# Health Home Redesignation Domain 2 Documentation

Version 1.0

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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. The three domains are weighted as follows: Domain 1: 20 percent; Domain 2: 20 percent; and Domain 3: 60 percent.

Domain 2 is weighted at 20% of the overall redesignation score. Quality Measures account for 10%, Process Measures account for 5% and the overall redesignation score from the Health Home’s last redesignation accounts for 5%. Data sources for the Quality and Process Measures include the Care Management Assessment Reporting Tool (CMART) 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 period 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), depending on what percentile they fall into. 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 to calculate the total score for Quality Measures.

**Table 1. Quality Measures included in Adult and Children's Health Home Redesignation Domain 2.**

| Measure | Measure Description | Adult or Children | Where to Find More Info* |
|---|---|---|---|
| Asthma Medication Ratio (AMR) | The percent of members who were identified as having persistent asthma with a ratio of controller medications to total asthma medications of 0.50 or greater during the measure year | Adult & Children | Adult Core Set Technical Specifications Children Core Set Technical Specifications |
| Follow up care for Children Prescribed ADHD Medication-Initiation (ADD_INIT) | The percent 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 percent 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 |
| Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics (APP) | The percent of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment | Children | Children Core Set Technical Specifications |
| Follow Up After Emergency Department Visit for Alcohol and Other Drug Dependence-7 & 30 Days (FUA 07/30) | The percent 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 percent 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 |
| Prevention Quality Indicator – Chronic Condition Composite (PQI 92) | The total number of hospital admissions for chronic conditions per 100,000 enrollees | Adult | Health Home Core Set Technical Specifications |
| Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA) | The percent 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 |
| Child and Adolescent Well-Care Visits (WCV) | The percent 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 percent 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.*

**Table 2. Percent of Points and Points a Health Home Earns Per Measure by Percentile Performance.**

| Percentile Performance | 0-25 | 26-50 | 51-75 | 76-100 |
|---|---|---|---|---|
| Percent of Possible Points | 25% | 50% | 75% | 100% |
| Points Per Measure (with 10 Available Measures) | 2.5 | 5 | 7.5 | 10 |

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 |
|---|---|---|---|---|---|
| Asthma Medication Ratio | 12/2022 - 11/2023 | 72 | 100 | 10 | 10 |

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 follow validated Healthcare Effectiveness Data & Information Set (HEDIS), Center for Medicare & Medicaid Services (CMS), or NYS 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) are not compared to Health Homes Serving Children (HHSC) scores and HHSC scores are not compared to HHSA scores. For each measure, the top performing Health Home sets the ceiling for the percentile. Below is an example using Asthma Medication Ratio (AMR) for HHSA for December 2022 - November 2023:

**Example Calculation Using Asthma Medication Ratio (AMR)**
For the period December 2022 - November 2023, the top-performing Health Home had an AMR 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 AMR would receive 100% of the available points for that measure.
- A Health Home scoring 35.9 would receive 25% of the available points.

**Table 4. An Example of the Percentile Thresholds for AMR.**

| Measure | 0 - 25th percentile | 26 - 50th percentile | 51- 75th percentile | 76 - 100th percentile |
|---|---|---|---|---|
| **Asthma Medication Ratio Rate** | 0 - 54.29 | 54.30 - 59.60 | 59.70 - 65.33 | 65.34 – 84.00 |

## 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 NY Medicaid Managed Care Quality Incentive Program and the Essential Plan Quality Incentive Program assess at the 90th, 75th, and 50th percentiles of Quality Measures to award points that contribute to 80% of the quality incentive score. The MLTC quality incentive includes 12 quality measures comprising 50% of the total 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.

We changed the methodology to enable our use of the most up to date 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.

## 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 4 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 a small sample size, 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 |
|---|---|---|
| Comprehensive Annual Assessment (ANN_ASSESS) | Percent 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 |
| Initial Comprehensive Assessment within 60 Days of Enrollment (ASSESS_60DAY) | Percent 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 60 days after the last day of their enrollment month. | Adult & Children |
| CANS-NY Assessment within 30 Days of Enrollment (CANS_30DAY) | Percent of newly enrolled HHSC members who had a CANS-NY assessment finalized between the first day of their enrollment month and 30 days after the last day of their enrollment month. | Children |
| Care Management Follow Up After Emergency Department Discharge 2 & 7 Days (CMFUED 02/07) | Percent of members with a completed intervention within two/seven days of the day of the ED visit. | Adult & Children |
| Care Management Follow Up After Inpatient Discharge 2 & 7 Days (CMFUIP 02/07) | Percent of members with a completed intervention within two/seven days of the day of the inpatient discharge. | Adult & Children |
| High or Medium Acuity Children with a Face-to-Face Intervention Each Month (HM_F2F) | Percent of High or Medium acuity HHSC enrolled members with a completed face to face intervention each month they are enrolled during the measure quarter. | Children |
| Initial Plan of Care within 60 Days if Enrollment (POC_60DAY) | Percent of newly enrolled Health Home members who had an initial plan of care completed between the first day of their enrollment month and 60 days after the last day of their enrollment month. | Adult & Children |

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, considering all relevant covid exceptions. The Threshold column indicates whether the Health Home's rate falls below, meets, or exceeds the threshold in the corresponding "Required Threshold" column.

# Appendix A: Process Measures Specifications

# Comprehensive Annual Assessment (ANN_ASSESS)

**Measure shows whole Health Home enrolled population. Data for quarters 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

*COVID-19 Exception: None*

## 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 is 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 amount 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 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

# Initial Comprehensive Assessment within 60 Days of Enrollment (ASSESS_60DAY)

## Policy

The 2017 (updated 2019) Health Home Comprehensive Assessment Policy (Adult and Children) states the initial comprehensive assessment needs to be completed within 60 days of enrollment.

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

*COVID-19 Exception: Between March 2020 and March 2023 the time to complete an initital comprehensive assessment was changed to 120 days after enrollment.*
*https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_covid_19_faq.pdf* ,
*https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/changes_for_hh_participants.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 60 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 60 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 60 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 60 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.
- Between March 2020 and March 2023, the time to complete a comprehensive assessment was increased to 120 days after enrollment.

## 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

**Timeframes Included in Recent Quarters:**

| Measurement Quarter | Months Included in Calculation | COVID Exceptions |
|---|---|---|
| Q1 2023 | Sept 2022, Oct 2022, Nov 2022 | All months qualify for 120-day COVID exception |
| Q2 2023 | Dec 2022, Jan 2023, Feb 2023, Apr 2023 | Dec 2022, Jan 2023, Feb 2023 qualifies for 120-day COVID exception |
| Q3 2023 | Mar 2023, May 2023, June 2023, July 2023 | March 2023 qualifies for 120-day COVID exception |
| Q4 2023 | August 2023, Sept 2023, Oct 2023 | 60-day rule applies to all months |

# CANS-NY Assessment within 30 Days of Enrollment (CANS_30DAY)

## Policy

Section F of the Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations states a CANS-NY Assessment needs to be completed within 30 days of a member's enrollment in a Health Home Serving Children (HHSC) Health Home.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

*COVID-19 Exception: None*

## Measure Description

Percent of newly enrolled HHSC members who had a CANS-NY assessment finalized between the first day of their enrollment month and 30 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 30 days after the last day of their enrollment month.

- Only the most recent completed assessment per member is counted towards the numerator. Members cannot have a numerator higher than 1.

## Data Sources

**Enrollment & CANS-NY 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

# 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

*COVID-19 Exception: None*

## Measure Description

Percentage of Health Home enrolled members emergency department visits 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 2022 | Q4 2021 |
| Q2 2022 | Q1 2022 |
| Q3 2022 | Q2 2022 |
| Q4 2022 | Q3 2022 |
| Q1 2023 | Q4 2022 |

- 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.

## 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

# 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

*COVID-19 Exception: None*

## Measure Description

Percentage of Health Home enrolled member0's inpatient discharges 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:

- Looks at 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 2022 | Q4 2021 |
| Q2 2022 | Q1 2022 |
| Q3 2022 | Q2 2022 |
| Q4 2022 | Q3 2022 |
| Q1 2023 | Q4 2022 |

- 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 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

# High or Medium Acuity Health Homes Serving Children Enrolled Members with a Face to Face Intervention Each Month (HM_F2F)

**Changes for Q4 2023**

- Per OHIP adding in members with Early Development, Intensive, and Complex
  - These members need to have one F2F intervention each month they are enrolled.
- NOTE: Updates to HHSC Core Intervention Requirements are coming in May 2024

## Policy

Section F of the Health Home Standards and Requirements for Health Homes, Care Management Agencies, and Managed Care Organizations states care managers need to provide one face to face Health Home service to High and Medium acuity Health Home Serving Children (HHSC) members each month.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_mco_cm_standards.pdf

*COVID-19 Exception: Starting March 2020 Health Homes are allowed to use telehealth or telephonic methods can be used unless face to face methods are medically necessary.*
*https://health.ny.gov/health_care/medicaid/covid19/docs/2020-03-14_guide_hhsa_hhsc.pdf*

## Measure Description

Percent of High, Medium, Early Development, Intensive, or Complex acuity HHSC enrolled members with a completed face to face intervention each month they are enrolled during the measure quarter.

Note:

- Members needed to have a High, Medium, Early Development, Intensive, or Complex acuity at any point during the measure quarter.
- Outreach interventions are excluded.

## Denominator

HHSC enrolled members with a High, Medium, Early Development, Intensive, or Complex acuity at any point during the measure quarter.

- Enrollment months are defined as enrolled segment months that were not pended or voided.
- Members are included if they are active enrolled in a HHSC.
- Members in outreach are excluded.

## Numerator

HHSC enrolled members with a High, Medium, Early Development, Intensive, or Complex acuity that had a completed face to face intervention each month they are enrolled during the measure quarter.

- Interventions must be marked as completed and the mode must be in person or phone to count towards the numerator.

## Data Sources

**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

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 |
|---|---|---|---|
| HHSC | 1864, 1869 | Low, Standard | Needs a core service provided. For members with a CANS-NY assessment finalized on or after 11/15/2023: members 0-5 years old are Low and members 6-21 years old are Standard |
| HHSC | 1865, 1870 | Medium, Early Development, Intensive | Needs a core service provided. For members with a CANS-NY assessment finalized on or after 11/15/2023: members 0-5 years old are Early Development and members 6-21 years old are Intensive |
| HHSC | 1866, 1871 | High, Complex | Needs a core service provided. For members with a CANS-NY assessment finalized on or after 11/15/2023: all members are Complex |

**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

# Initial Plan of Care within 60 Days of Enrollment (POC_60DAY)

## Policy

The 2019 Health Home Plan of Care Policy states a health home needs to create a plan of care within 60 days of HH enrollment.
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/hh0008_plan_of_care_policy.pdf

*COVID-19 Exception: Between March 2020 and March 2023 the time to complete the initial plan of care was changed to 120 days after enrollment.*
*https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_covid_19_faq.pdf*,
*https://health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/changes_for_hh_participants.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 60 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 60 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 60 days after the last day of their enrollment month.

- Between March 2020 and March 2023, the time to complete a Plan of Care was increased to 120 days after enrollment.

## 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.

**Timeframes Included in Recent Quarters:**

| Measurement Quarter | Months Included in Calculation | COVID Exceptions |
|---|---|---|
| Q1 2023 | Sept 2022, Oct 2022, Nov 2022 | All months qualify for 120-day COVID exception |
| Q2 2023 | Dec 2022, Jan 2023, Feb 2023, Apr 2023 | Dec 2022, Jan 2023, Feb 2023 qualifies for 120-day COVID exception |
| Q3 2023 | Mar 2023, May 2023, June 2023, July 2023 | March 2023 qualifies for 120-day COVID exception |
| Q4 2023 | August 2023, Sept 2023, Oct 2023 | 60-day rule applies to all months |

# Appendix B: 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.<br>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. |

# Appendix C: Provisional Designation Domain 2 Information

Domain 2 for provisional designation will be comprised of the same three components as regular designation.

1) Quality Measures (10%)
2) Process Measures (5%)
3) Previous redesignation score from 2021-2022 (5%)

For a Health Home in a **6-month provisional redesignation status**:

1. Option 1: Previous Redesignation Quality Measures & Previous Redesignation Process Measures
2. Option 2: Previous Redesignation Quality Measures & New Process Measures *

** Due to the limited timeframe, the data used in the Health Home's previous redesignation review will be the data available for the Health Home's quality measures in the 6-month provisional redesignation review.*

For a Health Home in a **1-year provisional redesignation status**:

1. Option 1: Previous Redesignation Quality Measures & Previous Redesignation Process Measures
2. Option 2: New Quality Measures & New Process Measures

The previous redesignation score from the prior redesignation round (2021-2022) will be included in Domain 2.

# Appendix D: 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 is 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

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.

| CY2022 (or RY2022-01; Data ranges from 01/01/2022 - 12/31/2022) | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RY2022-04 (Data ranges from 04/01/2022 - 03/31/2023 | | | | | | | | | | | | | | | | |
| | | | | | | RY2022-07 (Data ranges from 07/01/2022 - 06/30/2023) | | | | | | | | | | | | | |
| 22-Jan | 22-Feb | 22-Mar | 22-Apr | 22-May | 22-Jun | 22-Jul | 22-Aug | 22-Sep | 22-Oct | 22-Nov | 22-Dec | 23-Jan | 23-Feb | 23-Mar | 23-Apr | 23-May | 23-Jun | 23-Jul | 23-Aug |

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 60 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 60 Days of Enrollment - Members are included in the quarter if the due date for the completed intervention falls within the specified quarter.
- CANS-NY Assessment within 30 Days of Enrollment - Members with a finalized CANS-NY assessment between the first day of their enrollment month and 30 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.