NEW YORK STATE | Department of Health

2025 Quality Assurance Reporting Requirements (QARR)

Technical Specifications Manual (2025 QARR/HEDIS® 2025)

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I. Submission Requirements

The 2025 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, the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Oregon Health Sciences University (OSHU), and New York State (NYS)-specific measures. The 2025 QARR incorporates measures from HEDIS 2025.

Areas of performance included in the 2025 QARR:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Measures Collected Using Electronic Clinical Data (ECDS)
- Experience of Care
- NYS-Specific Measures

Organizations Required to Report

Article 44 licenses	• Medicaid and Commercial Managed Care plans (HMO/PHSP, HIVSNP) certified by the New York State Department of Health **prior** to 2024 must report all applicable QARR measures for which there are enrollees meeting the continuous enrollment criteria. • Plans certified during 2025 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 the Department
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 2024 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, 2025, for MY 2025 (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 2024 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 measures by product type required for submission.
- This manual describes in detail **only** the NYS-specific measures. Plans must purchase the HEDIS 2025 Technical Specifications for Health Plans for specifications of the required HEDIS measures.
- QHP 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 2025 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 2025 QARR guidance 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 2025 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 the 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 the Department 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), the Department 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.
- For all NYS-specific measures, do not submit data for Medicaid/Medicare dual enrollees.
- 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.
- The Department incorporates combined PPO/HMO submissions with HMO data tables.
- The Department incorporates combined PPO/EPO submissions with PPO data tables.
- Members who have any of the 'medical' benefits, 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 2025 and QARR 2025 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)

- The Department incorporates combined PPO/EPO submissions with PPO data tables.
- Members who have any of the 'medical' benefits, 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 2025 and QARR 2025 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.
- The Department 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 2025 instructions regarding commercial POS products.
- Commercial specifications should be followed for all required HEDIS 2025 and QARR 2025 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' benefits, 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.
- QRS Measure Technical Specifications should be followed for all required measures. The Department 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' benefits, 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.
- QRS Measure Technical Specifications should be followed for all required measures. The Department 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.
- QRS Measure Technical Specifications should be followed for all required measures. The Department 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.
- QRS Measure Technical Specifications should be followed for all required measures. The Department 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' benefits, 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 2025 and QARR 2025 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 2025 and QARR 2025 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)

- Individuals living with HIV/AIDS or are homeless or are transgender, can choose to enroll in a HIV Special Needs Plan (HIVSNP)
- Plans should follow Medicaid specifications in HEDIS 2025 and QARR 2025 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 2025 and QARR 2025 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 2025 NYS Technical Specifications?

The Quality Assurance Reporting Requirements (QARR) are continuously evolving to ensure the reports created and published by the Office of Health Services Quality and Analytics on managed care performance to aid New Yorkers make information-based choices to improve overall health outcomes and healthcare value. Please **fully read** this updated MY2025 QARR Technical Specifications Manual, any questions you may have can be sent to the New York State Department of Health QARR Unit at: nysqarr@health.ny.gov.

NYS-Specific Measure Retired or Removed

- None

NYS-Specific Measure New

- None

NYS-Specific Measure Updated

- COVID-19 Immunization Status (CVS)
- Prenatal Care Measures/Birth File
- Use of Pharmacotherapy for Alcohol Use or Dependence (POA)
- Utilization of Recovery-Oriented Services for Mental Health (URO)

Non - NYS-Specific Measure Retired or Removed

- Antidepressant Medication Management (AMM)
- Cervical Cancer Screening (CCS) - (Only ECDS version will be reported)
- Childhood Immunization Status (CIS) - (Only ECDS version will be reported)
- Immunizations for Adolescents (IMA) - (Only ECDS version will be reported)

HEDIS Measures Added or Required to NYS QARR List of Required Measures

- Blood Pressure Control for Patients with Hypertension (BPC-E) - (ECDS version)
- Documented Assessment After Mammogram (DBM-E) - (ECDS version)
- Follow-Up After Abnormal Mammogram Assessment (FMA-E) - (ECDS version)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

HEDIS Measures with Significant Changes

- Adult Immunization Status (AIS-E) (Specification Change)
- Eye Exam for Patients with Diabetes (EED) (Removed the Hybrid Data Collection Method)
- Chlamydia Screening ~~in Women~~ (CHL) (Name Change)

Changes to NCQA Race and Ethnicity Stratified Measures (RES):

- Source of Race Data
  - Removed the data source reporting requirement from the race stratification.
- Source of Ethnicity Data
  - Removed the data source reporting requirement from the ethnicity stratification.

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 2025 (General Guidelines Volume 2, HEDIS 2025) 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 to incorporate information from the database into HEDIS/QARR reporting. The Department 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 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 2025 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 the 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.

The Department of Health 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. The Department 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 MY2025 is March 2025**.

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.

I. Submission Requirements

- **Any plan failing to submit the files by 9:00 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 9*:00 p.m. ET *on the date indicated***
	MY2025 Data Due Date
IDSS file for all payers – IDSS files must be locked by auditor	**June 12, 2026**
CAHPS de-identified member-specific file for CPPO, CEPO, CHMO, EP	**June 12, 2026**
Enrollee Survey de-identified member-specific file for QEPO, QPPO, QHMO, QPOS	**June 12, 2026**
Patient-Level-Detail file for all products (includes NYS-specific measures)	**June 12, 2026**
Optional enhancement files for MA, HIVSNP, and HARP	**June 12, 2026**
Live Birth files for all payers	**August 3, 2026**

Questions Concerning the MY2025 QARR Submission

- Interactive Data Submission System (IDSS): https://my.ncqa.org/
- Other required files: nysqarr@health.ny.gov
- HEDIS 2025 measures: Updates can be found on NCQA's web site: https://my.ncqa.org/. Submit questions to NCQA's Policy Support System at the web site. The Department 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. The Department 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, is no longer contained within the QARR Technical Specification Manual. It is now a stand-alone document that has been posted to the Managed Care website under Health Plan Guidelines > Quality Assurance Reporting Requirements (QARR) > 2025 section.

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, 2025.** The copy can be sent in PDF format via email to:

  BQME, QARR Unit
  Office of Health Services Quality and Analytics
  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 12 deadline (recommended by June 8 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 Health Services Quality and Analytics upon receipt from your auditor (email to nysqarr@health.ny.gov **by July 17, 2026**). The FAR must contain audit validation signatures.
- The Department 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	2025 Due Date
Copy of written agreement with an NCQA licensed organization that indicates **all products** included in the audit.	**December 1, 2025**
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 17, 2026**

IV. Reporting Schedule

Subject to change with any modifications to the NCQA MY2025 timeline.

Deliverable	MY2025 Due Date / Destination	MY2025 Products
Copy of written agreement with an NCQA licensed organization that indicates **all products** included in the audit.	**December 1, 2025** Email: The Department 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 12, 2026**, by 9:00 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 12, 2026**, by 9:00 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 3, 2026,** by 9:00 p.m. ET To: jworden@ipro.org	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS

IV. Reporting Schedule

Deliverable	MY2025 Due Date / Destination	MY2025 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 12, 2026**, by 9:00 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 17, 2026** Email: The Department nysqarr@health.ny.gov	✓CPPO ✓ CEPO ✓ CHMO ✓ EP ✓ MA/CHP ✓ HIVSNP ✓ HARP ✓ QPPO ✓ QEPO ✓ QHMO ✓ QPOS

The Department 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 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

Continued Engagement in Substance Use Disorder (SUD) Treatment (CET)

Description:

The percentage of individuals with a new episode of Substance Use Disorder (SUD) treatment within the intake period and at least one subsequent SUD treatment every 30 days through 180 days from the date of the initial SUD treatment.

Definitions:

IESD	Index Episode State Date (IESD): July 1 of prior year to June 30 of the measurement year. This period is used to identify a new episode of SUD treatment service.
Direct Transfer	A **direct transfer** is when the discharge date from one inpatient rehabilitation setting and the admission date to a second inpatient rehabilitation setting are one calendar day apart or less. For example: • An inpatient rehabilitation discharge on June 1, followed by an admission to another inpatient rehabilitation setting on June 1, is a direct transfer. • An inpatient rehabilitation discharge on June 1, followed by an admission to an inpatient rehabilitation setting on June 2, is a direct transfer. • An inpatient rehabilitation discharge on June 1, followed by an admission to another inpatient rehabilitation setting on June 3, is not a direct transfer; these are two distinct inpatient rehabilitation stays. Use the following method to identify admission to and discharges from inpatient rehabilitation settings. 1. Identify all acute and nonacute inpatient stays (NYS Inpatient Stay Value Set). 2. Identify if the inpatient stay includes a primary diagnosis of one of the following: NYS Alcohol Use and Dependence, NYS Opioid Use and Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set. 3. Identify the admission and discharge dates for the stay. To combine direct transfers, keep the first admission date of the first admission and the discharge date of the last discharge date as one episode.

Eligible Population

Product Lines	**Commercial** (PPO/EPO, HMO/POS, EP), **Medicaid** (HMO/PHSP, HIVSNP, HARP).
Ages	18 years and older as of December 31 of the measurement period.
Continuous Enrollment	60 days (2 months) prior to the IESD through 180 days after the IESD.
Allowable Gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/diagnosis	The earliest SUD service during the intake period. Follow the steps below to identify the eligible population.

New York State Specific Measures

Step 1	Identify the initial service. Identify members who during the intake period had a primary diagnosis of SUD and one of the following: • An outpatient visit, intensive outpatient visit, residential, opioid treatment service, or partial hospitalization. Any of the following code combinations meet these criteria: 0 NYS Standalone Visits Set **with** a primary diagnosis using one of the following: NYS alcohol use and dependence, NYS Opioid Use And Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set. 0 NYS Visits Group 1 Value Set **with** NYS pos group 1 value set and a primary diagnosis using one of the following: NYS Alcohol Use And Dependence, NYS Opioid Use And Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set 0 NYS Visits Group 2 Value Set **with** NYS pos group 2 value set and a primary diagnosis using one of the following: NYS Alcohol Use And Dependence, NYS Opioid Use And Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set • An acute or nonacute inpatient discharge identified with codes in the inpatient stay value set with a primary diagnosis using one of the following: NYS Alcohol Use And Dependence Value Set, NYS Opioid Use And Dependence Value Set, NYS Stimulant Value Set, NYS Other Drug Value Set. For Medication Assisted Treatment (MAT): Identify members who during the intake period had **ANY** diagnosis of SUD **and** one of the following: • ***If the Initial Service was for a diagnosis of Alcohol Dependence*** (NYS Alcohol Use and Dependence) a MAT dispensing event (MAT for Alcohol Use Or Dependence Medications List) or a claim for MAT (NYS AOD Medication Treatment Value Set). • ***If the Initial Service was for a diagnosis of Opioid Dependence*** (NYS Opioid Use and Dependence), a MAT dispensing (MAT for Opioid Use or Dependence Medications List), or a claim for MAT (NYS AOD Medication Treatment Value Set). Identify the discharge date for the stay. For members with more than one SUD treatment visit, use the first service. Select the index episode start date (IESD).
Step 2	Test for Negative Diagnosis History. Exclude members who had an inpatient, outpatient, residential, or opioid treatment claim/encounter with a primary diagnosis of SUD or MAT with any SUD diagnosis during the 60 days before the IESD. For an inpatient IESD, use the admission date to determine the 60-day Negative History.
Step 3	Calculate continuous enrollment. Members must be continuously enrolled for 60 days before the IESD through 180 days after the IESD, with no gaps.

New York State Specific Measures

Administrative Specification

Denominator	The eligible population.
Numerator	At least one treatment visit for an inpatient, outpatient, residential or opioid service with a primary diagnosis of SUD or MAT with any SUD diagnosis every 30 days through 180 days from the IESD during the covered period. Note - there must be at least one visit in each of the following six time periods: Days 1-30, 31-60, 61-90, 91-120, 121-150, 151-180. If one treatment service is being provided over the 180-day period (e.g., a visit with a visit end date >= 180 days following the visit start date), then that service meets numerator compliance. Any of the following code combinations meet the numerator criteria: • An outpatient visit, intensive outpatient visit, residential, opioid treatment service or partial hospitalization. Any of the following code combinations meet these criteria: o NYS Stand Alone Visits Value Set, with or without telehealth (NYS Telehealth POS Value Set), ***with*** a primary diagnosis using one of the following: NYS Alcohol Use and Dependence, NYS Opioid Use and Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set. o NYS Visits Group 1 Value Set, with or without telehealth (NYS Telehealth POS Value Set), ***with*** NYS POS Group 1 Value Set ***and*** a primary diagnosis using one of the following: NYS Alcohol Use and Dependence, NYS Opioid Use and Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set o NYS Visits Group 2 Value Set, with or without telehealth (Telehealth POS Value Set), ***with*** NYS POS Group 2 Value Set ***and*** a primary diagnosis using one of the following: NYS Alcohol Use and Dependence, NYS Opioid Use and Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set • An acute or nonacute inpatient discharge identified with codes in the Inpatient Stay Value Set ***with*** a primary diagnosis using one of the following: NYS Alcohol Use and Dependence, NYS Opioid Use and Dependence, NYS Stimulant Value Set, NYS Other Drug Value Set. A MAT dispensing event (MAT for Alcohol Use or Dependence Medications List; MAT for Opioid Use or Medications List) or claims for MAT (NYS AOD Medication Treatment Value Set).

Medication-Assisted Treatment for Opioid or Alcohol Use or Dependence.

Description	***Prescription***	
Alcohol Dependence Treatment	• Acamprosate • Naltrexone (oral)	• Naltrexone (injectable) • Disulfiram
Opioid Dependence Treatment	• Methadone • Buprenorphine • Naltrexone (oral)	• Buprenorphine/naloxone • Depot Naltrexone/Naltrexone implants

New York State Specific Measures

COVID-19 Immunization Status (CVS) UPDATED

Description:

The percentage of members aged 6 months and older who have received at least one dose of a COVID-19 vaccine.

Eligible Population:

Product Lines	**Commercial** (PPO/EPO, HMO/POS, EP), **Medicaid** (HMO/PHSP, HIVSNP, HARP).
Ages	Members who were at least 6 months old at the start of the Measurement Period (as of **September 1, 2024)**. Report four age stratifications: ▪ 6 months – 4 years. ▪ 5-11 years. ▪ 12-17 years. ▪ 18-64 years. **Reporting of age stratification is based on the member's age as of September 1, 2024**.
Continuous Enrollment	Continuously enrolled from September 1, 2024, to August 31, 2025.
Allowable Gap	No more than one gap in continuous enrollment of up to 30 days during the measurement period. 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 August 31, 2025.

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	The eligible population.
Numerator	Members in the denominator who received ***at least one dose*** of any COVID-19 vaccine any time **on or between September 1, 2024 - August 31, 2025, of the measurement period**. COVID vaccine CPT, vaccine administration, NDC, and CVX codes shown in Table 1 below were based on guidance from the American Medical Association (AMA) and the Centers for Disease Control and Prevention (CDC). Please reference the full updated list of codes at the time of measurement calculation at the following websites: https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes and https://www.cdc.gov/vaccines/programs/iis/COVID-19-related-codes.html. 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. • Vaccine Administration codes without a CPT, CVX, ***OR*** NDC code do not contribute to compliance.

New York State Specific Measures

Table 1: COVID-19 vaccine codes and descriptors.

Please reference the following source for the full list of updated codes: https://www.cdc.gov/iis/downloads/Fall-2024-COVID-19-Vaccine-Codes-Crosswalk.xlsx (Accessed September 2024)

Vaccine CPT Code	Manufacturer	Vaccine Name	NDC 10 /NDC11 Product ID	CVX Code
91318	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine (2024-2025 Formula)	59267-4315-1/ 59267-4315-01	308
91319	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine (2024-2025 Formula)	59267-4331-1/59267-4331-01	310
91320	Pfizer, Inc	COMIRNATY (COVID-19 Vaccine, mRNA, 2024-2025 Formula)	0069-2362-01/00069-2362-01; 0069-2392-01/00069-2392-01	309
91321	Moderna, Inc	Moderna COVID-19 Vaccine (2024-2025 Formula)	80777-287-07/80777-0287-07	311
91322	Moderna, Inc	SPIKEVAX (2024-2025 Formula)	80777-102-04/80777-0102-04;80777-102-01/80777-0102-01	312
91304	Novavax, Inc	Novavax Covid-19 Vaccine, Adjuvanted (2024-2025 Formula)	80631-107-01 80631-0107-01	313

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 (OHSU).

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 aged 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 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.

New York State Specific Measures

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 after their first and before or on their second birthday.
	Numerator 3	Children in Denominator 3 who had a claim with CPT code 96110 and ICD-10-CM Code Z13.42 after their second and before or on their third 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:

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)
- Survey of Well-being of Young Children (SWYC)

Tools not included in this measure: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Tools listed above: The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that have met the above criteria. Bright Futures cites a 2020 statement on Developmental Screening by the American Academy of Pediatrics. New and updated recommendations are anticipated and may include additional tools that meet these criteria. In addition, new tools meeting these criteria may be developed and may be included in future versions of Bright Futures.
https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

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 use 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 use or dependence (NYS Opioid Use and Dependence Value Set). Any of the following code combinations meet the criteria:
	  • NYS Stand Alone Visits Set ***with*** a diagnosis of opioid Use or dependence (NYS Opioid Use and Dependence Value Set).
	  • NYS Visits Group 1 Value Set ***with*** NYS POS Group 1 Value Set ***and*** with a diagnosis of opioid use or dependence (NYS Opioid Use and Dependence Value Set).
	  • NYS Visits Group 2 Value Set ***with*** NYS POS Group 2 Value Set ***and*** with a diagnosis of opioid use or dependence (NYS Opioid Use and Dependence Value Set).
	  • An ED visit (NYS ED Value Set) ***with*** a diagnosis of opioid use or dependence (NYS Opioid Use and Dependence Value Set).
	  • A detoxification visit (NYS Detoxification Value Set) ***with*** a diagnosis of opioid use or dependence (NYS Opioid Use and Dependence Value Set).
	• An acute or nonacute inpatient discharge with a diagnosis of opioid use or dependence (NYS Opioid Use 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 HEDIS MY2025 Technical Specifications, ***General Guideline****: Visits That Result in an Inpatient Stay* for updated 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 use or dependence (NYS Opioid Use 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 use 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 use or dependence: • A Medication Assisted Therapy Dispensing Event (NYS AOD Medication Treatment Value Set). • Dispensed a prescription for Opioid Use 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: A comprehensive list of medications and NDC codes can be found on the Managed Care website.

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 Health Services Quality and Analytics.

Calculation of Measure

Upon close of **the measurement year** the following performance measure will be calculated by the Office of Health Services Quality and Analytics 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 Health Services Quality and Analytics.

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. 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.

New York State Specific Measures

Time Frame	Discharges on or between January 1 through December 1 of the measurement year.
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)** • 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)** • 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

New York State Specific Measures

Prenatal Care Measures/Birth File

The following prenatal care performance measures will be calculated by the Office of Health Services Quality and Analytics 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.
- **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.
- **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.
- **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 Health Services Quality and Analytics. 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 Health Services Quality and Analytics 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 (MY 2025) 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**

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., 1998).
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., 2025).
Hospital of Delivery	57-62	Left Justified	Please use 888888 for 'out of state'; 999999 for 'unknown hospital'; and 111111 for 'not in hospital' birth. *PFI numbers for birth centers are now available, see note below for coding these facilities.* **If using less than a six-digit PFI, it must be LEFT justified. Do not add a leading zero.**
Mother's Date of Admission	63-70	DDMMYYYY	Year must include four digits (e.g., 2025).
Number of Enrollment Days Prior to Delivery	71-74	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	75-79	Left Justified	Enter the NCQA five-digit submission ID
Product Line	80-81	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)	82-89	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)	90-97	For Medicaid: AA#####A For CHP: 0####### or 5#######	Omit for commercial; it is not applicable. (Medicaid, HIVSNP, HARP, and CHP only)

Important Note: 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.

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.

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 any alcohol use or dependence diagnosis (NYS Alcohol Use and Dependence Value Set) during the measurement year. *** Do not include laboratory claims (claims with POS code 81).**

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 use or dependence: • Dispensed a prescription for Alcohol Use or Dependence (NYS Alcohol Use Disorder Treatment Medications List) during the measurement year. • Medication treatment during a visit with a primary alcohol use or dependence diagnosis (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: A comprehensive list of medications and NDC codes can be found on the THE DEPARTMENT Managed Care website.

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 and up 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	HARP
Ages	21 and up 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	(Duals remain excluded but refer to blanket Reporting Requirement Guidelines for NYS Measures, page 2.)

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 Health Services Quality and Analytics using the Department's HIV Surveillance System.

Calculation of Measures

Upon close of **the measurement year (January 1 through December 31)** Department 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 Department 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 Health Services Quality and Analytics.

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.

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

The Office of Health Services Quality and Analytics (OHSQA) 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

The Department 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**.
- In an effort to reduce duplicate reporting efforts by plans, NYS is transitioning to collect member attributed National Provider Identifiers (NPIs) and Practice Tax Identification Number (TINs). For MY2025, reporting of NPIs and TINs will be optional. Reporting will become required for MY2026.

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

2025 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 2025 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 12, 2026 for MY2025**.

The file should be named PLDF_SubID_MMDDYYYY_Version

Example: PLDF_12345_11132025_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 to 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 the 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	Location	Coding	Data Elements
Plan Name	1-20	First 20 characters of plan name including blanks - Left justified	
Product Line	21-38	CPPO, CEPO, CHMO, MEDICAID, HIVSNP, HARP, or EP, QHP_HMO, QHP_POS, QHP_PPO, QHP_EPO	
Submission ID	39-43	Right justified	
LSC Eligible Population	44-49	Right justified	Eligible population (before optional exclusions).
LSC Numerator	50-55	Right justified	Number of numerator events by administrative data in the eligible population (before exclusions).
LSC Rate	56-60	Must include 4 digits after the decimal (e.g., .2019), except for when rate=1, must include 3 digits after the decimal (e.g., 1.000)	Current year’s administrative rate (before exclusions).
POD-N Eligible Population	61-66	Right justified	
POD-N Numerator	67-72	Right justified	Numerator events by administrative data.
POD-N Rate	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	78-83	Right justified	
POA Numerator	84-89	Right justified	Numerator events by administrative data.
POA Rate	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.

VI. Patient-Level Detail File Submission

NYS Patient-Level Detail File Notes

- Include one row for every member who was enrolled in the product and who meets the 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 to which they belonged 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, **excluding the Essential Plan**, Member ID should be the health plan's internal, individual member identifier. Do not report a family identifier, and do not report the identifier used in HEDIS.
- For the **Essential Plan**, report the NYS-issued member ID. The NYS-issued member ID for non-Aliessa members should be an 8-digit number beginning with 7. For Aliessa members, report the assigned CIN, an 8-digit number starting with two alpha characters followed by five digits and one alpha.
- For Marketplace plans, the Member ID should be the member's NYS-issued HIXNY Member ID for QARR PLD reporting.

Hybrid Measures

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

VI. Patient-Level Detail File Submission

Administrative Measures

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

Product Specific Reporting

- Commercial Plans with approval from NCQA and the Department to combine report their HMO and PPO membership should place these members in their CHMO product line.
- Commercial Plans with approval from NCQA and the Department 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 the QARR Unit at (518) 486-9012 or nysqarr@health.ny.gov.

VII. FIPS[1] 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			

[1] FIPS stands for Federal Information Processing Standards

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

Optional Enhancements for Medicaid, HIVSNP, and HARP

The Office of Health Services Quality and Analytics will enhance results for several measures for this reporting year:

- Chlamydia Screening (CHL)
- Colorectal Cancer Screening – Electronic (COL-E)
- Follow-Up after Hospitalization for Mental Illness* (FUH)
- Follow-Up after High-Intensity Care for Substance Use Disorder* (FUI)
- Follow-Up After Emergency Department Visit for Mental Illness* (FUM)
- Follow-Up After Emergency Department Visit for Substance Use* (FUA)
- Follow-Up Care for Children Prescribed ADHD Medication -Electronic***** (ADD-E)

***** 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. As measures become electronic, NYS is considering retiring the required enhancement file. However, for MY2025, please continue to report the above-noted measures.

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 Use 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 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 and Colorectal Cancer Screening

The Office of Health Services Quality and Analytics 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.

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

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 Health Services Quality and Analytics 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 Health Services Quality and Analytics 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 the emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Health Services Quality and Analytics 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 Health Services Quality and Analytics 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 the 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
	Submission ID	1-5	

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

Measure	Data Elements	Fields	File Name
Follow-Up After Emergency Department Visit for Mental Illness: **1) 7-Day and** **2) 30-Day**	Product Line 1 = Medicaid 2 = HIVSNP 3 = HARP	6	FUM.txt
	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 periods 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 the emergency department (ED) visit, and up to 30 days after the ED visit. The Office of Health Services Quality and Analytics 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 Health Services Quality and Analytics 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 the 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 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	

Follow-Up Care for Children Prescribed ADHD Medication Electronic:

The Office of Health Services Quality and Analytics 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 the 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 2025 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 period, please select the visits that allow 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-E: **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	

Measure	Data Elements	Fields	File Name
Follow-Up Care for Children Prescribed ADHD Medication-E: (continued) **1) Initiation Phase** **2) Continuation and Maintenance Phase**	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.