below for example vaccination scenarios and numerator compliance.

Table 2: COVID-19 Vaccination Codes - Booster Series (as of October 2022)
Please reference the following source for the full list of updated codes:
https://www.ama-assn.org/system/files/covid-19-immunizations-appendix-q-table.pdf

Vaccine CPT Code	Vaccine Administration Code(s)	Patient Age	Manufacturer	Vaccine Name(s)	NDC 10/NDC11 Product ID	CVX Code
91300	0004A (Booster)	12 years and older	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine / Comirnaty	59267-1000-1 59267-1000-01	208
91305	0054A (Booster)	12 years and older	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1025-1 59267-1025-01	217
91307	0074A (Booster)	5 years through 11 years	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine	59267-1055-1 59267-1055-01	218
91312	0124A (Booster)	12 years and older	Pfizer, Inc	Pfizer-BioNTech COVID-19 Bivalent	59267-0304-1 59267-0304-01 59267-1404-1 59267-1404-01	300
91315	0154A (Booster)	5 years through 11 years	Pfizer, Inc	Pfizer-BioNTech COVID-19 Bivalent	59267-0565-1 59267-0565-01	301
91306	0064A (Booster)	18 years and older	Moderna, Inc	ModernaCOVID-19 Vaccine	80777-273-10 80777-0273-10	207
91309	0094A (Booster)	18 years and older	Moderna, Inc	ModernaCOVID-19 Vaccine	80777-275-05 80777-0275-05	221
91313	0134A (Booster)	18 years and older	Moderna, Inc	Moderna COVID -19 Vaccine, Bivalent	80777 - 282 -05 80777 - 0282 -05	229
91314	0144A (Booster)	6 years through 11 years	Moderna, Inc	Moderna COVID -19 Vaccine, Bivalent	80777 - 282 -05 80777 - 0282 -05	229
91303	0034A (Booster)	18 years and older	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	212
91310	0104A (Booster)	18 years and older	Sanofi Pasteur	Sanofi Pasteur COVID-19 Vaccine, (Adjuvanted for	49281-618-20 49281-0618-20	

	Booster Immunization)	225

Note: Members will be counted in the numerator based on ***receipt of the full primary series*** of an approved COVID vaccine (either one dose of the Janssen COVID-19 Vaccine or two doses of the Moderna or Pfizer COVID-19 Vaccine (or three if under five-year-old)). Members that have received only one dose of a two-dose vaccine or two doses of a three-dose will not be considered numerator compliant.

- CPT, CVX, or NDC codes that are only found in Table 2 cannot be used for numerator 1 compliance (e.g., 91306, 91310, 91313, 91314, 91315). CPT, CVX, or NDC codes found in both Table 1 and Table 2 can be used for numerator 1 and numerator 2 compliance.
- The Sanofi Pasteur Booster vaccine (see Table 2 above) contributes to Numerator 2 only. The member must already be Numerator 1 compliant by other vaccine regimens if using this vaccine for Numerator 2 compliance.

Table 3: Vaccination Data Scenarios and Numerator Compliance Examples

	Member	Date of Service	Vaccine CPT/CVX/NDC	Vaccine Admin	Numerator 1 Compliant?	Numerator 2 Compliant?
Scenario 1a: Missing Vaccine Administration Code	Member 1	1/1/2021	91300		**Y** Two doses with valid CPT on distinct dates. Dose #2 on date after dose #1 and within 56 days of dose #1	**N** No eligible booster dose found
	Member 1	2/1/2021	91300			
Scenario 1b: Missing Vaccine Administration Code	Member 2	1/1/2021	91300		**Y** Two doses with valid CPT on distinct dates. Dose #2 on date after dose #1 and within 56 days of dose #1	**Y** Three doses with a valid CPT on distinct dates. Dose #3 (counts as booster) on date after dose #2 and at least 60 days after dose #2
	Member 2	2/1/2021	91300			
	Member 2	5/1/2021	91300			
Scenario 2: Delayed second dose	Member 3	1/1/2021	91300	0001A	**Y** Doses with valid CPT on distinct dates. Dose #2 is not within 56 days of dose #1. Dose #3 is within 56 days of dose #2	N No eligible booster dose found. Third dose only counts as eligible second dose since dose #2 was not within 56 days of dose #1
	Member 3	6/1/2021	91300	0002A		
	Member 3	7/1/2021	91300			
Scenario 3: 4-year-old member turns 5 between doses	Member 4 (age 4)	1/1/2021	91308	0081A	**Y** Dose #2 (Moderna) within 56 days of dose #1 (Pfizer). Received dose #3 (Pfizer) at least 56 days after dose #2	**NA** Members under 5 years old are not eligible for numerator 2
	Member 4 (age 5)	2/1/2021	91311	0111A		
	Member 4 (age 5)	4/1/2021	91308	0083A		

Table 3: Vaccination Data Scenarios and Numerator Compliance Examples (continued)

	Member	Date of Service	Vaccine CPT/CVX/NDC	Vaccine Admin	Numerator 1 Compliant?	Numerator 2 Compliant?
Scenario 4: Combination of vaccine manufacturers	Member 5	1/1/2021	91300	0001A	**Y** Two doses with valid CPT (different manufacturers) on distinct dates. Dose #2 on date after dose #1 and within 56 days of dose #1	**Y** Three doses with a valid CPT on distinct dates. Dose #3 (booster) on date after dose #2 and at least 60 days after dose #2
	Member 5	2/1/2021	91301	0012A		
	Member 5	5/1/2021	91300	0004A		
Scenario 5: Combination of CPT and NDC codes	Member 6	1/1/2021	91300	0001A	**Y** Two doses with valid CPT/NDC on distinct dates. Dose #2 on date after dose #1 and within 56 days of dose #1	**Y** Three doses with a valid CPT/NDC on distinct dates. Dose #3 (booster) on date after dose #2 and at least 60 days after dose #2
	Member 6	2/1/2021	80777 273-10			
	Member 6	5/1/2021	91300	0004A		

V. New York State Specific Measures

Viral Load Suppression (VLS)

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

Calculation of Measures
Upon close of **the measurement year (January 1 through December 31)** NYSDOH staff will apply an algorithm to identify Medicaid members who are potentially HIV-positive using available claims and encounters. This algorithm captures HIV+ Medicaid recipients based on their HIV-related service utilization, including outpatient visits, laboratory testing, inpatient stays, filling prescriptions for antiretroviral medications, and HIV Special Needs Plans enrollment. DOH staff will then employ a multistage matching algorithm to link information on potentially HIV-positive members to the HIV Surveillance System. Newly identified members are then added to the existing capture of HIV-positive matched members enrolled in Medicaid.

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

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

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

Eligible Population:

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

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

V. New York State Specific Measures

Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N)

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

Definitions

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

Eligible Population

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

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

	2. Identify the discharge date for the stay. *For members whose index episode was an ED visit that resulted in an inpatient stay, or other inpatient stay,* use the inpatient discharge as the IESD. Refer to General Guideline 44 for new instructions. *For direct transfers*, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer).
Step 2 Exclusions	Test for Negative Diagnosis History. Exclude members who had an index visit with a diagnosis of opioid abuse or dependence (NYS Opioid Abuse and Dependence Value Set) during the 60 days (2 months) before the IESD. *For an inpatient stay,* use the admission date to determine the Negative Diagnosis History. *For ED visits that result in an inpatient stay,* use the ED date of service to determine the Negative Diagnosis History. *For direct transfers,* use the first admission to determine the Negative Diagnosis History.
Step 3	Calculate continuous enrollment. Members must be continuously enrolled without any gaps, 60 days (2 months) before the IESD through 29 days after the IESD. For members with more than one episode of opioid abuse or dependence, use the first episode.

Administrative Specification

Denominator	The eligible population
Numerator	Initiation of pharmacotherapy treatment within 30 days of the Index Episode. Any of the following will identify initiation of pharmacotherapy treatment for opioid abuse or dependence: • A Medication Assisted Therapy Dispensing Event (NYS AOD Medication Treatment Value Set). • Dispensed a prescription for Opioid Abuse or Dependence (NYS Opioid Use Disorder Treatment Medications List). *If the Index Episode was an inpatient admission,* the 30-day period for the MAT begins on the day of discharge. Opioid Use Disorder Treatment Medications

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

Note: NYS will post a comprehensive list of medications and NDC codes to NYSDOH Managed Care website in March 2023.

V. New York State Specific Measures

Use of Pharmacotherapy for Alcohol Use or Dependence (POA)

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

Eligible Population

Product Lines	Medicaid, HIVSNP, HARP
Ages	18 years and older as of December 31 of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefits	Medical, Chemical Dependency, and Pharmacy
Event/ Diagnosis	Members with at least one alcohol use or dependence diagnosis (NYS Alcohol Abuse and Dependence Value Set) during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	Number of individuals with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year. Any of the following will identify initiation of pharmacotherapy treatment for alcohol abuse or dependence: • Dispensed a prescription for Alcohol Abuse or Dependence (NYS Alcohol Use Disorder Treatment Medications List) during the measurement year. • Medication treatment during a visit (NYS AOD Medication Treatment Value Set). Alcohol Use Disorder Treatment Medications

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

Note: NYS will post a comprehensive list of medications and NDC codes to NYSDOH Managed Care website in March 2023

V. New York State Specific Measures

Utilization of Recovery-Oriented Services for Mental Health (URO)

This measure will be calculated and reported by New York State. No plan reporting is required.

Description
The percentage of HARP enrolled members 21-64 years of age who received any of the following mental health recovery-oriented services for at least three months during the measurement year:

- Personalized Recovery Oriented Services (PROS)
- Home and Community Based Services (HCBS)
- Certified Community Behavioral Health Clinic (CCBHC) Rehabilitation/Peer Services
- Any recovery-oriented services (listed above)

Eligible Population

Product Lines	Medicaid, HARP
Ages	21-64 years old as of January 1 of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 30 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	None.
Benefits	Medical, Mental Health, and Chemical Dependency
Event/ Diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	PROS: Use codes (PROS Value Set) to identify months in which claims for PROS were submitted during the measurement year. Because PROS services are bundled into a single claim submitted once per month, only one PROS claim is required in any given month. The member is numerator compliant if at least one monthly PROS claim was submitted for three or more months during the measurement year. HCBS: Use Codes (HCBS Value Set) to identify months in which claims for HCBS were submitted during the measurement year. HCBS is billed individually, with each claim representing a single service. The member is numerator compliant if at least one HCBS claim was submitted for three or more months during the measurement year. CCBHC: Use codes (CCBHC Value Set) to identify months in which claims for CCBHC peer or rehabilitation service(s) were submitted during the measurement year. CCBHC peer and rehabilitation services are billed individually, with each claim representing a single service. The member is numerator compliant if at least one CCBHC peer or rehabilitation service claim was submitted for three or more months during the measurement year. Any Recovery-oriented Service: The member is numerator compliant if any of the numerator requirements listed above (PROS, HCBS, or CCBHC) are met.

	Note: Members who meet the numerator requirements for more than one recovery-oriented service type will only be counted once in the numerator of Any Recovery-oriented Service.
Exclusions	Medicare duals are excluded.

V. New York State Specific Measures

Potentially Preventable Mental Health Related Readmission Rate 30 Days (PPR-MH)

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

Calculation of Measure

Upon close of **the measurement year** the following performance measure will be calculated by the Office of Quality and Patient Safety using health plan submitted encounter data and output from 3M™.

Reporting Requirements

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

Description

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

Definitions

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

Eligible Population

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

V. New York State Specific Measures

Allowable Gap	No gaps in enrollment.
Anchor Date	Date of discharge.
Continuous Enrollment	3 months prior to the index admission, at the time of admission, and 1-month post discharge.
Benefits	Medical, Mental Health (Inpatient and Outpatient)
Event/ Diagnosis	Identify all acute inpatient article 28 MH-related discharges on or between January 1 to December 1 of the measurement year.
Step 2 Exclusions	Exclude direct transfers and admissions where the patient died. Identify and exclude admissions related to complex medical conditions, non-events as listed in the following tables: **Readmission Exclusions (Specific to 3M™ Grouper Version 31)** • Admissions for immunocompromised or metastatic malignancy • Neonatal or obstetrical admissions • Multiple Trauma Admissions • Admissions for burns • Transplant admissions • Planned readmissions • Patient left against medical advice • Data errors **Non-events (At Risk Admission Exclusions: Specific to 3M™ Grouper Version 31)** • Admissions to non-acute care facilities • Admissions to an acute care hospital for patients assigned to the APR DRGs for rehabilitation, aftercare, and convalescence • Same-day transfers to an acute care hospital for non-acute care (e.g., hospice care) • Malignancies with a chemotherapy or radiotherapy procedure • Selected hematological disorders • Certain blood disorder/procedure combinations • Certain planned chemotherapy, radiation procedure
Step 3	Restrict to initial admissions and only admissions.

Administrative Specifications

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

V. New York State Specific Measures

Prenatal Care Measures/Birth File

The following prenatal care performance measures will be calculated by the Office of Quality and Patient Safety using the birth data submitted by plans and from the Department's Vital Records Birth File.

Risk-Adjusted Low Birthweight Rate

The adjusted rate for live infants weighing less than 2500 grams among all deliveries by women continuously enrolled in a plan for 10 or more months.

Prenatal Care in the First Trimester

The rate of continuously enrolled (10 months or more) women with a live birth who had their first prenatal care visit in the first trimester, defined as a prenatal care visit within 90 days of the date of last normal menses. For this analysis, the first prenatal care visit is defined as the date of the first physical and pelvic examinations performed by a physician, nurse practitioner, physician's assistant, and/or certified nurse midwife at which time pregnancy is confirmed, and a prenatal care treatment regimen is initiated.

Risk-Adjusted Primary C-section

The adjusted rate of live infants born by cesarean delivery to women, continuously enrolled for 10 or more months, who had no prior cesarean deliveries.

Vaginal Birth After C-section

The percentage of women continuously enrolled for 10 or more months who delivered a live birth vaginally after having had a prior cesarean delivery.

Calculation of Measures

Upon receipt of the list of mothers who gave birth during **the measurement year** DOH staff will employ a multistage matching algorithm to link information provided by plans to the Vital Records Birth File. Risk-adjustment models will also be used to calculate low birthweight and primary C-section rates. Using the data submitted by the plans and from the Department's Vital Statistics Birth File, risk factors or confounding factors such as race, age, plurality, education level, and complications of labor and delivery will be used to construct a predictive model. Risk-adjusted rates are more comparable across plans because the methodology considers that these risk factors are beyond the plans' control.

The Vital Records File provides information on the first prenatal care visit, the number of visits, birthweight, type of delivery, age, race, level of education, and maternal risk factors associated with labor and delivery. Matching plan data to the birth certificate data improves the data reporting by allowing for: 1) the calculation of performance measures using the same DOH data source, and 2) the risk adjustment of the measures when applicable.

Reporting Requirements

Plans are to report all live births that occurred during the measurement year of January 1, through December 31, to the Office of Quality and Patient Safety. Information provided will be used to link to the Vital Records Birth File. The following information is required:

- Mother's Last Name (List mother more than once in cases of multiple births.)
- Mother's First Name
- Mother's Date of Birth
- Mother's Resident Zip Code at Time of Delivery
- Date of Delivery (The date of delivery is a critical field for matching to the Department's Vital Records Birth File. The mother's admission date is not on the Vital Records Birth File, nor is it necessarily the same as the date of delivery. However, if the date of delivery is truly unavailable, the Office of Quality and Patient Safety will use the mother's admission date to obtain the highest match rate possible.)
- Hospital of Delivery (PFI)
- Mother's Date of Admission

- Number of Enrollment Days Prior to Delivery
- Plan ID
- Product Line
- Mother's Client ID Number
- Baby's Client ID Number

The plan's data will be formatted in a file as described in the following reporting Specifications:

Format: Standard ASCII file with all entries **left** justified unless otherwise indicated.
Separate files for each product line.

Commercial PPO: Submit one file containing commercial PPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Commercial EPO: Submit one file containing commercial EPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Commercial HMO/POS: Submit one file containing commercial HMO/POS members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Qualified Health Plan PPO: Submit one file containing Qualified Health Plan PPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Qualified Health Plan EPO: Submit one file containing Qualified Health Plan EPO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Qualified Health Plan HMO: Submit one file containing Qualified Health Plan HMO members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Qualified Health Plan POS: Submit one file containing Qualified Health Plan POS members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Medicaid HMO/PHSP: Submit one file containing Medicaid, and CHP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-96. This includes CHP births.

Medicaid HIVSNP: Submit one file containing HIVSNP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-96.

Medicaid HARP: Submit one file containing HARP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-96.

EP: Submit one file containing EP members/mothers who had a live birth during the reporting year. The file should contain information in positions 1-80.

Eligible Group

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

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

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

V. New York State Specific Measures

Record Format for Product lines

Element	Location	Coding	Notes
Mother's Last Name	1-20	Left Justified	No numeric entries. **List mother more than once in the case of multiple births.**
Mother's First Name	21-35	Left Justified	Do not include middle initial or punctuation.
Mother's Date of Birth	36-43	DDMMYYYY	Year must include four digits (e.g., 1985).
Mother's Resident Zip Code at Time of Delivery	44-48	Right Justified	No blanks, use 99999 if unknown.
Date of Delivery	49-56	DDMMYYYY	Year must include four digits (e.g., 2019).
Hospital of Delivery	57-61	Left Justified	Please use 88888 for 'out of state'; 99999 for 'unknown hospital'; and 11111 for 'not in hospital' birth. *PFI numbers for birth centers are now available, see note below for coding these facilities.* **If using a four-digit PFI*, it must be LEFT justified. Do not add a leading zero.**
Mother's Date of Admission	62-69	DDMMYYYY	Year must include four digits (e.g., 2019).
Number of Enrollment Days Prior to Delivery	70-73	Right Justified	The number of days the mother was enrolled in the plan during the 10-month period immediately prior to delivery. Cannot be a negative number. The number of days should not include the delivery date and should not include gap days.
Submission ID	74-78	Left Justified	Enter the NCQA five-digit submission ID
Product Line	79-80	Left Justified	1 = MA 2 = HIVSNP 3 = HARP 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10 = CEPO 11 = EP
Mother's Client ID Number (CIN)	81-88	For Medicaid: AA#####A For CHP: 0######## or 5########	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)
Baby's Client ID Number (CIN)	89-96	For Medicaid: AA#####A For CHP: 0######## or 5########	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)

Important Note: New PFI INSTRUCTIONS

A list of current hospital PFI codes is available on the Health Data NY website: (https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r/data).
Please use the link to access the listing. On the main page, click "Filter" button, and under "Description is" filter, select all the check boxes that list the following Description:

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

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

V. New York State Specific Measures

HEADER RECORD
To be submitted in standard ASCII format as the first row on the live birth file.

HEADER FORMAT

Element	Location	Coding
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified
Product Line	21-38	CPPO, CEPO, CHMO, QHP_PPO, QHP_EPO, QHP_HMO, QHP_POS, MEDICAID, HIVSNP, HARP, EP Left justified
Number of deliveries on file	39-43	Right justified
Date file written	44-51	DDMMYYYY

Technical Assistance
If you need clarification of prenatal data requirements and/or assistance creating a flat ASCII file, please email the Quality Assurance Reporting Requirements Unit at nysqarr@health.ny.gov.

V. New York State Specific Measures

Developmental Screening in the First Three Years of Life (DEV-N)

This measure was adapted with permission by NYS DOH from the "Developmental Screening in the First Three Years of Life" measure stewarded by Oregon Health and Sciences University.

Description
Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Eligible Population

Age	Children age 1, 2, or 3 between January 1 and December 31 of the measurement year. Report three age stratifications and a total rate: • Children who turned 1 • Children who turned 2 • Children who turned 3 • All Children
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
Anchor date	Enrolled on the child's first, second, or third birthday
Benefit	Medical
Event/Diagnosis	None
Exclusions	None

Administrative Specification

Denominator	**Denominator**	
	Denominator 1	The children in the eligible population who turned 1 during the measurement year.
	Denominator 2	The children in the eligible population who turned 2 during the measurement year.
	Denominator 3	The children in the eligible population who turned 3 during the measurement year.
	Denominator 4	All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.
Numerator	Numerator 1	Children in Denominator 1 who had a claim with CPT code 96110 and ICD-10-CM Code Z13.42 before or on their first birthday.
	Numerator 2	Children in Denominator 2 who had a claim with CPT code 96110 and ICD-10-CM Code Z13.42 before or on their first birthday.
	Numerator 3	Children in Denominator 3 who had a claim with CPT code 96110 and ICD-10-CM Code Z13.42 before or on their first birthday.
	Numerator 4	Children in the entire eligible population who had a claim with CPT code 96110 and ICD-10-CM Code Z13.42 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2, and 3).

Note: Developmental screening as described here requires a global (multi-domain) screen and not a single-domain screen like autism. Tools must meet the following criteria:

V. New York State Specific Measures

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The following tools are cited by Bright Futures (and the American Academy of Pediatrics statement on developmental screening) and meet the above criteria:

- Ages and Stages Questionnaire (ASQ) - 2 months to age 5
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

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

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

1) validate summary-level data submitted by measure in the IDSS
2) create composite measures
3) enhance Medicaid
4) monitor health disparities
5) conduct research and evaluation

NYSDOH requires all plans to use the NYS PLD file and variables listed in the table below. For specific file formats, refer to the NYS Patient-Level Detail Specifications.

Patient-Level Detail

- Follow NCQA Specifications for those measures included in the NYS PLD file for each product. Follow the NYS Specifications for NYS-Specific measures included in the NYS PLD.
- Submit separate product-level-specific PLD files.
- Submission should not include header row.
- The patient-level data must match the plan reported data in the NCQA IDSS.
- The NYS patient-level data will not match the summary-level data for hybrid measures.
- All fields in the NYS PLD file specifications are mandatory.
- If a member qualifies for the denominator of a measure that requires race and ethnicity reporting to NCQA, then the patient level detail file that includes that member should have the member's race and ethnicity and the method used to identify the race and ethnicity (direct or indirect) so that NYS may be able to match rates submitted to NCQA via IDSS.
- Plans are required to submit PLD files **for all measures applicable to the product line**.

NYS-Specific Measures Summary-Level Data

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

VI. Patient-Level Detail File Submission

2023 NYS Patient-Level Detail File Specifications

Prepare a fixed width text file in the following format. Include one row for every member who was enrolled in the product and who meets criteria for one or more of the specified PLD measures for 2023 measurement year. Numeric values should be right justified and blank filled to the left of the value; text fields should be left-justified and blank filled to the right of the value. **All PLD files are due on June 28, 2024, for MY2023**.

The file should be named PLDF_SubID_MMDDYYYY_Version

Example: PLDF_12345_11132015_v1

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

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

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

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

VI. Patient-Level Detail File Submission

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

Hybrid Measures

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

Administrative Measures

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

Record Format for all Product lines

Element	Field Length	Location	Coding	Data Elements
Plan Name	20	1 -20	First 20 characters of plan name including blanks - Left justified	
Product Line	18	21-38	CPPO, CEPO, CHMO, MEDICAID, HIVSNP, HARP, or EP, QHP_HMO, QHP_POS, QHP_PPO, QHP_EPO	
Submission ID	5	39-43	Right justified	
LSC Eligible Population	6	44-49	Right justified	Eligible population (before optional exclusions).
LSC Numerator	6	50-55	Right justified	Number of numerator events by administrative data in eligible population (before exclusions).
LSC Rate	5	56-60	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Current year's administrative rate (before exclusions).
POD-N Eligible Population	6	61-66	Right justified	
POD-N Numerator	6	67-72	Right justified	Numerator events by administrative data.
POD-N Rate	5	73-77	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Reported rate.
POA Eligible Population	6	78-83	Right justified	

VI. Patient-Level Detail File Submission

Element	Field Length	Location	Coding	Data Elements
POA Numerator	6	84-89	Right justified	Numerator events by administrative data.
POA Rate	5	90-94	Must include 4 digits after decimal (e.g., .2019), except for when rate=1, must include 3 digits after decimal (e.g., 1.000)	Reported rate.

NYS Patient-Level Detail File Notes

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

Members to Exclude

- Exclude members who are not in any eligible population of any measure in the product line-specific PLD.
- Only include member months for those members included in any measure specified in the PLD.
- Enrollment by Product Line is not a measure in the PLD. Use the member months contribution this member adds according to the Enrollment by Product Line measure. If the member is only in Enrollment by Product Line measure, they would not be included in the PLD.

Audit Designations

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

Member ID

- The Member ID on the NYS PLD file format should be the Client Identification Number (CIN) for Medicaid members (including HIV/SNP and HARP Members). **If the Medicaid/CHP CIN is invalid, the member will not be eligible for measure enhancement, if applicable.**
- For Exchange-enrolled Child Health Plus (CHP) members, health plans are to use the 8-digit Member Policy, or Member ID number, assigned by the Exchange as the Member ID submitted in the PLD file for QARR. This should be the same member ID used for encounter data reporting.
- For non-Exchange-enrolled CHP members, health plans are to use the 8-digit member ID assigned by KIDS as the Member ID submitted in the PLD file for QARR. This should be the same ID used for encounter data reporting.
- Members enrolled in different product lines (Medicaid, CHP) at different times during the measurement year or year prior should report the member ID for the product which they belonged to at the end of the measurement year. For example, a member enrolled in the CHP product line who switches to the Medicaid product line during the measurement year, the Medicaid CIN is reported for the Member ID in the PLD file.
- For Commercial plans, Member ID should be the health plan's internal, individual member identifier for QARR PLD reporting. Do not report the member's family, or subscriber identifier, unless it is the same as the member'. If applicable, do not report a randomly generated member identifier that may be used for HEDIS reporting; only report the member identifier used in HEDIS if it matches the plan's internal, individual member identifier from the plans' claims system.
- For Market Place plans, the Member ID should be the member's NYS-issued HIXNY Member ID for QARR PLD reporting.

Hybrid Measures

- The PLD file should only include the patient-level details from the hybrid method. The denominator and numerator results (Numerator events by administrative data, Numerator events by

supplemental data and Numerator events by medical record data) should reflect those members used to calculate the hybrid reported rate.
- The patient-level data will not match the summary-level data (NYS-Specific Measures Summary-Level File) for measures calculated using the hybrid method.
- If your plan reports LSC using the administrative method, then follow the instructions for administrative measures.

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

Product Specific Reporting
- Commercial Plans with approval from NCQA and NYSDOH to combine report their HMO and PPO membership should place these members in their CHMO product line.
- Commercial Plans with approval from NCQA and NYSDOH to combine report their EPO and PPO membership should place these members in their CPPO product line.
- Measures that are not applicable to the member should be zero-filled.
- Commercial Products should report Lead Screening in Children in their NYS-Specific PLD.

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

Technical Assistance
For Commercial, Medicaid, Exchange IDSS support, please submit questions to PCS at https://my.ncqa.org/.

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

VII. FIPS COUNTY CODES

NYS Counties	FIPS Code		NYS Counties	FIPS Code		NYS Counties	FIPS Code
ALBANY	001		JEFFERSON	045		ST LAWRENCE	089
ALLEGANY	003		KINGS	047		SARATOGA	091
BRONX	005		LEWIS	049		SCHENECTADY	093
BROOME	007		LIVINGSTON	051		SCHOHARIE	095
CATTARAUGUS	009		MADISON	053		SCHUYLER	097
CAYUGA	011		MONROE	055		SENECA	099
CHAUTAUQUA	013		MONTGOMERY	057		STEUBEN	101
CHEMUNG	015		NASSAU	059		SUFFOLK	103
CHENANGO	017		NEW YORK	061		SULLIVAN	105
CLINTON	019		NIAGARA	063		TIOGA	107
COLUMBIA	021		ONEIDA	065		TOMPKINS	109
CORTLAND	023		ONONDAGA	067		ULSTER	111
DELAWARE	025		ONTARIO	069		WARREN	113
DUTCHESS	027		ORANGE	071		WASHINGTON	115
ERIE	029		ORLEANS	073		WAYNE	117
ESSEX	031		OSWEGO	075		WESTCHESTER	119
FRANKLIN	033		OTSEGO	077		WYOMING	121
FULTON	035		PUTNAM	079		YATES	123
GENESEE	037		QUEENS	081		OUTOFSTATE	000
GREENE	039		RENSSELAER	083		UKNOWN/MISSING	999
HAMILTON	041		RICHMOND	085			
HERKIMER	043		ROCKLAND	087			

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

Optional Enhancements for Medicaid, HIVSNP, and HARP

The Office of Quality and Patient Safety will enhance results for several measures for this reporting year:

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

Enhancement files for these measures should be submitted for **all members from the denominator for plans wishing to have applicable measures screened for out-of-plan services.*

The submission of these enhancement files is optional. Plans will be notified of their updated rates following the incorporation of out-of-plan numerator events. Plans with more than one product should submit one enhancement file for each measure as applicable.

Enhancement File Requirements

- Only valid Medicaid or CHP CINs will be included in the enhancement process.
- All discharges included in the denominator for the Follow-up After Hospitalization for Mental Illness **must** be included in the enhancement file submitted.
- All emergency department visits included in the denominator for the Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **must** be included in the enhancement file submitted.
- Plans should be using the CINs relevant to the measurement year. For example, if a member has a previous CIN and a CIN from the measurement year, the CIN from the measurement year should be the CIN on the file.
- Members enrolled in different product lines (Medicaid, HARP, CHP) at different times during the measurement year or year prior should report the member CIN for the product for which they belonged to at the end of the measurement year. For example, for a member enrolled in the CHP product line who switches to the Medicaid product line during the measurement year, the Medicaid CIN is reported in the member-level file.

Chlamydia Screening in Women and Colorectal Cancer Screening

The Office of Quality and Patient Safety will use the Patient-level detail file to evaluate Medicaid fee-for-service (FFS) data to determine whether out-of-plan services were received by members noted to be numerator non-compliant for the measures. No additional data elements are needed for this enhancement process.

Follow-Up After Hospitalization for Mental Illness

There are two time periods in which a follow-up visit must have taken place to be considered a numerator "hit": up to 7 days after hospital discharge, and up to 30 days after discharge. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these

discharges with admissions to a State-operated psychiatric facility. Any discharge with a readmission within 30 days to a State-operated psychiatric facility will be removed. The Office of Quality and Patient safety will use the remaining discharges and Medicaid FFS data to determine whether out-of-plan services were used for either of these components of the measure. The optional files should include the CIN and the discharge date for each qualifying index event for every event in the denominator; the count of records in the file should match the denominator in the IDSS. In addition to the CIN, the files require the discharge date, the date of any qualifying visit within 7 days, and the date of any qualifying visit within 30 days. If there is a 7-day follow-up visit, but no visit between 8 and 30 days after discharge, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

Measure	Data Elements	Fields	File Name
Follow-Up After Hospitalization for Mental Illness: 1) 7-Day and 2) 30-Day	Submission ID	1-5	FUH.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA######A For CHP – 0######## or 5########	
	Discharge Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

Follow-Up After Emergency Department Visit for Mental Illness:

There are two time periods in which a follow-up visit must have taken place to be considered a numerator "hit": up to 7 days after emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these visits with admissions to a State-operated psychiatric facility. Any visit with a readmission within 30 days to a State-operated psychiatric facility will be removed. The Office of Quality and Patient Safety will use the remaining visits and Medicaid FFS data to determine whether out-of-plan services were used for either of these components of the measure. The optional files should include the CIN and the visit date for each qualifying index event for every event in the denominator; the count of records in the file should match the denominator in the IDSS. In addition to the CIN, the files require the visit date, the date of any qualifying visit within 7 days, and the date of any qualifying visit within 30 days. If there is a 7-day follow-up visit, but no visit between 8 and 30 days after visit, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

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

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

Measure	Data Elements	Fields	File Name
1) 7-Day and 2) 30-Day	CIN	7-14 For Medicaid – AA#####A For CHP – 0######## or 5########	
	ED Visit Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

Follow-Up After High-Intensity Care for Substance Use Disorder

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

Measure	Data Elements	Fields	File Name
Follow-Up After High-Intensity Care for Substance Use Disorder 1) 7-Day and 2) 30-Day	Submission ID	1-5	FUI.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0######## or 5########	
	Episode Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

Follow-Up After Emergency Department Visit for Substance Use:

There are two time periods in which a follow-up visit must have taken place to be considered a numerator "hit": up to 7 days after emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Quality and Patient Safety will work with the Office of Mental Health to match these visits with admissions to a State-operated psychiatric facility. Any visit with a readmission within 30 days to a State-operated psychiatric facility will be removed. The Office of Quality and Patient safety will use the remaining visits and Medicaid FFS data to determine whether out-of-plan services were used for either of these components of the measure. The optional files should include the CIN and the visit date for each qualifying index event for every event in the denominator; the count of records in the file should match the denominator in the IDSS. In addition to the CIN, the files require the visit date, the date of any qualifying visit within 7 days, and the date of any qualifying visit within 30 days. If there is a 7-day follow-up visit, but no visit between 8 and 30 days after visit, please duplicate the date of the 7-day visit for the 30-day visit. If no visits were found for a CIN, enter zeros for both visit date fields.

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

Measure	Data Elements	Fields	File Name
Follow-Up After Emergency Department Visit for Substance Use: 1) 7-Day and 2) 30-Day	Submission ID	1-5	FUA.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	
	CIN	7-14 For Medicaid – AA#####A For CHP – 0######## or 5########	
	ED Visit Date (YYYYMMDD)	15-22	
	7-Day Follow-up Visit Date (YYYYMMDD)	23-30	
	30-Day Follow-up Visit Date (YYYYMMDD)	31-38	

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

Follow-Up Care for Children Prescribed ADHD Medication:

The Office of Quality and Patient Safety will use Medicaid FFS data to determine whether out-of-plan services were used for the two numerators of the measure. Members not meeting the numerator criteria for Initiation Phase or Continuation and Maintenance Phase will be eligible for enhancement in the FFS data. The optional files should include the CIN and the index episode start date for each member in the denominator; the count of records in the file should match the denominator in the IDSS. Please note that, per HEDIS 2023 specifications, **the initiation phase visit must be with a prescribing practitioner** to count as a numerator "hit." If members have more than three visits in the specified time period, please select the visits that allowed the member to qualify. For example, if a member had two visits in the first 30 days, and the second visit is with a prescribing practitioner, the plan would include the second visit date for the initiation numerator. Members indicated as not being compliant for the two numerators will be reviewed with FFS data to determine if visits occurred and which facilities were used for the visits. Any "missing" or "not applicable" dates should be submitted as zeros in the YYYYMMDD format (00000000).

Measure	Data Elements	Fields	File Name
Follow-Up Care for Children Prescribed ADHD Medication: **1) Initiation Phase** **2) Continuation and Maintenance Phase**	Submission ID	1-5	Add.txt
	Product Line (1 = Medicaid 2 = HIVSNP 3 = HARP)	6	
	CIN ('0' fill the first position of this for CHP CINs)	7-14 For Medicaid – AA######A For CHP – 0######## or 5########	
	Included in Denominator 1? (1=Yes; 0=No)	15	
	Index Episode Start Date (YYYYMMDD)	16-23	
	Subsequent Visit Date1 (YYYYMMDD)	24-31	
	Indicator of Prescribing Provider for Visit Date1 (1=Yes; 0=No)	32	
	Indicator of Numerator Compliance for Initiation measure (1=Yes; 0=No)	33	
	Included in Denominator 2? (1=Yes; 0=No)	34	
	Subsequent Visit Date2 (YYYYMMDD)	35-42	
	Subsequent Visit Date3 (YYYYMMDD)	43-50	
	Indicator of Numerator Compliance for Continuation and Maintenance measure (1=Yes; 0=No)	51	

Technical Assistance

If you need clarification on these files, please contact the BQME, QARR Unit at nysqarr@health.ny.gov.