Health Home Redesignation Domain 2 Documentation

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Overview of Domain 2 in New York State (NYS) Health Home Redesignation

Redesignation is the process NYS Department of Health uses to approve a Health Home's continued operation based on their performance. The Health Home's redesignation score consists of three areas: Domain 1, Administrative Review Management; Domain 2, Quality and Process Measures; and Domain 3, Chart Review Analysis.

Domain 2 is weighted at 20% of the overall redesignation score.

Health Homes Serving Adults (HHSA) Breakdown:

- Quality measures: 5.0%
- Process measures: 5.0%
- AIDS Institute (AI) measures: 3.0%
- Office of Mental Health (OMH) measures: 4.0%
- CMA satisfaction survey: 3.0%

Health Homes Serving Children (HHSC) Breakdown:

- Quality measures: 5.0%
- Process measures: 5.0%
- CMA satisfaction survey: 3.0%
- CTQA measures: 7.0%

Data sources for the quality and process measures include the Care Management Assessment Reporting Tool (CMART), the Medicaid Analytics Performance Portal Health Home Tracking System, and the Medicaid Claims and Encounters member-level data.

Quality Measures Description and Scoring

Quality measures are tools that measure or quantify healthcare processes, outcomes, patient perceptions, and organizational systems that are associated with the ability to provide high-quality health care or that relate to one or more quality goals for health care.

The "Quality Measure" portion of Domain 2 is based on the results of the quality measures listed in Table 1. Each quality measure contributes points to the score based on relative performance during the most recent time frame available. There are 100 total points available for quality measures. If a Health Home has 10 available measures, each measure is worth up to 10 points (100 total points/10 measures=10 points per measure). If a Health Home has 7 available measures, each measure equates up to a maximum of 100/7=14.29 points per measure. See Table 2 for an example of points available per measure if the Health Home has 10 measures available. Each measure is scored according to the percentile performance for that measure, and points are allotted accordingly. The points are summed up to calculate the total score for quality measures.

Example Calculation Using Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence-7 Day (FUA-07)

For the period December 2023 - November 2024, the top-performing Health Home had an FUA-07 score of 84, setting the ceiling. A Health Home does not need a rate of 100 to earn the maximum points. Percentile cut-off ranges are recalculated each rolling year using available rates per measure.

- A Health Home scoring 67.5 on FUA-07 would receive 100% of the available points for that measure.
- A Health Home scoring 35.9 would receive 25% of the available points.

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Table 1. An Example of the Percentile Thresholds for FUA-07.

Measure	0 - 25th percentile	26 - 50th percentile	51- 75th percentile	76 - 100th percentile
FUA-07 Rate	0 - 54.29	54.30 - 59.60	59.70 - 65.33	65.34 – 84.00

Table 2. Percent of Points and Points Per Measure by Percentile Performance.

Percentile Performance	0-25	26-50	51-75	76-100
Percent of Possible Points	25%	50%		100%
Points Per Measure (with 11 Available Measures)	2.28	4.55	6.81	9.09

The Domain 2 Scoring Tool (example shown in Table 3) shows the Health Home's rate for an example measure. The Health Home "Percentile" column represents the percent of points the Health Home earns for a measure based on percentile performance. The possible points for the measure multiplied by the percentage corresponding to the Health Homes' percentile for that measure determines the points earned for that measure.

Table 3. Example Output from Domain 2 Scoring Tool Showing Quality Measure Results

Measure	Measure year	Rate	Percentile	Points per measure	Score
Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence-7 Days	12/2023 - 11/2024	72	100	9.09	9.09

Quality measures with fewer than 30 members for a Health Home are excluded from Domain 2 due to insufficient sample size, which can compromise confidentiality or produce unreliable rates. Health Homes are not penalized for missing measures caused by small sample sizes.

Quality measures are pulled from the Department's Clinical Data Mart using Medicaid Claims and Encounters and followed Healthcare Effectiveness Data & Information Set (HEDIS), Center for Medicare & Medicaid Services (CMS), or New York State Department of Health specifications. Dual-Eligible members (covered by Medicaid and Medicare) are not included as the Department's data set does not include Medicare claims. Health Homes Serving Adults (HHSA) and Health Homes Serving Children (HHSC) scores are not compared to each other. For each measure, the top performing Health Home sets the ceiling for the percentile.

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Table 4. Quality Measures included in Adult and Children's Health Home Redesignation Domain 2.

Measure	Measure Description	Adult or Children	Where to Find More Info*
Follow Up Care for Children Prescribed ADHD Medication-Initiation (ADD_INIT)	The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.	Children	Children Core Set Technical Specifications
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	Children	Children Core Set Technical Specifications
Eye Exam for Patients with Diabetes (EED)	The percentage of persons 18–75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam.	Adults	EED Measure Information
Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence-7 & 30 Days (FUA 07/30)	The percentage of ED visits for members with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow-up visit for AOD within 7/30 days of ED visit.	Adult	Health Home Core Set Technical Specifications
Follow Up After Hospitalization for Mental Illness-7 & 30 Days (FUH 07/30)	The percentage of discharges for members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7/30 days of discharge.	Adult & Children	Health Home Core Set Technical Specifications
Follow Up After Emergency Department Visit for Mental Illness-7 & 30 days (FUM 07/30)	The percent of ED visits for members with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7/30 days of ED visit.	Adult & Children	Health Home Core Set Technical Specifications
Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA)	The percentage of members with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period during the measurement year.	Adult	Adult Core Set Technical Specifications
Statin Therapy for Patients with Cardiovascular Disease: Received Statin Therapy (SPC-Receipt)	The percentage of males 21-75 years of age and females 40-75 years of age who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed a prescription for at least one high-intensity or moderate-intensity statin medication.	Adult	SPC-Receipt Measure Information
Statin Therapy for Patients with Diabetes: Received Statin Therapy (SPD-Receipt)	The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who were dispensed at least one statin medication of any intensity during the measurement year.	Adult	SPD-Receipt Measure Information
Child and Adolescent Well-Care Visits (WCV)	The percentage of members (3-21 years) who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measure year.	Children	Children Core Set Technical Specifications
Viral Load Suppression (VLS)	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.	Adult	See Appendix B for VLS Technical Specifications

**The Adult and Child Core Set Technical Specifications were developed for federal reporting on the entire Adult and/or Children's Medicaid population. We provide these documents to give Health Homes an overall idea of inclusions and exclusions, as well as numerator and denominator definitions.*

Relative Percentile Scoring for Quality Measures

Relative percentile scoring is a standard method in quality assessment and is used across New York in health plan and nursing home quality incentive programs, as well as nationally for health plans. The Essential Plan Quality Incentive Program assesses at the 90th, 75th, and 50th percentiles of quality measures to award points that contribute to 80% of the quality incentive score. Points are awarded per measure dependent on the percentile. The Nursing Home Quality Initiative methodology also bases 75% of the score on quintiles or thresholds of quality measure performance.

The current methodology enables use of the most current data, reflecting outcomes closest to the contemporary Health Home policy and program. Measure specifications change over time, occasionally impacting the ability to trend measures year over year.

Percentile Functioning

Using percentiles of the current Health Home statewide performance allows a Health Home's performance to be rated amongst peers, so all scores are feasible. Our scoring provides some points for each percentile, including the poorest performers. Health Homes receive points for each quality measure, so Health Homes can perform across many domains. With the percentile methodology, we considered and reviewed the distribution of each measure to avoid any 'ceiling effect'. We will review the variability of measures after each redesignation cycle to ensure there is meaningful variation across each measure. If a measure lacks variation, it will be removed from redesignation.

Case Mix

Quality measures are designed to only include the selected population in the denominator to avoid population 'sickness' driving performance. These measures are used because their inclusion and exclusion criteria create a "level-setting" effect, ensuring fair comparisons. This approach allows us to evaluate whether individuals are receiving appropriate care rather than assessing their overall health or illness.

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Process Measures Description and Scoring

Process measures use data from the Care Management Assessment Reporting Tool (CMART), the Medicaid Claims and Encounters member-level data, and the Health Home Tracking System (HHTS). The measures are described in Table 5. Health Homes receive a score of 1 for every process measure that meets or exceeds the required threshold. For example, if a Health Home scores 55% on the Comprehensive Assessment measure and the threshold for that measure is set at 60%, they receive a 0 for that measure. If they scored 66% on the Plan of Care measure and the threshold is 60%, they receive a score of 1 for that measure. All Health Homes are compared against the same required thresholds. There are no percentiles in calculating the process measure score. The final rate for each measure uses the most recent four quarters of data available. To create the total score, the number of points the Health Home earns is divided by the number of possible points.

For example, if a Health Home earns points for 3 out of 7 measures, its total score is calculated as 3/7×100= 42.86%. If a Health Home does not have a score available for a measure due to no members meeting the denominator criteria, that measure is excluded from the overall score calculation.

Table 5. Process Measures included in Health Home Redesignation Domain 2.

Measure	Measure Description	Adult or Children	Threshold
Comprehensive Annual Assessment (ANN_ASSESS)	Percentage of members enrolled during the quarter who have a comprehensive assessment in the 379 days (365 days + 14 days) before their most recent comprehensive assessment.	Adult	70%
Initial Comprehensive Assessment within 56 Days of Enrollment (ASSESS_56DAY)	Percentage of newly enrolled Health Home members who were newly enrolled and had a comprehensive assessment completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.	Adult	70%
CANS-NY Comprehensive Assessment within 56 Days of Enrollment (CANSCOMP_56DAY)	Percentage of newly enrolled HHSC members who had a CANS-NY comprehensive assessment finalized between the first day of their enrollment month and 56 days after the last day of their enrollment month.	Children	60%
Care Management Follow Up After Emergency Department Discharge 2 & 7 Days (CMFUED 02/07)	Percentage of members with a completed intervention within two/seven days of the day of the ED visit.	Adult	2 Day: 60% 7 Day: 65%
Care Management Follow Up After Emergency Department Discharge 2 & 7 Days (CMFUED 02/07)	Percentage of members with a completed intervention within two/seven days of the day of the ED visit.	Children	2 Day: 60% 7 Day: 70%
Care Management Follow Up After Inpatient Discharge 2 & 7 Days (CMFUIP 02/07)	Percentage of members with a completed intervention within two/seven days of the day of the inpatient discharge.	Adult	2 Day: 60% 7 Day: 65%

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Care Management Follow Up After Inpatient Discharge 2 & 7 Days (CMFUIP 02/07)	Percentage of members with a completed intervention within two/seven days of the day of the inpatient discharge.	Children	2 Day: 65% 7 Day: 80%
Initial Plan of Care within 56 Days of Enrollment (POC_56DAY)	Percentage of newly enrolled Health Home members who had an initial plan of care completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.	Adult	70%
Initial Plan of Care within 56 Days of Enrollment (POC_56DAY)	Percentage of newly enrolled Health Home members who had an initial plan of care completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.	Children	80%
Children's Core Service Requirements for Billing– All Care Coordination Levels of Service (CCLS) (ALL_REQ)	Percentage of Health Home Serving Children enrolled member months with a rate code of Low/Standard, Early Development/Intense, or Complex during the measure quarter that met the core service requirements for the rate code.	Children	85%
Children's Multidisciplinary Team Meeting Requirements – 6 Months (MDTM_REQ_6M)	Percentage of HHSC members who were enrolled for all 6 months before the end of the measure quarter with a rate code of Complex who had a MDTM during the 6 months before the end of the quarter.	Children	60%
Children's Multidisciplinary Team Meeting Requirements – One Year (MDTM_REQ_1Year)	Percentage of HHSC members who were enrolled for all 12 months before the end of the measure quarter with a rate code of Low/Standard or Early Development/Intensive who had a MDTM during the 12 months before the end of the quarter.	Children	60%
Office of Mental Health (OMH) Serious Mental Illness (SMI) HH Plus Measures			
OMH SMI HH Plus Identification	The percentage of members who are HH Plus eligible and HH-enrolled that have been identified by the Health Home as HH Plus eligible. Measure calculated by OMH	Adult	85%
OMH SMI HH Plus Specialty CMA Enrollment	The percentage of members who are HH Plus eligible that are enrolled in a specialty mental health CMA. Measure calculated by OMH.	Adult	95%
OMH SMI HH Plus Members with HH Plus Service	Percentage of members who are HH Plus eligible that have received the HH Plus level of care. Measure calculated by OMH.	Adult	75%
OMH SMI HH Plus Billing Core Service Requirements (HHP_SMI_CS_REQ)	The percentage of SMI HH Plus/ AOT member months that members received the necessary core services for each month billed at the HH Plus or AOT rate code.	Adult	95%
AIDS Institute (AI) HIV HH+ Measures			

AI HIV HH Plus Specialty CMA Enrollment (HIV_HHPLUS_CMA)	The percentage of member months that HIV HH+ members are enrolled in a HH Plus specialty CMA.	Adult	95%
AI HIV HH Plus Members with HH Plus Service (HIV_HHPLUS_SRV)	The percentage of HIV HH Plus enrolled member months with a rate code of 1853-HH Plus/Care Management or the HH has stated the required level of service was received by the member in MAPP HHTS.	Adult	75%
AI HIV HH Plus Billing Core Service Requirements (HHP_HIV_CS_REQ)	The percentage of HIV HH Plus member months that members received the necessary core services billing requirements during the quarter for each month billed at the HH Plus rate code.	Adult	95%

OMH SMI HH Plus Identification, OMH SMI HH Plus Specialty CMA Enrollment, and OMH SMI HH Plus Members with HH Plus Service measures are calculated by The Office of Mental Health, Office of Population Health and Evaluation. These measures can be found on the PSYCKES Health Home Plus Dashboards. For any questions regarding these measures, please reach out to dataophe@omh.ny.gov. All other process measures are calculated by The Department of Health, Office of Health Services Quality and Analytics. For any questions regarding these measures, please reach out to CareManagement_QHSQA@health.ny.gov.

The Domain 2 Scoring Tool provides the Health Home's rate for the corresponding measure. The "Required Threshold" column in the Scoring Tool represents the required rate a Health Home must achieve for that measure to be considered met. The Threshold column indicates whether the Health Home's rate falls below, meets, or exceeds the threshold in the corresponding "Required Threshold" column.

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Appendix A: OHSQA Process Measures Specifications

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Comprehensive Annual Assessment (ANN_ASSESS)

Measure shows entire Health Home enrolled population. Quarterly data are not mutually exclusive. Data cannot be rolled up, to get information for a year take the most recent quarter seen for the year

Policy

The Health Home Comprehensive Assessment Policy (Adult and Children) states a member needs to have a comprehensive assessment completed annually except when there is a significant change in medical and/or behavioral health or social needs before the annual reassessment.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/comprehensive_assessment_policy.pdf

Measure Description

Percent of enrolled members with a completed comprehensive assessment during the 379 days (365+14 days) before the last day of the measure quarter.

Note:

- Members with less than 3 months of continuous enrollment in their assigned HH are excluded.
- Assessments occurring in the 379 days (365+14 days) before the end of the quarter are used to account for possible delays (ex: scheduling, sickness) preventing an annual assessment being completed in 365 days. Adding 14 days to the acceptable period for the annual assessment to be completed contributed to a large increase in the number of members meeting the requirement.

Denominator

All members enrolled at least 3 months during the 379 days (365+14 days) before the last day of the measurement quarter. Members continuously enrolled 2 months or less in their assigned HH are excluded.

- Enrollment months are defined as enrolled segment months that were not pended or voided. Enrollment can occur at any point during the 379 days prior the last day of the quarter. Members do not need to be enrolled during the quarter to be included in the denominator if the member was enrolled for at least 3 months during the 379 day period.
- Members in outreach are excluded.

Numerator

All members included in the denominator with a completed comprehensive assessment during the 379 days.

Note: Data regarding significant change in medical and/or behavioral health or social needs is not currently available

- Only comprehensive assessments marked ‘completed’ (as specified in the HH-CMART specifications) will count towards the numerator.
- Only the most recent completed comprehensive assessment per member is counted towards the numerator. Members cannot have a numerator higher than 1.

Data Sources

Enrollment Information

Enrollment and segment information is determined using Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) data. This includes information such as a member’s Medicaid ID, member’s Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member’s rate code, and member’s Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

Assessment Information

Assessment data is provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and

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contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Initial Comprehensive Assessment within 56 Days of Enrollment (ASSESS_56DAY)

Policy

The Health Home Comprehensive Assessment Policy states the initial comprehensive assessment needs to be completed within 56 days of enrollment.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0002_comprehensive_assessment_policy.pdf

Measure Description

Percent of newly enrolled Health Home members who had a comprehensive assessment completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.

Note:

- Members are included in the quarter if the due date for the completed intervention falls within the specified quarter. See end of document for example of months included in recent quarters.

Denominator

Newly enrolled members with a completed assessment due within the quarter. A newly enrolled member is a member with no enrollment in their assigned Health Home in the 6 months before their first enrollment during the quarter.

- Intervention due date is calculated as 56 days from the last day of the member's first enrollment month.
- Enrolled member segments do not include pended or voided segments.
- Members have to be enrolled at least 56 days within a quarter.
- Members in outreach are excluded.

Numerator

Newly enrolled members with a comprehensive assessment completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.

- Only comprehensive assessments marked 'completed' (as specified in the HH-CMART specifications) will count towards the numerator.
- Only the most recent completed comprehensive assessment per member is counted towards the numerator.

Data Source

Enrollment Information

Enrollment and segment information is determined using Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) data. This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

Assessment Information

Assessment data is provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Timeframes Included in Recent Quarters:

Measure Quarter	Months Included in Calculation
Q1 2026	November 2025, December 2025, January 2026
Q2 2026	February 2026, March 2026, April 2026
Q3 2026	May 2026, June 2026, July 2026
Q4 2026	August 2026, September 2026, October 2026

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CANS-NY Comprehensive Assessment within 56 Days of Enrollment (CANSCOMP_56DAY)

Policy

The Health Home Comprehensive Assessment Policy (HH0002) states the comprehensive assessment must be completed within 56 days of enrollment in a HHSC HH. For the HHSC program the CANS-NY assessment and UAS-NY are used to collect comprehensive assessment information.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0002_comprehensive_assessment_policy.pdf

Measure Description

Percent of newly enrolled HHSC members who had a CANS-NY assessment finalized between the first day of their enrollment month and 56 days after the last day of their enrollment month.

Denominator

Newly enrolled HHSC members. A newly enrolled member is a member with no enrollment in the 6 months before their first enrollment during the measure quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members in outreach are excluded.

Numerator

Newly enrolled HHSC members with a CANS-NY finalized between the first day of their enrollment month and 56 days after the last day of their enrollment month.

- Members cannot have a numerator higher than 1.

Data Sources

Enrollment & CANS-NY Information

Enrollment, segment, and CANS-NY information is determined using Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) data. This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

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Care Management Follow Up After Emergency Department Discharge (CMFUED)

Policy

Section B of the Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations states care managers must contact enrollees within 48 hours of Emergency Department (ED) discharge.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

Measure Description

Percentage of Health Home enrolled members who had a completed intervention after the ED visit. Rates reported:

1. Percentage of ED visits with a completed intervention between the ED visit date and **two** days after the ED visit date.
2. Percentage of ED visits with a completed intervention between the ED visit date and **seven** days after the ED visit date.

Note:

- ED visits resulting in an inpatient stay are not included.
- Only ED visits occurring during a members HH enrollment in the previous measure quarter are included.
- ED visits used for the measure quarter will be visits occurring during a member's enrollment during the previous measure quarter. For example:

Measure Quarter	Quarter Used for ED visits
Q1 2026	Q4 2025
Q2 2026	Q1 2026
Q3 2026	Q2 2026
Q4 2026	Q3 2026
Q1 2027	Q4 2026

- Outreach and letter interventions are excluded.
- Stratifications: Overall, Health Homes Serving Adults (HHSA), Health Homes Serving Children (HHSC), Individuals with Intellectual and/or Developmental Disabilities (IDD)

Denominator

Number of ED visits a HH enrolled member has during their enrollment during the previous measure quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members in outreach are excluded.

Numerators

Intervention within 2 Days: ED visits with at least one completed intervention between the ED visit date and 2 days after the ED visit date. Outreach and letter interventions are excluded.

Intervention within 7 Days: ED visits with at least one completed intervention between their ED visit date and 7 days after the ED date. Outreach and letter interventions are excluded.

Interventions must be marked as completed to be included in the numerators.

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Data Sources

Enrollment Information

Enrollment and segment information is determined using Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) data. This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

ED Visit Information

ED visit information is pulled from Medicaid claims data.

Intervention Information

Intervention data is provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Care Management Follow Up After Inpatient Discharge (CMFUIP)

Policy

Section B of the Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations states care managers must contact enrollees within 48 hours of inpatient discharge. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

Measure Description

Percentage of Health Home enrolled members with a completed intervention after their inpatient discharge. Rates reported:

1. Percentage of inpatient discharges with a completed intervention between two days before and two days after the day of the inpatient discharge.
2. Percentage of inpatient discharges with a completed intervention between two days before and seven days after the day of the inpatient discharge.

Note:

- Evaluates all inpatient visits including mental health and substance use disorder visits.
- Only inpatient visits occurring during a member's Health Home enrollment are included.
- Inpatient visits used for the measure quarter will be visits occurring during a member's enrollment during the previous measure quarter. For example:

Measure Quarter	Quarter Used for Inpatient visits
Q1 2026	Q4 2025
Q2 2026	Q1 2026
Q3 2026	Q2 2026
Q4 2026	Q3 2026
Q1 2027	Q4 2026

- Outreach and letter interventions are excluded.
- Stratifications: Overall, Health Homes Serving Adults (HHSA), Health Homes Serving Children (HHSC), Individuals with Intellectual and/or Developmental Disabilities (IDD)

Denominator

Number of inpatient discharges a Health Home enrolled member has during their enrollment during the previous measure quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members in outreach are excluded.

Numerators

Intervention within 2 Days: Inpatient discharges with at least one completed intervention between 2 days before and two days after the date of inpatient discharge. Outreach and letter interventions are excluded.

Intervention within 7 Days: Inpatient discharges with at least one completed intervention between 2 days before and seven days after of date of discharge. Outreach and letter interventions are excluded.

Interventions must be marked as completed to be included in the numerators.

Data Sources

Enrollment Information

Enrollment and segment information is determined using Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) data. This includes information such as a member's Medicaid ID, member's

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Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

Inpatient Visit Information

Inpatient visit information is pulled from Medicaid claims data.

Intervention Information

Intervention data is provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Initial Plan of Care within 56 Days of Enrollment (POC_56DAY)

Policy

The Health Home Plan of Care Policy states a Health Home needs to create a plan of care within 56 days of HH enrollment.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf

Measure Description

Percent of newly enrolled Health Home members who had a plan of care completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.

Note: Members are included in the quarter if the due date for the Plan of Care falls within the specified quarter. See end of document for example of months included in recent quarters.

Denominator

Newly enrolled members with a plan of care due within the quarter. A newly enrolled member is a member with no enrollment in their assigned HH in the 6 months before their first enrollment during the quarter.

- Plan of Care due date is calculated as 56 days from the last day of the member's first enrollment month.
- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members in outreach are excluded.

Numerator

Newly enrolled members with a plan of care completed between the first day of their enrollment month and 56 days after the last day of their enrollment month.

Data Source

Enrollment information

For HHSA and HHSC members is based on data that is in the Medicaid Analysis Performance Portal Health Home Tracking System (MAPP HHTS). This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

Plan of Care Information

Plan of Care data is provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf. Beginning in July 2024 (Q3 2024) when the plan of care billing block became effective, Plan of Care data submitted via MAPP HHTS can also contribute to the numerator.

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Timeframes Included in Recent Quarters:

Measure Quarter	Months Included in Calculation
Q1 2026	November 2025, December 2025, January 2026
Q2 2026	February 2026, March 2026, April 2026
Q3 2026	May 2026, June 2026, July 2026
Q4 2026	August 2026, September 2026, October 2026

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Health Homes Serving Children Core Service Requirements for Billing– All Care Coordination Levels of Service (CCLS) (ALL_REQ)

ALL_REQ is comprised of three process measures evaluating the percentage of member months that met the billing policies for Low/Standard (LS_REQ), Early Development/Intensive (EDI_REQ), and Complex (C_REQ) acuities. This measure will replace the HM_F2F measure starting with Q2 2025 data.

Health Homes Serving Children Low/Standard Core Service Requirements (LS_REQ)

Policy

The Health Home Serving Children Care Management Core Service Requirements and Billing Policy (HH0017) effective April 1, 2025 states members with a rate code of Low/Standard (1864 or 1869) must have:

- Two core services each month
- One core service targeted to the member each quarter
    - If requested this can be delivered by telehealth

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/updated_policy_hh0017.htm

Measure Description

Percentage of Health Home Serving Children (HHSC) enrolled member months with rate code of Low/Standard during the measurement quarter that met the core service requirements for Low/Standard.
Note:

- This measure is calculated per month during the specified quarter.
- If members are enrolled in multiple HHs during the quarter, then the member is assigned to the last HH they were seen in the quarter.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.
- Outreach and letter core services are excluded.

Denominator

Number of months HHSC enrolled members had a rate code of Low/Standard during the measurement quarter.

Numerator

Number of months HHSC enrolled members had a rate code of Low/Standard and met the core service requirements for Low/Standard in the table below during the measurement quarter.

Note: The number next to the mode and target corresponds to the data type associated with the interventions file submitted to HHCMART here.

Core Service Requirement	Core Service Mode	Core Service Target	Core Service Type
Two core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	All	Care Management or Care Coordination and Health Promotion or Transitional Care or Individual and Family Support or Community and Support Services
One in-person or telehealth member core service each quarter	2-Phone or 3-In-Person (Face to face) or 6-Video Conference	1-Member	

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Health Homes Serving Children Early Development/Intense Core Service Requirements (EDI_REQ)

Policy

The Health Home Serving Children Care Management Core Service Requirements and Billing Policy (HH0017) effective April 1, 2025 states members with a rate code of Early Development/Intense (1865 or 1870) must have:

- Two core services each month with at least one contact with the member
- Each quarter:
    - One of the three member contacts must be in-person
    - Two of the three member contacts can be done by telehealth

Members found eligible for the Short-Term In-Person Waiver for Medically Fragile who request telehealth must have:

- Two core services each month with at least one contact with the member
    - The member contact can be telehealth
        - Two additional core services targeting the provider are required if the member contact is done by telehealth

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/updated_policy_hh0017.htm

Measure Description

Percentage of Health Home Serving Children (HHSC) enrolled member months with a rate code of Early Development/Intense during the measure quarter that met the core service requirements for Early Development/Intense.

Note:

- This measure is calculated per month during the specified quarter.
- If members are enrolled in multiple HHs during the quarter, then the member is assigned to the last HH they were seen in the quarter.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.
- Outreach and letter core services are excluded.
- Members are considered in the Short-Term In-Person Waiver for Medically Fragile Members if they meet all the following requirements during the measurement quarter:
    - Active Home and Community Based Services (HCBS) K Code of K1-HCBS LOC and K4-Medically Fragile or K6-Developmentally Disabled and Medically Fragile
    - Enrolled in HHSC for at least 3 months
    - Not a High Fidelity Wraparound member
    - No active HCBS K Code of K3-Serious Emotional Disturbance (SED)
    - No HHSC qualifiers of SED or mental health

Denominator

Number of months HHSC enrolled members had a rate code of Early Development/Intense during the measurement quarter.

Numerator

Number of months HHSC enrolled members had a rate code of Early Development/Intense and met the core service requirements for Early Development/Intense in the table below during the measurement quarter.

Note: The number next to the mode and target corresponds to the data type associated with the interventions file submitted to HHCMART here.

Core Service Requirement	Core Service Mode	Core Service Target	Core Service Type

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All Members			
Two core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	All	Care Management or Care Coordination and Health Promotion or Transitional Care or Individual and Family Support or Community and Support Services
One in-person or telehealth member core service each month	2-Phone or 3-In-Person (Face to face) or 6-Video Conference	1-Member	
One in-person member core service each quarter	3-In-Person (Face to face)	1-Member	
Short-Term In-Person Waiver for Medically Fragile Members*			
Two core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	All	Care Management or Care Coordination and Health Promotion or Transitional Care or Individual and Family Support or Community and Support Services
One telehealth member core service each month	2-Phone or 6-Video Conference	1-Member	
Two provider core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	4-External Doctor/Provider	

*Only applies to members flagged as in the Short-Term In-Person Waiver for Medically Fragile Members

Health Homes Serving Children Complex Core Service Requirements (C_REQ)

Policy

The Health Home Serving Children Care Management Core Service Requirements and Billing Policy (HH0017) effective April 1, 2025 states members with a rate code of Complex (1866 or 1871) must have:

- Three core services each month with at least two contacts with the member:
  - One of the two member contacts per month must be in-person
  - One of the two member contacts per month can be telehealth

Members found eligible for the Short-Term In-Person Waiver for Medically Fragile who request telehealth contact must have:

- Three core services each month with at least two contacts with the member:
  - The two contacts with the member can be telehealth
    - Two additional core services targeting the provider are required if the member contacts are done by telehealth

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/updated_policy_hh0017.htm

Measure Description

Percentage of Health Home Serving Children (HHSC) enrolled member months with rate code of Complex during the measurement quarter that met the core service requirements for Complex.

Note:

- This measure is calculated per month during the specified quarter.
- If members are enrolled in multiple HHs during the quarter, then the member is assigned to the last HH they were seen in the quarter.

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- A core service is defined as mode/target/intervention date.
- Only completed core services are included.
- Outreach and letter core services are excluded.
- Members are considered in the Short-Term In-Person Waiver for Medically Fragile Members if they meet all the following requirements during the measure quarter:
    - Active Home and Community Based Services (HCBS) K Code of K1-HCBS LOC and K4-Medically Fragile or K6-Developmentally Disabled and Medically Fragile
    - Enrolled in HHSC for at least 3 months
    - Not a High Fidelity Wraparound member
    - No active HCBS K Code of K3-Serious Emotional Disturbance (SED)
    - No HHSC qualifiers of SED or mental health

Denominator

Number of months HHSC enrolled members had a rate code of Complex during the measurement quarter.

Numerator

Number of months HHSC enrolled members had a rate code of Complex and met the core service requirements for Complex in the table below during the measure quarter.

Note: The number next to the mode and target corresponds to the data type associated with the interventions file submitted to HHCMART here.

Core Service Requirement	Core Service Mode	Core Service Target	Core Service Type
All Members			
Three core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	All	Care Management or Care Coordination and Health Promotion or Transitional Care or Individual and Family Support or Community and Support Services
Two in-person or telehealth member core services each month	2-Phone or 3-In-Person (Face to face) or 6-Video Conference	1-Member	
One in-person member core service each month	3-In-Person (Face to face)	1-Member	
Short-Term In-Person Waiver for Medically Fragile Members*			
Three core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	All	Care Management or Care Coordination and Health Promotion or Transitional Care or Individual and Family Support or Community and Support Services
Two telehealth member core services each month	2-Phone or 6-Video Conference	1-Member	
Two provider core services each month	2-Phone or 3-In-Person (Face to face) or 4-Email or 5-SMS/Text or 6-Video Conference	4-External Doctor/Provider	

*Only applies to members flagged as in the Short-Term In-Person Waiver for Medically Fragile Members

Data Source

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HHSC enrollment and rate codes are extracted from the Health Home Tracking System. Member HCBS K Codes are pulled from Medicaid. Data for the core services is pulled from intervention data provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Health Homes Serving Children Multidisciplinary Team Meeting Requirements-1 Year (MDTM_REQ_1Year)

Policy

The Health Home Serving Children Care Management Core Service Requirements and Billing Policy (HH0017) effective April 1, 2025 states:

- Members with a rate code of Low / Standard or Early development / Intense must have a multidisciplinary team meeting (MDTM) annually.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/updated_policy_hh0017.htm

Measure Description

Percentage of Health Home Serving Children (HHSC) members who were enrolled for all 12 months before the end of the measure quarter with a rate code of Low / Standard or Early Development / Intensive who had a MDTM during the 12 months before the end of the quarter.
Note:

- If members are enrolled in multiple HHs during the year, then the member is assigned to the last HH they were seen in during the year.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.
- Outreach and letter core services are excluded.
- A MDTM is defined as a core service with a target of Multidisciplinary Team/Case Review Meeting (Internal/External).

Denominator

Number of HHSC members enrolled all 12 months before the end of the measure quarter with a rate code of Low / Standard or Early Development / Intense each month.

Numerator

Number of HHSC enrolled members with a rate code of Low / Standard or Early Development / Intense who had completed MDTM during the 12 months before the end of the quarter.

Data Sources

Enrollment and MDTM Information

HHSC enrollment and rate codes are extracted from the Health Home Tracking System. Data for the core services is pulled from intervention data provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Health Homes Serving Children Multidisciplinary Team Meeting Requirements 6 Months (MDTM_REQ_6M)

Policy

The Health Home Serving Children Care Management Core Service Requirements and Billing Policy (HH0017) effective April 1, 2025 states:

- Members with a rate code of Complex must have a multidisciplinary team meeting (MDTM) every six months

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/updated_policy_hh0017.htm

Measure Description

Percentage of Health Home Serving Children (HHSC) members who were enrolled for all 6 months before the end of the measure quarter with a rate code of Complex who had a MDTM during the 6 months before the end of the quarter.

Note:

- If members are enrolled in multiple HHs during the 6 months, then the member is assigned to the last HH they were seen during the 6 months.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.
- Outreach and letter core services are excluded.
- A MDTM is defined as a core service with a target of Multidisciplinary Team/Case Review Meeting (Internal/External).

Denominator

Number of HHSC members enrolled during all 6 months before the end of the quarter with a rate code of Complex each month.

Numerator

Number of HHSC enrolled members with a rate code of Complex who had a completed MDTM during the 6 months before the end of the quarter.

Data Sources

Enrollment and MDTM Information

HHSC enrollment and rate codes are extracted from the Health Home Tracking System. Data for the core services is pulled from intervention data provided by the Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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AIDS Institute HIV HH Plus Members with a HH Plus Service (HIV_HHPLUS_SRV)

Policy

Health Home Plus Program Guidance for Individuals with HIV states Health Homes need to make sure individuals receive the required level of service.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/health_home_plus_for_hiv.htm

Measure Description

Percent of HIV HH Plus enrolled member months during the 365 days before the last day of the measure quarter with a rate code of 1853-HH Plus/Care Management or the HH has stated the required level of service was received by the member in MAPP HHTS.

Note:

- A HIV HH Plus member is defined as a Health Home Serving Adults enrolled member having one or more of the following MAPP HHTS HH Plus population types:
    - Yes. HH+ HIV- Virally Unsuppressed (B)
    - Yes HH+ HIV – SMI and 3+ in-patient hospitalizations in the last year (C)
    - Yes. HH+ HIV – SMI and 4+ ED visits in the last year (D)
    - Yes. HH+ HIV – SMI and homelessness (HUD 1 definition) (E)
    - Yes. HH+ HIV- Injection Drug use and 3+ in-patient hospitalizations in the last year (F)
    - Yes. HH+ HIV- Injection Drug Use and 4+ ED visits within the last 12 months (G)
    - Yes. HH+ HIV- Injection Drug use and homelessness (H)
    - Yes. HH+ HIV- Clinical Discretion MCP (I)
    - Yes. HH+ HIV- Clinical Discretion Medical Providers (J)
- If members are enrolled in multiple HHs, then the member is assigned to the last HH they were seen in

Denominator

HIV HH Plus enrolled member months members during the 365 days before the last day of the measure quarter.

Numerator

HIV HH Plus enrolled member months during the 365 days before the last day of the measure quarter with a rate code of 1853-HH Plus/Care Management or the HH stated the required level of service was received by the member in MAPP HHTS.

Data Sources

Enrollment Information. Member enrollment is based on data that is in the Medicaid Analysis Performance Portal Health Home Tracking System (MAPP HHTS). This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program and CMA. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

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AIDS Institute HIV HH Plus Members in a HH Plus Specialty CMA (HIV_HHPLUS_CMA)

Policy

The Health Home Plus Program Guidance for Individuals with HIV states members who are referred to the HH Plus program need to be assigned to a care management agency that is qualified to serve HH Plus members. For members diagnosed with serious mental illness and HIV the care management agency should determine the most appropriate HH Plus CMA assignment.

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/health_home_plus_for_hiv.htm

Measure Description

Percent of HIV HH Plus enrolled member months during the 365 days before the last day of the measure quarter where the member is in a HH Plus Specialty CMA.

Note:

- A HIV HH Plus member is defined as a Health Home Serving Adults (HHSA) enrolled member having one or more of the following MAPP HHTS HH Plus population types:
    - Yes. HH+ HIV- Virally Unsuppressed (B)
    - Yes HH+ HIV – SMI and 3+ in-patient hospitalizations in the last year (C)
    - Yes. HH+ HIV – SMI and 4+ ED visits in the last year (D)
    - Yes. HH+ HIV – SMI and homelessness (HUD 1 definition) (E)
    - Yes. HH+ HIV- Injection Drug use and 3+ in-patient hospitalizations in the last year (F)
    - Yes. HH+ HIV- Injection Drug Use and 4+ ED visits within the last 12 months (G)
    - Yes. HH+ HIV- Injection Drug use and homelessness (H)
    - Yes. HH+ HIV- Clinical Discretion MCP (I)
    - Yes. HH+ HIV- Clinical Discretion Medical Providers (J)
- HH Plus CMA is defined as an AIDS Institute or Office of Mental Health HH Plus specialty CMA.
- If members are enrolled in multiple HHs, then the member is assigned to the last HH they were seen in.

Denominator

HIV HH Plus enrolled member months during the 365 days before the last day of the measure quarter.

Numerator

HIV HH Plus enrolled member months during the 365 days before the last day of the measure quarter where the member is in a HH Plus CMA.

Data Sources

Enrollment Information. Member enrollment is based on data that is in the Medicaid Analysis Performance Portal Health Home Tracking System (MAPP HHTS). This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program and CMA. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

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Health Home Plus HIV Members Meeting Core Services Billing Requirements (HHP_HIV_CS_REQ)

Policy

Guidelines state that care managers should provide at least four core services for HH Plus enrollees billed at HH Plus rate code, with at least two being in-person.

AIDS Institute (AI) Guidance for HIV HH Plus Members:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/special_populations/docs/health_home_plus_for_hiv.pdf

Measure Description

Percentage of HH Plus member months with a rate code of HH Plus during the measure quarter that met the core service requirements for HH Plus.

Note:

- A HIV HH Plus member is defined as a Health Home Serving Adults (HHSA) enrolled member having one or more of the following MAPP HHTS HH Plus population types:
  - Yes. HH+ HIV- Virally Unsuppressed (B)
  - Yes HH+ HIV – SMI and 3+ in-patient hospitalizations in the last year (C)
  - Yes. HH+ HIV – SMI and 4+ ED visits in the last year (D)
  - Yes. HH+ HIV – SMI and homelessness (HUD 1 definition) (E)
  - Yes. HH+ HIV- Injection Drug use and 3+ in-patient hospitalizations in the last year (F)
  - Yes. HH+ HIV- Injection Drug Use and 4+ ED visits within the last 12 months (G)
  - Yes. HH+ HIV- Injection Drug use and homelessness (H)
  - Yes. HH+ HIV- Clinical Discretion MCP (I)
  - Yes. HH+ HIV- Clinical Discretion Medical Providers (J)
- Outreach and letter core services are excluded.
- If members are enrolled in multiple HHs during the quarter, then the member is assigned to the last HH they were seen in the quarter.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.

Denominator

HHSA enrolled member months with HH Plus rate code during the measurement quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members are included if they are active and enrolled in a HHSA, and HH Plus eligible with an HH Plus rate code for any month during the measurement quarter.
- Members in outreach are excluded.

Numerator

HHSA enrolled member months with HH Plus rate code during the measurement quarter that met the core service requirements.

Data Sources

Enrollment Information. Member enrollment is based on data that is in the Medicaid Analysis Performance Portal Health Home Tracking System (MAPP HHTS). This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

The following table shows the rate codes and descriptions used for service dates on or after May 1, 2018:

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HH Program	Rate Code	Description	Notes
HH Plus	1853	HH Plus	At least 4 completed core services each month with at least 2 completed in-person core services each month.

Intervention Information

Intervention data is provided by Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Health Home Plus SMI Members Meeting Core Services Billing Requirements (HHP_SMI_CS_REQ)

Policy

Guidelines state that care managers should provide at least four core services for HH Plus enrollees billed at HH Plus rate code, with at least two being in person. Assisted Outpatient Treatment (AOT) enrollees billed at the AOT rate code must receive at least four in-person interventions each month.

Office of Mental Health (OMH) Guidance for Serious Mental Illness (SMI) HH Plus and AOT Members:
https://omh.ny.gov/omhweb/adults/health_homes/hh-plus-high-need-smi-guidance.pdf

Measure Description

Percentage of HH Plus member months with a rate code of HH Plus or AOT during the measure quarter that met the core service requirements for HH Plus or AOT.

Note:

- Outreach and letter core services are excluded.
- If members are enrolled in multiple HHs during the quarter, then the member is assigned to the last HH they were seen in the quarter.
- A core service is defined as mode/target/intervention date.
- Only completed core services are included.

Denominator

HHSA enrolled member months with HH Plus or AOT rate code during the measurement quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members are included if they are active and enrolled in a HHSA, and HH Plus eligible or AOT eligible, and an AOT or HH Plus rate code for any month during the measurement quarter.
- Members in outreach are excluded.

Numerator

HHSA enrolled member months with HH Plus or AOT rate code during the measurement quarter that met the core service requirements.

Data Sources

Enrollment Information. Member enrollment is based on data that is in the Medicaid Analysis Performance Portal Health Home Tracking System (MAPP HHTS). This includes information such as a member's Medicaid ID, member's Health Home ID, if a member is in outreach or enrolled, segment begin and end month, member's rate code, and member's Health Home program. More information and the specifications for the data can be found here: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/mapp/index.htm

The following table shows the rate codes and descriptions used for service dates on or after May 1, 2018:

HH Program	Rate Code	Description	Notes
HH Plus	1853	HH Plus	At least 4 completed core services each month with at least 2 completed in-person interventions each month.
AOT	1876	AOT	At least 4 completed in-person core services each month.

Intervention Information

Intervention data is provided by Health Homes through the Health Home Care Management Assessment Reporting Tool (HH-CMART) data submission process. These data are submitted on a quarterly basis and contain information about assessments, plans of care, and interventions provided by Health Homes. More information and the specifications for submissions can be found here:

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https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/hh_cmart_specs.pdf

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Appendix B: Office of Mental Health (OMH) Serious Mental Illness (SMI) Process Measures Specifications

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OMH Health Home Plus SMI Identification

Policy

The Department of Health (DOH) Medicaid Analytics Performance Portal ("MAPP") will be used to identify individuals as HH Plus. MAPP users will be prompted in the monthly HML questionnaire with the questions "Is the member in the AOT population?" and "Is the member in the expanded HH Plus population?" If the user responds "Yes", the user is then prompted with "Were the minimum required AOT or HH Plus services provided?" By responding "Yes", the CMA attests that the minimum service requirements for AOT or HH Plus have been provided. This data will additionally be used by OMH for oversight purposes. It is important that CMAs accurately complete this data in MAPP monthly.

Measure Description

The percentage of members who are HH Plus eligible and HH enrolled that have been identified by the Health Home as HH Plus eligible. Annualized using average (mean) monthly percentage for most recent 12-month period (with 3 month data lag).

Denominator

Number of HH enrolled and HH Plus eligible members as determined by the OMH PSYCKES algorithm and/or identified by HH/CMA as HH Plus eligible in MAPP HHTS (see Data Sources for details).

- Members who were identified in the MAPP HHTS Billing Support Table as HH Plus eligible based on HIV status only and not identified as SMI in the PSYCKES algorithm are excluded.

Numerator

Number of HH enrolled and HH Plus eligible members who were identified by HH/CMA as HH Plus eligible in MAPP HHTS.

Data Sources

- Health Home enrollment and segment information is identified from the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS).
- OMH PSYCKES algorithm identifies persons who are HH Plus eligible from a set of administrative data sources and Medicaid claims data:
    - Individuals on a current AOT order or with an expired AOT court order within the past year: TACT/AOTWorkspace
    - Individuals discharged from State Psychiatric Centers: MHARS
    - Individuals released from the Central NY Psychiatric Center (CNYPC) and its corrections-based mental health units: REMS
    - Individuals transitioning off Assertive Community Treatment (ACT) to a lower level of service: CAIRS
    - Individuals meeting HUD Category 1 Homeless definition in the past 6 months with SMI: NYC Shelter/Outreach Data (NYC only), Medicaid Claims (statewide using Z code)
    - Individuals with high rates of inpatient/emergency department service utilization (3+ MH Inpatient admissions in past 13 months, 4+ MH ER visits past 13 months, or 3+ Medical Inpatient admissions and comorbid schizophrenia or bipolar disorder): Medicaid claims, MHARS
    - Individuals ineffectively engaged in care (2+ MH Inpatient or 3+ MH ER visits but no MH Outpatient visits in past 12 months): Medicaid claims, MHARS
- Some people who are eligible for HH Plus but cannot be identified by the PSYCKES algorithm, may be identified by the HH/CMA. These include:
    - Individuals with a voluntary agreement to receive an Enhanced Service Package in lieu of AOT
    - Individuals with criminal justice system involvement including release from incarceration within the past year
    - Clinical discretion of SPOA or MCO

HH/CMA identification of HH Plus eligibility: MAPP HHTS Billing Support Table

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OMH Specialty Mental Health CMA Enrollment for HH Plus SMI Eligible

Policy

Only CMAs designated by the NYS OMH as Specialty Mental Health Care Management Agencies (SMH CMAs) will be eligible to enroll newly referred individuals meeting HH+ SMI eligibility criteria. Only Specialty MH CMAs with authorization by the State, LGU and lead HH (s) will have the ability to accept referrals, serve and bill HH Plus for individuals on AOT. In the case where a HH member becomes HH Plus SMI eligible while enrolled with a non-Specialty MH CMA, lead HH shall ensure CMs are informing HH Plus eligible members of their option to transfer to a Specialty MH CMA, and ensuring access to Specialty MH Care Management, as appropriate.

Measure Description

The percentage of members who are HH Plus eligible and HH enrolled that are enrolled in a Specialty Mental Health CMA. Annualized using average (mean) monthly percentage for most recent 12-month period (with 3 month data lag).

Denominator

Number of HH enrolled and HH Plus eligible members based on both PSYCKES algorithm and MAPP

Numerator

Number of HH enrolled and HH Plus eligible members who are enrolled in a Specialty Mental Health CMA.

Data Sources

- For HH enrollment and HH Plus eligibility, see detailed description of data sources under Measure 1.
- Specialty Mental Health CMA enrollment: OMH maintains a list of Medicaid ID and name of Designated and Provisionally Designated Specialty Mental Health CMAs that are matched to the MAPP HHTS Billing Support Table to determine member enrollment in a Specialty Mental Health CMA.

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OMH HH Plus SMI Members with HH Plus Service

Policy

HH Plus services will be available for adults with SMI and who meet certain indicators of high need, such as risk for disengagement from care and/or poor outcomes (e.g., multiple hospitalizations, incarceration, and homelessness). These individuals may benefit from the enhanced support of HH+ for up to 12 consecutive months.

Measure Description

Percentage of members who are HH enrolled and HH Plus eligible that have received the HH Plus level of care. Annualized using average (mean) monthly percentage for most recent 12-month period (with 3 month data lag).

Denominator

Number of members who are HH enrolled and HH Plus eligible based on PSYCKES algorithm and MAPP.

Numerator

Number of members who are HH enrolled and HH Plus eligible who received a HH Plus level of service.

Data Sources

- For HH enrollment and HH Plus eligibility, see detailed description of data sources under Measure 1.
- Members who received a HH Plus eligible level of service: indicated in the MAPP HHTS Billing Support table for:
    - AOT: indicator=MINREQUIREDSERVICESPROVIDEDIND
    - Non-AOT: indicator=MINIMUMHHSERVICESPROVIDED

Acronyms

- AOT: Assisted Outpatient Treatment
- ACT: Assertive Community Treatment
- MAPP: Medicaid Analytics Performance Portal
- HHTS: Health Home Tracking System
- TACT/AOT Workspace: Tracking of AOT Cases and Treatment
- CAIRS: Child and Adult Integrated Reporting System
- MHARS: Mental Health Automated Reporting System
- SPOA: Single Point of Access

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Appendix C: Viral Load Suppression Technical Specifications

Viral Load Suppression

The Viral Load Suppression measure will be calculated by the AIDS Institute and the Office of Health Services Quality and Analytics using the Department of Health HIV Surveillance System.

Calculation of Measures

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

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Appendix D: Provisional Designation Domain 2 Information

Updated information coming soon…

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Appendix E: FAQs

1. Our Health Home has concerns about the Qualified Entity (QE) alerts.

We recognize alerts can be complicated and are not always timely. For this reason, we do not expect 100% compliance One measure has even incorporated an extended window into the policy to accommodate this challenge. We think Health Home follow-up is important to measure and hold Health Homes accountable. We recognize the data systems are still evolving and the Health Homes cannot ensure 100% success, which is why we have set our threshold at 60%. That said, we encourage Health Homes to investigate their alert system with the QEs to ensure the Health Homes are using the best practices for alerts. There are a few things you can do to ensure you are receiving the relevant alerts at the right time:

- Talk to your QE about their recommended settings for your needs. Alerts can be sent for a variety of reasons and when establishing an alert system, the Health Home determines when and what type of alerts they were receiving. Talk to your QE to ensure you have your alert settings to receive all potential relevant alerts and you are getting them as soon as possible. For example, an alert for an event may be sent at discharge or when the labs and relevant documentation about the event are completed. You may choose to set up your alerts to receive event notifications at the time rather than once the event details are complete.
- Ensure the appropriate individuals are signed up to receive alerts.
- Make sure your roster files submitted to the QEs are up to date.

If you are still struggling to receive timely alerts or feel like you are not receiving the correct alerts, the first course of action is to contact your QE. QEs have staff who help users navigate the system. If a QE is unresponsive or not fulfilling their roles, you can reach out to the SHIN-NY governance using this website: https://nyehealth.org/contact-us/

2. Are Dual Eligibles included in our Domain 2 measures?

Dual eligible members are not included in the calculation of quality measures. Dual eligibles are included in the process measures.

3. We're concerned that data issues are putting us below the threshold.

Health Homes are expected to perform these duties as per Department of Health Health Home policy. The Process Measures threshold was lowered to 60% to allow for some data issues and discrepancies. We encourage Health Homes to validate their data submissions and work with their vendors to ensure data completeness and accuracy.

4. We do not think our CMART data is correct, what should we do?

Review the QA reports that are sent back when you submit your data. If it doesn't look correct, please contact caremanagement_ohsqa@health.ny.gov as soon as possible within the quarter. We may be able to work with you. Also reach out to your EHR vendor to identify why your CMART data is not correct and discuss options on how to fix it.

5. How can we get specifications for Quality Measures?

Most Quality Measure specifications are proprietary. The most accurate information can be found in Table 1.

6. We are worried about a certain population impacting our quality measure data.

Quality Measures are designed to only include members in the denominator that are eligible for the numerator and have all data available to determine that. For example, if foster care members have a CIN change the quality

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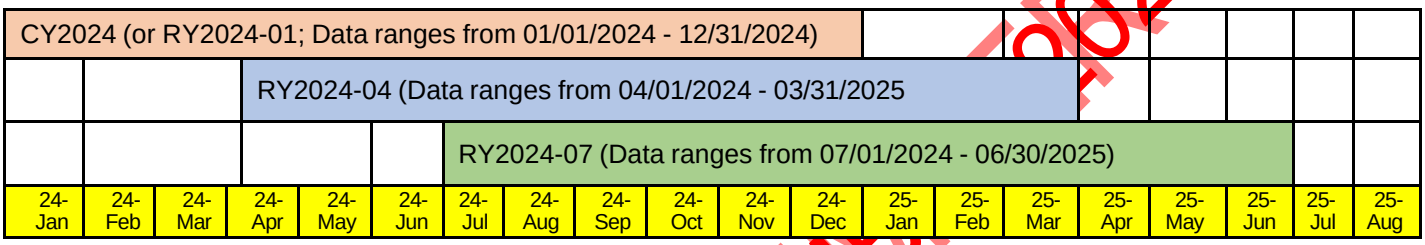
measure denominator looks for continuous enrollment under one CIN. If a member remains enrolled under the same CIN during the measurement period, they will be included in the denominator. However, if their CIN changes during the period and they no longer meet enrollment criteria, they will be excluded from the denominator.

7. These times frames are super confusing! Why is our data delayed?

Quality Measures use rolling years which are 'rolling' 12-month window that always uses a year's worth of data but can move the start and end date of the measurement period to reflect the most recent data available. Quality measures specifications require a year's worth of data to calculate. Most measures have a continuous enrollment component to make sure the members included in the denominator are representative of the measure. There is additional lag time after the end of the measurement period to allow for claims processing, data completeness, and measure validation.



Process Measures each have a lag due to data processing:

- Comprehensive Annual Assessment - 79 days (365+14 days) before the last day of the measure quarter.
- Initial Comprehensive Assessment within 56 Days of Enrollment - Members are included in the quarter if the due date for the completed intervention falls within the specified quarter.
- Initial Plan of Care within 56 Days of Enrollment - Members are included in the quarter if the due date for the completed intervention falls within the specified quarter.
- CANS-NY Comprehensive Assessment within 30 Days of Enrollment - Members with a finalized CANS-NY assessment between the first day of their enrollment month and 56 days after the last day of their enrollment month.
- Care Management Follow Up After Emergency Department - ED visits used for the measure quarter will be visits occurring during a member's enrollment during the previous measure quarter to allow time for claims processing.
- Care Management Follow Up After Inpatient Discharge - IP visits used for the measure quarter will be visits occurring during a member's enrollment during the previous measure quarter to allow time for claims processing.

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