2018 Value Based Payment Reporting Requirements

Technical Specifications Manual

New York State Department of Health
Email Address: vbp@health.ny.gov

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Table of Contents

I. SUBMISSION REQUIREMENTS 3

Introduction 3
Organizations Required to Report 4
Reporting Requirement Guidelines 4
Measure Changes 5
New Measure Requirements 6
Where to Submit VBP 6
What to Send for VBP Submission 6
Questions concerning the 2018 VBP submission 6

II. REPORTING REQUIREMENTS 7

Table 1: 2017 VBP List of Required Measures 7
Table 2: 2018 MLTC VBP List of Required Measures 11

III. FILE SPECIFICATIONS 12

APC Scorecard Patient-Level Detail File 12
Patient Attribution File 14

IV. APPENDIX 19

Table 3: 2017 VBP List of Category 2 Measures 19
Table 4: 2018 VBP MLTC List of Category 2 Measures 20

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I. Submission Requirements

Introduction

The purpose of this document is to make stakeholders aware of the quality measure reporting requirements for Medicaid Managed Care Organizations (MCOs) participating in the New York State Medicaid (NYS) VBP program. The 2018 Value Based Payment Reporting Requirements refer to 2017 Measurement Year (MY) data, except for Managed Long Term Care plans, for which the reporting requirements refer to 2018 MY data. Section II of the document includes guidance on the organizations responsible for reporting, the subset of measures for which reporting will be required by VBP Arrangement, and the changes to the reportable set of MY 2017 Quality Measure Sets (see the VBP Quality Measure tab) since the initial guidance was given in March of 2017.

The New York State Department of Health (NYS DOH) is mid-way through the first phase of a health transformation effort, known as the State Innovation Model (SIM) award, which focuses on transformation of primary care delivery and payment models statewide. The Advanced Primary Care (APC) model as part of the SIM initiative is intended to integrate a service delivery and reimbursement model to improve health quality outcomes that are financially sustainable. To reduce the burden on MCOs participating in both the APC model and Medicaid VBP, we are aligning the reporting for both programs and utilizing the APC Scorecard data request to fulfill reporting requirements for both programs. Section III describes File Specifications required for reporting. For more information on the State Health Innovation Plan, see: https://www.health.ny.gov/technology/innovation_plan_initiative/.

VBP Arrangements and Associated Quality Measures

The VBP Roadmap outlines five types of VBP arrangements to be included for MY 2017:

- Total Care for the General Population (TCGP) Arrangement: Includes all costs and outcomes for care, excluding certain subpopulations (specified below).
- Total Care for Special Needs Subpopulation Arrangements: Includes costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.
  - Health and Recovery Plans (HARP): For those with Serious Mental Illness or Substance Use Disorders
  - HIV/AIDS
  - Managed Long Term Care (MLTC)
- Episodic Care Arrangements:
  - Integrated Primary Care (IPC): Includes all costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - Maternity Care: Includes episodes associated with a pregnancy, including prenatal care, delivery and postpartum care through 60 days post-discharge for the mother, and care provided to the newborn from birth through the first month post-discharge.

Categorization of Quality Measures

Through a multigroup stakeholder engagement process, a set of quality measures was defined for each arrangement. Based on an analysis of clinical relevance, reliability, validity, and feasibility, each measure was placed into one of three categories:

- Category 1: Selected as clinically relevant, reliable, valid, and feasible. These measures are outlined in Table 1 below. **REQUIREMENT: Only the Category 1 measures that are indicated in this document as “Required to Report” are to be reported by the MCO to the State.**
- Category 2: Seen as clinically relevant, valid, and likely reliable, but with problematic feasibility. Category 2 measures are listed in the appendix of this guide.

I. Submission Requirements

- Category 3: Rejected based on a lack of relevance, reliability, validity, and/or feasibility. These measures are not included in this manual.

Classification of Quality Measures

Each measure is classified as either Pay-for-Performance (P4P) or Pay-for-Reporting (P4R). Pay-for-Performance measures are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible. P4R measures are intended to be used by the MCOs to incentivize the VBP Contractors for reporting data to monitor quality of care delivered to members in a VBP contract.

Organizations Required to Report

Medicaid Managed Care Organizations with Level 1 or higher value-based contracting arrangements or MCOs with a VBP Pilot contract are required to report.

Reporting Requirement Guidelines

- Table 1 lists, by arrangement, the 2017 VBP Category 1 Measure sets and indicates the 2017 measures the State is requiring for reporting.
- Table 2 lists, by arrangement, the 2018 MLTC VBP Category 1 Measure set and indicates the 2018 measures required for reporting.
- Section III describes File Specifications required for reporting.
  - This manual describes reporting requirements only. For VBP contracting questions, please contact bmcfhel@health.ny.gov
- Organizations must purchase the HEDIS® 2018 Technical Specifications for descriptions of the required HEDIS® measures. For specifications for other non-HEDIS measures, please contact the measure steward for the correct version of the specification.

Specific Instructions per contracted VBP arrangement:

TCGP/IPC: The State is requesting that Medicaid Managed Care (MMC) plans submit data files that leverage their 2018 QARR (HEDIS) submission which will be used to create aggregated quality results by VBP Contractor. Specifically, the State is asking insurers to provide a modified version of NCQA's Patient-Level Detail (PLD) file, along with provider and practice information. Submission of the Advanced Primary Care (APC) Scorecard file will fulfill this reporting requirement. The APC Patient-Level Detail File layout is included in Section III. A separate Patient Attribution file is not required for this arrangement. Patient attribution is included in the APC Patient-Level Detail File.

Maternity: The State is requesting that MMC plans submit data files that leverage their 2018 QARR Live Birth Files. Include the provider/practice that was attributed to the member using your own plan's attribution methodology for all members included in the 2018 QARR Live Birth File. Several fields regarding the provider and practice site of the service have been added to the layout request for this purpose. The Patient Attribution file layout is included in Section III.

HARP: HARP arrangements are required to report relevant TCGP/IPC measures and HARP-specific measures. The State is requesting that MMC plans submit data files that leverage their 2018 QARR (HEDIS) submission which will be used to create aggregated quality results by VBP Contractor. The State is asking plans to provide a modified version of NCQA's Patient-Level Detail (PLD) file, along with provider and practice information. Submission of the Advanced Primary Care (APC) Scorecard file will fulfill the IPC reporting requirement. Additionally, the State is asking insurers to provide an attribution file for all members enrolled in your HARP arrangement. The attribution file will be used to link to the 2018

I. Submission Requirements

QARR Patient-Level Detail (PLD) file and NYS calculated measure results to create aggregate quality results for HARP-specific measures by VBP Contractor. The Patient Attribution file layout is included in Section III.

HIV/AIDS: HIV/AIDS arrangements are required to report relevant TCGP/IPC measures and HIV-specific measures. The State is requesting that MMC plans submit data files that leverage their 2018 QARR (HEDIS) submission which will be used to create aggregated quality results by VBP Contractor. The State is asking plans to provide a modified version of NCQA's Patient-Level Detail (PLD) file, along with provider and practice information for all lines of business operating in New York. Submission of the Advanced Primary Care (APC) Scorecard file will fulfill the IPC reporting requirement. Additionally, the State is asking insurers to provide an attribution file for all members enrolled in your HIV/AIDS arrangement. The attribution file will be used to link to the 2018 NYS calculated measure results to create aggregate quality results for HIV-specific measures by VBP Contractor. The Patient Attribution file layout is included in Section III.

MLTC: The State is requesting insurers to submit a Patient Attribution file, which will be used to create aggregated quality results by VBP contractor. DOH will calculate all reportable Category 1 quality measure results for the arrangements. The attribution methodology and Patient Attribution file layout is included in Section III.

Measure Changes

Changes to the Reporting Requirements for 2017 Measure Set were made based on the feedback received by the DOH from the Clinical Advisory Groups, Measure Support Task Force and Sub-teams, and from other stakeholder groups. Those changes are indicated below. In instances where a measure was moved from Category 1 in MY 2017 to Category 2 in MY 2018, the State will not require reporting of the data related to those measures.

TCGP/IPC:

- Initiation of Pharmacotherapy for Alcohol Abuse and Dependence moved to Category 2
- Use of Imaging Studies for Low Back Pain moved from Category 2 to Category 3
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis moved from Category 2 to Category 3

Maternity:

- Frequency of Ongoing Prenatal Care measure was retired by NCQA and moved to Category 3.
- LARC Uptake was renamed to "Contraceptive Care – Postpartum Women."

HARP:

- Continuity of Care (CoC) within 14 Days of Discharge from Any Level of SUD Inpatient Care is now listed as two measures:
    1) Continuity of Care from Inpatient Detox to Lower Level of Care, and
    2) Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care
- Rate of Readmission to Inpatient Mental Health Treatment within 30 Days was renamed to "Potentially Preventable Mental Health Readmission within 30 Days."

HIV/AIDS:

- Renamed the measure "Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year" to "Potentially Avoidable Complication (PAC) in Patients with HIV/AIDS."

I. Submission Requirements

- Linkage to HIV Medical Care moved from Category 1 to Category 2.
- Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis moved from Category 1 to Category 2.

MLTC**:**
- Nursing Home Potentially Avoidable Hospitalization measure moved from Category 2 to Category 1.
- The Nursing Home Category 2 measures moved from Pay for Reporting to Pay for Performance.

New Measures

There were no new measures added to the 2017 measure set.

Where to Submit VBP Reporting Data

- Electronically submit all files (no later than 11:59p.m. ET on August 1, 2018) via a secure file transfer facility**.** Do not mail materials.
- Specific delivery instructions are given for each file.

What to Send for VBP Reporting

All submissions must be received electronically by 11:59 p.m. ET on August 1, 2018.

❒ Patient-Level Detail file: IPC, TCGP, HARP, HIV/AIDS
❒ Patient Attribution File: Maternity, HARP, HIV/AIDS, MLTC

Questions Concerning 2018 VBP Reporting

Please submit all questions to vbp@health.ny.gov

II. Reporting Requirements

Table 1: 2017 VBP List of Required Measures

Measures	Notes	Arrangement Type					NQF ID	Specifications	Class
		TCGP	IPC	Maternity	HARP	HIV/AIDS			
Total Care for the General Population (TCGP)/ Integrated Primary Care (IPC)									
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder		NR	NR	NA	NR	NR	1880	HEDIS 2018	P4P
Antidepressant Medication Management		4	4	NA	NA	4	0105	HEDIS 2018	P4P
Breast Cancer Screening		4	4	NA	4	4	2372	HEDIS 2018	P4P
Cervical Cancer Screening	2	4	4	NA	4	4	0032	HEDIS 2018	P4P
Childhood Immunization Status		4	4	NA	NA	NA	0038	HEDIS 2018	P4P
Chlamydia Screening in Women		4	4	NA	4	NA	0033	HEDIS 2018	P4P
Colorectal Cancer Screening	2	4	4	NA	4	4	0034	HEDIS 2018	P4P
Comprehensive Diabetes Care: Eye Exams	2	4	4	NA	4	4	0055	HEDIS 2018	P4P
Comprehensive Diabetes Care: Foot Exam		NR	NR	NA	NR	NR	0056	HEDIS 2018	P4R
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	2	4	4	NA	4	4	0575	HEDIS 2018	P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	2	4	4	NA	4	4	0059	HEDIS 2018	P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	2	4	4	NA	4	4	0057	HEDIS 2018	P4P
Comprehensive Diabetes Care: Medical Attention for Nephropathy	2	4	4	NA	4	4	0062	HEDIS 2018	P4P
Comprehensive Diabetes Screening: Received All Three Tests (HbA1c, Eye Exam, and Medical Attention for Nephropathy)	1	4	4	NA	4	4		NYS 2018	P4P
Controlling High Blood Pressure		NR	NR	NA	NR	NR	0018	HEDIS 2018	P4P
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications		4	4	NA	4	4	1932	HEDIS 2018	P4P

4 - Required to Report NA-Not Applicable to the Arrangement Shading – Purple– Not required to be reported

1- There are no reporting requirements for this measure. NYS will calculate the measure result for MY 2017

2- For measures that you may have reported using the hybrid sample in the PLD for QARR, we request that you report the administrative denominator and numerator for VBP.

II. Reporting Requirements

Measures	Notes	Arrangement Type					NQF ID	Specifications	Class
		TCGP	IPC	Maternity	HARP	HIV/AIDS			
Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment		4	4	NA	NA	4	0004	HEDIS 2018	P4P
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence		4	4	NA	4	4			P4P
Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse and Dependence		NR	NR	NA	NR	NR			
Medication Management for People with Asthma		4	4	NA	4	4	1799	HEDIS 2018	P4P
Potentially Avoidable Complications (PAC) in Routine Sick Care or Chronic Care		NR	NR	NA	NA	NA		Altarum	P4R
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		NR	NR	NA	NR	NR	0421	CMS 2018	P4R
Preventive Care and Screening: Influenza Immunization		NR	NR	NA	NR	NR	0041	AMA v1.0	P4R
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan		NR	NR	NR	NR	NR	0418	CMS 2018	P4R
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		NR	NR	NA	NR	NR	0028	AMA v1.0	P4R
Statin Therapy for Patients with Cardiovascular Disease		4	4	NA	4	4		HEDIS 2018	P4R
Statin Therapy for Patients with Diabetes		4	4	NA	4	4		HEDIS 2018	P4R
Use of Spirometry Testing in The Assessment and Diagnosis of COPD		4	4	NA	4	4	0577	HEDIS 2018	P4R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	2	4	4	NA	NA	NA	0024	HEDIS 2018	P4P
Maternity									
Contraceptive Care – Postpartum Women		NA	NA	NR	NA	NA	2902	CMS 2018	P4R
C-Section for Nulliparous Singleton Term Vertex (NSTV)		NA	NA	NR	NA	NA	0471	TJC 2017	P4R

4 - Required to Report NA-Not Applicable to the Arrangement Shading – Purple– Not required to be reported

1- There are no reporting requirements for this measure. NYS will calculate the measure result for MY 2017

2- For measures that you may have reported using the hybrid sample in the PLD for QARR, we request that you report the administrative denominator and numerator for VBP.

II. Reporting Requirements

Measures	Notes	Arrangement Type					NQF ID	Specifications	Class
		TCGP	IPC	Maternity	HARP	HIV/AIDS			
Frequency of On-Going Prenatal Care		NA	NA	NR	NA	NA			
Percentage of Babies Who Were Exclusively Fed with Breast Milk During Stay		NA	NA	NR	NA	NA	0408	TJC 2017	P4R
Incidence of Episiotomy [% of Vaginal Deliveries with Episiotomy]		NA	NA	NR	NA	NA	0470	NPIC	P4R
Low Birth Weight [Live births weighing less than 2,500 grams (preterm v. full term)]	1	NA	NA	4	NA	NA	0278	AHRQ v7.0	P4R
Percentage of Preterm Births		NA	NA	NR	NA	NA		NYS 2018	P4R
Prenatal and Postpartum Care	2	NA	NA	4	NA	NA		HEDIS 2018	P4P
Health and Recovery Program (HARP)									
Continuity of Care from Inpatient Detox to Lower Level of Care		NA	NA	NA	4	NA	1879	NYS 2018	P4P
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care		NA	NA	NA	4	NA		NYS 2018	P4P
Follow-Up After Emergency Department Visit for Mental Illness		NA	NA	NA	4	NA	2605	HEDIS 2018	P4P
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence		NA	NA	NA	4	NA	2605	HEDIS 2018	P4P
Follow-Up After Hospitalization for Mental Illness		NA	NA	NA	4	NA	0576	HEDIS 2018	P4P
Maintaining/Improving Employment or Higher Education Status	1	NA	NA	NA	4	NA		NYS 2018	P4R
Maintenance of Stable or Improved Housing Status	1	NA	NA	NA	4	NA		NYS 2018	P4R
No or Reduced Criminal Justice Involvement	1	NA	NA	NA	4	NA		NYS 2018	P4R

4 - Required to Report NA-Not Applicable to the Arrangement Shading – Purple– Not required to be reported

1- There are no reporting requirements for this measure. NYS will calculate the measure result for MY 2017

2- For measures that you may have reported using the hybrid sample in the PLD for QARR, we request that you report the administrative denominator and numerator for VBP.

II. Reporting Requirements

Measures	Notes	Arrangement Type					NQF ID	Specifications	Class
		TCGP	IPC	Maternity	HARP	HIV/AIDS			
Percentage of Members Enrolled in a Health Home	1	NA	NA	NA	NR	NA		NYS 2018	P4R
Percentage of Members who Receive PROS or HCBS for at least 3 Months in Reporting Year		NA	NA	NA	NR	NA		TBD	
Potentially Preventable Mental Health Related Readmission Rate 30 Days	1	NA	NA	NA	4	NA		NYS 2018	P4P
HIV/AIDS									
Viral Load Suppression	1	NA	NA	NA	NA	4		NYS 2018	P4P
Potentially Avoidable Complication (PAC) in Patients with HIV/AIDS	1	NA	NA	NA	NA	NR		Altarum	P4R
Substance Abuse Screening		NA	NA	NA	NA	NR		NYS 2018	P4R

4 - Required to Report NA-Not Applicable to the Arrangement Shading – Purple– Not required to be reported

1- There are no reporting requirements for this measure. NYS will calculate the measure result for MY 2017

2- For measures that you may have reported using the hybrid sample in the PLD for QARR, we request that you report the administrative denominator and numerator for VBP.

II. Reporting Requirements

Table 2: 2018 MLTC VBP List of Required Measures

Measures	Notes	Arrangement Type	NQF ID	Specifications	Class
		MLTC			
Managed Long Term Care (MLTC)					
Percentage of members who did not have an emergency room visit in the last 90 days	1	4		NYS 2018	P4P
Percentage of members who did not have falls resulting in medical intervention in the last 90 days	1	4		NYS 2018	P4P
Percentage of members who received an influenza vaccination in the last year	1	4		NYS 2018	P4P
Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection	1, 2	4		NYS 2018	P4P
Percentage of members who remained stable or demonstrated improvement in pain intensity	1	4		NYS 2018	P4P
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score	1	4		NYS 2018	P4P
Percentage of members who remained stable or demonstrated improvement in urinary continence	1	4		NYS 2018	P4P
Percentage of members who remained stable or demonstrated improvement in shortness of breath	1	4		NYS 2018	P4P
Percentage of members who did not experience uncontrolled pain	1	4		NYS 2018	P4P
Percentage of members who were not lonely and not distressed	1	4		NYS 2018	P4P

4 - Required to Report NA-Not Applicable to the Arrangement Shading – Purple– Not required to be reported

1- There are no reporting requirements for this measure. NYS will calculate the measure result for MY 2017

2- NYS will calculate this measure for the community-based providers and the Nursing Homes separately.

III. File Specifications

APC Scorecard Patient-Level Detail File

Please use your 2018 QARR/HEDIS data warehouse as the source for this information. Do not recalculate or update measure results. However, in addition to the measure elements that you reported for QARR/HEDIS in 2018, we are requesting that you include the provider/practice that was attributed to the member using your own plan's attribution methodology for the IPC or TCGP arrangement. Several fields regarding the provider and practice site of the service have been added to the layout request for this purpose (Fields #6-20, #103), specifically two separate fields for TIN: practice TIN and contractor TIN. This information has been added to allow us to aggregate the results by VBP Contractor across all New York State MCOs.

The APC data file is modeled after the HEDIS 2018 Patient-Level Detail file (PLD) that you prepared as part of your HEDIS submission, and many of the data elements in the APC file follow the same definitions and format as used to define the data elements in the HEDIS PLD. You may find it helpful to use the PLD as a resource or starting point in completing the APC file. We ask that you populate the PLD with all Lines of Business that you serve, e.g., Medicaid. Once completed, please upload the file to IPRO's ftp site. A subfolder in the "QARR 2018" folder where you will upload your 2018 QARR files entitled "APC 2018" will be created for your submission. If someone other than your QARR liaison will be responsible for APC reporting, please contact Paul Henfield at the email address below for access to the FTP site. Please note that the deadline for submission is **Wednesday, August 1, 2018.**

Exceptions to the PLD file are noted below:
1. The APC file requests Medicare HEDIS data, which is not required for QARR reporting.

2. The Plan ID is not your plan's QARR ID. The Plan ID field should be populated with the Organization ID that you used to submit the IDSS to NCQA. Note that the Organization ID is different from the Submission ID, which is specific to a particular Line of Business. The Organization ID provides for six digits. If your plan's ID is smaller, please right justify.

3. The Childhood Immunization measure requires only a 0 or 1 for the numerator value while QARR requests the actual number of antigens provided. Also, we request that you provide the results for Combo 3 and not by antigen.

4. For Medicaid, we ask that you populate the member's CIN in the ID field; for other products, please use an internally-defined ID number.

5. Provider/Practice attribution information is required for APC. Such information is not required for QARR.

Specific Instructions:
1. Please be aware that although the member ID for all products except Medicaid is an internal number assigned by your plan, you will need to link the member to the provider of service. You should use a naming convention that will facilitate this process.

2. If a member is reported for a specific measure in more than one product line (e.g., duals), please report them for only one product, using the following priority: Commercial, then Medicare, then Medicaid. This instruction affects only members who may be reported twice for the same service.

3. A Unique Member ID (Field #3), may be included on the file more than once if the member is in more than one product line during the reporting period.

III. File Specifications

4. For measures that you may have reported using the hybrid sample in the PLD, we request that you report the administrative denominator and numerator from the IDSS for APC.

5. Members in the file must be in at least one measure.

6. Measures that are not applicable to the member should be zero-filled.

7. Practice Name must be populated in the Practice Name (Field #9) only.

8. Practice Address Line 1 (Field #10) must contain the street address of the Practice, not the Practice Name.

9. For Fields #6-20, leave these fields blank if the member cannot be attributed to any provider and you are not able to identify the provider.

10. The IET Engagement numerator (Field #77 and 80) value must be less than or equal to the Initiation numerator (Field #76 and 79) value.

11. For the AAB (Field #72) and LBP (Field #74) measures, provide the actual numerator (non-inverted), e.g., for AAB, the numerator would be members receiving the antibiotic.

For questions regarding this request, please contact Paul Henfield of IPRO at phenfield@ipro.org or 516-209-5670 or Ran Meng at ran.meng@health.ny.gov or 518-486-9012.

The APC Patient-Level Detail File Layout will be released at the end of November.

III. File Specifications

Patient Attribution File

The State is asking insurers to provide an attribution file for all members enrolled in each arrangement per the methodology specified in your state-approved contract. The attribution file will be used to link to the 2018 NYS calculated measure results to create aggregate quality results for subpopulation-specific measures by VBP Contractor.

NOTE: MLTC attribution instructions are different than for other subpopulations. Follow the specified attribution methodology and file layout for each arrangement.

Attribution Methodology:
Maternity: Include the provider/practice TIN and contractor TIN that was attributed to the member using your own plan’s attribution methodology for all members included in the 2018 QARR Live Birth File.

HARP: Include the provider/practice TIN and contractor TIN that was attributed to the member using your own plan’s attribution methodology for all members included in any VBP Level 1 or higher arrangement.

HIV/AIDS: Include the provider/practice TIN and contractor TIN that was attributed to the member using your own plan’s attribution methodology for all members included in any VBP Level 1 or higher arrangement.

File format:

Element #	Name	Direction	Allowed Values	Required/ Optional	Length	Start	End
1	Plan ID#	Organization ID used to submit the IDSS to NCQA.	###### = IDSS Organization ID	R	6	1	6
2	Product Line	A member's product line at the end of the measurement period.	1 = MA 2 = SNP 3 = Medicare 4 = CPPO 5 = CHMO 6 = QHMO 7 = QPOS 8 = QPPO 9 = QEPO 10 = CEPO 11 = HARP	R	2	7	8
3	Unique Member ID#	Medicaid Client ID Number (CIN) The field is alphanumeric and should be treated as a text field. This field is mandatory – do not leave it blank!		R	15	9	23
4	County of Residence	Enter the 3-digit county FIPS code for each member's residence of county. See the attachment for codes and values to enter here.	### = FIPS Code 000 = Outside of NYS	R	3	24	26
5	Zip Code of Residence			R	5	27	31

III. File Specifications

Element #	Name	Direction	Allowed Values	Required/ Optional	Length	Start	End
6	Practice Tax ID#			R	10	32	41
7	PCMH Site ID#	If available plan must include a PCMH Site ID# or an Internal plan practice site ID# (see element #8)		O	10	42	51
8	Practice Site ID#	Internal plan practice site ID#		O	10	52	61
9	Practice Name			R	50	62	111
10	Practice Address Line 1			R	35	112	146
11	Practice Address Line 2			O	35	147	181
12	Practice Address Line 3			O	35	182	216
13	Practice Address City			R	25	217	241
14	Practice Address State			R	2	242	243
15	Practice Address Zip Code		#####	R	5	244	248
16	Practice Telephone Number		##########	O	10	249	258
17	Physician NPI			R	10	259	268
18	Physician First Name			R	15	269	283
19	Physician Middle Name			O	1	284	284
20	Physician Last Name			R	35	285	319
21	Contractor Tax ID#	Populate with valid TINs only. If unavailable or invalid set to '999999999'	#########	O	9	320	328

File Submission:
Files for the Maternity, HARP, HIV/AIDS arrangements are to be submitted to the New York State Department of Health via the Secure File Transfer 2.0 of the Health Commerce System. Files should be submitted to Lindsay Cogan (ljw02). ***Files are to be submitted by close of business on August 1, 2018.***

III. File Specifications

For 2018, all P4P Category 1 measures for the MLTC arrangement will be computed by DOH to reduce the burden on MTLC plans and VBP contractors.

Attribution methodology:
MLTC: Plan enrollees who have four or more months of continuous enrollment from April 2017 through June 2018 should be submitted in this attribution file. This attribution should be to provider organizations of **CHHA, LHCSA, and SNF,** which had the most frequent contact with the member and, therefore, could potentially affect the need for hospitalization or not.

File format:

1. Include only members who had 4 months or more continuous enrollment in an MLTC plan from April 2017 through June 2018.
2. For those meeting the criteria in step 1, provide at least one row for every member who was enrolled in the MLTC plan during the reporting period
3. For each member from step 2, list all provider organization(s) that provided at least one service per month, for 4 or more continuous months from April 2017 through June 2018. The data should be formatted in a long form containing one row of data for each member/provider combination. **Please provide one row of data for every provider a member was serviced by (see Example 2 below).** If a member does not have any providers from which they received 4 or more continuous months of care, THE MEMBER SHOULD STILL BE LISTED (see example 1 below).
4. The text file must be either: 1) fixed-width and named PROVIDERS_MLTC.TXT, or 2) comma separated values (CSV) and named PROVIDERS_MLTC.CSV.
   - Fixed-width files
     - **Must** have column start/end locations as documented in the following table.
     - Data **must not** include column names. The first row in the file must be data.
   - CSV files
     - **Must not** have additional columns beyond those shown in the following table.
     - Data **must** include column names. The first row in the file must be the column names as documented in the following table.
5. The following table provides instructions on the submission of member-level data.

#	Field Name	Data Type	Start Column Placement	End Column Placement	Details/Comments
1	CIN	Varchar	1	8	A Participant's Medicaid client identification number. The field should be continuous without any spaces or hyphens. The field is alpha- numeric and should be treated as a text field. **This field may not be NULL.**
2	MMIS_ID	Varchar	9	16	The MLTC Plan's numeric eight-digit ID. **This field may not be NULL.**
3	Prov_NPI	Varchar	17	26	The unique 10-digit National Provider Identifier (NPI) for the provider by which the member was serviced by during the reporting period.
4	Prov_start_date	Date	27	34	MMDDYYYY – Must be between April 2017 – June 2018
5	Prov_end_date	Date	35	42	MMDDYYYY – Must be between April 2017 – June 2018
6	TIN	Varchar	43	51	The unique 9-digit tax identification number of the VBP contractor, if applicable.

III. File Specifications

Field Definitions:

Prov_NPI: This is the unique 10-digit National Provider Identifier (NPI) of the provider the member was serviced by during the reporting period. This should be a provider organization which had frequent contact with the member and, therefore, could potentially affect the need for hospitalization or not. A member may be serviced by multiple providers during the same time period (provide one row of data for every provider a member was serviced by).
Prov_start_date: This is the service start date with the provider. This date must be during the reporting period. It should be in the format of MMDDYYYY with no intervening "-" or "/". The format is the same if data is submitted via a fixed-width file or CSV.
Prov_end_date: This is the service end date with the provider. This date must be during the reporting period. It should be in the format of MMDDYYYY with no intervening "-" or "/". The format is the same if data is submitted via a fixed-width file or CSV.
TIN: This is the unique 9-digit tax identification number of the VBP contractor the member is assigned to during the reporting period, if applicable. A member can only be assigned to one VBP contactor at a time.
File Submission:
Files are to be submitted to the New York State Department of Health via the Secure File Transfer 2.0 of the Health Commerce System. Files should be submitted to Brian Bandle (short name bxb22) and Raina Josberger (short name rej03). ***Files are to be submitted by close of business on August 1, 2018.***

Submission Examples:
Example 1:
The example below illustrates a member who was continuously enrolled for 4 or more months in the health plan, but did not receive least one service per month from a provider organization, for 4 or more continuous months from April 2017 through June 2018.

AA98765A12345678

CIN MMIS_ID Prov_NPI Prov_start_date Prov_end_date TIN

Example 2:
The example below illustrates two different providers, with overlapping services dates, aiding a single member from February through June 2018.

AA12345Z12345678N98765432102012018062920181234567890 Row 1
AA12345Z12345678N88899977702012018061520181234567890 Row 2 (same member, different provider)

CIN MMIS_ID Prov_NPI Prov_start_date Prov_end_date TIN

III. File Specifications

Fully Capitated Plans: Because the HEDIS and CMS based P4R category 1 measures cannot be calculated by the State, plans must calculate and report Plan/Provider- VBP Contractor performance to the State by June 17, 2019. Files must be submitted via the MLTC BML, at MLTCVBP@health.ny.gov. **Plans should submit an Excel file with the following format**. **Submit a row for each measure being reported. Plans are required to report on all measures for each plan-provider ("VBP Contractor") combinations**

#	Field Name	Data Type	Excel Column Placement	Details/Comments
1	MMIS_ID	Varchar	Column A	The MLTC Plan's numeric eight-digit ID. **This field may not be NULL.**
2	Prov_NPI	Varchar	Column B	The unique 10-digit National Provider Identifier (NPI) for the provider by which the member was serviced by during the reporting period. **This field may not be NULL. For PACE plans reporting on their own performance, use the MMIS_ID in this field.**
3	TIN	Varchar	Column C	The unique 9-digit tax identification number of the VBP contractor, if applicable.
4	Measure	Varchar	Column D	The name of the P4R measure.
5	Measure ID	Varchar	Column E	Use the NQF measure ID for the HEDIS measures, for the CMS measures assign 1=advance directive, 2=Not in Nursing home, 3= ED use.
6	Denominator for Measure	Varchar	Column F	Report the total number of members included in the denominator for the given measure
7	Numerator for Measure	Varchar	Column G	Report the total number of members that were included in the numerator for the given measure
8	Exclusions for Measure	Varchar	Column H	Report the number of members excluded from the given measure
9	Rate for Measure	Varchar	Column I	Report the rate to the hundredth decimal place

IV. Appendix

Table 3: 2017 VBP List of Category 2 Measures

Measures	Notes	Arrangement Type					NQF ID	Measure Steward
		IPC	TCGP	Maternity	HARP	HIV/AIDS		
Integrated Primary Care (IPC)/ Total Care for the General Population (TCGP)								
Asthma: Assessment of Asthma Control – Ambulatory Care Setting*		Cat 2	Cat 2	NA	Cat 2	Cat 2		The American Academy of Allergy, Asthma & Immunology (AAAAI)
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence		Cat 2	Cat 2	NA	Cat 2	Cat 2		NYS TBD
Continuity of Care from Inpatient Detox to Lower Level of Care		Cat 2	Cat 2	NA	Cat 2	Cat 2		NYS 2018
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care		Cat 2	Cat 2	NA	Cat 2	Cat 2		NYS 2018
Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver (asthma)		Cat 2	Cat 2	NA	Cat 2	Cat 2	0338	The Joint Commission
Lung Function/Spirometry Evaluation (asthma)		Cat 2	Cat 2	NA	Cat 2	Cat 2		AAAAI
Patient Self-Management and Action Plan (asthma)		Cat 2	Cat 2	NA	Cat 2	Cat 2		AAAAI
Topical Fluoride for Children at Elevated Caries Risk, Dental Services		Cat 2	Cat 2	NA	Cat 2	Cat 2	2528	American Dental Association
Use of Pharmacotherapy for Alcohol Use Disorder		Cat 2	Cat 2	NA	Cat 2	Cat 2	0034	NYS 2018
Use of Pharmacotherapy for Opioid Dependence		Cat 2	Cat 2	NA	Cat 2	Cat 2	0055	NYS 2018
Maternity								
Antenatal Hydroxyprogesterone		NA	NA	Cat 2	NA	NA		TBD
Antenatal Steroids		NA	NA	Cat 2	NA	NA	0476	TJC
Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery		NA	NA	Cat 2	NA	NA	0473	Hospital Corporation of America

IV. Appendix

Table 3: 2017 VBP List of Category 2 Measures

Measures	Notes	Arrangement Type					NQF ID	Measure Steward
		IPC	TCGP	Maternity	HARP	HIV/AIDS		
Experience of Mother with Pregnancy Care		NA	NA	Cat 2	NA	NA		TBD
Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Discharge		NA	NA	Cat 2	NA	NA	0475	Centers for Disease Control and Prevention
Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)		NA	NA	Cat 2	NA	NA	1746	Massachusetts General Hospital
Monitoring and Reporting of NICU Admission Rates		NA	NA	Cat 2	NA	NA		TBD
Postpartum Blood Pressure Monitoring				Cat 2				TBD
Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated				Cat 2				AHRQ
Health and Recovery Program (HARP)								
Percentage of Mental Health Discharges Followed by Two or More Mental Health Outpatient Visits within 30 Days		NA	NA	NA	Cat 2	NA		NYS 2018
HIV/AIDS								
Diabetes Screening		NA	NA	NA	NA	Cat 2		NYS DOH AIDS Institute
Hepatitis C Screening		NA	NA	NA	NA	Cat 2		HRSA
Housing Status		NA	NA	NA	NA	Cat 2		HRSA
Prescription of HIV Antiretroviral Therapy		NA	NA	NA	NA	Cat 2		HRSA
Sexual History Taking: Anal, Oral, and Genital		NA	NA	NA	NA	Cat 2		NYS DOH AIDS Institute

IV. Appendix

Table 4. 2018 VBP MLTC Category 2 Measures

Measures	Notes	Arrangement Type MLTC	Measure source/Steward
Percent of long stay high risk residents with pressure ulcers	1, 2	Cat 2	MDS 3.0 + /CMS
Percent of long stay residents who received the pneumococcal vaccine	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents who received the seasonal influenza vaccine	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents experiencing one or more falls with major injury	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents who lose too much weight	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents with a urinary tract infection	1, 2	Cat 2	MDS 3.0/CMS
Care for Older Adults – Medication Review		Cat 2	NCQA
Use of High–Risk Medications in the Elderly		Cat 2	NCQA
Percent of long stay low risk residents who lose control of their bowel or bladder	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents whose need for help with daily activities has increased	1, 2	Cat 2	MDS 3.0/CMS
Percentage of members who rated the quality of home health aide or personal care aide services within the last 6 months as good or excellent	3	Cat 2	MLTC Survey/New York State
Percentage of members who responded that they were usually or always involved in making decisions about their plan of care	3	Cat 2	MLTC Survey/New York State
Percentage of members who reported that within the last 6 months the home health aide or personal care aide services were always or usually on time	3	Cat 2	MLTC Survey/New York State
Percent of long stay residents who have depressive symptoms	1, 2	Cat 2	MDS 3.0/CMS
Percent of long stay residents with dementia who received an antipsychotic medication	1, 2	Cat 2	MDS 3.0/Pharmacy Quality Alliance
Percent of long stay residents who self–report moderate to severe pain	1, 2		MDS 3.0 + /CMS

1- Included in the NYS DOH Nursing Home Quality Initiative measure set
2- MDS 3.0 denotes the Centers for Medicare and Medicaid Services Minimum Data Set for nursing home members
3- Included in the NYS DOH MLTC Quality Incentive measure set