NEW YORK STATE OF OPPORTUNITY. Department of Health

Health Home Measure Specifications and Reporting Manual

Updated: September 2021

I. Introduction

The purpose of this document is to make stakeholders aware of the quality measures, performance goals and quality measure reporting requirements for the New York State Department of Health - Health Home Program (NYSDOH-HH).

Successful Health Home performance will ensure the Health Home goal of providing a person-centered system of care that improves outcomes and provides better services for high need Medicaid members. High performance in the Health Home program also supports the Center for Medicaid and Medicare Services' (CMS) overarching approach to improving health care through the pursuit of three goals: improving the experience of care; improving the health of populations; and reducing per capita costs of health care.

New York State is at the forefront of health system transformation. New York's Medicaid Redesign Team (MRT) has embraced the goals of health system transformation and created initiatives to move to a value-based payment (VBP) system in which Medicaid payments are tied to value, health outcomes, and best practice. As an integral part of the future of VBP, the Health Home Program must show quality outcomes and successful performance to be considered for and included in VBP arrangements.

II. Performance Measurement Overview

The Health Home Program will be evaluated using Performance Measures and HH reports submitted to the NYSDOH-HH. Performance Measures are separated into Quality and Process Measures. Quality Measures are identified in the State Plan Amendment, Health Home Core Set and Health Home Serving Children Application. Process Measures were derived from Health Home Care Management Annual Reporting Tool (HH-CMART) data and DOH State Agency Partner and stakeholder input.

Through a multigroup stakeholder engagement process, a set of quality measures were defined based on an analysis of relevance, reliability, validity, and feasibility of each measure. The measures were placed within six domains.

Measure Domains

Domain 1 – Preventive Care
Domain 2 – Care for Chronic Conditions
Domain 3 – Mental Illness
Domain 4 – Substance Use Disorders
Domain 5 – Utilization
Domain 6 – Avoidable Utilization

The NYSDOH-HH is required to report on the measure set identified in Appendix A, but NYSDOH-HH may identify an additional measure subset annually that guides technical assistance activities with the lead Health Homes to improve performance in underperforming areas. The Performance Support/Technical Assistance program is discussed in Section VIII. B.

Due to the importance of Health and Recovery Plan (HARP) member enrollment in the NYSDOH-HH, HARP enrollment and specific HARP measures will be monitored on a quarterly basis.

Care Coordination Organizations/Health Home (CCO/HH) specific measures have been added to the Measures Specification and Reporting Manual. At this time, CCO/HHs are required to monitor the CCO/HH specific measure set until reporting to NYS begins.

Managed Care Organizations (MCO) will increase oversight of Health Home outcomes in 2018. A measure set developed by the Health Home/MCO Workgroup will be monitored with reporting completed by NYSDOH-HH.

III. *Methodology for Establishing Performance Goals and Annual Improvement Targets*

Performance Goals (PG)

Performance Goals are intended to reflect the best performance expected in New York State. Performance Goals are the same, consistently applied to all Health Homes each year and will not be changed for a two-year period (until 2020), when the goals will be re-evaluated.

The NYSDOH-HH utilized 2015 Health Home performance data to calculate performance goals for each performance measure. The NYSDOH-HH will mirror the Delivery System Reform Incentive Payment Program (DSRIP) and use the CMS suggested top decile as a mechanism for establishing performance goals. Deciles sort data into ten equal parts by percentile. For performance measures where a higher result is desirable, the 90th percentile is used as a benchmark. The 90th percentile is equal to the value below which 90% of performance measures fall. For performance measures where a lower result is desirable, the 10th percentile is used as a benchmark. The 10th percentile is equal to the value above which 90% of performance measures fall.

If data for the measure was not available for 2015, the performance goals were established with the same methodology as above using Health Home results from 2016. Measures that are added in the future will be set to a default of 100% or 0% for the first measurement year and then reset using the most recent measurement year's results.

If measure specifications are changed to the degree that prior results are not comparable, NYSDOH-HH has established a process for resetting performance goals. Details about the process are in Section IX.

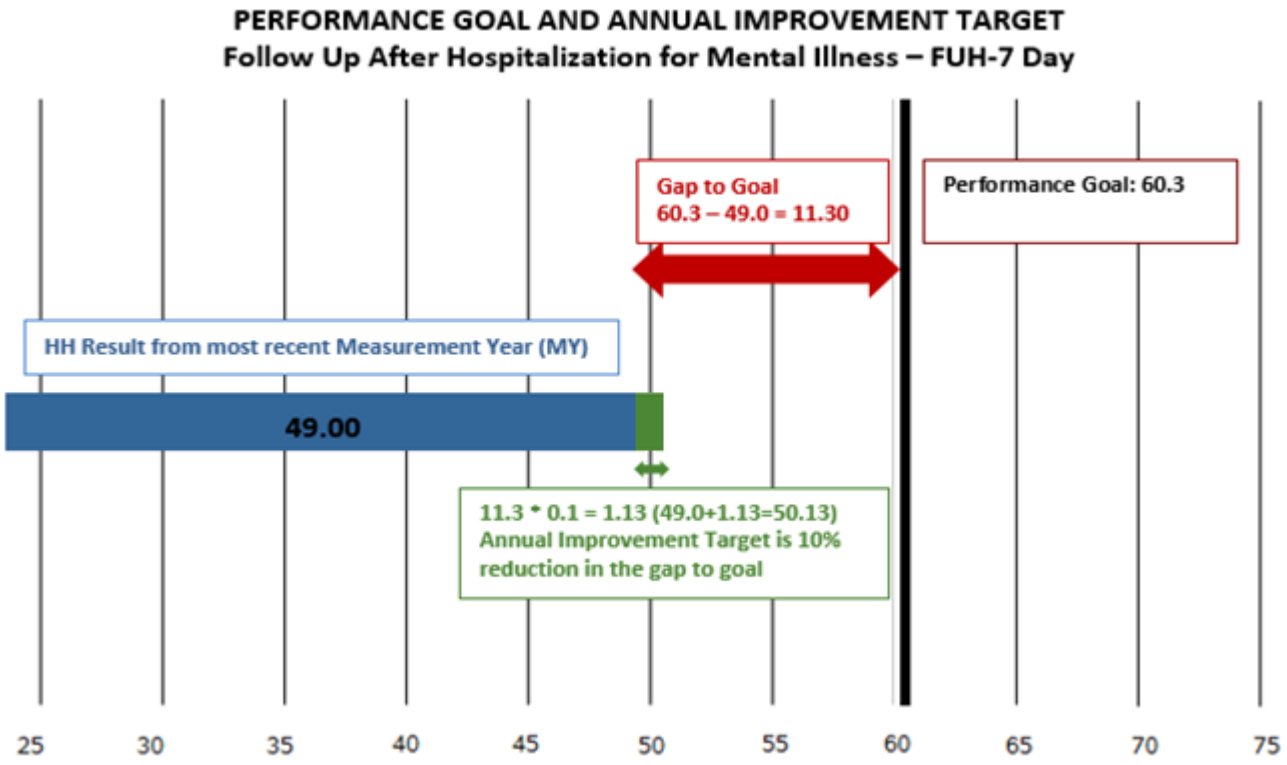
Annual Improvement Targets (AIT)

Annual improvement targets for a Health Home will be established using the methodology of reducing the gap to the goal by 10%. The most current Health Home measurement year (MY) result will be used to determine the gap between the Health Home result and the measure's performance goal, 10% of that gap is then added to the most current Health Home result to set the annual improvement target for the current MY.

Each subsequent year will continue to be set with an improvement target using results from the most recent year. This will account for smaller gains and losses in subsequent years as performance improves toward the goal or measurement ceiling. If a Health Home result for a MY meets or exceeds the performance goal, then the annual improvement target for the next MY will equal the Health Home's most recent result.

- Health Home Specific PG and AIT can be viewed in the Health Commerce System (HCS) Secure Collaboration Health Home Performance page. For access, lead Health Homes must submit a request to the Health Home BML. A limited number of Health Home staff will be granted access. Go to: https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action, select "Performance Management" in the Subject dropdown field.

Figure 1. Performance Goal and Annual Improvement Target



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

Process Step: Determine AIT	Description	Example
Establish gap amount	Goal – MY3 ('16) HH result =	60.3 – 49.0 = 11.3
Calculate 10% of gap amount (increment)	Gap *.10 = increment for MY4	11.3 * .10 = 1.13
Set annual improvement target (AIT) by adding increment to HH result	Increment + MY3 HH's result = MY4 ('17) AIT	1.13 + 49.0 = 50.13

In this example, the annual improvement target for the Health Home would be 50.13, and the Health Home result would need to meet or exceed that value.

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

Process Step: Determine next MY AIT	Description	Example
Establish gap amount	Goal – MY3 result = Gap	60.3 – 49.0 = 11.3
Calculate 10% of gap amount (increment) MY4	Gap *.10 = increment for MY4	11.3 * .10 = 1.13
Set annual improvement target (AIT) by adding increment to HH's result	Increment + MY3 result = AIT MY4	1.13 + 49.0 = 50.13
HH result for MY4 is used for MY5 gap amount	Goal –MY4 result = new gap for MY5	60.3 – 51.00 = 9.3
Calculate 10% of gap amount (increment) MY5	Gap *.10 = increment for MY5	9.3 * .10 = .93
Set annual improvement target (AIT) for MY5 by adding increment to HH's result	Increment + MY4 HH result = AIT MY5	.93 + 51.00 = 51.93

In this example, the MY4 annual improvement target was 50.13 The Health Home result (51.00) for MY4 met the AIT for MY4. MY4's result is then used to set MY5's AIT of 51.93.

IV. Performance Report Card

The Health Home Serving Adult Performance Report Card consists of the following data:

- Enrollment
- HARP Conversion Rate
- Retention (at least six months)
- PPE (Potentially Preventable Events) Efficiency Cost PMPM
- PPE Cost Change PMPM (from prior year)
- PPE Measure Set Composite Score
- HH Measure Set Composite Score
- Structural Measures

Enrollment: Total Health Homes Serving Adults (HHSA) enrollment by Health Home using the Adult/Child indicator (Adults only), for the measurement year

HARP Conversion Rate: Number of enrolled HHSA HARP members divided by the number of HARP assigned or in outreach with a HHSA

Retention (at least six months): Among members who were enrolled in the calendar year being measured, with no enrollment segments in the prior 6 months to their enrollment month, who were retained for 6 or more continuous months

PPE Efficiency Cost (PMPM): Actual cost/Expected cost for Enrolled, non-dual (Medicaid and Medicare) Members with 12 months continous enrollment within the measurement year for PPR and PPV. The Office of Quality and Patient Safety (OQPS) developed a composite score for PPE Efficiency Cost PMPM

PPE Cost Change PMPM (from prior year): Year-over-year comparison of PPE PMPM cost change for non-dual (Medicaid and Medicare) members with 12 months continuous enrollment within the measurement year of the report card and the previous calendar year

PPE Measure Set Composite Score: Composite score for Potentially Preventable Readmissions (PPR) and Potentially Preventable ED Visits (PPV). Composite score is developed by OQPS

HH Measure Set Composite Score: A composite score of the remaining Health Home Quality Measures. Composite score is developed by OQPS

Structural Measures: DOH defined and currently includes Redesignation Site Visit Score

A weight factor is applied to all elements to develop a Summary Score. Data is updated on a twelve-month rolling year. Each Health Home receives an individualized Performance Report Card on an annual basis.

V. *Defining the Eligible Population for Performance Measurement*

Measure Eligible Population

The eligible population is comprised of all enrolled members attributed to the Health Home who qualify for the measure. Members are attributed to the most recently enrolled Health Home for performance measurement. In addition to the member's attribution to a Health Home, performance measures use specific criteria to determine eligibility for the measure.

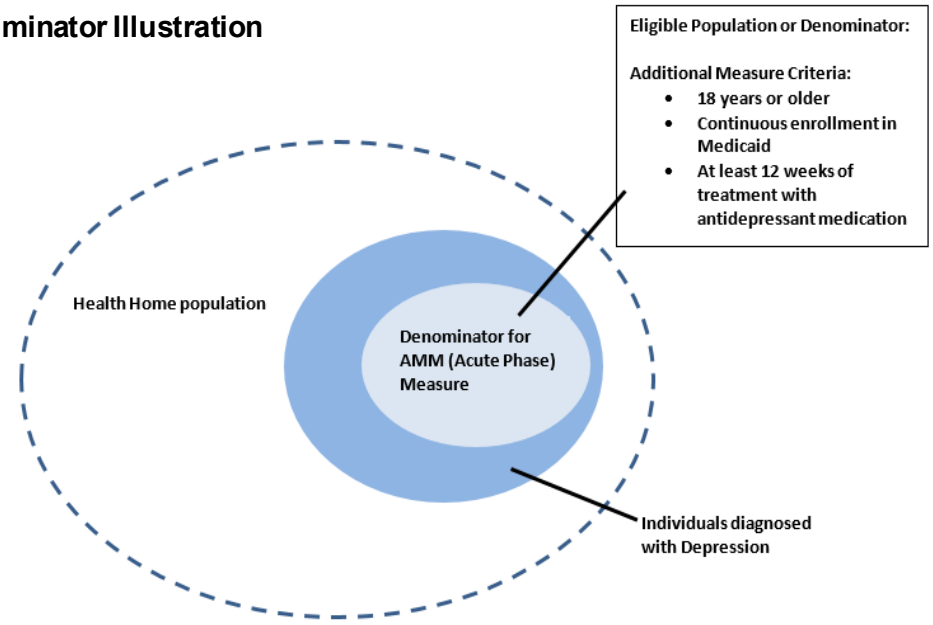
Measures are developed to capture the population for which a particular service is recommended; this is called the eligible population. To define the eligible population, measures often apply criteria such as age or diagnosis of a health condition to identify members in the eligible population. While some measures may apply to everyone in the Health Home (population-based), others may capture a smaller group within the Health Home that meet added measure-specific criteria such as diagnosis of a health condition (episode-based).

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

IMPORTANT NOTES:

1. Performance Measures exclude outreach members.
2. Calculation of measure results are member-centric, evaluating each member for meeting criteria for the measure. The member is then attributed to the Health Home as of the measurement time frame, such as end of the measurement year. Member eligibility information is evaluated for the measurement window, such as 12 months irrespective of Health Home attribution.
3. Members who are dually eligible (Medicare and Medicaid) will NOT be included in Health Home measure results.

Figure 2. Denominator Illustration

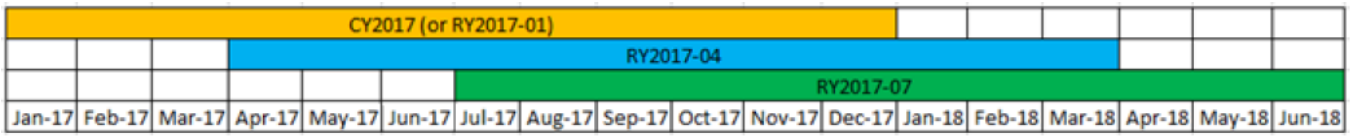


VI. Performance Reporting Schedule

The following provides the timeline for activities in the measurement year (Table 1):

DOH will release updated performance measure data to HHSA and HHSC via a Tableau dashboard on a quarterly basis. OQPS runs quarterly updates on the data for a rolling 12-month time period so that more up-to-date information can be delivered to HHs as part of their effort to effectively manage their network. These dashboard files will be made available to HHs via HCS.

Here is an example on how rolling years work:



VII. Reporting Submission Process

In this document, there are two parties that are responsible for reporting requirements used in measures:

1. Health Home – data reported by the Health Home to the NYS DOH
2. NYSDOH-HH – NYS DOH data sources used to calculate measures

Table 2 – Reporting Responsibilities

Data required	Responsibility	Process
Outcome Measures	NYSDOH-HH	Measure data is collected from existing measures and reported out to HHs based on timeline (Table 1)
Process Measures	Health Home and NYSDOH-HH	HHs are required to submit CMART data quarterly. NYSDOH will report on process measures based on CMART data and report out to HHs based on timeline (Table 1)
Care Management and Reporting Tool (CMART)	Health Home	HHs are required to submit CMART data quarterly. CMART analysis is completed by OQPS and NYSDOH-HH
HARP Measures	Health Home	HHs are required to complete the HARP Report quarterly. The report template is available on the NYSDOH-HH website
Performance Report Card	NYSDOH-HH	Measure data is collected from claims and encounters. NYSDOH-HH distributes Report Card on timeline (Table 1)

NYSDOH-HH website:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm

VIII. Technical Assistance

A. Resources

Several resources are available for collecting and reviewing data for measures required by the Health Home program:

1. Measure specifications are available from the Measure Stewards for each measure. A number of measures are from the National Committee for Quality Assurance (NCQA)'s HEDIS® Technical Specifications (Volume 2) which is available for purchase. National Quality Forum endorsed measures are available with some details on the National Quality Forum website (http://www.qualityforum.org/)
2. The NYS DOH's Office of Quality and Patient Safety staff can provide technical assistance for CMART specifications
3. Technical specifications for all NYS-specific/Process measures have been developed by OQPS: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf
4. Salient Performance Dashboards include data on Health Home performance

B. Performance Support/Technical Assistance

The NYSDOH-HH provides technical assistance to lead Health Homes with the goal of improving the skills and capabilities that are key drivers of performance in areas where the Health Homes most need improvement. The NYSDOH-HH and Health Home will work together to identify the root cause of low performance and develop a Performance Improvement Plan. DOH State Agency Partners are used as resources and are actively involved in the process, as appropriate.

The NYSDOH-HH will identify Health Homes that need technical assistance in low performance areas. Health Home can fall into four categories:

- High performer in current year and performance improved from prior year
- High performer in current year, but performance declined from prior year
- Low performer in current year but performance improved from prior year
- Low performer in current year and performance declined from prior year

Health Homes falling into the "Low performer in current year and performance declined from prior year" category will be prioritized for technical assistance. In addition, if performance on a statewide basis needs significant improvement, the NYSDOH-HH will categorize the measure into a measure subset for increased focus. Health Homes not falling within the "Low performer in current year but performance improved from prior year" category are eligible for performance support and can contact NYSDOH-HH to request assistance.

IX. Measure Calculation and Modifications

NYS DOH Measure Calculation Process

NYS DOH uses Medicaid claims and encounters as the basis for calculation of claims-based measures and identification of the eligible population for measures. Programs used to calculate measure results have been developed using the measure steward specifications.

Measure Retirement and Specification Modifications

The clinical measures and specifications associated with the program will be held consistent to the extent possible. Many of the measures reported in the Health Home Program are currently reported in CMS Medicaid quality core sets and to the NCQA as well as health plan reporting to New York State. Situations may arise when the measure stewards retire or alter measure specifications to reflect changes in clinical care guidelines, treatment recommendations, or current health care practices. To align collection of data from all health care providers, the measure modifications may also be incorporated in Health Home specifications.

Guiding Principles

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

1. Clinically relevant and meaningful quality measures reflecting recommended care and current health care practices; and
2. Alignment and consistent use of measure specifications for Health Home and core sets used by other programs in NYS, such as QARR, DSRIP, or through VBP arrangements

Determining Use in the Health Home Program

These two guiding principles are the key criteria for determining whether the retirement or modification will be incorporated into the Health Home Program. If clinical relevance is the reason for the recommended action by the measure steward, the modification will be incorporated into the Health Home Program. Clinically relevant, meaningful information will better engage providers in improvement activities by providing credible data for use in those activities.

Measure alignment between the Health Home Program and other programs facilitates coordination and comparability of results at various levels of health care delivery.

Process for Adjusting Performance Goals, Annual Improvement Targets

When the decision is made to retire a measure or to implement a modification with a measure, the method of implementing the change, its impact on the PG and AIT will be dependent on three factors:

- Necessity of implementation (clinical relevance and alignment concern);
- Availability of a replacement measure for the retired measure; and
- Ability to compare results with modification to previous results or to re-calculate previous results with modification

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

Availability of replacement measure for retired measure – If there is a standardized measure with similar focus available for replacement for the retired measure, the new measure will be introduced at the beginning of the next measurement year.

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

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

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

If there is more than a 10 percent change or significant impact to the previous year's result compared to results with the changed implemented, the performance goals and annual improvement targets will be re-established. If the data is available to re-calculate the previous year's results with the modification, such as with claims-based measures, the revised result can be created using previous year's claims. Non-claims based measures would need to have data collection before the baseline data would be available. The first year's results with the revised measure will be considered the baseline and will be used to set the performance goal and the annual improvement target for the next measurement year.

The decision process and any subsequent need for revising performance goals and annual improvement targets are described in two decision trees (Figures 3 and 4, below).

Figure 3. Measure Retired Decision Tree

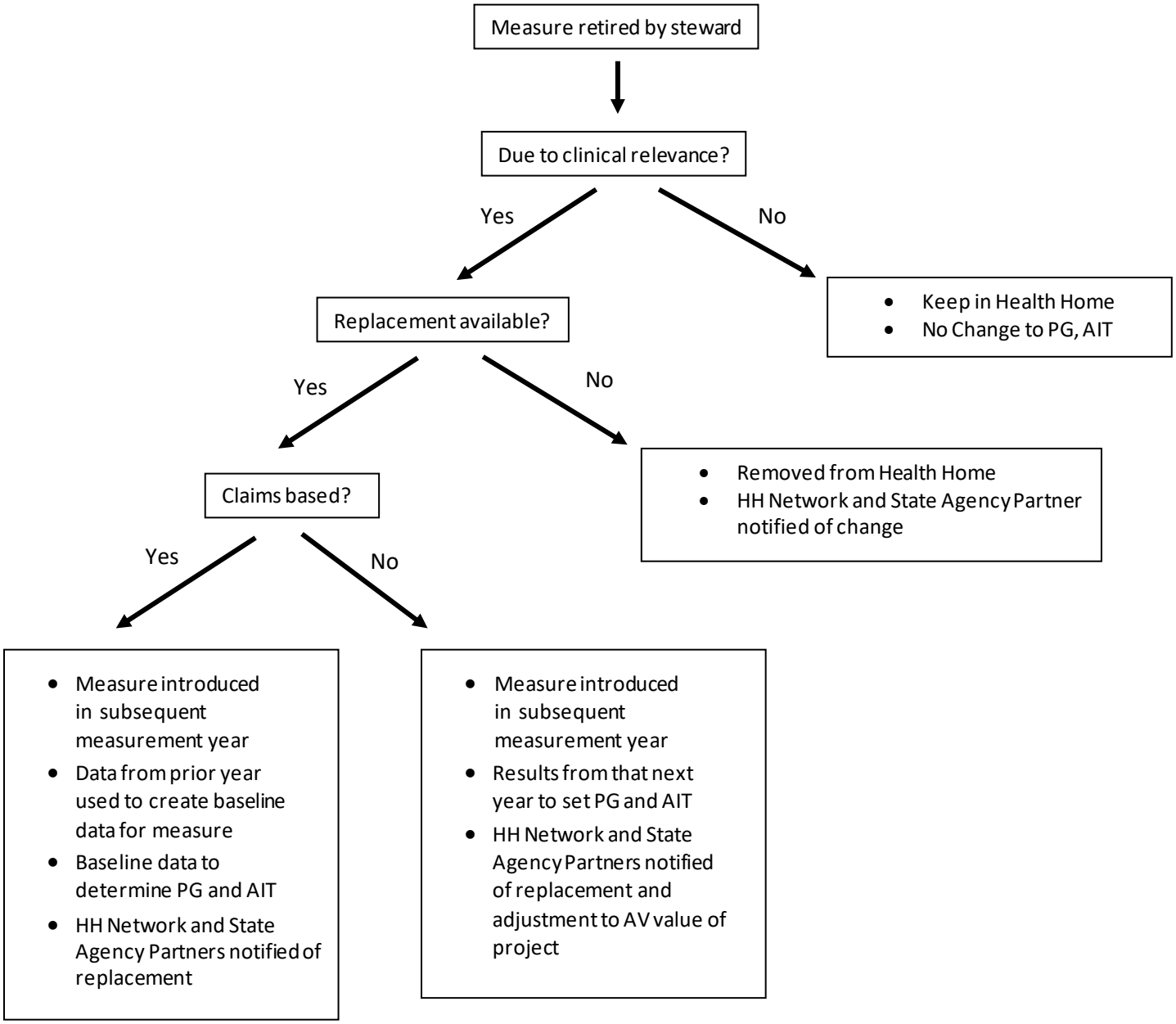
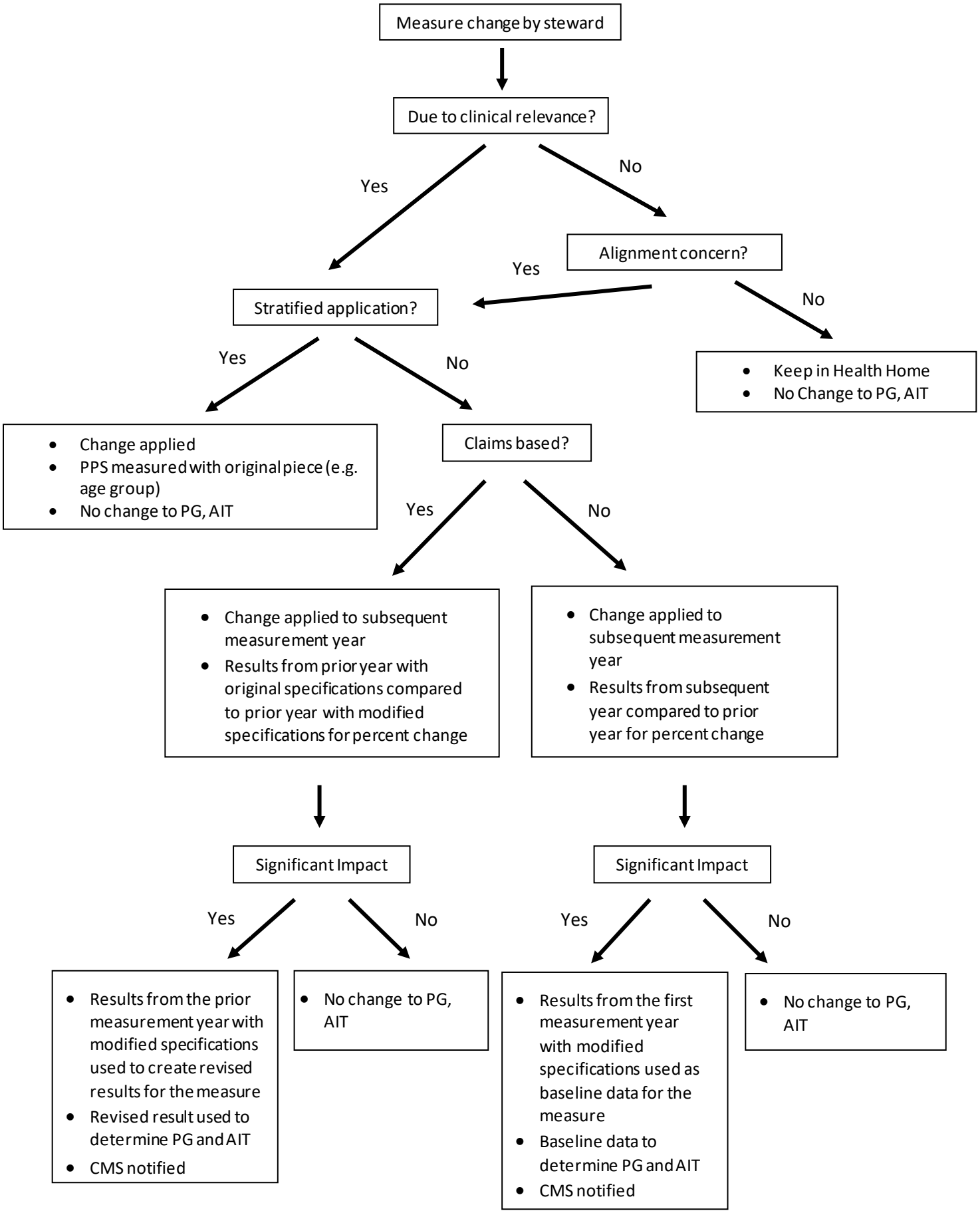


Figure 4. Measure Change Decision Tree



Common Scenarios

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

Scenario 1 - Measure specifications retired for reasons other than clinical relevance AND no alignment concern because measure is not in use in other levels of health care delivery in New York State (NYS).

For example, the HIV-Comprehensive Care Measure was retired by NCQA but NYS has the ability to use existing data sources with no additional burden on the plans.

Process decision: the original measure will continue to be utilized and will be maintained to allow for consistent measurement.

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

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

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

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

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

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

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

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

Process decision: the retirement will be incorporated

Glossary

A= Health Home Service Adults
C= Health Home Serving Children
IDD= Health Home Serving Individuals with Developmental or Intellectual Disabilities

A1. a. Quality Measures

Measure Name	Health Home Population	Measure Steward	NQF #	Numerator Description	Denominator Description
Preventive Care					
Adult BMI Assessment (ABA)	A/IDD	NCQA	N/A	Number of people* who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Number of people, ages 18-74 yrs
Chlamydia Screening (CHL)	A/C/IDD	NCQA	0033	Number of women who had at least one test for Chlamydia during the measurement year	Number of sexually active women, ages 16 to 24 yrs
Colorectal Cancer Screening (COL)	A/IDD	NCQA	0034	Number of people who had appropriate screening for colorectal cancer during the measurement year	Number of adults, ages 50 to 75 yrs
Annual Dental Visit (ADV)	C/IDD	NCQA	1388	Number of children* who had at least one dental visit within the measurement year	Number of children and adolescents, ages 2 to 20 yrs
Adolescent Well-Care Visits (AWC)	C/IDD	NCQA	N/A	Number of adolescents who had at least one comprehensive well-care visit with a primary care provider or OB/GYN practitioner during the measurement year	Number of adolescents, ages 12 to 21 yrs
Childhood Immunization Status (CIS)	C/IDD	NCQA	0038	Number of children who were fully immunized. The HEDIS specifications for fully immunized consists of the following vaccines: four DTap, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV and two flu vaccines	Number of children, age 2 yrs
Appropriate Testing for Children with Pharyngitis (CWP)	C/IDD	NCQA	0002	Number of children and who were given a group A streptococcus test	Number of children, ages 3 to 18 yrs, who were diagnosed with pharyngitis and prescribed an antibiotic

Immunizations for Adolescents (IMA)	C/IDD	NCQA	1407	Number of children who had one dose of meningococcal conjugate, one Tdap vaccine and have completed the HPV vaccine series by their 13th birthday	Number of members, age 13 yrs
Lead Screening in Children (LSC)	C/IDD	NCQA	N/A	Number of children who had one or more blood tests for lead poisoning by their 2nd birthday	Number of children, age 2 yrs
Well-Child Visits in the First 15 Months of Life (W15)	C/IDD	NCQA	1392	Number of children who had five or more well-child visits with a primary care provider during their first 15 months of life	Number of children age 15 months
Well-Child Visits in the 3rd, 4th, 5th & 6th Year (W34)	C/IDD	NCQA	1516	Number of children who had one or more well-child visits with a primary care provider during the measurement year	Number of children, ages 3 to 6 yrs
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	C/IDD	NCQA	0024	Number of children* who had an outpatient visit with a PCP or OB/GYN during the measurement year and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for nutrition and Counseling for physical activity	Number of children, ages 3 to 17 yrs
Care for Chronic Conditions					
Controlling High Blood Pressure (CBP)	A/C/IDD	NCQA	0018	Number of people* whose blood pressure was adequately controlled as follows: below 140/90 if ages 18-59; below 140/90 for ages 60 to 85 with diabetes diagnosis; or below 150/90 ages 60 to 85 without a diagnosis of diabetes	Number of people, ages 18 to 85 yrs, who have hypertension
Comprehensive Diabetes Care: Hemoglobin A1c test (CDC-hA1c)	A/C/IDD	NCQA	0059	The percent of members with diabetes who received at least one Hemoglobin A1c (HbA1c) test within the year	Number of people ages 18 to 75 yrs with diabetes
HIV/AIDS Comprehensive Care: Engaged in Care (HIV_ENGD)	A/C/IDD	NYSDOH	N/A	Number of people who had two visits for primary care or HIV related care with at least one visit during each half of the past year	Number of people living with HIV/AIDS, ages 18 yrs and older
HIV/AIDS Comprehensive Care: Viral Load Monitoring (HIV_VIRAL)	A/C/IDD	NYSDOH	N/A	Number of people who had two viral load tests performed with at least one test during each half of the past year	Number of people living with HIV/AIDS, ages 18 yrs and older

HIV/AIDS Comprehensive Care: Syphilis Screening (HIV_SYPH)	A/C/IDD	NYSDOH	N/A	Number of people who were screened for syphilis in the past year	Number of people living with HIV/AIDS, ages 18 yrs and older
Viral Load Suppression (VLS)	A/C/IDD	NYSDOH	2082	Number of people* whose most recent viral load result was below 200 copies	Number of people living with HIV/AIDS, ages 2 yrs and older.
Medication Management for People with Asthma–50% of Treatment Days Covered (MMA-50%)	A/C/IDD	NCQA	1799	Number of people who remained on an asthma controller medication during at least 50% of their treatment period	Number of people, ages 5 to 64 yrs, who have persistent asthma, and received at least one controller medication
Medication Management for People with Asthma–75% of Treatment Days Covered (MMA-75%)	A/C/IDD	NCQA	1799	Number of people who remained on an asthma controller medication during at least 75% of their treatment period	Number of people, ages 5 to 64 yrs, who were identified as having persistent asthma, and who received at least one controller medication
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	A/C/IDD	NCQA	0071	Number of people who received persistent beta-blocker treatment for six months after discharge	Number of people, ages 18 and older, who were hospitalized and discharged with a diagnosis of AMI
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	C/IDD	NCQA	0069	Number of children* who were not dispensed an antibiotic prescription	Number of children, ages 3 months to 18 yrs, who were diagnosed with an upper respiratory infection (URI)
Mental Health					
Follow-up care for Children Prescribed ADHD Medications – Initiation Phase (ADD-Init)	C/IDD	NCQA	0108	Number of children who had one follow-up visit with a practitioner during the 30 day Initiation Phase	Number of children, ages 6 to 12 yrs, who were newly prescribed ADHD medication
Follow-up care for Children Prescribed ADHD Medications – Continuation Phase (ADD-Cont)	C/IDD	NCQA	0108	Number of children who, remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits within 270 days (9- months) from the end of the Initiation Phase	Number of children, ages 6 to 12 yrs, who were newly prescribed ADHD medication
Antidepressant Medication Management – Effective Acute Phase Treatment (AMM-Acute)	A/C/IDD	NCQA	0105	Number of people who remained on antidepressant medication for at least 84 days (12 weeks)	Number of people 18 and older who were diagnosed with major depression and treated with an antidepressant medication

Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM-Cont)	A/C/IDD	NCQA	1881	Number of people who remained on antidepressant medication for at least 180 days (6 months)	Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication
Multiple Concurrent Antipsychotic Use in Children and Adolescents (APC)	C/IDD	NCQA	N/A	Number of children and adolescents on two or more concurrent antipsychotic medications for at least 90 consecutive days	Number of children and adolescents 1 to 17 yrs of age who were on two or more concurrent antipsychotic medications
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	C/IDD	NCQA	N/A	Number of children who had metabolic testing	Number of children and adolescents 1 to 17 yrs of age who had two or more antipsychotic prescriptions
Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics (APP)	C/IDD	NCQA	2801	Number of children who had documentation of psychosocial care as first-line treatment	Number of children and adolescents 1 to 17 yrs of age who had a new prescription for an antipsychotic medication
Adherence to mood Stabilizers for Individuals with Bipolar Disorder (BMS)	A/C/IDD	CMS	1880	Number of members that had a proportion of days covered (PDC) for mood stabilizer medication ≥0.8 during the measurement year	Number of members, ages 19 to 64 yrs with bipolar I disorder, or other bipolar disorder, who received a mood stabilizer medication
Follow-up after hospitalization for Mental Illness – within 7 days (FUH-7)	A/C/IDD	NCQA	0576	Number of discharges where the member had a follow-up visit with a mental health provider within 7 days after discharge	Number of discharges for members 6 and older who were hospitalized for treatment of selected mental illness diagnosis
Follow-up after hospitalization for Mental Illness – within 30 days (FUH-30)	A/C/IDD	NCQA	0576	Number of discharges where the member had a follow-up visit with a mental health provider within 30 days after discharge	Number of discharges for members 6 and older who were hospitalized for treatment of selected mental illness diagnosis
Follow Up After Emergency Department Visit for Mental Illness – 7 days (FUM)	A/C/IDD	NCQA	N/A	Number of follow-up visits with any practitioner, with a principal diagnosis of mental illness, ED within 7 days after the ED visit	Number of department (ED) visits for members 6 yrs of age and older with a principal diagnosis of mental illness

Follow Up After Emergency Department Visit for Mental Illness - 30 days (FUM)	A/C/IDD	NCQA	N/A	Number of follow-up visits with any practitioner, with a principal diagnosis of mental illness, ED within 30 days after the ED visit	Number of department (ED) visits for members 6 yrs of age and older with a principal diagnosis of mental illness
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	A/IDD	NCQA	1879	Number of members who remained on an antipsychotic medication for at least 80% of their treatment period	Number of members, ages 19 to 64 yrs, with schizophrenia who were dispensed antipsychotic medication
Substance Use Disorders					
Initiation of Alcohol and Other Drug Dependence Treatment (IET – Int)	A/C/IDD	NCQA	0004	Number of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, teleheatlh or Medication Assisted Treatment within 14 days of the diagnosis	Number of members age 13 and older with a new episode of alcohol or other drug (AOD) dependence
Engagement of Alcohol and Other Drug Dependence Treatment (IET-Eng)	A/C/IDD	NCQA	0004	Number of members who initiated treatment AND who had two or more additional AOD services or MAT within 34 days of the initial visit	Number of members age 13 and older with a new episode of alcohol or other drug (AOD) dependence
Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7 days (FUA)	A/C/IDD	NCQA	2605	Number of follow-up visits with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days)	Number of ED visits for members, 13 and older, with a principal diagnosis of alcohol or other drug (AOD) dependence
Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 days (FUA)	A/C/IDD	NCQA	2605	Number of follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days)	Number of ED visits for members, 13 and older, with a principal diagnosis of alcohol or other drug (AOD) dependence
Utilization					
Admission to an Institution (AIF)	A/C	NCQA	9999	Number of admissions to an institution from the community that results in a medium-term (21-100 days) stay. Per 1,000 enrollee months	Number of people ages 18 and older
Ambulatory Care - Emergency Department (AMB-ED)	A/C/IDD	NCQA	N/A	Number of ambulatory care ED visits Per 1000 member months	Cumulative number of months of Medicaid enrollment (member months) by the current eligible population

Inpatient Utilization (IPU)	A/C/IDD	NCQA	N/A	Number of acute visits for inpatient care and services for maternity, medicine, and surgery Per 1000 member months	Cumulative number of months of Medicaid enrollment (member months) by the current eligible population
Mental Health Utilization (MPT)	A/C/IDD	NCQA	N/A	Number of inpatient, intensive outpatient/partial hospitalization and outpatient or ED visits for mental health services Per 1000 member months	Cumulative number of months of Medicaid enrollment (member months) by the current eligible population
Nursing Facility Utilization (NFU)	A/C/IDD	NYSDOH	N/A	Number of admissions that result in a short-term stay (less than 101 days) during the measurement year Per 1,000 Health Home member enrollment months	Cumulative number of months of Health Home enrollment by the current eligible Health Home population, ages 18 yrs and older
Primary Care Utilization (PCP)	A/C/IDD	NYSDOH	N/A	Number of primary care visits to a primary care provider Per 1000 member months	Cumulative number of months of Medicaid enrollment (member months) by the current eligible population
Plan All-Cause Readmission (PCR)	A/C/IDD	NCQA	1768	Number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days	Number of acute inpatient stays, for Health Home members age 18 and older
Chronic Condition Hospital Admission Composite -Prevention Quality Indicator (PQI-92)	A/C/IDD	AHRQ	N/A	Number of hospital admissions for chronic conditions for members age 18 and older Per 100,000 enrollees (Includes admissions for one of the following conditions: diabetes with short-term complications,	Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older

Avoidable Utilization					
Potentially Preventable Emergency Room Visits (PPV)	A/C/IDD	3M	NA	Number of potentially preventable ED visits for ambulatory sensitive conditions per 100 enrollees	Cumulative number of Medicaid enrolled eligible population
Potentially Preventable Readmissions (PPR)	A/C/IDD	3M	N/A	Number of potentially preventable readmissions chains Per 100,000 enrollees	Cumulative number of Medicaid enrolled eligible population

*Denotes a measure derived utilizing a hybrid method of both administrative and medical record data for Medicaid Managed Care (MMC) members only.

A1 b. Process Measures

Measure Name	Health Home Population	Measure Steward	NQF #	Numerator Description	Denominator Description
Members without outreach/enrollment	C	NYSDOH	N/A	Number of children in assignment without outreach/enrollment segment by CMA by HH	Number of HHSC members in assignment
Outreach Interventions Completed	A	NYSDOH	N/A	Number of completed outreach interventions, excluding letter mode interventions	Number of attempted or completed outreach interventions, excluding letter mode
Enrolled Interventions Completed	A	NYSDOH	N/A	Number of completed enrolled interventions, excluding letter mode interventions	Number of attempted or completed enrolled interventions, excluding letter mode interventions
Members with One or More Interventions	A	NYSDOH	N/A	Number of enrolled members with at least one completed intervention during the measurement period	Number of enrolled members billed for at least one month during the measurement period
Length of Enrollment for Cohort of Members	A	NYSDOH	N/A	Average number of months of continuous enrollment up to the end of the measurement period, in the Health Home the member is last enrolled in period	
Intervention within Two Days of Inpatient Discharge	A/C	NYSDOH	N/A	Number of inpatient discharges with a completed intervention within 2 days before or after discharge during the measurement period	Number of inpatient discharges during the measurement period
Intervention within Two Days of ED Discharge	A/C	NYSDOH	N/A	Number of ED visits with a completed intervention within 2 days following the ED visit during the measurement period	Number of ED visits during the measurement period
Time from HH referral to O/E	C	NYSDOH	N/A	Average time from HH referral to outreach/enrollment segment for all children's Health Home members (from MCO, Health Home, CMA)	Number of HHSC members

A1 c. HARP Measures

Measure Name	Health Home Population	Measure Steward	NQF #	Numerator Description	Denominator Description
HARP/HH enrolled	A	NYSDOH	N/A	Number of HARP enrolled members	Number of HH enrolled members
% of NYS Eligibility Assessments Completed	A	NYSDOH	N/A	Number of members who completed the eligibility assessment.	Number of HARP enrolled members minus HARP members who declined assessment
% of LOSD Submitted to MCO	A	NYSDOH	N/A	Number of LOSD requests submitted to the MCO	Total number of eligibility assessments completed minus number of members who declined HCBS and number of members who are deemed not eligible for HCBS
% of POC Submitted to MCO	A	NYSDOH	N/A	Number of HCBS POC submitted to the MCO	Number of LOSD requests submitted to the MCO

A1 d. CCO/HH Specific Measures

Measure Name	Health Home Population	Measure Steward	NQF #	Numerator Description	Denominator Description
Implementation of CQL Personal Outcome Measures (POMs)	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members with Life Plans with a minimum of two POM measures	Total number of HH members with Life Plans
Implementation of Personal Safeguards	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members with Life Plans that reflect personal safeguards	Total number of HH members wth Life Plans
Transitioning to a More Integrated Setting*	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members who have moved to a more integrated setting from a 24-hour certified setting	Total number of HH members in a 24-hour certified setting

Employment	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members who are competitively employed	Total number of HH members who indicate a desire to pursue employment in their Life Plan AND Total number of HH members with Life Plans
Self-direction	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members enrolled in self-direction	Total number of HH members who indicate a desire to self-direct in their Life Plan AND Total number of HH members with Life Plans
Bladder and Bowel Continence	IDD	NYSOPWDD/ NYSDOH	N/A	Number of HH members with a Life Plan in place that includes reporting of support or device needs, bowel/incontinence tracking protocol and/or management protocol	Total number of HH members with an identified bladder/bowel health risk
Falls	IDD	NYSOPWDD/ NYSDOH	N/A	Number of CCO members with a Life Plan that includes supervision, contact guarding, adaptive equipment, environmental modifications or other directed support	Total number of HH members with an identified risk of falls
Choking	IDD	NYSOPWDD/ NYSDOH	N/A	Number of CCO members with a Life Plans with safeguard(s) including modified consistency of foods and/or liquids, avoidance of high risk foods, requires supervision, formal training/dining plan required	Total number of HH members with an identified risk of choking
Monitoring Placements into Institutional Settings	IDD	NYSOPWDD/ NYSDOH	N/A	TBD	TBD

*** Integrated Setting:** A movement to a "more integrated setting" takes place when a CCO/HH member is discharged from a supervised-model certified residence, which provides constant direct supervision and oversight whenever residents are present, to either: (a) a supportive-model certified residence, (b) a family care home, (c) uncertified housing (e.g. a private apartment, with or without a roommate or live-in caregiver), or (d) returns to a family living arrangement.

A.2 Glossary for Measure Components

The terminology below is included in components for measures described in the tables or in this manual.

Administrative Method: Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator.

Annual Improvement Target (AIT): The result the Health Home needs to meet or exceed for the measurement year. The annual improvement target is established using the HH's result from the previous measurement year. For example, the result for Measurement Year (MY) 1 is used to set the annual improvement target for MY 2 (see Section III).

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

Health Home Serving Adult (A)/Health Home Serving Children (C): The A/C indicator identifies whether a measure applies to Health Home Serving Adults (A), Health Home Serving Children (C) or both (A/C)

Hybrid Method: Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Organizations review administrative data to determine if members in the systematic sample received the service, and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.

Measure Eligible Population: Measures are developed to capture the population which is recommended for a particular service, called the eligible population. To define the eligible population, measures often have criteria such as age or diagnosis of a health condition to be included in the eligible population.

Measure Reporting Responsibility: The collection process for each measure will be identified as calculated by the NYSDOH-HH, or will be the responsibility of the Health Home to collect or report.

Measure ID: The HEDIS or NYSDOH-HH Program developed identification number.

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

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

Numerator: Description of criteria to determine compliance for the particular measure (e.g. all patients with an HbA1c test). Note: many measures include specific numerator inclusion and exclusion criteria.
Performance Goal (PG): The majority of measures have a performance goal established to represent the best performance expected in NYS. The goals are used in calculating the gap to goal for the annual improvement targets. This methodology used for establishing performance goals is described in Section III.

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