

**Integrated Healthcare Association
California Value Based
Pay for Performance Program**

Measurement Year 2015 P4P Manual

Updated December 1, 2015



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Summary Table of Measure Specification Changes

^CCommercial P4P measure

^MMedicare Stars measure

Overview

P4P Background

The California Value Based Pay for Performance (P4P) program is the largest nongovernmental physician incentive program in the United States. Founded in 2001, it is a statewide initiative managed by the Integrated Healthcare Association (IHA) on behalf of 10 health plans representing over 9 million insured persons. IHA is responsible for collecting data, deploying a common measure set and reporting results for approximately 35,000 physicians in about 200 physician organizations (PO). This program represents the longest running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. California consumers benefit from the availability of standardized performance results from a common measure set, available to the public through the State of California, Office of the Patient Advocate (OPA) Health Care Quality Report Card.

In July 2000, IHA convened health care stakeholders to address and coordinate statewide efforts to measure and improve clinical quality, patient experience, use of information technology, and publicly report provider performance results. Three goals resulted:

1. Measure PO performance using a common set of key measures that rely on national standards or on evidence-based medical practices.
2. Aggregate members from different health plans to increase PO sample sizes for credible public reporting, thereby helping consumers make informed provider choices.
3. Performance-based health plan incentive payments to POs based on aggregated results.

The planning phase and design of actual measures for a statewide P4P initiative were completed in late 2001. By January 2002, IHA stakeholders had developed a compelling vision for a collaborative initiative and a blueprint to secure health plan sponsorship. Funding and leadership by the California HealthCare Foundation (CHCF) were important contributions to the formation and early operation of the program.

Leading physician organizations then appealed to major California health plans to adopt a uniform set of quality performance measures and a single public report card. After much consensus-building, six health plans endorsed the initiative, and other plans joined in later. The following plans currently participate in commercial P4P program:

- Aetna.
- Anthem Blue Cross.
- Blue Shield of California.
- Chinese Community Health Plan.
- Cigna Health Care of California.
- Health Net.
- Kaiser Permanente.
- Sharp Health Plan.
- UnitedHealthcare.
- Western Health Advantage.

P4P Measure Set Evolution and Priorities

Since 2003, IHA has had an established common measure set for the P4P program, accompanied by standard processes, procedures and timelines for updating the measure set. IHA seeks to evolve the P4P measure set to reflect the changes in the healthcare environment. Specifically, IHA aims to ensure that the measure set:

- Assesses aspects of care that are most relevant to stakeholders.
- Reflects the move toward more coordinated, integrated team care, such as in-patient centered medical homes and ACOs.

- Incorporates new measures and new methods (e.g., electronic health records [EHR], health information exchanges [HIE]) as they are adopted.
- Incorporates cost, resource use and quality.
- Moves toward defining measurement suites for defined clinical areas that include measures of clinical quality, outcomes, patient experience and cost/efficiency of care.

Three strategies and three tactics have been identified to guide the evolution of the P4P measure set. The strategies are to maximize the established collaborative environment, strengthen/integrate the measure set and encourage improvement in measure results. The tactics are to conduct active surveillance and seek broad input for measures; identify and implement measures of specialty care; and expand and integrate measures of cost and **resource use as they relate to** care.

In short, IHA seeks to ensure that the P4P measure set continues to provide stakeholders with the most relevant, meaningful, valuable, effective information on health care quality and resource use, and that it does so in the most efficient way possible.

In response to unsustainable growth in the cost of care, the P4P program identified value as the ultimate measurement goal in its strategy for 2012–2015. In 2013, IHA began to transition the program to Value Based P4P—a shared savings model that holds physician organizations accountable for the total cost, cost trend and resources used for all care provided to their commercial HMO/POS members, as well as the quality of this care. Value Based P4P aligns with the national movement toward accountable care organizations and other value-based purchasing approaches.

The primary objectives of Value Based P4P are to reorder the priorities of the P4P Program to emphasize cost control and affordability; to continue to promote quality; to standardize health plan efficiency measures and payment methodologies; and to increase the amount of incentives available to POs, using a shared savings model.

Medicare Stars Measurement and Reporting

Introduction of the Centers for Medicare & Medicaid Services (CMS) Star Rating incentive program for Medicare Advantage plans prompted expansion of PO-level performance measurement and reporting to the Medicare Advantage population. While CMS' Star Rating program reports at the plan level, plans felt that measuring the same indicators at the PO level would be more actionable for quality improvement.

The HEDIS-based Star measure results are collected, aggregated and reported at the PO level using the same process as for the commercial P4P program. Each measure specification indicates whether the measure is for commercial or for Medicare Advantage, or both. Medicare Advantage results will be publicly reported, and health plans may choose to use the results as the basis of performance incentive payments, although no standard P4P program for Medicare Advantage currently exists. The following Medicare Advantage plans participate in measurement and reporting:

- Anthem Blue Cross.
- Blue Shield of California.
- Health Net.
- Humana.
- Kaiser Permanente.
- SCAN Health Plan.
- UnitedHealthcare.

Key Organizations Involved in Data Collection, Aggregation and Reporting

- IHA** The **Integrated Healthcare Association** manages P4P and convenes all relevant committees. IHA arranges for all necessary services, including measure development, data aggregation and publication of the results in a public report card.
- NCQA** The **National Committee for Quality Assurance** develops and maintains the clinical measures and audit methodologies and evaluates and collects data for the Meaningful Use of Health IT (MUHIT) domain. The majority of clinical quality measures are adapted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS)^{®1} measures, the most widely used set of performance measures in the managed care industry. Non-HEDIS measures are noted in the specifications. NCQA is a nonprofit organization committed to assessing, reporting on and improving the quality of care provided by organized delivery systems.
- PBGH/CHPI** The California Healthcare Performance Information System (CHPI) administers the Patient Assessment Survey (PAS), which is used to measure performance in P4P's Patient Experience domain. CHPI reports relevant PAS results to IHA for inclusion in the P4P reports. The Pacific Business Group on Health provides professional services to CHPI.
- TransUnion HealthCare** **TransUnion HealthCare** (formerly the Diversified Data Design Corporation, a subsidiary of TransUnion LLC), helps IHA collect clinical data from POs and health plans.
- Truven** **Truven Health Analytics** (formerly Thomson Reuters) helps develop and maintain the *Appropriate Resource Use (ARU)* and *Total Cost of Care (TCC)* measures; collects and standardizes claims, encounter and eligibility data from health plans; aggregates data across health plans for each PO and calculates the ARU and TCC measures; and creates reports for all parties.
- OPA** The **Office of the Patient Advocate** is an independent state office created to represent the interests of health plan members in getting the care they deserve and to promote transparency and quality health care. OPA uses P4P results as the basis of its annual Medical Group Quality of Care Report Card, at <http://www.opa.ca.gov>.

P4P Participation and Use of Results

The IHA P4P program measures all POs in California—regardless of specialty or geographic area—that contract with one or more of the health plans participating in the IHA P4P program to provide care for their commercial HMO or POS members.

P4P results for each PO are aggregated across participating health plans, and are intended to be used as the basis for health plan quality incentive payments and public reporting, and in determining P4P public recognition award winners. P4P produces results across four domains: Clinical, Meaningful Use of Health IT, Patient Experience and Appropriate Resource Use. Domains use these data sources:

- *Clinical Domain results* are calculated and submitted by health plans contracting with each PO, and/or by self-reporting POs, unless otherwise stated in the specifications.
- *Meaningful Use of Health IT Domain data* are collected by NCQA from CMS and Medicaid public-use files.
- *Patient Experience Domain data* are collected via the Patient Assessment Survey (PAS) and processed by the Center for the Study of Systems (CSS) on behalf of CHPI.

¹HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

- *Resource Use Domain results* are calculated by Truven using data submitted by health plans contracting with each PO, unless otherwise stated in the specifications. The Resource Use Domain includes the *Appropriate Resource Use* and *Total Cost of Care* measures.

Domains and Reporting Entities

Domain	Health Plans Report	POs Voluntarily Self-Report	CSS/CHPI	Truven	CMS Public Use files
Clinical	✓	✓			
Meaningful Use of Health IT					✓
Patient Experience		✓*	✓		
Resource Use				✓	

*POs voluntarily participate in the Patient Experience Domain, and must register with CHPI to confirm participation.

All POs that contract for commercial HMO or POS members with one or more health plans participating in P4P are eligible for P4P. POs must sign the P4P Consent to Disclosure Agreement to confirm their participation in P4P. No data are collected or reported for POs that have not signed a Consent to Disclosure Agreement.

Self-reporting POs must include all participating plans when submitting their results, whether the plans are commercial or Medicare. For example, if a PO contracts with a health plan, the PO's self-reported results must include data for that health plan. The following health plans participate in P4P for commercial and Medicare, as of the publication of this manual.

Health Plan	Commercial HMO/POS	Medicare
Aetna	✓	
Anthem Blue Cross	✓	✓
Blue Shield of California	✓	✓
Chinese Community Health Plan	✓	
Cigna Health Care of California	✓	
Health Net	✓	✓
Humana		✓
Kaiser Permanente	✓	✓
SCAN Health Plan		✓
Sharp Health Plan	✓	
UnitedHealthcare	✓	✓
Western Health Advantage	✓	

PO and Health Plan Report Types, Content and Uses

P4P generates several reports of PO measurement results.

P4P provides health plans with aggregated P4P measurement results for commercial HMO or POS members, for each PO they are contracted with (if the PO signed the P4P Consent to Disclosure Agreement).

Report Type	Aggregated Results	Questions, Issues and Appeals Accepted	Health Plan Incentive Payment	Public Reporting
PO and Health Plan Quality Preliminary Report (commercial)	✓	✓		
PO and Health Plan Quality Preliminary Report (Medicare)	✓	✓		
PO and Health Plan Quality Final Report (commercial)	✓	Reflects changes from appeals period	✓	✓
PO and Health Plan Quality Final Report (Medicare)	✓	Reflects changes from appeals period		✓
PO and Health Plan Appropriate Resource Use and Total Cost of Care Preliminary Report (commercial)	✓	✓		
PO and Health Plan Appropriate Resource Use and Total Cost of Care Final Report (commercial)	✓	Reflects changes from appeals period	✓	✓†

†Only the *All-Cause Readmissions (PCR)* measure is approved for public reporting.

P4P strives to improve PO and health plan reports each year, and we welcome your comments. We are particularly interested in feedback on the reports' usefulness to your organization. Send feedback to p4p@iha.org. P4P staff consider all comments and discuss them with P4P committees, as appropriate.

Joining P4P as a New Plan

New plans that want to join the P4P program should send an e-mail to p4p@iha.org. P4P staff can provide plans with estimated participation costs, which are per member, per year (PMPY). Plans must contract with an organization licensed by NCQA to conduct HEDIS and P4P compliance audits.

A list of NCQA-Certified HEDIS and P4P Licensed Organizations is available here: <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx> under "Certified HEDIS Compliance Auditor List" and "Licensed HEDIS Compliance Organizations List."

Plans can download the Health Plan Clinical and Testing Measure File Layouts from the IHA Web site in January, and submit their audited data files to TransUnion according to the timeline specified in this section.

Plans will also need to sign a P4P Health Plan Participation Agreement and determine appropriate agreement with Truven Health Analytics to cover submission of PHI for Appropriate Resource Use and Total Cost of Care data. IHA staff will put new plans in touch with Truven staff.

P4P Data Collection and Reporting Timeline

The timeline includes major milestones in the P4P Quality, Appropriate Resource Use and Total Cost of Care data collection and reporting processes. It ensures that data are as complete as possible, as early as possible, to maximize administrative reporting for P4P.

General P4P Program Dates

Activity or Milestone	Time Frame or Deadline
MY 2015 Summary of Changes posted to the IHA Web Site.	January 15, 2015
MY 2016 Measure Set document for Public Comment: Posted to IHA Web site. <ul style="list-style-type: none"> • Summary of Proposed Changes • Draft MY 2015 Manual • MY 2016 Proposed Measure Set 	September 1–October 1, 2015
Declaration of Intent to Participate: POs submit their declaration of intent to participate in the P4P program for MY 2015.	November 2–December 14, 2015
Final MY 2015 Manual: Final P4P MY 2015 Manual posted to the IHA Web site.	December 1, 2015
MY 2016 Measure Set and Summary of Changes posted to the IHA Web site.	December 14, 2015

Data Submission Deadlines

Activity or Milestone	PO Deadline	Health Plan Deadline
PAS: Application process for POs participating in the CHPI Patient Assessment Survey (PAS) survey begins.	September 2, 2015	N/A
NDC Lists: MY 2015 NDC lists posted to NCQA Web site.	November 2, 2015	
Auditors Guideline: P4P MY 2015 Auditors Guideline posted to NCQA and IHA Web site.	November 17, 2015	
Data Submission File Layout: MY 2015 data submission file layout posted to IHA Web site. E-mail notification will also be sent out to health plans and self-reporting POs notifying them of the most recent postings.	Preliminary File: January 15, 2016 Final File: February 1, 2016	
MUHIT NPI data file submission period: POs submit NPI files for Participation in CMS Incentive Program Measure.	January 4–29, 2016	
Q1-Q4 Encounter Data: POs that use TransUnion HealthCare as the encounter data intermediary must submit all remaining Q4 2015 encounter data to TransUnion HealthCare. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in P4P reporting.	February 18, 2016	N/A
Supplemental Data Collection Deadline: Organization completes and stops all nonstandard and member-reported supplemental data collection and entry.	February 16, 2016	March 1, 2016
Supplemental Data Validation Deadline For POs: Auditor finalizes approval of all supplemental data for POs. Primary source verification (PSV) for member-reported and nonstandard supplemental data must not occur prior to February 16 unless the PO finished all supplemental data processes, collection and entry. For Health Plans: Auditor finalizes approval of all supplemental data for health plans. Primary source verification (PSV) for member-reported and nonstandard supplemental data must not occur prior to March 1 unless the health plan finished all supplemental data processes, collection and entry.	March 15, 2016	March 31, 2016
Data Layout Test Files: Self-reporting POs and health plans submit data layout test files to TransUnion HealthCare.	March 21–May 2, 2016	
Supplemental Data to Health Plans: P4P health plans receive the audited supplemental data files and audit results from the PO.	March 31, 2016	

Activity or Milestone	PO Deadline	Health Plan Deadline
Appropriate Resource Use (ARU) Preliminary Data Submission: Health plans may submit <i>preliminary</i> files of claims, encounter and eligibility data to Truven for each contracted PO with a signed P4P Consent to Disclosure Agreement.	N/A	April 29, 2016
Submission Files to Auditors: Self-reporting POs and health plans send submission files to auditors.	May 2, 2016	
Auditor-Locked P4P Results: Self-reporting POs and health plans submit auditor-locked P4P clinical results to TransUnion HealthCare. Health plans must submit results for all clinical measures for each contracted PO with a signed P4P Consent to Disclosure Agreement.	May 9, 2016	
Appropriate Resource Use (ARU) Final Data Submission: Health plans submit <i>final</i> files of claims, encounter and eligibility data to Truven for each contracted PO with a signed P4P Consent to Disclosure Agreement.	NA	May 16, 2016
Total Cost of Care (TCC) Final Data Submission: Health plans submit to Truven <i>final</i> files of lump-sum payment amount for each member of contracted POs with a signed P4P Consent to Disclosure Agreement.	NA	May 31, 2016
Resubmission of Auditor-Locked P4P Results: Self-reporting POs and health plans submit auditor-locked P4P clinical results to TransUnion HealthCare, if needed.	June 29, 2016	

Report Release Dates and Review Periods

Activity or Milestone	Time Frame or Deadline
QUALITY REPORTS TIMELINE	
Preliminary Reports Release: IHA posts preliminary quality reports for physician organizations and health plans.	May 25, 2016
Questions and Appeals Period: IHA works with POs and Health Plans to address any data issues or questions related to quality results. Plans and POs may submit an appeal during this time.	May 25–June 15, 2016
Appeals Hearing: The P4P Appeals Panel reviews and decides on all appeals to change quality results, if needed.	June 22, 2016
Final Reports Released: IHA releases final quality reports to physician organizations and health plans.	July 6, 2016
RESOURCE USE REPORTS TIMELINE	
Preliminary Reports Released: IHA posts preliminary quality reports for physician organizations and Health Plan's Appropriate Resource Use and Total Cost of Care preliminary reports.	June 29, 2016
Review Period: IHA and Truven work with POs and health plans to address any questions or issues related to Appropriate Resource Use & Total Cost of Care results.	June 29–July 20, 2016
Final Reports Released: IHA releases Appropriate Resource Use & Total Cost of Care final reports to physician organizations and health plans.	August 17, 2016

Key Dates for Review and Correction of MY 2015 Results

IHA is committed to providing POs and health plans an opportunity to review their P4P results and to submit questions and requests for changes if they believe any of their results are in error.

The full timeline for reviewing P4P results and requesting corrections or changes is documented in the *Data Collection and Reporting Timeline*. P4P program staff encourage participants to seek corrections and additional information throughout the measurement cycle.

Organizations have at least 21 days to review preliminary results. Corrections or changes to results may be requested from the first date when the PO Preliminary Reports become available, through the last date of the

Results Questions and Appeals Periods. Detailed instructions on how to submit an appeal are provided before the Quality and Appropriate Resource Use Results Questions and Appeals Periods.

- Quality preliminary reports are released on **May 25, 2016**, and the final date to submit an appeal is **June 15, 2016**. IHA works with health plans and vendors to research and respond to PO questions about results provided in the PO Quality Preliminary Reports.
- Appropriate Resource Use and Total Cost of Care Preliminary Reports are released on **June 29, 2016**, and the final date to submit an appeal is **July 20, 2016**. IHA and Truven work with health plans to answer PO questions about results provided in the PO Appropriate Resource Use Preliminary Report.

Based on the findings and answers in response to a results inquiry, an organization may submit an appeal at any time during the results Questions and Appeals Period if they believe an error has been made. The burden of evidence is **on** the organization submitting the appeal. A multi-stakeholder Appeals Review Panel will consider the evidence and make a binding determination on the appeal. POs and health plans must comply with the determination of the Appeals Review Panel, including resubmission of data, if necessary. No further reconsideration is available.

The Appeals Review Panel is composed of **five members**: two representatives from health plans, two **members** from POs **and** an at-large member. The panel receives blinded appeal requests, supporting documentation and a summary from the P4P Data Aggregator describing the source and reason for possible error, the scope of the change requested and a recommendation for resolution. **Each appeal is voted on by the appeals panel. All Clinical Quality Domain results (i.e., clinical, PAS and MUHIT) are final after the close of the Appeals Period. It will not be possible to resolve errors in Clinical Quality Domain raised after the close of the appeals period.**

The P4P program process requires a firm deadline to finalize results for all participants and share them with health plans for payout, and with OPA for public reporting. Although late requests for additional data submission or reconsideration of results will be acknowledged, they will not be incorporated into the report. An exception may be made if the data aggregator (IHA or Truven) made an error that was discovered after the deadline.

Throughout the measurement cycle, participants can request additional information or clarification on program processes and methodology.

Manual Revisions

NCQA and IHA update the technical specifications twice a year.

- *Draft MY 2015 Value Based P4P Manual*, released on September 1, 2015, reflects applicable changes in *HEDIS 2015 Volume 2: Technical Specifications* (released in July 2015).
- *MY 2015 Final Value Based P4P Manual*, released on December 1, 2015, reflects applicable changes in *HEDIS 2016 Volume 2: Technical Specifications Update* (released in October 2015).

Specifications in the *MY 2015 Value Based P4P Manual* that are posted to the IHA Web site on December 1, 2015, are frozen. The National Drug Code (NDC) lists are published on the NCQA Web site in November. Health plans and POs are accountable for all changes included in the December manual and the November NDC lists. Auditors assess compliance based on these.

If You Have Questions About the Specifications

PCS System

P4P Stakeholders who have questions regarding a measure specification should submit them through NCQA's Policy Clarification Support (PCS) system.

Step 1 Go to the PCS page using the following link: <http://my.ncqa.org>

Step 2 Complete the **Register** section.

Step 3 Log in and click **My Questions**.

- To ask a new question click **Ask a Question**.
- Click **PCS Policy/Program Clarification Support**.
- For *Product/Program Type*, click **P4P—IHA Pay for Performance** in the drop-down box.
- For *General Content Area*, select the appropriate category for your question.
- For *Specific Area*, scroll down and click the appropriate measure for your question, or click **Not Applicable** if your question type is not listed.
- For *Publication Year*, click **2016** (for P4P MY 2015) from the drop-down box.
- For *Subject*, enter a short subject for your question.
- Type your question (3,000 characters or less).

Step 4 Click **Submit Your Question**.

FAQs

The FAQs clarify HEDIS and P4P specifications, and are posted to the NCQA Web site (www.ncqa.org) on the 15th of each month, and in the IHA Web site (www.iha.org), as needed.

What's in P4P MY 2015?

Clinical Domain

The P4P clinical measures are both HEDIS based and non-HEDIS based for measurement at the PO level. Health plans and self-reporting POs report data for most of the measures in the Clinical Domain. Each participating health plan submits clinical results for each of its contracted POs that serve commercial HMO and POS members. POs may also voluntarily self-report their own clinical results for one or more clinical measures.

All clinical results must be audited to ensure that results are an accurate reflection of PO performance. Audit review of the P4P clinical measures is based on NCQA's HEDIS Compliance Audit™ program. NCQA staff work with P4P participants to incorporate the relevant components of the HEDIS Compliance Audit, adapt policies and procedures where necessary and enhance the process based on previous years' experience. Because this program is an adaptation, it is considered a P4P audit review. The *MY 2015 P4P Audit Review Guidelines* for Measurement Year (MY) 2015 is scheduled for release in November 2015.

IHA aggregate data across health plans and compare the data with data from self-reporting POs (where applicable), selecting and reporting the higher rate for each measure. Refer to *Clinical Domain* for a list of the MY 2015 Clinical Measures.

Meaningful Use of Health IT Domain

This domain measures POs on adoption and use of health care IT that is designed to improve clinical outcomes by leveraging technology. The domain measures the level of provider participation in the CMS EHR incentive programs for Medicare and Medicaid, as well as providers' ability to generate clinical e-Measure results directly from their systems. POs may voluntarily participate in the respective domain components by providing an NPI list and submitting e-Measure results in the clinical file submission.

Refer to *Meaningful Use of Health IT Domain* for more information.

Patient Experience Domain

The survey used to collect data for the Patient Experience Domain is the national standard CAHPS^{®2} Clinician & Group (CG-CAHPS) Patient Experience Survey endorsed by the National Quality Forum (NQF). The CG-CAHPS was developed by the Agency for Healthcare Research and Quality (AHRQ) and its research partners in the CAHPS consortium. The survey has both primary care practitioner (PCP) and specialist versions, which overlap substantially. CHPI is in charge of the CG-CAHPS survey for the California physician organizations that choose to participate. P4P reports rates for primary care doctors and specialists separately for some measures, but only combined rates are recommended for payment.

POs voluntarily participate in the Patient Experience domain through the PAS survey; health plans do not submit data for this domain.

Refer to *Patient Experience Domain* for a list of the MY 2015 Patient Experience measures.

Resource Use Domain

This domain assesses use of key health care services to identify variation and maximize limited resources, and includes both Appropriate Resource Use and Total Cost of Care measures. Health plans submit claims, encounter and eligibility data to Truven, which calculates the measures in the Resource Use Domain; POs and health plans do not report this domain.

Beginning in MY 2013 and MY 2014, respectively, the *All-Cause Readmissions* and *Total Cost of Care* measures are approved for public reporting. All other Resource Use results are not publicly reported, but may be used by health plans as the basis for performance incentives.

The *Resource Use* section of the manual also includes specifications for four maternity measures that will be generated in partnership with an external IHA vendor. These measures will link claims and encounter data provided by health plans to Truven with California birth certificate data. Health plans and POs are not expected to run these measures.

Refer to *Resource Use Domain* for a list of the MY 2015 appropriate Resource Use measures.

Testing Measures

The P4P measure set includes testing measures for voluntary data collection and submission. P4P uses the results to evaluate measures for future inclusion in the measure set. There is opportunity for Public Comment before testing measures are finalized by the P4P Technical Measurement and Governance Committees in November 2015. Selected measures will be tested in MY 2015 and added to the MY 2016 P4P measure set (barring problems identified during testing). The P4P Governance Committee will confirm adoption of these measures in November 2015, with input from Public Comment and recommendations from the P4P Technical Measurement Committee.

²CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

All health plans and self-reporting POs are strongly encouraged to participate in testing.

Clinical	<ul style="list-style-type: none">• <i>Statin Therapy for Patients With Diabetes (SPD).</i>• <i>Statin Therapy for Patients With Cardiovascular Disease (SPC).</i>• <i>Antidepressant Medication Management (AMM).</i>
Medicare	None.
Meaningful Use of Health IT	None.
Patient Experience	None.
Resource Use	None.

Read the entire guidelines section and measure specifications before implementing the P4P MY 2015 measures.

General Guidelines for Data Collection and Reporting

**For Value Based P4P MY 2015
Health Plans and Self-Reporting POs**

General Guidelines for Data Collection and Reporting

Reporting Options

1. Two Data Sources

Health plan reporting

Participating health plans produce administrative results for each of their contracted POs that have signed the P4P Consent to Disclosure Agreement by submitting results related to all the clinical measures attributable to the PO's eligible population. This includes data derived from all encounters, fee-for-service claims and in-network claims.

Health plans must follow the P4P clinical specifications and submit results for all clinical measures on behalf of all contracted POs with commercial HMO/POS contracts that have signed the P4P Consent to Disclosure Agreement, regardless of PO eligibility for P4P payments from the health plan.

For ARU measures, health plans submit to the **resource use** data aggregator (Truven Health Analytics) member-level enrollment, claims and encounter files for all contracted commercial POs that have signed the P4P Consent to Disclosure Agreement, regardless of PO eligibility for P4P payments from the health plan. Truven applies the ARU measure specifications and produces PO results.

Self-reporting PO

A PO may self-report data, collecting and submitting administrative results directly to the data aggregator for any or all clinical measures.

A self-reporting PO submits P4P clinical results based on all commercial HMO/POS members belonging to a participating health plan, regardless of its eligibility for P4P payments from the health plan.

IHA produces final PO rates using a combination of health plan-submitted results and PO-submitted results. For each measure, IHA determines the final rate by choosing the higher reportable rate from the aggregated health plan data or the self-reported PO data.

To begin self-reporting, a PO must contract with an organization licensed by NCQA to conduct HEDIS and P4P compliance audits. A list of NCQA-Certified HEDIS and P4P Licensed Organizations is available here:

<http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx> under "Certified HEDIS Compliance Auditor List" and "Licensed HEDIS Compliance Organizations List".

POs that intend to self-report in the coming year should indicate this in the intentions survey in November. POs can download the Physician Organization Clinical and Testing Measure File Layouts from the IHA Web site in January, and submit audited data files to TransUnion according to the timeline specified in the *Overview*.

Electronic data only

Regardless of data source, IHA requires that only electronic data (automated claims and encounter data and auditor-approved supplemental administrative databases) be used to calculate the measures. Sampling and the HEDIS Hybrid Methodology may not be used to collect data for P4P. All reported clinical measure results must be validated through a P4P Audit Review, described in *Audit Review*.

2. Reporting Level

P4P aggregates data at either the PO “parent” level or the PO “subgroup” level. For P4P to report data at the subgroup level for a PO, all of the PO’s contracted P4P health plans must also report clinical data at the PO subgroup level. If even one health plan cannot report at the more granular level, all P4P health plans must report the PO’s data at the PO parent level (i.e., the “00” level). Additionally, to report final P4P data at the PO subgroup level, the PO must have separate PAS surveys and Meaningful Use of Health IT submissions for each PO subgroup, if the PO participates in those domains.

Note: Before enrollment in PAS, POs must decide if they can report at the PO subgroup level (most POs report at the parent level only).

Encounter/Claims Submission

3. Submitting Data

All POs eligible for P4P (i.e., with a commercial HMO/POS contract during 2015, with any P4P participating health plan)—self-reporting or not—must submit encounter data to their contracted P4P health plans throughout the year. POs should follow the dates in the *Data Collection and Reporting Timeline* and other information communicated by contracted health plans to maximize the probability that their data are included in any P4P health plan-generated PO results. Although the encounter rate threshold requirement for clinical data to be included in aggregation was removed in MY 2012, full encounter submission is still expected. Encounter Rate by Service Type will continue to be collected and reported internally, and health plans may continue to require POs to meet an encounter rate threshold to qualify for incentive payments.

P4P Reporting Policies

4. P4P Policy on Handling Mergers and Acquisitions

There are a few PO acquisitions and mergers every year; each of these legal structural changes comes with its own set of complex circumstances. The P4P policy for handling mergers and acquisitions accommodates a variety of circumstances and ensures a consistent and fair process. To view the P4P policy on handling mergers and acquisitions, go to the IHA Web site:
http://www.ihp.org/pdfs_documents/p4p_california/P4P_Merger_Acquisition_Policy_effective2_11.pdf.

5. P4P Consent to Disclosure Agreement

POs must sign the P4P Consent to Disclosure Agreement to confirm their participation in P4P. No data are collected or reported for POs that have not signed a Consent to Disclosure Agreement. P4P posts reports for all POs that sign the Consent to Disclosure Agreement.

6. Attribution

P4P attributes patients to a PO in each of the following ways:

- Enrollment at the health plan level, communicated to the PO.
- Encounter data from the PO, including member identification or physician identification (so health plans can correctly attribute it), **and**
- Continuous enrollment in the PO; enrollment in the PO on the anchor date; and required benefits, as specified for each measure.

7. Peer Groups

P4P defines **peer groups** as “all POs participating in the P4P program.” POs eligible to participate in the P4P program have a commercial HMO/POS contract with any P4P participating health plan during the measurement year. These POs have been delegated the responsibility of managing a patient population for both the primary and specialty care provided in ambulatory and inpatient settings.

8. Risk Adjustment

Clinical Quality	NCQA is the measure developer for P4P clinical quality measures; therefore, P4P follows NCQA's risk adjustment protocol. NCQA's Committee on Performance Measurement (CPM) and its Board of Directors determined that risk adjustment would not be appropriate for HEDIS measures because the processes and outcomes being measured should be achieved regardless of the nature of the population. NCQA also creates the technical specifications for Clinical Quality measures that are not HEDIS based. Because those measures are also process and outcome measures, NCQA determined that risk adjustment was not appropriate.
Patient Experience	For Patient Experience measures, each PO's results are adjusted for patient case-mix, to control for differences across populations. Characteristics controlled for in the case-mix adjustment model are included in the Patient Experience Specifications.
Meaningful Use of Health IT	Meaningful Use of Health IT measures are not risk adjusted, to align with CMS/ONC regulations.
Resource Use	Most Resource Use measures are risk adjusted. The specifications describe the type of risk adjustment used for each measure.

9. Reliability Testing/Minimum Number of Observations

P4P considers measurement error and reliability for each of the three categories of measures:

- For Clinical Quality measures, the organization uses administrative data based on the PO member population. There is no sampling. Because statistical errors can result from small numbers, P4P requires a total eligible population of 30 or more for a particular measure, and excludes any measure with a bias of 5 percent or more, as determined by the auditor.
- Patient Experience data are based on surveying a sample of eligible members, and P4P does not use any results with reliability below 0.70.

10. Eligible Population

The **eligible population** for any measure is all members who satisfy all criteria specified in the measure, including age, continuous enrollment (including allowable gap), benefit, event or anchor-date requirement. The rate is calculated using the eligible population after exclusions.

11. Optional Exclusions

Some measures allow the PO or health plan to exclude **members** from the eligible population **who** are identified as having a **certain procedure or** comorbidity (e.g., exclude women who have had a bilateral mastectomy from the *Breast Cancer Screening* measure).

The technical specifications contain instructions **for** optional exclusions, **where applicable**. Look for exclusions only where administrative data indicate that the specified numerator service **or** procedure did not occur. The PO or **plan uses the eligible population to identify members for whom** administrative data show that the numerator services **or** procedures were rendered within the time frame specified in the measure, and **then** counts the members as having satisfied the measure (i.e., count these members in the numerator).

The PO or **health plan verifies that the** exclusions **occurred by the time specified in the measure**.

12. Product-Line Reporting

P4P clinical results must be collected and reported separately for two populations:

- The commercial HMO/POS population **(including Marketplace members)**.
- The Medicare Advantage population.

Results should not include Medi-Cal or PPO members.

Exclusion (optional): For P4P Medicare reporting, exclude members who elect the hospice benefit (i.e., begin using hospice services) any time during the measurement year. These members must be removed prior to determining a measure's eligible population. A plan or self-reporting PO must apply this exclusion consistently across all measures for Medicare reporting.

Note: *For P4P reporting, Marketplace HMO/POS members are reported with the commercial HMO/POS population. This deviates from HEDIS health plan reporting to NCQA.*

13. Members Who Switch Health Plans or POs

Members are considered continuously enrolled if they switch to a different organization or to a sister organization, if the organization assumes ownership of or responsibility for their administrative data for the entire period of continuous enrollment specified in the measure.

A health plan or PO that reports these members as continuously enrolled must follow the same definition of "continuous enrollment" as in General Guideline 20 and General Guideline 21, and must follow all other guidelines affecting continuous enrollment (i.e., allow switching between products [HMO, POS, **PPO, EPO**] or product lines [commercial, Medicare, **Marketplace**]) consistently across all measures. **For example, switching from a commercial HMO/POS to a Marketplace HMO/POS is not considered a gap in enrollment.**

14. Members Who Switch Health Plans or POs as the Result of a Merger or Acquisition

Members who switch entities because of a merger that occurred during the measurement year may be counted as continuously enrolled. A health plan or PO that adopts this guideline must do so consistently across all measures.

15. Members With Dual Coverage in Different Health Plans

Organizations should not try to account for coordination of benefits with other insurance carriers, because the burden of doing so is excessive and the impact on the final rate is likely to be small. Members with dual coverage in more than one P4P health plan, regardless of product line, should be included in all P4P reports of the plans to which the member belongs. For example, a member with both a Medicare Advantage plan and a commercial plan is included in both the commercial P4P report and the Medicare report for the applicable plan. The same applies if the member has coverage in more than one commercial plan.

16. Members With Dual Membership in the Same Health Plan

Members with dual coverage in the same plan (e.g., children enrolled under each parent) should be represented only once in each measure. Include members enrolled in each product only once in the HMO/POS combined report.

17. Self-Insured Members

Administrative Services Only

Include self-insured ASO members in the organization's P4P reports. Exclude self-insured members in either one of the following circumstances and only with auditor approval.

- The contract prohibits the health plan/PO from contacting members under any circumstances ("no-touch" policy).
 - A **no-touch contractual agreement** is a contract or other written agreement between the organization (i.e., HMO or PPO) and the ASO stating that the organization may not contact these members under any circumstances. The plan/PO may exclude no-touch members from P4P results because they are not managed in the same way as other members. ASO members can only be excluded due to "no touch" contractual agreements with identified purchasers.
- The health plan/PO is not responsible for administering both in-network and out-of-network claims for members (i.e., employer carve-out). If claims are administered through a third party on behalf of the plan/PO, is considered responsible the plan/PO is considered responsible for administering claims.

18. Members Who Switch Product Lines

Measures with a continuous enrollment requirement

Members enrolled in different product lines (commercial/**Marketplace**, Medicare) at different times during the measurement year should be reported in the product line to which they belonged at the end of the continuous enrollment period. **For example, a member enrolled in the commercial product line who switches to the Medicare product line during the continuous enrollment period is reported in the P4P Medicare report.**

Members who switch to or "age in" to a Medicare product line mid-year are considered continuously enrolled if they were members of the organization through another product line (e.g., commercial) during the continuous enrollment period and their enrollment did not exceed allowable gaps.

Measures without a continuous enrollment requirement

Assign members to a category based on the product line in which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services).

19. Members Who Switch Products

Measures with a continuous enrollment requirement

Members who switch among HMO, POS, EPO and PPO products, in the time specified for continuous enrollment for a measure are considered continuously enrolled and are included in the P4P HMO/POS report if they were enrolled in HMO/POS as of the end of the continuous enrollment period.

The organization must use all available claims data from all products, even when there is a gap in enrollment.

Enrollment in a Medicare Private Fee-for-Service (PFFS) plan is considered a gap in HMO/POS enrollment.

Required Enrollment Periods and Benefits

20. Continuous Enrollment and Allowable Gaps

Continuous enrollment specifies the minimum amount of time a member must be enrolled in the organization before becoming eligible for a measure. The member must also be continuously enrolled in the benefit specified for each measure (e.g. pharmacy or mental health) accounting for any allowable gaps to be considered continuously enrolled.

One of several criteria used to identify the eligible population, continuous enrollment ensures that the health plan or PO had sufficient time to render services to its members to be accountable for providing those services. The continuous enrollment period and allowable gaps are specified in each measure.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member was covered on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a one-day gap because the member was not covered on July 1.

An **allowable gap** (less than 45 days) can occur at any time during continuous enrollment. For example, the *Diabetes Care* measure requires continuous enrollment from January 1–December 31 and allows one gap of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is continuously enrolled if there are no other gaps throughout the remainder of the measurement year (the member had a 38-day gap, January 1–February 7).

Enrollment in a Medicare PFFS plan is considered a gap in HMO/POS enrollment.

21. Continuous Enrollment and Allowable Gaps Over Multiple Years

Unless otherwise specified, members are allowed one gap of up to 45 days during each year of continuous enrollment for measures spanning more than 1 year. A gap that extends over multiple years of a continuous enrollment period may exceed 45 days.

For example, in the *Colorectal Cancer Screening* measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

22. Anchor Dates

If a measure requires a member to be enrolled and to have a specified benefit on a particular date, the allowable gap must not include that date (i.e., the member must also have the benefit on that date). For example, a 55-year-old with only one gap in enrollment from November 30 of the measurement year through the remainder of the year is not eligible for the *Colorectal Cancer Screening* measure. Although the member meets the continuous enrollment criterion, she does not meet the anchor date criterion, which requires her to be enrolled as of December 31 of the measurement year.

23. Continuous Enrollment for Health Plans

For each measure, members are assessed for continuous enrollment in the health plan and continuous enrollment in the PO (parent level).

Plans that report P4P measures determine continuous enrollment using the following steps.

- Step 1** Determine if the member was continuously enrolled in the plan, including allowable gaps.
- Step 2** Determine if the member was continuously enrolled in the PO (parent level), including allowable gaps.
- Step 3** Determine if the member was enrolled in the plan and the PO (parent level) on the anchor date.
- Step 4** For POs eligible to report at the subgroup level, determine the subgroup to which the member was assigned on the anchor date.

24. Continuous Enrollment for POs

The P4P measures require calculation of continuous enrollment at the PO parent level. POs that self-report P4P measures determine continuous enrollment using the following steps.

- Step 1** Determine if the member was continuously enrolled in the PO (parent level), including allowable gaps.
- Step 2** Determine if the member was enrolled in the PO (parent level) and a P4P health plan on the anchor date.
- Step 3** For POs eligible to report at the subgroup level, determine the subgroup to which the member was assigned on the anchor date.

Note

- *Each PO approved to self-report at the subgroup level must also ensure that all plans reporting data for it report at the subgroup level.*
- *Members assigned to a PO must be included, whether or not they sought services from the PO.*
- *Members who change subgroups within a PO during the continuous enrollment period are considered continuously enrolled as long as they meet the other continuous enrollment criteria.*

25. Required Benefits

HEDIS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (i.e., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS measures do not define benefits at the service level. P4P follows the HEDIS protocol for required benefits.

Some measures require benefits in addition to medical (e.g., pharmacy) as part of the eligible population criteria. Health plans and POs must determine which benefits a member has before including the member in a measure.

...at the health plan level Health plans and POs must report P4P measures that require a specific benefit if the plan provides the benefit, either directly or through a contractor. Health plans and POs are not required to report measures that require a benefit that the plan does not offer.

...at the member level Members who do not have the benefit specified in the measure should not be counted in that measure by health plans or POs. For example, the *Annual Monitoring for Patients on Persistent Medication* measure requires a pharmacy benefit. Exclude members who do not have a pharmacy benefit.

Exhausted benefits (optional) For measures that require benefits other than medical (e.g., pharmacy), the benefits must be active for the period of continuous enrollment, accounting for any allowable gaps. Health plans and POs have the option to exclude a member if the period when the benefit is exhausted exceeds allowable gaps or includes the anchor date. For example, the *Annual Monitoring for Patients on Persistent Medication* measure requires a pharmacy benefit during the measurement year. Health plans and POs may exclude a member whose pharmacy benefit is exhausted in September of the measurement year because this gap exceeds the 45-day allowable gap period.

Carved-out benefits (optional) Some health plans and POs can obtain information from a carved-out entity and may include these members in the measures. For example, if an employer contracts directly with a pharmacy benefit manager (PBM) that shares pharmacy information, the health plan and PO may include the employer's members in the measure.

Organizations must apply the optional guidelines for exhausted and carved-out benefits consistently across all measures.

Data Collection

26. Administrative Method

The **Administrative Method** of data collection requires health plans and POs to use transaction or supplemental electronic clinical data from acceptable sources (e.g., administrative databases, registries, electronic medical records [EMR]). The PO's reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service identified in the numerator.

27. What Services Count?

With the exception of the ARU measures, health plans and self reporting POs should use all services related to each measure, including all paid, suspended, pending and denied claims. For ARU measures, health plans should submit to Truven all services for which the organization actually paid or expects to pay (i.e., claims incurred but not paid). Do not include services and days denied for any reason. In cases where a member is enrolled retroactively, count all services for which the organization has paid for or expects to pay.

When applying risk adjustment in the *Plan All-Cause Readmissions (PCR)* measure, include all services, whether or not the organization paid for them or expects to pay for them (i.e., include denied claims).

When identifying all other events (including the HIS) in the PCR measure, include *only* paid services and services the organization expects to pay (i.e., do not include denied services).

28. Supplemental Data

Supplemental data uses	To supplement claims data for calculating P4P measures, organizations may use sources other than claims and encounters to collect data about their members and about delivery of health services to their members. Validation and review of these data differ by the processes used to collect and report them.
Supplemental data may help determine:	<ul style="list-style-type: none"> • The numerator. • Optional exclusions. • Eligible-population required exclusions (labeled as <i>required exclusions in the specification</i>). For example: <ul style="list-style-type: none"> – <i>Asthma Medication Ratio</i>. Organizations may use supplemental data for members who have any condition in step 3, <i>Required Exclusions</i> for the event/diagnosis.
Supplemental data may not be used for:	<ul style="list-style-type: none"> • Denominator events. Organizations <i>may not</i> create and use records to identify denominator events, other than for optional exclusions and appropriate required exclusions. For example: <ul style="list-style-type: none"> – <i>Appropriate Testing for Children With Pharyngitis</i>. Organizations may not use supplemental data to find additional diagnoses for any claim that qualifies for the eligible population. Exclude “claims” with multiple diagnoses only. • Organizations <i>may not</i> create and use records, on an ongoing basis, for exclusions for clinical conditions that change. • Correcting bills or identifying valid data errors. Organizations <i>may not</i> use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed. For example: <ul style="list-style-type: none"> – Organizations may not exclude a member from the <i>Osteoporosis Management in Women Who Had a Fracture</i> measure if the medical record shows that a fracture did not occur in the time frame required by the measure but was billed by a provider for ongoing therapy. • Risk adjustment. Organizations <i>may not</i> use supplemental data sources when applying the risk adjustment methodology to the Risk Adjusted Utilization (i.e., in the PCR measure).

Supplemental Data Definitions

Standard supplemental data Electronic files that come from service providers (providers who rendered the service). Production of these files follows clear policies and procedures; standard file layouts remain stable from year to year.

Electronic files that may be used as standard supplemental data:

- Laboratory result files.
- Current or historic state transactional files in a standard electronic format.
- Immunization data in state or county registries (might vary from state to state, but are consistent for all records in each state's registry).
- Transactional data from behavioral healthcare vendors.
- **Electronic health record** (EHR) vendor systems.

Audit requirements. Standard supplemental files are not required to be accompanied by proof-of-service documents, and the audit does not require primary source verification unless requested by the auditor.

Nonstandard supplemental data Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard files described above, whether collected by an organization, a provider or a contracted vendor. These types of data might be collected from sources on an irregular basis and could be in files or formats that are not stable over time.

Organizations must have clear policies and procedures that describe how the data are collected, validated and used for P4P reporting.

Organizations *may not* conduct phone calls to members or providers to collect information about services rendered.

Examples of nonstandard supplemental data:

- EHR modules (e.g., eMeasure modules).
- Provider portals (i.e., electronic systems providers use to enter information about services rendered).
- Health Information registries.
- Provider abstraction forms.

Audit requirements. All nonstandard supplemental data must be substantiated by proof-of-service documentation from the legal health record. Proof-of-service documentation is required for only a sample, selected by the auditor, as part of the audit's annual primary source verification.

Proof-of-service documents for primary source verification. Documents *that are allowed*:

- A copy of **information from the** member's chart from the service provider or **the** PCP.
- A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred).
- A screen shot of:
 - Online EHR **records**.
 - State- or county-sponsored immunization registry **records**.

Proof-of-service documents for primary source verification. Documents that *are not* allowed:

- *Member surveys.* Organizations and providers may not use information obtained from surveys or other documents completed by the member.
- *Phone calls.* Recorded phone calls to collect information about services rendered are not proof of service.

Member-reported services

Acceptable *only* if accompanied by proof-of-service documents from the legal health record, whether reported to a disease- or case-management clinician, collected during targeted quality improvement programs or reported during any other data collection process.

Proof-of-service documents. Documents must be mailed, faxed or delivered by the member to the entity contacting the member for the information. Permitted proof-of-service documents are:

- Lab or radiology reports.
- Sections of the member's legal health record showing the service or assessment.
 - Documentation from the legal health record must be rendered, signed and dated by the rendering provider.

When original proof-of-service documents are not available, member-reported information is acceptable only if:

- The information is collected by the end of the measurement year, by a PCP³ or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history.
- The information is recorded, dated and maintained in the member's legal health record.
 - Obtain copies of the member's legal health record from the practitioner who recorded the information.
- The information meets the specific requirements of the measure.

All documents must meet the requirements for supplemental data and the measure they apply to, and must be available for auditor review.

Organizations collecting member-reported information must have documents describing the policies and procedures for contacting members and for obtaining copies of legal health records.

Organizations *may not* conduct phone calls to members to collect information about services rendered.

Audit requirements. Member-reported services must be accompanied by proof-of-service documents for every record, and the audit requires primary source verification annually.

³**Primary care practitioner:** A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.

Required Data Elements

Standard supplemental data	Organizations must have policies and procedures for using data files as standard supplemental data. Files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by the measure specifications.
Nonstandard supplemental data	<p>Nonstandard supplemental data files must have all the data elements required to meet the criteria specified by the measure specifications.</p> <p>Electronic sources (i.e., portal, e-Measure module). Data collected or reported from the practitioner who renders the clinical service must have evidence of accountability by the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/PIN data in each session or header record.</p> <p>Provider-abstracted forms. Provider forms may not be simple “yes or no” responses as evidence of member compliance. Forms must have all necessary data elements required by the measure and be signed by the rendering practitioner, attesting to the accuracy of the information.</p>
Member-reported services	<p>Proof-of-service documents. Proof-of-service documents required for member-reported services must include all data elements required by the measure (i.e., date and place of service, procedure, prescription, test result or finding, practitioner type).</p>
All supplemental data	<p>All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to General Guideline 30 for date specificity requirements).</p> <p>If a P4P health plan uses audited PO supplemental data to report HEDIS results to NCQA, any P4P measure that can be reported using the hybrid methodology for HEDIS must contain all hybrid data elements.</p> <p>For all measures, the organization must be able to determine that a test or service was <i>performed</i> within the period specified, not merely ordered.</p> <p>All supplemental data used to show eligibility for exclusion must follow the requirements for exclusion in each measure.</p>
Supplemental data sharing between POs and health plans	<p>P4P health plans that use supplemental data collected for P4P measures to report hybrid HEDIS measures to NCQA must follow the hybrid measure specifications and collect all data elements required by the hybrid specifications. If all hybrid data elements are not collected, the data cannot be used for HEDIS reporting.</p>

Supplemental Data Timeline

Supplemental data may be collected during the measurement year and into the beginning of the reporting year, but data collection for nonstandard and member-reported service supplemental data must be completed by the **deadlines** listed in the P4P Data Collection and Reporting Timeline. Standard supplemental data files that are loaded as part of a data refresh may be processed after the deadline, as long as they were reviewed and approved by the auditor by the deadline.

P4P health plans that use audited PO supplemental data should receive the audited data files and **PO auditor's final** audit results from the PO by the deadline listed in the P4P Data Collection and Reporting timeline. The health plan should receive all supporting documents for each supplemental data source (e.g., **PO Roadmap section 4, data** file layouts, training materials) at the time the Roadmap is submitted to the auditor. The PO is responsible for sending the health plan all necessary documentation to support the use of supplemental data.

Refer to the P4P Data Collection and Reporting timeline for all deadline requirements.

Identifying and Validating Supplemental Data

All supplemental data (standard, nonstandard and member-reported) must be identifiable. Because supplemental data can affect reporting and incentives, **POs**, plans or vendors that include supplemental data files for P4P reporting must mark the supplemental data files, regardless of the source. **Auditors must be able to assess the contribution of each supplemental data source to the applicable components of the measure (numerator events or appropriate exclusions).**

The auditor must review all supplemental data annually—there are no exceptions. **At a minimum, the annual review includes the following for each supplemental data source:**

- A completed current year's **PO Roadmap Section 4**, including all attachments.
- Impact from supplemental data, by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data.)
- Primary source verification, where required or requested by the auditor.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate P4P rates by either the PO or the health plan. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

Additional details about audit requirements for supplemental data are described in the *P4P MY 2015 Audit Review Guidelines*, released each November.

Note: *Only health plans that participate in the P4P program can use audited PO supplemental data for their NCQA HEDIS submission. If health plans use audited PO supplemental data for HEDIS data submissions, the data must follow the hybrid HEDIS specification or they will not be approved. The PO must provide the health plan with a completed Roadmap section for each supplemental data source, all applicable attachments, the auditor's review findings. The P4P health plans are not required to also collect the proof-of-service documents for these audited and approved PO data. Refer to the P4P Audit Review Guidelines, released each November.*

29. Measures That Require Results From the Most Recent Test

For measures that require the use of results from the most recent test, search for evidence that indicates a test was performed, not merely ordered. Documentation indicating only that a test was ordered (and not performed) may not be included when identifying the most recent test. For example, documentation that the patient was sent to the lab or that a lab test was ordered does not mean a test was performed. These situations may not be included when identifying the most recent test.

Evidence indicating that a test was performed (that should be included when identifying the most recent test) includes documentation of a numeric value, interpretation of a numeric value (e.g., within normal limits, average, high) or documentation that a test was performed but results could not be calculated. To determine numerator compliance for rates that require results to be at a certain level, documentation of a numeric result is required. Documentation that a result is “within normal limits” or “under control” would be considered a “missing” result and would not be compliant for rates that require results to be at a certain level.

If the organization uses a combination of administrative and supplemental data, the most recent test must be used, regardless of data source.

Multiple dates of service may be associated with a single lab test. For example, a laboratory test may have a collection date (i.e., the date when the specimen was drawn), a reported date (i.e., the date when results were calculated and reported) and a claim date (i.e., the date of service on the claim). Because of this, the “result” may not be associated with the most recent date. An organization may consider all events with dates no more than seven days apart to be the same test and may use the result associated with that event (even if it is not the most recent date of service). **If there are two or more events with results, the most recent result must be used. The most recent data among all events must be in the time frame specified by the measure and must be used for reporting.** For example, a test with a collection date of December 1 and a reported date of December 8 may be considered the same test and the most recent date of December 8 must be used for reporting. Tests with dates more than seven days apart are considered different tests; the most recent must be used.

Undated lab results may not be used for P4P reporting. To be eligible for use, documentation must include the collection date or the reported date.

30. Date Specificity

P4P measures require a date to be specific enough to determine that an event occurred during the time established in the measure. For example, in the *Childhood Immunization Status—12-Month Continuous Enrollment* measure, members should receive three hepatitis B vaccines. Assume a member was born on February 5, 2013. Documentation that the first hepatitis B vaccine was given “at birth” is specific enough to determine that it was given prior to the deadline for this measure (i.e., the child’s second birthday), but if the documentation states that the third hepatitis B vaccine was given in February 2015, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member’s second birthday.

There are instances when documentation of the year alone is adequate; these include most optional exclusions and measures that look for events in the “measurement year or year prior to the measurement year.” Terms such as “recent,” “most recent” or “at a prior visit” are not acceptable.

For documented history of an event (e.g., documented history of a disease), undated documentation may be used as long as it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the *Breast Cancer Screening* measure, undated documentation on a problem list stating “bilateral mastectomy in 1999” is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.

31. Collecting Data for Measures With Multiple Numerator Events

The following measures require more than one event to satisfy the numerator:

- *Childhood Immunization Status.*
- *Diabetes Care—At Least Two HbA1c Tests indicator.*
- *Human Papillomavirus Vaccine for Adolescents.*
- *Cervical Cancer Overscreening.*

For only the measures listed above, the organization may use a single data source, such as claims/encounter data only, or a combination of administrative (i.e., claims/encounter data) and supplemental data to determine numerator compliance for members in the denominator. To avoid double-counting, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15.

32. Measures That Use Pharmacy Data

Some measures require the use of available pharmacy data. Self-reporting POs must have pharmacy data from all contracted P4P plans to run these measures. For measures requiring pharmacy data, the tables in the specifications include a *Description* column, which indicates the therapeutic category, and a *Prescription* column, which includes all appropriate medications in their generic form. Additionally, NCQA specifies a standardized list of medications known as the National Drug Code (NDC) list that applies to each pharmacy-dependent measure. POs and health plans are required to use the list for applicable measures.

The most current NDC list can be found on NCQA's Web site at <http://www.ncqa.org>. Select **HEDIS 2016** for P4P MY 2015. NCQA posts the final NDC lists for pharmacy-related measures on the NCQA Web site on November 2, 2015.

33. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Laboratory claims and data may be used only for the Lab Panel Value Set, the Obstetric Panel Value Set, the Pregnancy Tests Value Set, the Sexual Activity Value Set (which do not contain LOINC⁴ codes) and value sets that contain LOINC codes.

Claims data indicating a member had a laboratory test during a visit with a provider are not considered laboratory data. Laboratory data are claims or lab result data for the sole purpose of a laboratory test performed outside of a visit with a provider. Organizations determine how to differentiate between laboratory claims data and clinical/provider claims that may include a laboratory test.

Diagnosis codes on pharmacy claims may not be used.

⁴LOINC[®] is a registered trademark of the Regenstrief Institute.

34. Facility Data

With the exception of ARU and certain maternity measures, P4P measures do not *require* facility data (e.g., inpatient, ED) for reporting rates, but facility data may be used as specified. Professional codes associated with facility-based events may help capture some services, such as ED care for asthmatics.

35. Member-Collected Samples and Biometric Values

Test results from member-collected samples may be used for FOBT, urinalysis testing and blood spots for HbA1c, LDL-C, glucose and total cholesterol. Member-collected samples must be sent to the laboratory or provider's office for analysis.

Other member-collected biometric values (i.e., BP, BMI, height and weight) may not be used for P4P reporting.

Coding Conventions

36. Coding Systems Included in P4P

P4P includes codes from the following coding systems.

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).⁵
- Medicare Severity Diagnosis-Related Group (MS-DRG).
- Healthcare Common Procedure Coding System (HCPCS) Level II.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).⁶
- **International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).**⁶
- **International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).**⁶
- Logical Observation Identifiers Names and Codes (LOINC).
- Uniform Bill (UB) Revenue and type of bill (TOB). Prescription Drugs Hierarchical Condition Categories (RXHCC).

⁵ CPT codes copyright 2015 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use

⁶ Updates to the **International Classification of Diseases diagnosis and procedure codes** are released annually on October 1 by the American Hospital Association (AHA). The *HEDIS Technical Update* is released on the same date and therefore does not include the AHA's coding updates. Content from the October *HEDIS Technical Update* is the last update to the P4P specifications before they are frozen at the end of November. Consequently, AHA's coding updates are not included in the final P4P specifications for that year, and should not be used for P4P reporting. This policy ensures consistency in reporting across health plans and POs and reduces burden by eliminating updates to the P4P specifications after the freeze date. The codes will be considered for the following P4P cycle.

37. Presentation of Codes in P4P Value Sets

Measure specifications reference value sets that must be used for P4P reporting. In the specifications, value set references are capitalized and underlined (e.g., Hypertension Value Set). Only use the codes included in the value sets for P4P reporting. Value sets used for P4P reporting are included in the Value Set Directory and can be downloaded at <http://store.ncqa.org/index.php/catalog/product/view/id/2223/s/my-2015-p4p-manual-and-value-set-directories/>

38. Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout the specifications. Generally, a **principal diagnosis** is the diagnosis given at discharge and is listed in the first position on a claim/encounter form. A **secondary diagnosis** is any diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis. A claim or encounter can contain several secondary diagnoses. Organizations should follow the measure specifications to determine if a diagnosis must be the principal diagnosis or if it can be secondary. If the specification does not state that the principal or primary diagnosis must be used, any applicable diagnosis must be used.

Some measures require a specific principal diagnosis for a member to be in the eligible population; other measures allow any diagnosis (principal or secondary) for a member to be eligible. For example, the *Diabetes Care* measure specifies a member with any diagnosis of diabetes as eligible. If a member's claim lists the principal diagnosis as severe head injury trauma, but diabetes is listed as a second, third, fourth or fifth diagnosis on the same claim, the member should be included in the *Diabetes Care* measure. If the measure specifies that a principal diagnosis is required, health plans and POs should search for only the principal diagnosis (e.g., identifying the eligible population for the *Use of Imaging Studies for Low Back Pain*).

On a UB-04 claim form, the principal diagnosis is listed in Form Locator 67, *Principal Diagnosis Code*, and secondary diagnoses are listed in Form Locators 67A–Q, *Other Diagnosis Codes*. Data in Form Locators 69, *Admitting Diagnosis Code* and 70a–c, *Patient's Reason for Visit*, should not be included in HEDIS reporting.

On a CMS1500 claim form, the principal diagnosis is listed in Item Number 21, line 1; secondary diagnoses are listed in Item Number 21, lines 2–4.

39. CPT Code Modifiers

Current Procedural Terminology (CPT) modifiers are two- or five-digit extensions that, when added to CPT codes, provide additional information about a service or procedure. The same procedure should never be counted twice for the same date of service. Follow the guidelines below if procedure codes have modifiers (xxxxx denotes the five-digit CPT code).

- **xxxxx-26** indicates the professional component of a service (**xxxxx-TC** is used by some organizations to indicate the technical component of the same service). For a given procedure, the organization should count one or the other of these codes, but not both.
- **xxxxx-54** denotes surgical care only; **xxxxx-55** denotes postoperative management only; **xxxxx-56** denotes preoperative management only. The organization should count only one of these codes for a given procedure.
- **xxxxx-80** and **xxxxx-82** indicate charges for surgical assistant services; **xxxxx-81** indicates a charge for minimum surgical assistant services. The organization should count only one of these codes if the primary surgeon does not submit a claim for a procedure, and should not count any of these codes if the primary surgeon submits a claim.

Unless otherwise specified, a CPT code specified in P4P specifications that appears in the organization's database with any modifier other than those specified above may be counted in the HEDIS measure.

40. Uniform Bill Codes Specificity

Uniform Bill (UB) codes, primarily type of bill and revenue codes, are used to identify services.

The P4P Value Set Directory specifies UB Type of Bill codes using four digits. The organization may also use the equivalent three-digit version of the code (which consists of the four-digit code without the leading zero); for example, to identify skilled nursing facility (SNF) encounters, use either 21x or 021x.

Note: Three-digit versions of the codes are not included in the Value Set Directory.

41. Mapping Proprietary or Other Codes

For all measures, health plans and POs that do not use the specified **coding system** must “map” the codes they used to the codes specified in the manual. The organization may map proprietary codes, Level III and state-specific Level II HCPCS codes and NDC codes; it may not map standard codes or deleted codes to the codes used in the measures. It is important that health plans and POs match the clinical specificity required when mapping codes. NDC code mapping should be linked to the generic name, strength/dose and route indicated in the NDC lists posted on the NCQA Web site (www.ncqa.org).

For audit purposes, health plans and POs should document methods used to map codes. At a minimum, documentation should include a crosswalk containing the relevant codes, descriptions and clinical information.

Health plans and POs must document the policies and procedures they use to implement codes other than the specified coding systems. For Level III and state-specific Level II HCPCS mapping, organizations must provide state instructions for using state-specific codes. Auditors may request additional information.

42. Retiring Codes

NCQA annually tracks obsolete billing, diagnostic and procedure codes, but does not remove codes in the year in which they receive the designation of “obsolete” because of the look-back period in many P4P measures. Codes designated obsolete are not deleted from the P4P specifications until the look-back period for applicable measures is exhausted, plus one additional year. For example, since the *Breast Cancer Screening* measure counts a mammogram in the measurement year or the year prior to the measurement year, it has a two-year look-back period. A mammogram code that is designated obsolete effective January 1, 2014, is not deleted from the specifications until MY 2016 after the two-year look-back period (2015, 2016) plus one additional year (2014) is exhausted.

NCQA uses the NDC system. Obsolete NDC codes are phased out of the specification based on the look-back period for the measure, plus three years. This allows pharmacies to use up their inventory and change their systems to reflect the NDC code changes. NCQA encourages plans and POs to update their information systems and to ensure that complete, accurate and consistent coding is used for all encounters and claims so that measure specifications can be followed. This will help the industry move toward a uniform system of performance measurement.

43. Table Format

Measure specifications contain tables to present specification requirements. A standardized naming system is used to refer to the tables. Table names begin with the three-character abbreviation for the measure; for example, *Diabetes Care* tables begin with “CDC.”

Specification tables	Tables that are part of the specifications (i.e., medication tables) begin with the measure abbreviation and end with a hyphen (-) and a capital letter to distinguish its order in the measure’s specifications.
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P4P Data Submission

44. Reporting Small Numbers

Health plans and POs must report all available denominators, numerators and rates to the data aggregator even if the denominators are small. Only measures with aggregated denominators (the total for all health plans) of 30 or more are recommended for payment and public reporting. Measures with denominators less than 30 will be publicly reported as “Too Few Patients in Sample to Report.”

45. Reporting Date

The previous calendar year is the standard measurement year for P4P clinical data. IHA supplies the data submission file format to POs and health plans, and the Certified Auditor validates and locks the submission file before it is sent to TransUnion HealthCare. All health plan and PO-reported audited clinical data should be submitted to TransUnion HealthCare on or before the date specified in the *Data Collection and Reporting Timeline*.

Note

- *POs that use TransUnion HealthCare as the encounter data intermediary must submit all Q 1–Q4 2015 encounter data to TransUnion HealthCare by February 18, 2016. No new data will be accepted after this deadline. POs that use a different data intermediary or supply encounters directly to health plans should confirm the final acceptance date of encounter data to be included in P4P reporting.*
- *Self-reporting POs and health plans must submit auditor-locked P4P clinical results by May 9, 2016. Health plans must submit results for all clinical measures for each contracted PO with a signed P4P Consent to Disclosure Agreement.*

46. Required Data Elements

Health plans and POs should report data based on all services delivered through December 31 of the measurement year, not encounters submitted or claims paid through that date. Data elements that must be submitted for each measure are listed below.

- Record type (Header—HDR, Detail—DTL, Trailer—TRL).
- PO ID (parent level, or subgroup level, for eligible POs).
- P4P enrollment (HMO and POS separately) with the PO as of December 31 of the measurement year.
- Measure ID.
- Numerator.
- Denominator.
- Rate.
- Audit result.
- Vendor ID (for NCQA-certified vendors).

The Certified Auditor approves and locks the submission file before it is sent to TransUnion HealthCare.

The P4P Audit Review

47. Audit Review Principles

P4P requires health plans and self-reporting POs to undergo an audit review of clinical results conducted by an NCQA Certified Auditor. This review ensures that results are an accurate report of PO performance. The P4P Audit Review incorporates P4P-relevant components of the HEDIS Compliance Audit described in the current volume, *HEDIS Compliance Audit™: Standards, Policies and Procedures*. A separate manual with P4P Audit Specifications will be posted to the IHA Web site in November 2015.

The underlying principles of the Audit Review are:

- Ensure accurate, reliable, publicly reportable data that can be used to compare POs.
- Verify that measure calculation processes conform to technical specifications, including, but not limited to, use of administrative only data, correct calculation of encounter rates and appropriate application of continuous enrollment requirement.
- Assess information system capabilities and evaluate an organization's ability to process medical, member and practitioner information to report clinical measures accurately.
- Ensure consistency across audit reviews by having the audit review conducted by an NCQA Licensed Organization and a Certified HEDIS Compliance Auditor using NCQA's P4P standard audit methodology.

The audit review is conducted during the data collection process, allowing the auditor to detect errors while there is time to correct them and minimize the possibility of a *Biased Rate (BR)*. The audit review process includes initial offsite activities, an onsite visit, post-onsite activities and data reporting. A PO that does not self-report clinical measures does not need an audit.

48. Audit Components

P4P audit review components depend on the reporting option.

Health plan reporting	<p>A health plan that undergoes a HEDIS Compliance Audit and also reports P4P data on behalf of contracted POs must have a Certified Auditor review the PO results. The auditor reviews and confirms any additional activities required for calculating results at the PO level, including the following.</p> <ul style="list-style-type: none"> • The health plan's ability to attribute members to POs, including enrollment spans, and report the data at the PO level. • The health plan's ability to produce P4P measures according to P4P specifications. • The algorithms and source code used to report rates by PO.
PO self-reporting	<p>A PO that collects and reports P4P clinical measures must undergo an audit review adapted from NCQA's HEDIS Compliance Audit. The review includes all PO-relevant HEDIS Compliance Audit standards and policies and procedures described in the <i>P4P Audit Review Guidelines</i>.</p>

Note: Health plans that use supplemental data audited at the PO are not required to collect the proof-of-service documents also. Refer to the P4P Audit Review Guidelines, released in November 2015.

49. Audit Results

P4P Audit Reviews result in audited rates at the measure level and indicate if a measure can be publicly reported. All P4P clinical measures and encounter rate metrics must have a final, audited rate/result.

Health plan results

Audit reviews for health plans provide assessments for each of their contracted POs, indicating each measure's suitability for data aggregation. The auditor gives a designation for the rate of each measure included in the audit, as shown in the table below.

Rate/Result	Description	Notes
0-XXX	Reportable	Reportable rate for P4P measure. The rate of 0 includes instances when the health plan calculated the rate but found that no members met the criteria specified in the denominator.
BR	Biased Rate	The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
NR	Not Reported	The health plan did not report the measure (may only be used for testing measures).

PO results

For self-reporting POs, audit results indicate the suitability of each measure for public reporting. The auditor approves the rate or result of each measure included in the audit, as shown in the table below.

If the denominator for any measure is 0, the result should be 0, BR, NB or NR. The rate of 0 indicates that the PO calculated the measure, but no members met the criteria specified for the denominator.

Rate/Result	Description	Notes
0-XXX	Reportable	Reportable rate for P4P measure. The rate of 0 includes instances when the PO calculated the rate but found that no members met the criteria specified in the denominator.
BR	Biased Rate	The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.
SD	Small Denominator	The PO calculated the result, but the denominator was too small to report a valid rate (denominator between 1 and 29 members).
NB	No Benefit	The health plan did not offer the health benefit required by the measure (e.g., pharmacy).
NR	Not Reported	The PO did not report the measure.

50. Multiple Audit Designations

Measures with multiple rates may have multiple audit results. For example, it is possible for the *Childhood Immunization* measure to be assigned a reportable rate for the MMR rate but a *BR* for VZV.

51. Material Bias

Any error that causes a (+/-) 5 percentage point or greater difference in the reported rate is considered materially biased and receives a *BR* for the affected measures.

52. Marketing

Release of P4P Audit results must be in accordance with NCQA's *Guidelines for Advertising and Marketing*, posted on the NCQA Web site at www.ncqa.org. Organizations may release the entire Final Audit Report without prior authorization from NCQA, but must obtain written authorization from NCQA before releasing abridged, summarized or quoted information from the Final Audit Report.

Organizations that refer to the P4P audit or to P4P data audited by a Certified HEDIS Compliance Auditor must adhere to the guidelines.

Clinical Domain Technical Specifications

**For Value Based P4P MY 2015
Health Plans and Self-Reporting POs**

Overview

This section includes the P4P technical specifications for use in collecting California PO clinical performance data in 2016 for MY 2015. The P4P specifications are based on HEDIS measures and non-HEDIS measures. For P4P, NCQA adapts measures for assessing performance at the PO level. All measures are collected using administrative data systems, including EHRs, registries and other clinical databases. The Hybrid Methodology or medical chart review *is not* permitted.

The following P4P Clinical Domain Technical Specifications apply to P4P health plans and self-reporting POs. Differences between the HEDIS Technical Specifications for Health Plans and the P4P Clinical Domain Technical Specifications are clearly noted under each measure's *Modifications From HEDIS* section. It is the policy of the P4P program to change HEDIS specifications only if the specifications are not possible for the program (i.e., they include manual chart review), or there is a very compelling reason to differ from HEDIS.

The MY 2015 P4P Clinical Domain measures being collected are listed in the table below. Health plans report all measures; self-reporting POs choose which measures to voluntarily report.

Priority Area	Clinical Measures	Commercial HMO/POS	Medicare*	Non-HEDIS	Differs From HEDIS
Encounter Rate for Clinical Measures	Encounter Rate by Service Type	✓		✓	
Cardiovascular	Annual Monitoring for Patients on Persistent Medications	✓			
	Controlling High Blood Pressure for People With Hypertension	✓		✓	
	Proportion of Days Covered by Medications—Renin Angiotensin System (RAS) Antagonists	✓	✓	✓	
	Proportion of Days Covered by Medications—Statins	✓	✓	✓	
Diabetes	Proportion of Days Covered by Medications—Diabetes All Class	✓	✓	✓	
	Diabetes Care—Two HbA1c tests	✓			✓
	Diabetes Care—HbA1c Poor Control (9.0%)	✓	✓		
	Diabetes Care—HbA1c Control (<8.0%)	✓			
	Diabetes Care—HbA1c Control (<7.0%) for a Selected Population	✓			
	Diabetes Care—Eye Exam		✓		
	Diabetes Care—Nephropathy Monitoring	✓	✓		
	Diabetes Care—BP Control (<140/90)	✓			✓
	Diabetes Care—Optimal Diabetes Care Combination Rate	✓		✓	
Musculoskeletal	Use of Imaging Studies for Low Back Pain	✓			
	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		✓		
	Osteoporosis Management in Women Who Had a Fracture		✓		

Priority Area	Clinical Measures	Commercial HMO/POS	Medicare*	Non-HEDIS	Differs From HEDIS
Prevention	Childhood Immunization Status	✓			✓
	Immunizations for Adolescents	✓			
	Human Papillomavirus Vaccine for Female Adolescents	✓			
	Human Papillomavirus Vaccine for Male Adolescents	✓		✓	
	Chlamydia Screening in Women	✓			
	Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women	✓		✓	
	Cervical Cancer Screening	✓			✓
	Cervical Cancer Overscreening	✓		✓	
	Breast Cancer Screening	✓	✓		
	Colorectal Cancer Screening	✓	✓		
	Adult BMI Assessment		✓		
Respiratory	Asthma Medication Ratio	✓			
	Appropriate Testing for Children With Pharyngitis	✓			
	Appropriate Treatment for Children With Upper Respiratory Infection	✓			
	Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	✓			
Maternity	Unexpected Complications in Full-Term Newborns	✓		✓	
	Incidence of Episiotomy	✓		✓	
Utilization	All-Cause Readmissions	✓	✓		✓
Other Medicare Measures	High-Risk Medications		✓	✓	
E-Clinical Measures	Controlling High Blood Pressure (e-Measure)	✓		✓	
	Screening for Clinical Depression and Follow-Up Plan (e-Measure)	✓		✓	

*All Medicare measures are CMS Stars measures.

Encounter Rate by Service Type (ENRST)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure.

Description

The encounter rate is the number of encounters and claims by service type for each PO. Each health plan calculates the rate for each PO with which it contracts and uses it to measure data completeness. The method for identifying encounters by service type is based on the HEDIS Use of Service measures and the General Guidelines. Each service type is calculated as a separate rate.

Calculation

The encounter rate is total encounters and claims/total member years. Plans should report the total number of unduplicated encounters or claims for each service type and the member years.

Definitions

Member years	Calculate the member years of enrollment for the measurement year for all members. Include all members (adults and children) in the commercial HMO and POS lines of business, regardless of the type of reimbursement contract. This will be the denominator for rates 1–6.
Step 1	Determine the PO's total member months for a health plan using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the health plan's administrative processes. The day selected must be consistent from member to member, month to month and year to year. For example, if the health plan or PO computes membership on the 15th of the month and Ms. X is enrolled in the PO on January 15, Ms. X contributes one member month in January.
Step 2	Use the member's product line and PO affiliation on the specified day of each month to determine the product line and PO to which the member months will be contributed.
Step 3	For each PO, calculate member years by dividing total member months by 12. $X \text{ member months} / 12 \text{ months} = Y \text{ member years}$
Encounter	An encounter differs from a claim in that it represents a service for which there is no claim for payment sent to the health plan (i.e., all member encounters are covered in the health plan's capitation payment), or a service where the PO may pay the provider a fee for service for the encounter but does not bill the health plan for the service. Follow these guidelines for determining encounters. Include all encounters and claims for services rendered, whether or not they were approved or paid by the PO.

Determining encounters/claims	<p>Count any code that represents a unique date of service, a unique provider identifier and a unique patient.</p> <p>Count multiple lab tests in one day by the same lab provider as one unique encounter. An encounter for the same date of service, provider and patient that contains multiple types of services should be counted in each category, as appropriate (e.g., an office visit with lab procedures should be included in both categories).</p> <p>Allow at least a two-month lag in submission and count all commercial HMO and POS member encounters or transactions (including out of network POS claims) with a date of service in 2015. Do not include encounters with 2012 or 2013 dates of service that were received in 2014 or 2015.</p> <p>Report services without regard to practitioner type, training or licensing. Include after-hours, nonemergency urgent care, nursing home visits and outpatient surgical procedures.</p> <p>IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.</p>
Overall encounter rate	Sum of the numerators for rates 1, 2, 3, 4a, 5a and 6, divided by member years for the PO.

Encounter Rate 1: Office and Other Outpatient Services

Denominator	Member years.
Numerator	Count the total number of unduplicated office and other outpatient services encounters/claims using the (<u>Outpatient Services Value Set</u>) and the (<u>Observation Value Set</u>).

Note

- Count office-based surgeries/procedures in this category.

Encounter Rate 2: Preventive Medicine

Denominator	Member years.
Numerator	Count the total number of preventive medicine encounters/claims using the (<u>Preventive Medicine Services Value Set</u>).

Encounter Rate 3: Ophthalmology and Optometry

Denominator	Member years.
Numerator	Count the total number of ophthalmology or optometry encounters/claims (<u>Ophthalmological Services Value Set</u>). Report services without regard to practitioner type, training or licensing.

Encounter Rate 4: Laboratory/Pathology Services

Denominator Member years.

Numerator

Rate 4a Count the total number of encounters/claims (Laboratory and Pathology Services Value Set).

Note: Identify one encounter/claim as the same person receiving at least one test on the same day from the same (lab) provider. Do not count multiple tests (i.e., codes) separately that occurred on the same day with the same provider (either within the same encounter/claim record or on a different encounter/claim record).

Rate 4b Calculate the total number of tests (Laboratory and Pathology Services Value Set).

Count all laboratory/pathology procedure codes separately. For example, if an encounter record contains three different codes (i.e., for three different lab tests), record three “tests.” Sum all the tests to calculate the total numerator.

Encounter Rate 5: Radiology and Imaging

Denominator Member years.

Numerator

Rate 5a Count the total number of radiology and imaging encounters/claims using the (Radiology and Imaging Services Value Set).

Note: Identify one encounter/claim as the same person receiving at least one test on the same day from the same provider. Do not count multiple tests (e.g., CPT codes) separately that occurred on the same day with the same provider (either within the same encounter/claim record or on a different encounter record).

Rate 5b Calculate the total number of tests using the (Radiology and Imaging Services Value Set). Count all radiology procedure codes separately for this metric. For example, if an encounter record contains three different CPT codes (i.e., for three different imaging tests), record three “tests.” Sum all the tests to calculate the total numerator.

Encounter Rate 6: Ambulatory Surgery/Procedures

Denominator Member years

Numerator Count the total number of ambulatory surgery/procedure encounters/claims. A claim with a code from any of the following value set combinations meet the criteria:

- Ambulatory Surgery Option A Value Set **with** Ambulatory Surgery POS Value Set.
- Ambulatory Surgery Option A Value Set **with** Ambulatory Surgery UBTOB Value Set.

Report services without regard to practitioner type, training or licensing.

The health plan/PO must avoid double counting and report only ambulatory surgery/procedures performed at a hospital outpatient facility or at a free-standing surgery center. Count every ambulatory surgery/procedure encounter/ claim, which is one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site on that day for that member).

Note

- *Do not report office-based surgeries/procedures in this category; report them under Office and Other Outpatient Services.*
- *Do not count emergency department (ED) claims.*

Exclusions (required)

- Duplicate encounters/claims within a service type. Do not count multiple encounters/claims within this service type where the member, provider and date of service are the same, regardless of whether the procedure (CPT) codes are the same or different; if this occurs, only record one encounter/claim.
- Rates 4b and 5b should count the actual number of tests performed and are not subject to de-duplication by:
 - Member.
 - Provider.
 - Date of service.

Annual Monitoring for Patients on Persistent Medications (MPM)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added value sets to identify acute and nonacute inpatient encounters for the optional exclusions.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the three rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on digoxin.
- Annual monitoring for members on diuretics.
- Total rate (the sum of the three numerators divided by the sum of the three denominators).

Eligible Population

Product lines	Commercial HMO/POS.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year in the health plan and the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefits	Medical and pharmacy.

Event/diagnosis Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to *Additional Eligible Population Criteria* for each rate.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year.

Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

Administrative Specification

Report each of the three rates separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year. Refer to Table MPM-A to identify ACE inhibitors and ARBs.

Note: Members may switch therapy with any medication listed in Table MPM-A during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

Table MPM-A: Drugs to Identify Members on ACE Inhibitors or ARBs

Description	Prescription					
Angiotensin converting enzyme inhibitors	• Benazepril	• Enalapril	• Lisinopril	• Perindopril	• Ramipril	
	• Captopril	• Fosinopril	• Moexipril	• Quinapril	• Trandolapril	
Angiotensin II inhibitors	• Azilsartan	• Eprosartan	• Losartan	• Telmisartan		
	• Candesartan	• Irbesartan	• Olmesartan	• Valsartan		
Antihypertensive combinations	• Aliskiren-valsartan		• Candesartan-hydrochlorothiazide		• Hydrochlorothiazide-olmesartan	
	• Amlodipine-benazepril		• Captopril-hydrochlorothiazide		• Hydrochlorothiazide-quinapril	
	• Amlodipine-hydrochlorothiazide-valsartan		• Enalapril-hydrochlorothiazide		• Hydrochlorothiazide-telmisartan	
	• Amlodipine-hydrochlorothiazide-olmesartan		• Eprosartan-hydrochlorothiazide		• Hydrochlorothiazide-valsartan	
	• Amlodipine-olmesartan		• Fosinopril-hydrochlorothiazide		• Trandolapril-verapamil	
	• Amlodipine-telmisartan		• Hydrochlorothiazide-irbesartan			
	• Amlodipine-valsartan		• Hydrochlorothiazide-lisinopril			
	• Azilsartan-chlorthalidone		• Hydrochlorothiazide-losartan			
	• Benazepril-hydrochlorothiazide		• Hydrochlorothiazide-moexipril			

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Numerator At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) **and** a serum creatinine test (Serum Creatinine Value Set).

Note: The tests do not need to occur on the same service date, only within the measurement year.

Rate 2: Annual Monitoring for Members on Digoxin

Additional eligible population criteria Members who received at least 180 treatment days of a digoxin (Table MPM-B) during the measurement year.

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	<ul style="list-style-type: none"> • Digoxin

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Numerator At least one serum potassium, at least one serum creatinine **and** at least one serum digoxin therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set) and a serum digoxin test (Digoxin Level Value Set).
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set) and a serum digoxin test (Digoxin Level Value Set).

Note: The tests do not need to occur on the same service date, only within the measurement year.

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria Members who received at least 180 treatment days of a diuretic (Table MPM-C), during the measurement year.

Note: Members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days supply for those medications count toward the total 180 treatment days.

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription		
Antihypertensive combinations	<ul style="list-style-type: none"> • Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spirolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan 		
Loop diuretics	<ul style="list-style-type: none"> • Bumetanide • Ethacrynic acid • Furosemide • Torsemide 		
Potassium-sparing diuretics	<ul style="list-style-type: none"> • Amiloride • Eplerenone • Spironolactone • Triamterene 		
Thiazide diuretics	<ul style="list-style-type: none"> • Chlorothiazide • Chlorthalidone • Hydrochlorothiazide • Indapamide • Methyclothiazide • Metolazone 		

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Numerator

At least one serum potassium *and* a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test ([Lab Panel Value Set](#)).
- A serum potassium test ([Serum Potassium Value Set](#)) and a serum creatinine test ([Serum Creatinine Value Set](#)).

Note: Tests do not need to occur on the same service date, only within the measurement year.

Exclusion (optional)

Exclude members from each eligible population rate who had an inpatient encounter ([Acute Inpatient Value Set](#)) or nonacute inpatient encounter ([Nonacute Inpatient Value Set](#)) during the measurement year.

Controlling Blood Pressure for People With Hypertension (CBPH)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Removed the criteria for polycystic ovaries when assigning a flag of “not diabetic” in the event/diagnosis.
- Clarified Step 2 in *Required exclusion: Diabetes*

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure adapted from the P4P Comprehensive Diabetes Care: Blood Pressure Control measure.

Description

- The percentage of nondiabetic members 18–59 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
- The percentage of non-diabetic members 60–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<150/90 mm Hg) during the measurement year.
- *Total rate:* The percentage of nondiabetic members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled according to the appropriate criteria based on their age. The percentage is calculated by totaling the two rates for members 18–59 years of age and members 60–85 years of age.

Eligible Population

Product line Commercial HMO/POS.

Ages 18–85 years as of December 31 of the measurement year.

Continuous enrollment

...for self-reporting POs The measurement year in the PO (parent level).

...for health plans The measurement year in the health plan and the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.

...for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical.

**Event/
diagnosis** Members who met the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

At least two outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service, with a diagnosis of hypertension (Essential Hypertension Value Set). Visit type need not be the same for the two visits.

**Required
exclusion:
Diabetes**

Step 1 Exclude members with diabetes. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CBPH-A).

Step 2 Of those members identified in Step 1, remove from the exclusion (i.e., include in the denominator) members who **do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year *and* who had** a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Note: *Members classified as diabetic in Step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are included in the denominator.*

Table CBPH-A: Prescriptions to Identify Members With Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

Denominator The eligible population.

BP Control for members 18–59: <140/90 mm Hg Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set).

Members 18-59 years of age are numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the value sets below and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than/Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than/Equal To 90 Value Set</u>	Diastolic not compliant

BP Control for members 60–85: <150/90 mm Hg

Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set).

Members 60–85 are numerator compliant if the BP is <150/90 mm Hg. The member is not compliant if the BP is ≥150/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the value sets below and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than/Equal To 140 Value Set*</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than/Equal To 90 Value Set</u>	Diastolic not compliant

*The CPT Category II code (3077F) in this value set indicates the most recent systolic reading is greater than or equal to 140, and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data) to identify the actual value and determine if the systolic reading was <150 mm/Hg.

Similar to the other P4P measures, *Controlling Blood Pressure for People With Hypertension* is an electronic-only measure. Organizations may rely on CPT II codes, registry data or EHRs to collect blood pressure, but chart review is not an option. The most recent reading during the measurement year must be used; therefore, documentation of systolic and diastolic blood pressure on different dates of service is not permitted. If the most recent reading has multiple measurements on the same date, the lowest systolic and lowest diastolic reading may be used.

Exclusions (optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

Note

- BP readings taken by the member may not be used for this measure, regardless of the setting.

Proportion of Days Covered by Medications (PDC)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Clarified the percentage threshold for Step 4 of each rate.
- Added a Note to the denominator exclusion in the Diabetes All Class rate.
- Added a new class, SGLT2 Inhibitor Combinations, and medications to Table PDC-C.
- Added Insulin Regular (Human) Inhalation Powder to Table PDC-D.

MODIFICATIONS FROM HEDIS

- This non-HEDIS measure is based on the work of the Pharmacy Quality Alliance (PQA). It is a NQF-endorsed measure.

Description

- Proportion of Days Covered by Medications—Renin Angiotensin System (RAS) Antagonists is the same as the CMS Stars measure Medication Adherence for Hypertension (RAS Antagonists).
- Proportion of Days Covered by Medications—Statins is the same as the CMS Stars measure Medication Adherence for Cholesterol (Statins).
- Proportion of Days Covered by Medications—Oral Diabetes Medications is the same as the CMS Stars measure Medication Adherence for Oral Diabetes Medications.

The percentage of members 18 years of age and older who met the proportion of days covered (PDC) threshold of 80 percent for select medications during the measurement period. Members must have filled at least two prescriptions in a given medication category to be included in the measure.

Report a performance rate for each of the following:

- | | |
|-----------------------|---|
| Cardiovascular | <ul style="list-style-type: none"> • <i>Proportion of Days Covered by Medications:</i> RAS antagonists (ACEI, ARB, direct renin inhibitors). • <i>Proportion of Days Covered by Medications:</i> HMG-CoA inhibitors (i.e., statins). |
| Diabetes | <ul style="list-style-type: none"> • <i>Proportion of Days Covered by Medications:</i> Oral diabetes medications (biguanides, sulfonylureas, thiazolidinediones or DPP-IV inhibitors, incretin mimetic agents, meglitinides and sodium glucose co-transporter 2 (SGLT2) inhibitors). |

Note: Refer to the Value Set Directory for a comprehensive list of medications and associated codes (PQA December 2015 NDC List). Do not distribute NDC lists outside your organization.

Definitions

IPD	<p>Index prescription date. The date of the first fill of the target medication that meets the following criteria:</p> <ul style="list-style-type: none"> • The fill date is between January 1 and September 30 of the measurement year. • The member has 90 days continuous enrollment with no gaps during the measurement year after the fill date. <p>The member's treatment period begins on this date. Only paid, nonreversed claims for target medications count for this measure.</p>
Treatment period	The period of time beginning on a member's IPD through the last day of the measurement year, or until death or disenrollment. Disenrollment from the pharmacy benefit counts as disenrollment. The treatment period must be at least 90 days long.
PDC	The proportion of days in the treatment period covered by prescription claims for the same medication or another in its therapeutic category.
PDC threshold	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (i.e., 80 percent).

Eligible Population

Product lines	Commercial HMO/POS, Medicare.
Age	18 years and older as of the last day of the treatment period.
Continuous enrollment	
<i>...for self-reporting POs</i>	<p><i>Treatment period:</i> The index prescription date (IPD) through the end of the measurement year or until death or disenrollment from the PO (parent level). Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.</p>
<i>...for health plans</i>	<p><i>Treatment period:</i> The IPD through the end of the measurement year or until death or disenrollment from in the health plan and from the PO (parent level). Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.</p>
Allowable gap	No gaps in enrollment.
Anchor date	
<i>...for self-reporting POs</i>	None.
<i>...for health plans</i>	None.
Benefit	Medical, Pharmacy.
Event/diagnosis	Refer to <i>Additional Eligible Population Criteria</i> for each rate.

Note

- If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit, and that the pharmacy benefit dates align with the medical benefit dates.
- Do not include members who disenroll and reenroll more than one day later at any time during the measurement year, after the treatment period.

Administrative Specification

Report each rate separately. Members may be counted in the denominator for multiple rates if they have been dispensed the relevant medications, though for each rate, the proportion of days covered should only be counted once per member.

PDC for Renin Angiotensin System (RAS) Antagonists

Additional eligible population criteria Members who filled at least two prescriptions for a RAS antagonist: ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor combination (Table PDC-A: Renin Angiotensin System (RAS) antagonist medications) on two unique dates of service during the treatment period. Use only paid, nonreversed claims for target medications to determine if members are eligible.

Denominator exclusion Patients with ESRD (ESRD Status Value Set) **any time during the treatment period.**

Table PDC-A: Renin Angiotensin System (RAS) Antagonists

Renin Angiotensin System (RAS) Antagonists					
Direct renin inhibitor medications	<ul style="list-style-type: none"> • Aliskiren 				
Angiotensin receptor blockers (ARB) medications	<ul style="list-style-type: none"> • Candesartan • Eprosartan 	<ul style="list-style-type: none"> • Irbesartan • Losartan 	<ul style="list-style-type: none"> • Olmesartan • Telmisartan 	<ul style="list-style-type: none"> • Valsartan • Azilsartan 	
Angiotensin converting enzyme inhibitors (ACEI) medications	<ul style="list-style-type: none"> • Benazepril • Captopril 	<ul style="list-style-type: none"> • Enalapril • Fosinopril 	<ul style="list-style-type: none"> • Lisinopril • Moexipril 	<ul style="list-style-type: none"> • Perindopril • Quinapril 	<ul style="list-style-type: none"> • Ramipril • Trandolapril
Antihypertensive combinations	<ul style="list-style-type: none"> • Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-olmesartan • Amlodipine-valsartan • Amlodipine-valsartan-hydrochlorothiazide • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Irbesartan-hydrochlorothiazide • Lisinopril-hydrochlorothiazide • Losartan-hydrochlorothiazide • Moexipril-hydrochlorothiazide • Olmesartan-amlodipine-hydrochlorothiazide • Olmesartan-hydrochlorothiazide • Quinapril-hydrochlorothiazide • Telmisartan-amlodipine • Telmisartan-hydrochlorothiazide • Trandolapril-verapamil HCL • Valsartan-hydrochlorothiazide 				
Direct renin inhibitor combination products	<ul style="list-style-type: none"> • Aliskiren-amlodipine • Aliskiren-amlodipine-hydrochlorothiazide • Aliskiren-hydrochlorothiazide • Aliskiren-valsartan 				

Note: Active ingredients are limited to oral formulations only.

- Numerator** The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.
- Step 1** Determine the treatment period, defined as the index prescription date (IPD) to the end of the calendar year, disenrollment, or death.
- Step 2** Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, adjust the prescription start date to be the day after the previous fill has ended.*
- *Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.*
- Step 3** Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member.
- Step 4** Count the number of members who had a PDC of 80 percent or greater.
- Calculate performance rate** Divide the number of members from step 4 by the total number of eligible members.

PDC for Statin Medications

- Additional eligible population criteria** Members who filled at least two prescriptions for a statin or statin combination (Table PDC-B) on two unique dates of service during the treatment period. Use only paid, nonreversed claims for target medications to determine if members are eligible.

Table PDC-B: Statin Medications

Statins and Statin Combinations				
Statins	<ul style="list-style-type: none"> • Lovastatin • Rosuvastatin 	<ul style="list-style-type: none"> • Fluvastatin • Atorvastatin 	<ul style="list-style-type: none"> • Pravastatin • Pitavastatin 	<ul style="list-style-type: none"> • Simvastatin
Statin combinations	<ul style="list-style-type: none"> • Niacin-lovastatin • Atorvastatin-amlodipine 	<ul style="list-style-type: none"> • Niacin-simvastatin • Ezetimibe- atorvastatin 	<ul style="list-style-type: none"> • Ezetimibe-simvastatin 	<ul style="list-style-type: none"> • Sitagliptin-simvastatin

Note: Active ingredients are limited to oral formulations only.

- Numerator** The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.
- Step 1** Determine the treatment period, defined as the index prescription date (IPD) to the end of the calendar year, disenrollment, or death.

Step 2 Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, adjust the prescription start date to be the day after the previous fill has ended.*

**Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.*

Step 3 Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member.

Step 4 Count the number of members who had a PDC 80 percent **or greater**.

Calculate performance rate Divide the number of members from step 4 by the total number of eligible members.

PDC Diabetes All-Class Medications

Additional eligible population criteria Members who filled at least two prescriptions for any oral diabetes medication (Table PDC-C) on two unique dates of service during the treatment period. Use only paid, nonreversed claims for target medications to determine if members are eligible.

Denominator exclusion Members who **have** one or more prescriptions for insulin (Table PDC-D) **any time** during the treatment period.

Patients with ESRD (ESRD Status Value Set) **any time during the treatment period**.

Note: Use the most current information for the ESRD exclusion; using diagnosis codes is the preferred method. The RxHCC code can be found in the CMS Medicare Advantage and Prescription Drug System (MARx), which provides a monthly report of members' RxHCCs to plan sponsors. If the MARx System output is used, then the most recent version applies. Although the time frames are not consistent between diagnosis codes and the MARx System, using the most recent version provides the most current information to identify patients with ESRD.

Table PDC-C: Diabetes All Class Medications

Diabetes All Class Medications		
Biguanides	• Metformin	
Biguanide and sulfonylurea combinations	• Glipizide-metformin	• Glyburide-metformin
Biguanide and thiazolidinedione combinations	• Rosiglitazone-metformin	• Pioglitazone-metformin
Biguanide and meglitinide combinations	• Repaglinide-metformin	
Sulfonylureas	• Chlorpropamide • Glimepiride • Glipizide	• Glyburide • Tolazamide • Tolbutamide
Sulfonylurea and thiazolidinedione combinations	• Rosiglitazone-glimepiride	• Pioglitazone-glimepiride
Thiazolidinediones	• Pioglitazone	• Rosiglitazone
DPP-IV inhibitors	• Sitagliptin • Linagliptin	• Saxagliptin • Alogliptin
DPP-IV inhibitor combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Sitagliptin-metformin (IR and SR) • Linagliptin	• Saxagliptin-metformin SR • Sitagliptin-simvastatin • Linagliptin-metformin • Empagliflozin

Diabetes All Class Medications		
Incretin mimetic agents	<ul style="list-style-type: none"> • Exenatide • Albiglutide 	<ul style="list-style-type: none"> • Liraglutide • Dulaglutide
Meglitinides	<ul style="list-style-type: none"> • Nateglinide • Repaglinide 	<ul style="list-style-type: none"> • Repaglinide-metformin
Sodium glucose co-transporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin • Empagliflozin 	<ul style="list-style-type: none"> • Dapagliflozin
SGLT2 Inhibitor Combinations	<ul style="list-style-type: none"> • Dapagliflozin-metformin • Cagliflozin-metformin 	<ul style="list-style-type: none"> • Empagliflozin-linagliptin

Note: Active ingredients are limited to oral formulations only.

Table PDC-D: Insulin Medications

Insulin Medications		
Human insulin	<ul style="list-style-type: none"> • Insulin aspart • Insulin aspart protamine-aspart • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin isophane and regular human insulin 	<ul style="list-style-type: none"> • Insulin isophane (human N) • Insulin lispro • Insulin lispro protamine-insulin lispro • Insulin regular (human R) • Insulin regular (human) inhalation powder

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below for each member to determine whether the member meets the PDC threshold.

Step 1 Determine the treatment period, defined as the index prescription date (IPD) to the end of the enrollment year, disenrollment, or death.

Step 2 Within the treatment period, count the days the member was covered by at least one drug **from any of the diabetes drugs listed in Table PDC-C** based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, adjust the prescription start date to be the day after the previous fill has ended.*

** Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the target single drug or when there is an overlap of a combination product to another combination product where at least one of the drugs is common.*

Step 3 Divide the number of covered days found in step 2 by the number of days found in step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each member.

Step 4 Count the number of members who had a PDC 80 percent **or greater**.

Calculate performance rate Divide the number of members from step 4 by the total number of eligible members.

Exclusions (optional)

None.

Diabetes Care (CDC)

**Two HbA1c Tests, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),
HbA1c Control (<7.0%) for a Selected Population, Eye Exam, Medical Attention for
Nephropathy, Blood Pressure Control (<140/90),
ODC: Optimal Diabetes Care**

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the CABG criteria in the required exclusions for HbA1c Control <7% for a Selected Population indicator.
- Clarified when reporting the HbA1c Control <8% indicator using CPT Category II code 3045F that documentation must follow the requirements in General Guideline 29.
- Added the Total Inpatient POS Value Set, to Option B of the BP Control indicator.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a method and value sets to identify discharges for the applicable required exclusions for the HbA1c Control (<7.0%) for a Selected Population indicator.
- Added a method and value sets to identify acute discharges for Option B: Exclusions to Identify Appropriate Setting.
- Revised the requirements for urine protein testing for the Medical Attention for Nephropathy indicator; a screening or monitoring test meets criteria, whether the result is positive or negative.
- Removed the optional exclusion for polycystic ovaries.
- Added a Note clarifying optional exclusions.
- Removed the indicator for a single Hemoglobin A1c (HbA1c) test.
- Reordered some of the exclusions and made clarifications to Option B: Exclusions to Identify Appropriate Setting under the BP Control indicator.

MODIFICATIONS FROM HEDIS

- Optimal Diabetes Care Combination Rate is a non-HEDIS measure that is an “all or none” combination rate composed of four indicators.
- HEDIS Volume 2 has an indicator that looks for at least one HbA1c test, the P4P indicator looks for at least two HbA1c tests. Two HbA1c Tests is a non-HEDIS indicator used by the Wisconsin Collaborative for Healthcare Quality in their Diabetes All or None Process measure, which is the basis for the Optimal Diabetes Care Combination Rate.
- *Blood Pressure Control (<140/90)*: POs and plans may choose to use either the requirement that the blood pressure reading must be in conjunction with an outpatient visit code or a nonacute inpatient visit code or to use optional exclusions to identify BPs taken in the appropriate setting.

Description

- *Diabetes Care—Medical Attention for Nephropathy* is the same measure as the CMS Stars measure *Diabetes Care—Kidney Disease Monitoring*.
- *Diabetes Care—HbA1c Poor Control (>9.0%)* is the same measure as the CMS Stars measure *Diabetes Care—Blood Sugar Controlled*.
- *Eye Exams for Diabetics* is the same measure as the CMS Stars measure *Diabetes Care—Eye Exam*.

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- At least two HbA1c tests.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population*.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Additionally, report the following measure:

- Optimal Diabetes Care Combination Rate**
 - HbA1c Control (<8.0%), 2 HbA1c tests, BP Control (<140/90 mm Hg), Medical Attention for Nephropathy.

**Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial product line.*

***The Optimal Diabetes Care Combination Rate measure comprises four process and outcome indicators; “all or none” criterion is used to qualify for each combination rate.*

Eligible Population

Product line Report each product line separately.

Clinical Measures	Commercial HMO/POS	Medicare	Non-HEDIS
Diabetes Care—Two Hemoglobin A1c (HbA1c) Tests	✓		✓
Diabetes Care—HbA1c Poor Control (>9.0%)	✓	✓	
Diabetes Care—HbA1c Control (<8.0%)	✓		
Diabetes Care—HbA1c Control (<7.0%) for a Selected Population	✓		
Diabetes Care—Eye Exam (Retinal) Performed		✓	
Diabetes Care—Medical Attention for Nephropathy	✓	✓	
Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	✓		
Diabetes Care—Optimal Diabetes Care	✓		✓

Ages 18–75 years as of December 31 of the measurement year.

Continuous enrollment

...for self-reporting POs The measurement year in the PO (parent level).

...for health plans The measurement year in the health plan and the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan on December 31 of the measurement year.

...for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical.

**Event/
diagnosis**

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).

Table CDC-A: Prescriptions to Identify Members With Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

Denominator

The eligible population.

Note: The eligible population for the HbA1c Control <7% for a Selected Population indicator is reported after required exclusions are applied.

Required exclusions for HbA1c Control <7% for a Selected Population indicator

Exclude members who meet any of the following criteria:

- 65 years of age and older as of December 31 of the measurement year.
- **CABG.** Members who had CABG (CABG Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- **PCI.** Members who had PCI (PCI Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- **IVD.** Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
 - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set).
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- **Thoracic aortic aneurysm.** Members who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
 - At least one outpatient visit (Outpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
 - At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of thoracic aortic aneurysm (Thoracic Aortic Aneurysm Value Set).
- Any of the following, in any setting, any time during the member's history through December 31 of the measurement year.
 - Chronic heart failure (CHF). A diagnosis of CHF (Chronic Heart Failure Value Set).
 - Prior MI. A diagnosis of MI (MI Value Set).
 - ESRD. ESRD (ESRD Value Set; ESRD Obsolete Value Set).
 - Chronic kidney disease (stage 4). Stage 4 chronic kidney disease (CKD Stage 4 Value Set).
 - Dementia. A diagnosis of dementia (Dementia Value Set; Frontotemporal Dementia Value Set).
 - Blindness. A diagnosis of blindness (Blindness Value Set).
 - Amputation (lower extremity). Lower extremity amputation (Lower Extremity Amputation Value Set).

Numerators

Two HbA1c Tests At least two HbA1c tests (HbA1c Tests Value Set) during the measurement year with service dates 14 days or more apart, as identified by claim/encounter or automated laboratory data. For example, if the service date for the first test was February 1 of the measurement year, the service date for the second test must be on or after February 15.

HbA1c Poor Control >9% Use codes in the (HbA1c Tests Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Not compliant
<u>HbA1c Level 7.0–9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Compliant

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

HbA1c Control <8% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Compliant
<u>HbA1c Level 7.0–9.0 Value Set</u>	Not compliant*
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Not compliant

*The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed. **The date of service for the Category II code and the test result must follow the requirements outlined in General Guideline 29 (i.e., the dates of service for the code and the test result must be no more than seven days apart).**

**HbA1c
Control <7%
for a Selected
Population**

Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <7.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not performed during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Compliant
<u>HbA1c Level 7.0–9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Not compliant

Note: This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).

Eye Exam An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year.
- Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.

**Medical
Attention for
Nephropathy**

A nephropathy screening **or monitoring** test **or** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test ([Urine Protein Tests Value Set](#)).
- Evidence of treatment for nephropathy or ACE/ARB therapy ([Nephropathy Treatment Value Set](#)).
- Evidence of stage 4 chronic kidney disease ([CKD Stage 4 Value Set](#)).
- Evidence of ESRD ([ESRD Value Set](#)).
- Evidence of kidney transplant ([Kidney Transplant Value Set](#)).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (Table CDC-B).

Note: A process flow diagram is included at the end of this specification to help implement this specification.

Table CDC-B: ACE Inhibitors/ARBs

Description	Prescription					
ACE inhibitors	• Benazepril	• Enalapril	• Lisinopril	• Perindopril	• Ramipril	
	• Captopril	• Fosinopril	• Moexipril	• Quinapril	• Trandolapril	
Angiotensin II inhibitors	• Azilsartan	• Eprosartan	• Losartan	• Telmisartan		
	• Candesartan	• Irbesartan	• Olmesartan	• Valsartan		
Antihypertensive combinations	• Aliskiren-valsartan	• Azilsartan-chlorthalidone	• Hydrochlorothiazide-losartan			
	• Amlodipine-benazepril	• Benazepril-hydrochlorothiazide	• Hydrochlorothiazide-moexipril			
	• Amlodipine-hydrochlorothiazide-valsartan	• Candesartan-hydrochlorothiazide	• Hydrochlorothiazide-olmesartan			
	• Amlodipine-hydrochlorothiazide-olmesartan	• Captopril-hydrochlorothiazide	• Hydrochlorothiazide-quinapril			
	• Amlodipine-olmesartan	• Enalapril-hydrochlorothiazide	• Hydrochlorothiazide-telmisartan			
	• Amlodipine-telmisartan	• Eprosartan-hydrochlorothiazide	• Hydrochlorothiazide-valsartan			
	• Amlodipine-valsartan	• Fosinopril-hydrochlorothiazide	• Trandolapril-verapamil			
		• Hydrochlorothiazide-irbesartan				
		• Hydrochlorothiazide-lisinopril				

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

BP Control <140/90 mm Hg Use automated data to identify the most recent BP reading taken during an outpatient visit (Outpatient Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Similar to the other P4P measures, *Blood Pressure Control for Diabetes* is an electronic-only measure. Organizations may rely on CPT II codes, registry data or EHRs to collect blood pressure, but chart review is not an option. The most recent reading during the measurement year must be used; therefore, documentation of systolic and diastolic blood pressure on different dates of service is not permitted. If the most recent reading has multiple measurements on the same date, the lowest systolic and lowest diastolic reading may be used.

Value Set	Numerator Compliance
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than/Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than/Equal To 90 Value Set</u>	Diastolic not compliant

For the BP Control indicator, the BP must be during an outpatient or nonacute inpatient visit. POs and plans can use either of the following methods to identify BPs taken in the appropriate setting; POs and plans must choose one of these methods and use it consistently.

Note: BP readings taken by the member may not be used for this measure, regardless of which option is used.

Option A: Identify Outpatient and Nonacute Inpatient Visits

To identify outpatient visits use the Outpatient Value Set and for nonacute inpatient visits use Nonacute Inpatient Value Set. The BP must be in conjunction with one of these codes.

Option B: Exclusions to Identify Appropriate Setting

When identifying the most recent BP reading noted during the measurement year, do not include BP readings that meet the following criteria.

- BP taken during an acute inpatient stay. Use the following method to identify acute inpatient discharges and do not include BPs taken during the admission. To identify acute inpatient discharges:
 1. Identify all acute and nonacute inpatient stays ([Inpatient Stay Value Set](#)).
 2. Exclude nonacute inpatient stays ([Nonacute Inpatient Stay Value Set](#)).
- BP taken during an acute inpatient encounter ([Total Inpatient POS Value Set](#)).
- BP taken during an ED visit. Identify ED visits using either of the following:
 - An ED visit ([ED Value Set](#)).
 - An ED procedure code ([ED Procedure Code Value Set](#)) with an ED place of service code ([ED POS Value Set](#)).
- BP taken during an outpatient visit whose sole purpose to have a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). A claim with a code from any of the following value set combinations meets the criteria:
 - [Ambulatory Surgery Option A Value Set](#) with [Ambulatory Surgery POS Value Set](#).
- BPs obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) at a hospital outpatient facility or at a free-standing surgery center. A claim with a code from any of the following value set combinations meets the criteria:
 - [Ambulatory Surgery Option A Value Set](#) with [Ambulatory Surgery UBTOB Value Set](#).
- BP readings taken by the member.

Optimal Diabetes Care Combination rate

Calculate the following combination rate:

- HbA1c Control (<8.0%).
- BP Control (<140/90 mm Hg).
- Two HbA1c Tests.
- Medical Attention for Nephropathy.

Exclusions (optional)

Members who do not have a diagnosis of diabetes ([Diabetes Value Set](#)), in any setting, during the measurement year or the year prior to the measurement year **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes ([Diabetes Exclusions Value Set](#)), in any setting, during the measurement year or the year prior to the measurement year.

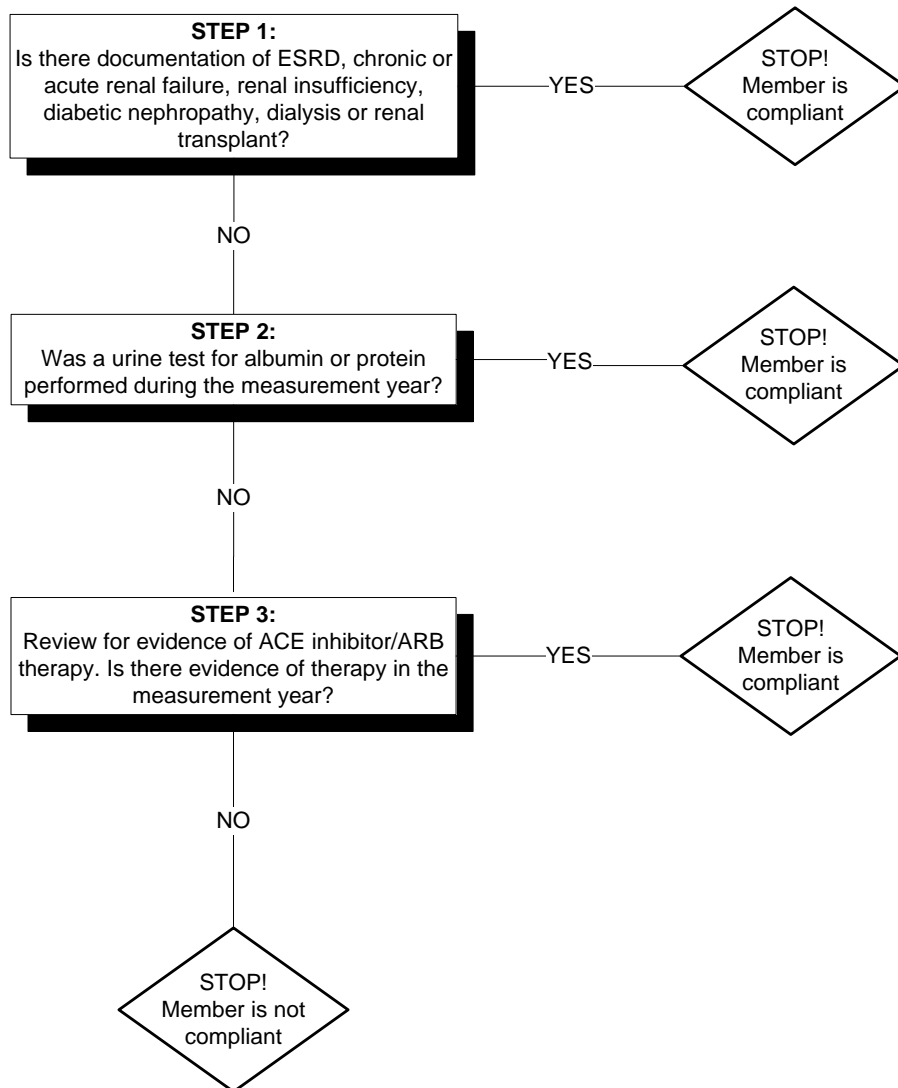
Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same, with the exception of the *HbA1c Control (<7.0%) for a Selected Population* denominator.

If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Note

- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam. If a combination of administrative and supplemental data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
- *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]). Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*

Monitoring for Diabetic Nephropathy



Use of Imaging Studies for Low Back Pain (LBP)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Submit the data for the measure as the direct rate not as the inverted calculation of numerator and denominator.

Calculation

After submission, the measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Definitions

Intake Period	January 1–December 3 of the measurement year. The Intake Period is used to identify the first outpatient or ED encounter with a primary diagnosis of low back pain.
IESD	Index Episode Start Date. The earliest date of service for an outpatient or ED encounter during the Intake Period with a principal diagnosis of low back pain.
Negative Diagnosis History	A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

Product line	Commercial HMO/POS.
Ages	18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	180 days (6 months) prior to the IESD through 28 days after the IESD in the PO (parent level).
<i>...for health plans</i>	180 days (6 months) prior to the IESD through 28 days after the IESD in the health plan and PO (parent level).

Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	
...for self-reporting POs	IESD in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan.
...for health plans	IESD in the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefit	Medical.
Event/ diagnosis	Outpatient or ED visit with a primary diagnosis of low back pain. Follow the steps below to identify the eligible population.
Step 1	Identify all members in the specified age range who had any of the following during the Intake Period: <ul style="list-style-type: none">• Outpatient visit (<u>Outpatient Value Set</u>), with a principal diagnosis of low back pain (<u>Low Back Pain Value Set</u>).• Observation visit (<u>Observation Value Set</u>), with a principal diagnosis of low back pain (<u>Low Back Pain Value Set</u>).• ED visit (<u>ED Value Set</u>), with a principal diagnosis of low back pain (<u>Low Back Pain Value Set</u>). Do not include ED visits that result in an inpatient admission.• Osteopathic manipulative treatment (<u>Osteopathic Manipulative Treatment Value Set</u>), with a principal diagnosis of low back pain (<u>Low Back Pain Value Set</u>).
Step 2	Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.
Step 3	Test for Negative Diagnosis History. Exclude members with a diagnosis of low back pain (<u>Low Back Pain Value Set</u>) during the 180 days (6 months) prior to the IESD.
Step 4 Required exclusions	Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria: <ul style="list-style-type: none">• <i>Cancer.</i> Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:<ul style="list-style-type: none">- <u>Malignant Neoplasms Value Set</u>.- <u>Other Neoplasms Value Set</u>.- <u>History of Malignant Neoplasm Value Set</u>.• <i>Recent trauma.</i> Trauma (<u>Trauma Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.• <i>Intravenous drug abuse.</i> IV drug abuse (<u>IV Drug Abuse Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.• <i>Neurologic impairment.</i> Neurologic impairment (<u>Neurologic Impairment Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
Step 5	Calculate and continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator An imaging study (Imaging Study Value Set) with a diagnosis of low back pain (Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a method and value sets to identify nonacute inpatient discharges for the event/diagnosis.

MODIFICATIONS FROM HEDIS

- Limited to the Medicare Advantage product line only.

Description

- *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis* is the same measure as the CMS Stars measure Rheumatoid Arthritis Management.

The percentage of Medicare members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

Eligible Population

Product line	Medicare.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan on December 31 of the measurement year.
Benefit	Medical and pharmacy.

- Event/
diagnosis** Two of the following with different dates of service on or between January 1 and November 30 of the measurement year. Visit type need not be the same for the two visits.
- Outpatient visit (Outpatient Value Set), with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set).
 - Nonacute inpatient discharge, with any diagnosis of rheumatoid arthritis (Rheumatoid Arthritis Value Set). **To identify nonacute inpatient discharges:**
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.

Administrative Specification

Denominator The eligible population.

Numerator Members who had at least one ambulatory prescription dispensed for a DMARD during the measurement year. There are two ways to identify members who received a DMARD: by claim/encounter data and by pharmacy data. The organization may use both methods to identify the numerator, but a member need only be identified by one method to be included in the numerator.

Claim/encounter data. A DMARD prescription (DMARD Value Set) during the measurement year.

Pharmacy data. Members who were dispensed a DMARD during the measurement year on an ambulatory basis (Table ART-A).

Table ART-A: DMARDs

Description	Prescription		
5-Aminosalicylates	• Sulfasalazine		
Alkylating agents	• Cyclophosphamide		
Aminoquinolines	• Hydroxychloroquine		
Anti-rheumatics	• Auranofin • Gold sodium thiomalate	• Leflunomide • Methotrexate	• Penicillamine
Immunomodulators	• Abatacept • Adalimumab • Anakinra • Certolizumab	• Certolizumab pegol • Etanercept • Golimumab	• Infliximab • Rituximab • Tocilizumab
Immunosuppressive agents	• Azathioprine	• Cyclosporine	• Mycophenolate
Janus kinase (JAK) inhibitor	• Tofacitinib		
Tetracyclines	• Minocycline		

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Exclusions (optional)

- A diagnosis of HIV (HIV Value Set) any time during the member's history through December 31 of the measurement year.
- A diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.

Osteoporosis Management in Women Who Had a Fracture (OMW)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Defined “active prescription.”
- Revised the method and value sets to identify acute and nonacute inpatient events for steps 1 and 2 of the event/diagnosis.
- Clarified when to use admission or discharge dates when determining Negative Diagnosis History.
- Clarified that bone mineral density tests that occur in an inpatient setting (either during an inpatient IESD or during the 180-day (6-month) period after the IESD) meet numerator criteria.
- Added long-acting osteoporosis therapy administered during an inpatient IESD to the numerator.

MODIFICATIONS FROM HEDIS

- Physician organizations without access to inpatient claim/encounter data may use an alternative method to determine the IESD.

Description

- *Osteoporosis Management in Women Who Had a Fracture* is the same measure as the CMS Stars measure Osteoporosis Management in Women Who Had a Fracture.

The percentage of women 67–85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Definitions

Intake Period A 12-month (1 year) window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period is used to capture the first fracture.

IESD Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture.

For an outpatient or ED visit, the IESD is date of service.

For an inpatient encounter, the IESD is the date of discharge.

For direct transfers, the IESD is the discharge date from the second admission.

Note: POs that do not have access to inpatient claim/encounter data may use professional claims indicating that a physician saw the member in the hospital, as a proxy. In this scenario, the PO uses the physician’s first visit with the member as a proxy for the admission date and uses the last visit as a proxy for the discharge date. This method may be used only by POs that do not have access to inpatient claim/encounter data.

Negative Diagnosis History	<p>A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of fracture.</p> <p><i>For fractures requiring an inpatient stay, use the date of admission to determine Negative Diagnosis History.</i></p> <p><i>For direct transfers, use the first admission to determine the Negative Diagnosis History.</i></p>
Active prescription	A prescription is considered active if the “days supply” indicated on the date the member filled the prescription is the number of days or more between that date and the relevant service date.

Eligible Population

Product line	Medicare.
Ages	Women 67-85 years of age and older as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	12 months (1 year) before the IESD through 180 days (6 months) after the IESD in the PO (parent level).
<i>...for health plans</i>	12 months (1 year) before the IESD through 180 days (6 months) after the IESD in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	
<i>...for self-reporting POs</i>	IESD in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan.
<i>...for health plans</i>	IESD in the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefit	Medical and pharmacy.
Event/diagnosis	<p>The earliest fracture during the Intake Period.</p> <p>Follow the steps below to identify the eligible population.</p> <p>Step 1 Identify all members who had either of the following during the Intake Period.</p> <ul style="list-style-type: none"> • An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set), for a fracture (Fractures Value Set). • An acute or nonacute inpatient discharge for a fracture (Fractures Value Set). <ul style="list-style-type: none"> 1. To identify acute and nonacute inpatient discharges: Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. <p>If the member had more than one fracture, include only the first fracture.</p> <p>Note: POs that do not have access to inpatient claim/encounter data may use professional claims indicating that a physician saw the member in the hospital, as a proxy. In this scenario, the PO uses the physician’s first visit with the member as a proxy for the admission date and uses the last visit as a proxy for the discharge date.</p>

This alternative method may be used only by POs that do not have access to inpatient claim/encounter data.

Step 2 Test for Negative Diagnosis History. Exclude members who had either of the following during the 60-day (2 months) period prior to the IESD.

- An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) for a fracture (Fractures Value Set).
- An acute or nonacute inpatient discharge for a fracture (Fractures Value Set). To identify acute and nonacute inpatient discharges:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
 2. Identify the discharge date for the stay.

For an acute or nonacute inpatient IESD, use the IESD date of admission to determine the 60-day period.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled during the 12 months prior to the fracture through 180 days (6 months) post-fracture.

Step 4 Exclude members who met any of the following criteria:

- Members who had a BMD test (Bone Mineral Density Tests Value Set) during the 730 days (24 months) prior to the IESD.
- Members who had a claim/encounter for osteoporosis therapy (Osteoporosis Medications Value Set) during the 365 days (12 months) prior to the IESD.
- Members who received a dispensed prescription or had an active prescription to treat osteoporosis (Table OMW-A) during the 365 days (12 months) prior to the IESD.

For an acute or nonacute inpatient IESD, use the IESD date of admission to determine the number of days prior to the IESD.

Administrative Specification

Denominator The eligible population.

Numerator Appropriate testing or treatment for osteoporosis after the fracture defined by any of the following criteria:

- A BMD test (Bone Mineral Density Tests Value Set), *in any setting*, on the IESD or in the 180-day (6-month) period after the IESD.
- *If the IESD was an inpatient stay, a BMD test (Bone Mineral Density Tests Value Set) during the inpatient stay.*
- Osteoporosis therapy (Osteoporosis Medications Value Set) on the IESD or in the 180-day (6-month) period after the IESD.
- *If the IESD was an inpatient stay, long-acting osteoporosis therapy (Long-Acting Osteoporosis Medications Value Set) during the inpatient stay.*
- A dispensed prescription to treat osteoporosis (Table OMW-A) on the IESD or in the 180-day (6-month) period after the IESD.

Table OMW-A: Osteoporosis Therapies

Description	Prescription	
Biphosphonates	<ul style="list-style-type: none"> • Alendronate • Alendronate-cholecalciferol • Calcium carbonate-risedronate 	<ul style="list-style-type: none"> • Ibandronate • Risedronate • Zoledronic acid
Other agents	<ul style="list-style-type: none"> • Calcitonin • Denosumab 	<ul style="list-style-type: none"> • Raloxifene • Teriparatide

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Note

- Fractures of finger, toe, face and skull are not included in this measure.

Childhood Immunization Status (CIS)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added Influenza and Combination 10.
- Added a *Note* to MMR clarifying that the “14-day rule” does not apply to this vaccine.
- Added a new value set to the administrative method to identify Hepatitis B vaccines administered at birth.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of enrolled children two years of age who were identified as having completed the following antigen series by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

- Four diphtheria, tetanus and acellular pertussis (DTaP).
- Three polio (IPV).
- One measles, mumps, rubella (MMR).
- Three haemophilus type B (HiB).
- Three hepatitis B (HepB).
- One chicken pox (VZV).
- Four pneumococcal conjugate (PCV).
- One hepatitis A (HepA).
- Two or three rotavirus (RV).
- At least two influenza vaccinations.
- Combination 3 and 10.

Eligible Population

Product line Commercial HMO/POS.

Age Children who turn 2 years of age during the measurement year.

Continuous enrollment

...for self-reporting POs 12 months prior to the child's second birthday in the PO (parent level).

...for health plans 12 months prior to the child's second birthday in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on the child's second birthday.

...for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the child's second birthday.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator The eligible population.

Numerators For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine, **or**
- Documented history of the illness, **or**
- A seropositive test result for each antigen.

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count *only*:

- Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.

DTaP At least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR Any of the following with a date of service on or before the child's second birthday meet criteria:

- At least one MMR vaccination (Measles, Mumps, and Rubella (MMR) Vaccine Administered Value Set).
- At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) **and** at least one mumps vaccination **or** history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service.
- At least one measles vaccination **or** history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) **and** at least one mumps vaccination **or** history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) **and** at least one rubella vaccination **or** history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service.

Note: General Guideline 31 (i.e., the 14-day rule) does not apply to MMR.

HiB At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B Either of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service.
 - One of the three vaccinations may be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis (Hepatitis B Value Set).

VZV Either of the following on or before the child's second birthday meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service on or before the child's second birthday.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set).

Pneumococcal conjugate At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A Either of the following on or before the child's second birthday meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Vaccine Administered Value Set), with a date of service on or before the child's second birthday.
- History of hepatitis A illness (Hepatitis A Value Set).

Rotavirus Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.

- At least two doses of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) **and** at least two doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set), all on different dates of service.

Influenza At least two influenza vaccinations (Influenza Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.

Combination rates Calculate the following rates for Combinations 3 and 10.

Combination Vaccination for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Exclusion (optional)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the member's second birthday meet optional exclusion criteria:

- Any particular vaccine**
 - Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).
- DTaP**
 - Encephalopathy (Encephalopathy Due To Vaccination Value Set) **with** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).
- MMR and VZV**
 - Immunodeficiency (Disorders of the Immune System Value Set)
 - HIV (HIV Value Set).
 - Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
 - Anaphylactic reaction to neomycin.
- IPV**
 - Anaphylactic reaction to streptomycin, polymyxin B or neomycin.
- Hepatitis B**
 - Anaphylactic reaction to common baker's yeast.

Immunizations for Adolescents (IMA)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

Product lines Commercial HMO/POS.

Age Adolescents who turn 13 years of age during the measurement year.

Continuous enrollment

...for self-reporting POs 12 months prior to the member's 13th birthday in the PO (parent level).

...for health plans 12 months prior to the member's 13th birthday in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on the member's 13th birthday.

...for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the member's 13th birthday.

Benefit Medical.

Event/diagnosis None.

Administrative Specification

Denominator	The eligible population.
Numerators	For meningococcal and Tdap or Td, count <i>only</i> evidence of the antigen or combination vaccine.
<i>Meningococcal</i>	At least one meningococcal conjugate or meningococcal polysaccharide vaccine (<u>Meningococcal Vaccine Administered Value Set</u>), with a date of service on or between the member's 11th and 13th birthdays.
<i>Tdap/Td</i>	Any of the following with a date of service on or between the member's 10th and 13th birthdays meet criteria: <ul style="list-style-type: none"> • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (<u>Tdap Vaccine Administered Value Set</u>). • At least one tetanus, diphtheria toxoids (Td) vaccine (<u>Td Vaccine Administered Value Set</u>). • At least one tetanus vaccine (<u>Tetanus Vaccine Administered Value Set</u>) and at least one diphtheria vaccine (<u>Diphtheria Vaccine Administered Value Set</u>) on the same date of service or on different dates of service.
<i>Combination 1 (Meningococcal, Tdap/Td)</i>	Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td).

Exclusion (optional)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Human Papillomavirus Vaccine for Adolescents (HPV)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- The HEDIS HPV measure does not include male adolescents.

Description

The percentage of adolescents 13 years of age who had three doses of human papillomavirus (HPV) vaccine by their 13th birthday. Report male and female adolescents separately.

Eligible Population

Product lines	Commercial HMO/POS.
Age	Adolescents who turn 13 years of age during the measurement year. Report males and females separately.
Continuous enrollment	
<i>...for self-reporting POs</i>	12 months prior to the member's 13th birthday in the PO (parent level).
<i>...for health plans</i>	12 months prior to the member's 13th birthday in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on the member's 13th birthday.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerators

Females At least three HPV vaccinations (HPV Vaccine Administered Value Set), with different dates of service on or between the member's 9th and 13th birthdays.

Males At least three HPV vaccinations (HPV Vaccine Administered Value Set), with different dates of service on or between the member's 9th and 13th birthdays.

Exclusion (optional)

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Chlamydia Screening in Women (CHL)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Eligible Population

Product line	Commercial HMO/POS.
Ages	<p>Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 16–20 years. • 21–24 years. • Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.
Benefit	Medical.

**Event/
diagnosis**

Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:

- Pregnancy Value Set.
- Sexual Activity Value Set.
- Pregnancy Tests Value Set.

Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription
Contraceptives	<ul style="list-style-type: none"> • Desogestrel-ethinyl estradiol • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate biphasic • Estradiol-medroxyprogesterone • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel • Ethinyl estradiol-norelgestromin • Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindrone
Diaphragm	<ul style="list-style-type: none"> • Diaphragm
Spermicide	<ul style="list-style-type: none"> • Nonoxynol 9

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification

Denominator The eligible population.

Numerator At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Exclusion (optional)

Exclude members who qualified for the denominator based on a *pregnancy test* (Pregnancy Tests Value Set) **alone and** who meet either of the following criteria:

- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year **and a prescription for isotretinoin (Table CHL-B) on the date of the pregnancy test or during the six days after the pregnancy test.**
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year **and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or during the six days after the pregnancy test.**

Table CHL-B: Medications to Identify Exclusions

Description	Prescription
Retinoid	<ul style="list-style-type: none"> • Isotretinoin

Note: An NDC list for isotretinoin will be available on www.ncqa.org by November 2, 2015.

Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women (ECS)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Revised the service dates in the example for Step 2 of Rate 2.

MODIFICATIONS FROM HEDIS

- This non-HEDIS measure is based on a measure used by Health Partners in Minnesota.

Description

Women 21 years of age and older who received cervical cancer screening in accordance with evidence-based standards. Three separate overall rates are calculated for this measure based on the same eligible population. The denominator represents the entire population of women; the three rates are mutually exclusive categories that represent all the possible scenarios of care for a woman. The goal of the measure is to move as many women as possible into the “Appropriately Screened” category, where a higher rate is better. A lower rate is better for the “Underscreened” and “Screened Too Frequently” categories. A woman can only fall into one of the three categories; no member should be counted in more than one category.

The eligible population starts at 24 years of age to account for the look-back period. Rate 1, Appropriately Screened, will be the only measure recommended for public reporting and payment. Because of the three-year look back period, 66-year-olds are excluded from the specifications. They fall into both the “Appropriately Screened” and “Screened Too Frequently” categories, depending on when their birthday falls during the measurement year and the timing of the cervical cytology.

Rate 1: Appropriately Screened

Women who were screened for cervical cancer according to evidence-based guidelines. A higher rate indicates better performance. Women in the “Appropriately Screened” rate include the following:

- Age 24–65 with a hysterectomy and *did not* have a cervical cancer screening in the measurement year or two years prior, or subsequent to their hysterectomy, if the hysterectomy took place within the measurement year or two years prior.
- Age 24–65 with no hysterectomy and had a *single* cervical cancer screening in the last the measurement year or two years prior.
- Age 30–65 and had a cervical cancer screening *with* an HPV test in the third or fourth years prior to the measurement year.
- Age 67 and over and had no cervical cancer screening in the measurement year.

Rate 2: Underscreened

Women who should have been screened for cervical cancer but were not, based on the available data. A lower rate indicates better performance. Additional outreach could be done to encourage these women to come in for screening. Women in the “Underscreened” rate include the following:

- Age 24–65 with no hysterectomy and no cervical cancer screening in the measurement year or two years prior.

Note: Women aged 30–65 years who did not have a hysterectomy and had a single cervical cytology screening with an HPV test in the three or four years prior to the measurement year do not fall into the “Underscreened” category.

Rate 3: Screened Too Frequently

Women who received more cervical cancer screenings than necessary according to evidence-based guidelines. A lower rate indicates better performance. This represents an educational opportunity to reach out to physicians to reinforce the most current evidence and guidelines, and to discuss potential overuse. Women in the “Screened Too Frequently” rate including the following:

- Age 24–65 with a hysterectomy and one or more cervical cancer screenings subsequent to their hysterectomy in the measurement year or the two years prior to the measurement year.
- Age 24–65 without a hysterectomy and had two or more cervical cancer screenings in the measurement year or the two years prior to the measurement year.
- Age 30–65 without a hysterectomy and had two or more cervical cancer screenings *with* an HPV test in the third or fourth years prior to the measurement year.
- Age 67 and over and had one or more cervical cancer screenings in the measurement year.

Eligible Population

Population	Commercial HMO/POS.
Age	Women 24–65 years old and 67 years old and older as of December 31 of the measurement year.
Continuous enrollment:	
....for self-reporting POs	The measurement year and the two years prior to the measurement year in the PO (parent level).
....for health plans	The measurement year and the two years prior to the measurement in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
....for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and a P4P plan as of December 31 of the measurement year.
....for health plans	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) as of December 31 of the measurement year.
Benefits	Medical.

Event/
diagnosis None.

Administrative Specification

Report each of the three rates separately. Women are only counted in one step for each rate; a woman who was already counted is not counted in subsequent steps.

Rate 1: Appropriately Screened

Denominator The eligible population.

Numerator The number of women who had the appropriate number of cervical cancer screenings according to evidence-based guidelines.

Note: If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 120 days of each other, count only the first one.

Step 1 Screening and hysterectomy. Identify the number of women 24–65 years of age with hysterectomies who had cervical cytology (Cervical Cytology Value Set) subsequent to their hysterectomy in the measurement year or the two years prior to the measurement year.

Either of the following meet criteria for hysterectomy:

- A hysterectomy procedure code (Hysterectomy Procedure Value Set).
- A code for history of hysterectomy (History of Hysterectomy Value Set) where the organization can identify the date when the hysterectomy occurred.

If the member had a hysterectomy prior to the last three years (look as far back as possible for a hysterectomy):

- She is in the “Appropriately Screened” category if she had no cervical cytology in the last three years.

If the member had a hysterectomy in the last three years:

- She is in the “Appropriately Screened” category if she had no cervical cytology after her hysterectomy.
 - A hysterectomy that occurs on the same day as a cervical cytology should be considered subsequent to the cervical cytology.

Note: Count any cervical cancer screening methodology that includes collection and microscopic analysis of cervical cells. Do not count biopsies for this measure because they are used for diagnostic and therapeutic purposes and are not valid for primary cervical cancer screening.

Step 2 Cervical cytology. For women 24–65 years as of December 31 of the measurement year who have not had a hysterectomy, identify the number of women who had a single cervical cytology (Cervical Cytology Value Set) in the measurement year or the two years prior to the measurement year.

Either of the following meet criteria for hysterectomy:

- A hysterectomy procedure code (Hysterectomy Procedure Value Set).
- A code for history of hysterectomy (History of Hysterectomy Value Set) where the organization can identify the date when the hysterectomy occurred.

Step 3 Cervical cytology and HPV co-test. For women 33–65 years as of December 31 of the measurement year who have not had a hysterectomy and did not meet the criteria for compliance in step 2, identify the number of women who had a single cervical cytology co-test during the third or fourth year prior to the measurement year.

A **co-test** is defined as cervical cytology screening (Cervical Cytology Value Set) **and** a human papillomavirus (HPV) test (HPV Tests Value Set), with service dates four or fewer days apart **and** who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

Step 4 Over 67 years. Identify the number of women 67 years and older as of December 31 of the measurement year who had no cervical cytology (Cervical Cytology Value Set) in the measurement year.

Step 5 Add the numbers from steps 1–4 to obtain the numerator for *Rate 1: Appropriately Screened*.

Rate 2: Underscreened

Denominator The eligible population.

Numerator The number of women who did not receive a cervical cytology screening according to evidence based guidelines.

Step 1 Identify the women 24–65 years as of December 31 of the measurement year who have not had a hysterectomy and who had no cervical cytology (Cervical Cytology Value Set) in the measurement year or the two years prior to the measurement year.

Either of the following meet criteria for hysterectomy:

- A hysterectomy procedure code (Hysterectomy Procedure Value Set).
- A code for history of hysterectomy (History of Hysterectomy Value Set) where the organization can identify the date when the hysterectomy occurred.

Step 2 From the women identified in step 1, count the women 33–65 years who had a cervical cytology co-test during the three or four years prior to the measurement year.

A co-test is defined as cervical cytology screening (Cervical Cytology Value Set) **and** a human papillomavirus (HPV) test (HPV Tests Value Set), with service dates four or fewer days apart **and** who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was **December 1** of the measurement year, the HPV test must include a service date on or between **November 27** and December 5 of the measurement year. These women were appropriately screened, as identified in step 3 of Rate 1.

Step 3 Subtract the women identified in step 2 from the women identified in step 1. This number is the numerator for *Rate 2: Underscreened*.

Rate 3: Screened Too Frequently

Denominator The eligible population.

Numerator The number of women who received more cervical cytology than necessary according to evidence-based guidelines.

Note: If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 120 days of each other, count only the first one.

Step 1 Identify the number of women 24–65 years as of December 31 of the measurement year with hysterectomies who had one or more cervical cytology screenings (Cervical Cytology Value Set) subsequent to their hysterectomy in the measurement year or the two years prior to the measurement year.

Either of the following meet criteria for hysterectomy:

- A hysterectomy procedure code (Hysterectomy Procedure Value Set).
- A code for history of hysterectomy (History of Hysterectomy Value Set) where the organization can identify the date when the hysterectomy occurred.

If the member had a hysterectomy prior to the last three years (look as far back as possible for a hysterectomy):

- She is in the “Screened Too Frequently” category if she had one or more Pap tests in the last three years.

If the member had a hysterectomy in the last three years:

- She will be in the “Screened Too Frequently” category if she had one or more Pap tests after her hysterectomy.

Step 2 For women ages 24–65 years as of December 31 of the measurement year who have not had a hysterectomy, count the number of women who had two or more cervical cytology screenings (Cervical Cytology Value Set) in the measurement year or the two years prior to the measurement year.

Step 3 For women aged 33–65 years as of December 31 of the measurement year who have not had a hysterectomy (Hysterectomy Procedure Value Set) and (History of Hysterectomy Value Set) and did not meet the criteria for compliance in step 2, identify the number of women with two or more cervical cytology and HPV co-tests during the three or four years prior to the measurement year. A co-test is defined as cervical cytology screening (Cervical Cytology Value Set) **and** a human papillomavirus (HPV) test (HPV Tests Value Set), with service dates four or fewer days apart **and** who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

Step 4 Count the number of women ages 67 and older as of December 31 of the measurement year who had one or more cervical cytology screenings (Cervical Cytology Value Set) in the measurement year.

Step 5 Add the numbers from steps 1–4 to obtain the numerator for *Rate 3: Screened Too Frequently*.

Exclusions

Exclude members from the denominator who meet either of the following criteria:

- A diagnosis of dysplasia, HPV codes or an abnormal cervical cytology screening (ECS Exclusions Group 1 Value Set) during the measurement year or the four years prior to the measurement year.
- A history of cervical cancer, DES exposure, HIV or immunodeficiency, including genetic (congenital) immunodeficiency syndromes (ECS Exclusions Group 2 Value Set) any time during the member's history through December 31 of the measurement year.

Cervical Cancer Screening (CCS)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added to the MY 2015 measure set.

MODIFICATIONS FROM HEDIS

- The measure exclusion is required.

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every three years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Eligible Population

Product lines	Commercial
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year and the two years prior to the measurement year in the PO (parent level).
...for health-plans	The measurement year and the two years prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
...for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
...for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.

Step 1 Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.

Step 2 From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and an HPV test (HPV Tests Value Set) with service dates four days or less apart during the measurement year or the four years prior to the measurement year, **and** who were 30 years or older on the date of both tests.

For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

Step 3 Sum the events from steps 1 and 2 to obtain the rate.

Exclusion (*required*)

Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set) any time during the member's history through December 31 of the measurement year.

Note

- *CCS assesses whether women received recommended cervical cancer screening and includes women who were screened according to guidelines and women who received more screenings than recommended by clinical guidelines.*

Cervical Cancer Overscreening (CCO)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added to the MY 2015 measure set.
- Clarified the denominator for each rate in the measure description.
- Added a note to Step 1 and Step 2 to the Administrative Specifications.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure.

Description

The percentage of women 21–64 years of age who received more cervical cancer screenings than necessary according to evidence-based guidelines, using either of the following criteria:

- Women 21–64 who had more than one cervical cytology performed every three years.
- Women 30–64 who had more than one cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Report each of the two rates separately and as a total rate.

- Women age 21–64 with more than one cervical cytology performed every three years (denominator is the total eligible population).
- Women age 30–64 with more than one cervical cytology/HPV co-test performed every 5 years (denominator is the total eligible population).
- Total rate is the sum of the two numerators divided by the eligible population.

Because this measure assesses overscreening, a lower rate indicates better performance.

Eligible Population

Product lines	Commercial
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year and the two years prior to the measurement year in the PO (parent level).
...for health-plans	The measurement year and the two years prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.

...for health-plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefit Medical.

**Event/
diagnosis** None.

Administrative Specification

Denominator The eligible population.

Numerator The number of women who were screened too frequently for cervical cancer, as identified in steps 1 and 2 below.

Note: A three-month grace period is included to account for members who may be screened up to three months early.

Step 1 Identify women 24–64 years of age as of December 31 of the measurement year who had more than one cervical cytology screening (Cervical Cytology Value Set) **any time on or between** April 1 two years prior to the measurement year **and** December 31 of the measurement year.

Note: If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 14 days of each other, count only the first one. Refer to General Guideline 31.

Step 2 From the women who did not meet step 1 criteria, identify women 30–64 years as of December 31 of the measurement year with more than one cervical cytology and HPV co-test **any time on or between** April 1 **four** years prior to the measurement year **and** December 31 of the measurement year.

A **co-test** is defined as cervical cytology screening (Cervical Cytology Value Set) **and** an HPV test (HPV Tests Value Set), with service dates four or fewer days apart, **and** women were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

Note: If two or more claims/encounters with qualifying numerator codes for cervical cytology occur within 14 days of each other, count only the first one. Refer to General Guideline 31.

Step 3 Sum the events from steps 1 and 2 to obtain the total rate. Report the two rates from step 1 and step 2 separately, as well as the total rate.

Exclusions (*required*)

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set) any time during the member's history through December 31 of the measurement year.
- A diagnosis of dysplasia, HPV codes or an abnormal cervical cytology screening (ECS Exclusions Group 1 Value Set) during the measurement year or four years prior to the measurement year.
- A history of cervical cancer, DES exposure, HIV or immunodeficiency, including genetic (congenital) immunodeficiency syndromes (ECS Exclusions Group 2 Value Set) any time during the member's history through December 31 of the measurement year.

Breast Cancer Screening (BCS)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the optional exclusion so that any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service meets criteria.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added new value sets to identify bilateral mastectomy.

MODIFICATIONS FROM HEDIS

- None.

Description

Breast Cancer Screening is the same measure as the CMS Stars Measure Breast Cancer Screening.

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. The eligible population starts at 52 years of age to account for the look-back period.

Eligible Population

Product lines	Commercial HMO/POS, Medicare (report each product line separately).
Ages	<ul style="list-style-type: none"> 52 to 74 years–<i>Medicare product line</i>. 52 to 74 years–<i>commercial product line</i>.
Continuous enrollment	
<i>...for self-reporting POs</i>	October 1 two years prior to the measurement year through December 31 of the measurement year in the PO (parent level).
<i>...for health plans</i>	October 1 two years prior to the measurement year through December 31 of the measurement year in the health plan and in the PO (parent level).
Allowable gap	<p>No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year).</p> <p>No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.</p>
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more mammograms (<u>Mammography Value Set</u>) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion (optional)

Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service.

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same date of service)	Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same date of service)
Absence of the left breast (<u>Absence of Left Breast Value Set</u>)	Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>)	Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

Note: This measure evaluates primary screening. Do not count biopsies, breast ultrasounds or MRIs because they are not appropriate methods for primary breast cancer screening.

Colorectal Cancer Screening (COL)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

- *Colorectal Cancer Screening* is the same measure as the CMS Stars measure Colorectal Cancer Screening.

The percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Commercial HMO/POS, Medicare (report each product line separately).
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year and the year prior to the measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

Exclusion (optional)

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set).

Adult BMI Assessment (ABA)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the age criteria from “21 years of age or older” to “20 years of age or older” for BMI and BMI percentile in the numerator.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Revised the age criteria for BMI and BMI percentile in the numerator.

MODIFICATIONS FROM HEDIS

- Limited to Medicare Advantage product line only.

Description

Adult BMI Assessment is the same measure as the CMS Stars measure Adult BMI Assessment.

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Definitions

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention’s (CDC) BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among those of the same sex and age.

Eligible Population

Product lines	Medicare.
Ages	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year and the year prior to the measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan on December 31 of the measurement year.

...for health plans Enrolled in the health plan and the PO on December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Members who had an outpatient visit (Outpatient Value Set) during the measurement year or the year prior to the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator For members 20 years of age or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.

For members younger than 20 years of age on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year.

Exclusions (optional)

Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

Asthma Medication Ratio (AMR)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added the table AMR-A.
- Added the 65-85 age stratification.
- Added a total rate for ages 5-85.

MODIFICATIONS FROM HEDIS

- To establish a baseline for the new 5-85 age band, P4P will collect two total rates: the total rate for ages 5-64 and the total rate for ages 5-85.

Description

The percentage of members 5–85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medication of 0.50 or greater during the measurement year. This measure calculates an unweighted medication ratio of units of controller medications over units of controller medications plus units of short acting beta-agonists (SABA)/reliever medications for persistent asthmatics.

Units of Controller

Units of Controller+ Units of Reliever

Patients with a ratio of 0.50 or greater experience significantly fewer asthma exacerbations, defined as either ED visits, with asthma listed as the primary diagnosis, or an oral corticosteroid dispensing event determined from medical and pharmacy claims. The intent is that patients have both controllers and relievers in their regimens, instead of relievers alone.

Oral medication dispensing event

An oral medication dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date when the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day should be assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the drug ID to determine if the prescriptions are the same or different.

- *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
- *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).

- *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days)
- *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaler dispensing event

When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the NDC list to determine if the medications are the same or different.

Injection dispensing event

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Units of medications

When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and one dispensing event.

Use the package size and units columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.

Eligible Population for Persistent Asthmatics

Product lines Commercial HMO/POS.

Ages 5–85 years by December 31 of the measurement year. Report **five** age stratifications and **two** total rates.

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- **65–85 years.**
- Total: 5–64 years.
- **Total: 5–85 years.**

Each total rate is the sum of the age stratifications.

Continuous enrollment

...for self-reporting POs The measurement year and the year prior to the measurement year in the PO (parent level)

...for health plans The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan on December 31 of the measurement year.

...for health plans Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.

Benefits Medical during the measurement year and the year prior to the measurement year. Pharmacy during the measurement year.

Event/ diagnosis

Follow the steps below to identify the eligible population.

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) **and** at least two asthma medication dispensing events (Table **AMR-A**). Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events (Table **AMR-A**).

Table AMR-A: Asthma Medications

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol	• Pirbuterol

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

**Step 3:
Required
exclusions**

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
 - Emphysema Value Set.
 - Other Emphysema Value Set.
 - COPD Value Set.
 - Obstructive Chronic Bronchitis Value Set.
 - Chronic Respiratory Conditions Due to Fumes/Vapors Value Set.
 - Cystic Fibrosis Value Set.
 - Acute Respiratory Failure Value Set.
- Members who have no asthma controller or reliever medications dispensed (Table AMR-B) during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to determine the number of numerator-compliant members.

Step 1 For each member, count the units of controller medications (Table AMR-B) dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of reliever medications (Table AMR-B) dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Medications (step 3)}}$$

Step 5: Sum the total number of members who have a ratio of 0.50 or greater in step 4.
Calculate
performance
rate

Table AMR-B: Asthma Controller and Reliever Medications

Type	Description	Prescriptions		
Asthma controller medications	Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
	Antibody inhibitor	• Omalizumab		
	Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
	Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone	• Triamcinolone
	Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
	Mast cell stabilizers	• Cromolyn		
	Methylxanthines	• Aminophylline • Dyphylline	• Theophylline	
Asthma reliever medications	Short-acting, inhaled beta-2 agonists	• Albuterol • Levalbuterol	• Pirbuterol	

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Appropriate Testing for Children With Pharyngitis (CWP)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Increased the lower age limit to 3 years of age.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

Note: ICD-10 codes are not in effect during the Intake Period for the measure. To accommodate the ICD-10 codes in P4P MY 2016, we anticipate the removal of the single diagnosis code requirement from the measure specifications and the addition of comorbid conditions and competing conditions (ICD-10 coding guidelines for respiratory diagnoses encourage multiple codes on claims).

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	<p>The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of pharyngitis.</p> <p>Exclude claims/encounters with more than one diagnosis.</p>
IESD	<p>Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:</p> <ul style="list-style-type: none"> Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date. A 30-day Negative Medication History prior to the Episode Date. The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date.
Negative Medication History	<p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none"> A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.

A prescription is considered **active** if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Eligible Population

Product lines Commercial HMO/POS.

Ages Children 3 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment:

....for self-reporting POs 30 days prior to the Episode Date through 3 days after the Episode Date in the PO (parent level).

....for health plans 30 days prior to the Episode Date through 3 days after the Episode Date in the health plan and in the PO (parent level).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date:

....for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on the Episode Date.

....for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the Episode Date.

Benefits Medical and pharmacy.

Event/diagnosis Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population.

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the intake period, with only a diagnosis of pharyngitis (Pharyngitis Value Set).

Exclude claims/encounters with more than one diagnosis and ED visits that result in an inpatient admission.

Step 2 Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis.

Step 3 Determine if antibiotics (Table CWP-A) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to three days after. Exclude Episode Dates if the member did not receive antibiotics on or three days after the Episode Date.

Table CWP-A: Antibiotic Medications

Description	Prescription
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin • Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate
First generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil • Cephalexin • Cefazolin
Folate antagonist	<ul style="list-style-type: none"> • Trimethoprim
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Erythromycin ethylsuccinate • Clarithromycin • Erythromycin lactobionate • Erythromycin • Erythromycin stearate
Miscellaneous antibiotics	<ul style="list-style-type: none"> • Erythromycin-sulfisoxazole
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G potassium • Penicillin V potassium • Penicillin G sodium
Penicillinase-resistant penicillins	<ul style="list-style-type: none"> • Dicloxacillin
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Moxifloxacin • Levofloxacin • Ofloxacin
Second generation cephalosporins	<ul style="list-style-type: none"> • Cefaclor • Cefuroxime • Cefprozil
Sulfonamides	<ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim • Sulfisoxazole
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline • Tetracycline • Minocycline
Third generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Ceftibuten • Cefixime • Cefditoren • Cefpodoxime • Ceftriaxone

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-A) was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the IESD through three days after the IESD.

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

Note: ICD-10 codes are not in effect during the Intake Period for the measure. To accommodate the ICD-10 codes in P4P 2016, we anticipate the removal of the single diagnosis code requirement from the measure specifications and the addition of comorbid conditions and competing conditions (ICD-10 coding guidelines for respiratory diagnoses encourage multiple codes on claims).

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. Submit the data for the measure as the direct rate not as the inverted calculation of numerator and denominator.

Calculation

After submission, the measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics *were not* prescribed).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of URI. Exclude claims/encounters with more than one diagnosis.
IESD	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria: <ul style="list-style-type: none"> • A 30-day Negative Medication History prior to the Episode Date. • A Negative Competing Diagnosis on or 3 days after the Episode Date. • The member was continuously enrolled 30 days prior to the Episode Date through 3 days after the Episode Date.

Negative Medication History

To qualify for Negative Medication History, the following criteria must be met:

- A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.

A prescription is considered **active** if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Competing Diagnosis

The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Product line Commercial HMO/POS.

Ages Children 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.

Continuous enrollment

...for self-reporting POs 30 days prior to the Episode Date through 3 days after the Episode Date in the PO (parent level).

...for health plans 30 days prior to the Episode Date through 3 days after the Episode Date in the health plan and in the PO (parent level).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date

...for self-reporting POs Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on the Episode Date.

...for health plans Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on the Episode Date.

Benefits Medical and pharmacy.

Event/diagnosis Outpatient or ED visit with only a diagnosis of URI during the Intake Period.

Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with only a diagnosis of URI (URI Value Set).

Exclude claims/encounters with more than one diagnosis code and ED visits that result in an inpatient admission.

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with only a URI diagnosis.

- Step 3** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table URI-A) was filled 30 days prior to the Episode Date or was active on the Episode Date.
- Step 4** Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis Value Set.
 - Competing Diagnosis Value Set.
- Step 5** Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.
- Step 6** Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for antibiotic medication (Table URI-A) on or three days after the IESD.

Table URI-A: Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	• Sulfisoxazole
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Cefibuten • Cefditoren • Ceftriaxone

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AAB)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. Submit the data for the measure as the direct rates not as the inverted calculation of numerator and denominator.

Calculation

After submission, the measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were *not* prescribed).

Definitions

Intake Period	January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.
IESD	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria: <ul style="list-style-type: none"> • A 30-day Negative Medication History prior to the Episode Date. • A 12-month Negative Comorbid Condition History prior to and including the Episode Date. • A Negative Competing Diagnosis during the 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive). • The member was continuously enrolled 1 year prior to the Episode Date through 7 days after the Episode Date.

Negative Medication History

To qualify for Negative Medication History, the following criteria must be met:

- A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.

A prescription is considered **active** if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Comorbid Condition History

A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters containing either a principal or a secondary diagnosis for a comorbid condition.

Negative Competing Diagnosis

A period of 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive), when the member had no claims/encounters with any competing diagnosis.

Eligible Population**Product lines**

Commercial HMO/POS.

Ages

Adults 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year.

Continuous enrollment**....for self-reporting POs**

One year prior to the Episode Date through 7 days after the Episode Date in the PO (parent level).

....for health plans

One year prior to the Episode Date through 7 days after the Episode Date in the health plan and the PO (parent level).

Allowable gap

No more than one gap of 45 days is permitted from 365 days (1 year) prior to the Episode Date through 7 days after the Episode Date.

Anchor date:**....for self-reporting POs**

Episode Date in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan.

....for health plans

Episode Date in the health plan and the PO (parent level, or, for eligible POs, subgroup level).

Benefits

Medical and pharmacy.

Event/ diagnosis

Outpatient or ED visit during the Intake Period with any diagnosis of acute bronchitis. Follow the steps below to identify the eligible population:

Step 1

Identify all members in the specified age range who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of acute bronchitis (Acute Bronchitis Value Set).

Do not include ED visits that result in an inpatient admission.

- Step 2** Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with a diagnosis of acute bronchitis.
- Step 3** Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with a diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:
- HIV Value Set.
 - Malignant Neoplasms Value Set.
 - Emphysema Value Set.
 - COPD Value Set.
 - Cystic Fibrosis Value Set.
 - Comorbid Conditions Value Set.
- Step 4** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table AAB-A) was filled 30 days prior to the Episode Date or was active on the Episode Date.
- Step 5** Test for Negative Competing Diagnosis. Exclude Episode Dates where during the period 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive) the member had a claim/encounter with any competing diagnosis. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis Value Set.
 - Competing Diagnosis Value Set.
- Step 6** Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days (1 year) prior to the Episode Date through 7 days after the Episode Date.
- Step 7** Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for antibiotic medication (Table AAB-A) on or three days after the IESD.

Table AAB-A: Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Kanamycin • Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Antipseudomonal penicillins	• Piperacillin		
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	• Ticarcillin-clavulanate
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine • Sulfamethoxazole-trimethoprim		
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Unexpected Complications in Full-Term Newborns (UNC)

The *Unexpected Complications in Full-Term Newborns (UNC)* measure specifications are located in the *Appropriate Resource Use (ARU) Domain* section. Although this is a clinical measure, data for this measure are collected with the ARU measures. Truven and an external IHA vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.

Refer to page 179 for the complete measure specifications.

Incidence of Episiotomy (EPS)

The *Incidence of Episiotomy (EPS)* measure specifications are located in the *Appropriate Resource Use (ARU) Domain* section. Although this is a clinical measure, data for this measure are collected with the ARU measures. Truven and an external IHA vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.

Refer to page 182 for the complete measure specifications.

All-Cause Readmissions (PCR)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the example text and table in step 4 and step 5 of the Risk Adjustment Determination section.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a method and value sets to identify acute inpatient discharges in step 1 of the event/diagnosis.
- Added instructions for identifying the transfer setting in step 2 of the event/diagnosis.
- Added a Note to steps 4 and 5 of the event/diagnosis.
- Added a method and value sets to identify acute inpatient admissions in step 1 of the numerator.

MODIFICATIONS FROM HEDIS

- The 18–64 age band is not reported for Medicare.
- NCQA refers to this measure as “Plan All-Cause Readmissions.”
- Expected rates are normalized by Truven to reflect the performance of the population being measured (i.e., commercial P4P or Medicare Advantage).

Description

All-Cause Readmissions is the same measure as the CMS Stars measure Plan All-Cause Readmissions.

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an **unplanned** acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission.

POs are not expected to run this measure. For reporting purposes, expected rates are normalized to reflect the performance of the population being measured (i.e., commercial P4P or Medicare Advantage). Truven applies the normalization after plans submit the measure.

Note: For commercial, only members 18–64 years of age are reported. For Medicare, only members 65 years of age and older are reported.

Definitions

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.

Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the <i>Eligible Population</i> .
Classification Period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC-Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 2
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-MA-OtherWeights-65plus	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages 65 and older
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Note: The risk adjustment tables will be released on November 2, 2015, and posted to www.ncqa.org.

Eligible Population

Product line	Commercial, Medicare (report each product line separately).
Ages	For commercial, ages 18–64 as of the Index Discharge Date. For Medicare, ages 65 and older as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Index Discharge Date for the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefit	Medical.

Event/ diagnosis	<p>An acute inpatient discharge on or between January 1 and December 1 of the measurement year.</p> <p>The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year.</p> <p>Follow the steps below to identify acute inpatient stays.</p>
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Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year. **To identify acute inpatient discharges:**

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2 **Acute-to-acute transfers:** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. **Organizations must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the process in step 1.**

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Required exclusions Exclude **hospital** stays for the following reasons:

- The member died during the stay.
- A principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set).

Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use both the original stay and the transfer stay to identify exclusions in this step.

Step 5: Required exclusions For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days. **To identify To identify planned hospital stays, identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year:**

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.
4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria:
 - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
 - A principal diagnosis of rehabilitation (Rehabilitation Value Set).

- An organ transplant (Kidney Transplant Value Set), (Bone Marrow Transplant Value Set), (Organ Transplant Other Than Kidney Value Set).
- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the transfer stay).

Example 1 For a member with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

- *Stay 1 (January 30–February 1 of the measurement year):* Acute inpatient discharge with a principal diagnosis of COPD.
- *Stay 2 (February 5–7 of the measurement year):* Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy.

Example 2 For a member with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- *Stay 1 (January 15–17 of the measurement year):* Acute inpatient discharge with a principal diagnosis of diabetes
- *Stay 2 (January 30–February 1 of the measurement year):* Acute inpatient discharge with a principal diagnosis of COPD.
- *Stay 3 (February 5–7 of the measurement year):* Acute inpatient discharge with an organ transplant.
- *Stay 4 (February 10–15 of the measurement year):* Acute inpatient discharge with a principal diagnosis of rehabilitation.

Step 6 Calculate continuous enrollment.

Step 7 Assign each acute inpatient stay to one age category. Refer to Table PCR-A-2/3 and Table PCR-B-3.

Risk Adjustment Determination

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

Surgeries Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute transfers, use the transfer's primary discharge diagnosis.

Exclude diagnoses that cannot be mapped to Table PCR-DischCC.

Comorbidities

Step 1 Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:

- Outpatient visits ([Outpatient Value Set](#)).
- Observation visits ([Observation Value Set](#)).
- Nonacute inpatient encounters ([Nonacute Inpatient Value Set](#)).
- Acute inpatient encounters ([Acute Inpatient Value Set](#)).
- ED visits ([ED Value Set](#)).

Exclude the primary discharge diagnosis on the IHS.

Step 2 Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3 Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each stay's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4 Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the *Rank* column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example Assume a stay with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this discharge are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

Step 5 Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each stay's list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHF/renal/diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.

Based on the combinations, a member can have none, one or more of these added HCCs.

Example For a stay with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 or HCC-85.

Example: Table HCC—Combo

Combination: Diabetes and CHF			
Comorbid HCC	Comorbid HCC	Comorbid HCC	Combination HCC
HCC-17	HCC-85	NA	HCC-901
HCC-18	HCC-85	NA	HCC-901
HCC-19	HCC-85	NA	HCC-901

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender.

Note: The final weights table will be released on November 2, 2015.

Step 1 For each IHS with a surgery, link the surgery weight.

- For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.
- For commercial product lines: Use Table PCR-Comm-OtherWeights.

Step 2 For each IHS with a discharge CC Category, link the primary discharge weights.

- For Medicare product lines ages 65 and older: Use Table PCR-MA-DischCC-Weight-65plus.
- For commercial product lines: Use Table PCR-Comm-DischCC-Weight.

Step 3 For each IHS with a comorbidity HCC Category, link the weights.

- For Medicare product lines ages 65 and older: Use Table PCR-MA-ComorbHCC-Weight-65plus.
- For commercial product lines: Use Table PCR-Comm-ComorbHCC-Weight.

Step 4 Link the age and gender weights for each IHS.

- For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.
- For commercial product lines: Use Table PCR-Comm-OtherWeights.

Step 5 Identify the base risk weight.

- For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.
- For commercial product lines: Use Table PCR-Comm-OtherWeights to determine the base risk weight.

Step 6 Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).

Step 7 Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.

$$\text{Adjusted probability of readmission} = \frac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$$

OR

$$\text{Adjusted probability of readmission} = [\exp (\text{sum of weights for IHS })] / [1 + \exp (\text{sum of weights for IHS})]$$

Note: “Exp” refers to the exponential or antilog function.

Step 8 Use the formula below and the adjusted probability of readmission calculated in step 7 to calculate the variance for each IHS.

$$\text{Variance} = \text{Adjusted probability of readmission} \times (1 - \text{Adjusted probability of readmission})$$

Example: If the adjusted probability of readmission is 0.1518450741 for an IHS, then the variance for this IHS is $0.1518450741 \times 0.8481549259 = 0.1287881476$.

Note: The variance is calculated at the IHS level. Organizations must sum the variances for each age/gender and total category when populating the Total Variance cells in the reporting tables.

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age, Gender, Weight	Surgical Weight	ICD-9 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Adjusted Probability	Variance
								Category	Weight	Category	Weight			
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20	0.1400	-0.8600	0.2976	0.2090
4010	1	-1.08883	50.00	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.2811	0.2021
4010	2	-1.08883	50.00	Male	0.1200	NA	298.00	77	0.0600	5	0.0100	-0.5700	0.3615	0.2308
										47	0.3300			

*Each Member ID field with a value represents a unique IHS.

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year. **To identify acute inpatient admissions:**

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 2 **Acute-to-acute transfers:** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. **Organizations must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.**

Step 3 Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

Step 4 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: Denominator

Count the number of IHS for each age and enter these values into the reporting table.

Reporting: Risk Adjustment

Step 1 Calculate the average adjusted probability for each IHS for each age and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable age group to calculate the average (which is reported to NCQA). For the total age category, the probability of readmission for all hospital stays in the age categories must be averaged together; organizations cannot take the average of the average adjusted probabilities reported for each age.

Step 2 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Note: Do not take the average of the cells in the reporting table.

Example For the “18–44” age category:

- Identify all IHS by 18–44 year-old males and calculate the average adjusted probability.
- Identify all IHS by 18–44 year-old females and calculate the average adjusted probability.
- Identify all IHS by all 18–44 year-olds and calculate the average adjusted probability.

Repeat for each subsequent group.

Step 3 Calculate the total (sum) variance for each age and the overall total.

Step 4 Round to four decimal places using the .5 rule and enter these values into the reporting table.

Reporting: Numerator

Count the number of IHS with a readmission within 30 days for each age and enter these values into the reporting table.

Note

- Organizations may not use Risk Assessment Protocols to supplement diagnoses to calculate the risk adjustment scores for this measure. The PCR measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are implemented in the specification currently.

Table PCR-A-2: Plan All-Cause Readmission Rates by Age, and Risk Adjustment
(for the commercial product line)

Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Observed Readmission (Num/Den)	Average Adjusted Probability	Total Variance
18-44	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Table PCR-B-3: Plan All-Cause Readmission Rates by Age, and Risk Adjustment
(for the Medicare product line)

Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Observed Readmission (Num/Den)	Average Adjusted Probability	Total Variance
65-74	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

High-Risk Medication (HRM)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a Note to the measure description.
- Added further clarification for Calculating Cumulative Days Supply and Average Dose for B) reserpine, C) digoxin and D) doxepin.
- Revised the definition of “average daily dose.”

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure developed by the Pharmacy Quality Alliance (PQA), based on the HEDIS measure *Use of High-Risk Medications in the Elderly*.

Description

- *High-Risk Medication* is the same as the CMS Stars measure High Risk Medication.

The percentage of members 65 years of age and older who received two or more prescription fills for a high-risk medication during the treatment period. A lower rate represents better performance.

Note: Refer to the Value Set Directory for a comprehensive list of medications and associated codes (PQA December 2015 NDC List). Do not distribute NDC lists outside your organization.

Definitions

Treatment period	The beginning of the measurement year through the last day of the measurement year, or until death or disenrollment. Disenrollment from the pharmacy benefit counts as disenrollment.
High-risk medication	Select prescription drugs recommended to avoid in persons 65 years and older by the American Geriatric Society Beers Criteria for Potentially Inappropriate Medications Use in Older Adults.
Fill	A unique prescription drug claim.

Eligible Population

Product line	Medicare.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	<i>Treatment period:</i> The beginning of the measurement year through the end of the measurement year, or until death or disenrollment from the PO (parent level). Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.

...for health plans	<i>Treatment period:</i> The beginning of the measurement year through the end of the measurement year, or until death or disenrollment from in the health plan and from the PO (parent level). Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.
Allowable gap	No gaps in enrollment.
Anchor date	
...for self-reporting POs	None.
...for health plans	None.
Benefit	Medical, pharmacy.

Note

- *If a PO receives pharmacy claim information for a member, the PO can assume the member has a pharmacy benefit, and that the pharmacy benefit dates align with the medical benefit dates.*
- *Do not include members who disenroll and reenroll more than one day later at any time during the measurement year, after the treatment period.*

Administrative Specification

Denominator	The eligible population.
Numerator	Members who filled at least two prescriptions for the same high-risk medication (Table HRM-A) on two unique dates of service during the treatment period. Use only paid, nonreversed claims for target medications to determine if members meet the numerator.

Note: *The same high-risk medication is defined at the “active ingredient” level. The active ingredient is identified using ingredient flags on the NDC list.*

Table HRM-A: High-Risk Medications

Description	Prescription	
Anticholinergics (excludes TCAs), first-generation antihistamines (as single agent or as part of combination products)— <i>excludes OTC products</i>	<ul style="list-style-type: none"> • Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexchlorpheniramine 	<ul style="list-style-type: none"> • Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	<ul style="list-style-type: none"> • Benztropine (oral) 	<ul style="list-style-type: none"> • Trihexyphenidyl
Antithrombotics	<ul style="list-style-type: none"> • Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin) 	<ul style="list-style-type: none"> • Ticlopidine*
Anti-infective	<ul style="list-style-type: none"> • Nitrofurantoin (include when cumulative day supply is >90 days) (A) 	
Cardiovascular, alpha blockers, central	<ul style="list-style-type: none"> • Guanfacine* • Methyldopa* 	<ul style="list-style-type: none"> • Reserpine (>0.1mg/day)* (B)
Cardiovascular, other	<ul style="list-style-type: none"> • Disopyramide* • Digoxin (>0.125mg/day) (C) 	<ul style="list-style-type: none"> • Nifedipine, immediate release*
Central nervous system, tertiary TCAs (as a single agent or as part of a combination product)	<ul style="list-style-type: none"> • Amitriptyline • Clomipramine • Doxepin (>6mg/day) (D) 	<ul style="list-style-type: none"> • Imipramine • Trimipramine
Central nervous system, antipsychotics, first-generation (conventional)	<ul style="list-style-type: none"> • Thioridazine 	
Central nervous system, barbiturates	<ul style="list-style-type: none"> • Amobarbital* • Butabarbital* • Butalbital 	<ul style="list-style-type: none"> • Pentobarbital* • Phenobarbital • Secobarbital*
Central nervous system, other	<ul style="list-style-type: none"> • Chloral hydrate 	<ul style="list-style-type: none"> • Meprobamate
Central nervous system, Nonbenzodiazepine hypnotics (include when cumulative day supply is >90 days) (E)	<ul style="list-style-type: none"> • Eszopiclone • Zolpidem 	<ul style="list-style-type: none"> • Zaleplon
Central nervous system, vasodilators for dementia	<ul style="list-style-type: none"> • Ergot mesylates* 	<ul style="list-style-type: none"> • Isoxsuprine
Endocrine system	<ul style="list-style-type: none"> • Desiccated thyroid • Estrogens** with or without progesterone (oral and topical patch products only) 	<ul style="list-style-type: none"> • Megestrol
Endocrine system, sulfonylureas, long-duration	<ul style="list-style-type: none"> • Chlorpropamide 	<ul style="list-style-type: none"> • Glyburide
Gastrointestinal system	<ul style="list-style-type: none"> • Trimethobenzamide 	
Pain medications	<ul style="list-style-type: none"> • Meperidine 	<ul style="list-style-type: none"> • Pentazocine*
Pain medications, non-COX-selective NSAIDS***	<ul style="list-style-type: none"> • Indomethacin 	<ul style="list-style-type: none"> • Ketorolac
Skeletal muscle relaxants (as a single agent or as part of a combination product)	<ul style="list-style-type: none"> • Carisoprodol • Chlorzoxazone • Cyclobenzaprine 	<ul style="list-style-type: none"> • Metaxalone • Methocarbamol • Orphenadrine

*Infrequently used drugs. *Abbreviations:* TCAs, tricyclic antidepressants; OTC, over the counter.

** Conjugated estrogen, esterified estrogen, estradiol, estropiate (includes combination products and the following routes of administration: oral, and transdermal).

***Includes oral and injectable (IJ, SC, IM, IV) routes only.

Note: In general, unless specified otherwise: Includes combination products and the following routes of administration: oral, transdermal, injectable (IJ, SC, IM, IV), rectal, sublingual, buccal and inhalation.

Additional Information for Calculating Cumulative Days Supply and Average Dose

- A. *For Nitrofurantoin:* Include a patient in the numerator who received at least two prescription fills for the medication *and* the cumulative days supply for any nitrofurantoin product is more than 90 days during the treatment period.
- B. *For reserpine:* Include a patient in the numerator who received at least two prescription fills for the medication *and* if the average daily dose **for two or more prescriptions** is greater than 0.1mg.
- C. *For digoxin:* Include a patient in the numerator who received at least two prescription fills for the medication *and* the average daily dose **for two or more prescriptions** is greater than 0.125mg.
- D. *For doxepin:* Include a patient in the numerator who received at least two prescription fills for the medication *and* the average daily dose **for two or more prescriptions** is greater than 6mg.
- E. The cumulative calculation applies to the class of nonbenzodiazepine hypnotics and not for each individual medication. Include a patient in the numerator who received at least two prescription fills for any medication in the class and the cumulative days supply for any product is more than 90 days during the treatment period. For example, a patient who received a 30-day supply of zolpidem, a second fill for a 30-day supply of zolpidem and a fill for a 35-day supply of eszopiclone (all during the treatment period), would qualify for inclusion in the numerator.

Average Daily Dose: Use all fills during the treatment period to calculate average daily dose for each high-risk medication fill with the following equation: (quantity dispensed x dose)/days supply.

If the average daily dose for any two fills of the HRM exceed the threshold, then the member is numerator compliant.

Do not round when calculating the average daily dose.

Controlling High Blood Pressure (e-Measure) (ECBP)

This Meaningful Use of Health IT (MUHIT) measure is collected with the Clinical measures.

Refer to page 143 for the complete measure specifications.

Submitting Results

The e-Measures are a part of the MUHIT domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout.

For self-reporting POs, these measures are reported via the PO Clinical File Layout.

A separate layout is provided for non-self-reporting PO submission.

For each measure, collect two metrics:

- The percentage of providers who can report the *Controlling High Blood Pressure e-Measure* (i.e., report a numerator and denominator to the PO).
 - POs should use the same definition of “PCP” outlined in the NPI data file specification instructions. Providers in your denominator should include employed and contracted PCPs (MD or DO) in the following specialties: family/general practice, internal medicine and pediatrician/adolescent medicine. POs have the option of excluding pediatricians from the *Controlling High Blood Pressure e-Measure* denominator.
- The aggregated numerator and denominator, for providers who can report the *Controlling High Blood Pressure e-Measure*.
 - To calculate, pull the numerators and denominators from the EHR systems of all providers who can report the measures; specifications are programmed in the certified EHR systems of providers who can report. Certified EHR systems should be able to create general a report with the patient numerator and denominators for the e-Measures. Refer to pages 137–144.

Include all payer types in e-Measure reporting; do not limit to commercial HMO/POS.

Screening for Clinical Depression and Follow-Up Plan (e-Measure) (ESCD)

This Meaningful Use of Health IT (MUHIT) measure is collected with the Clinical measures.

Refer to page 144 for the complete measure specifications.

Submitting Results

The e-Measures are a part of the MUHIT domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout.

For self-reporting POs, these measures are reported via the PO Clinical File Layout.

A separate layout is provided for non-self-reporting PO submission.

For each measure, collect two metrics:

- The percentage of providers who can report the *Screening for Clinical Depression and Follow-Up Plan* e-Measure (i.e., report a numerator and denominator to the PO).
 - POs should use the same definition of “PCP” outlined in the NPI data file specification instructions. Providers in your denominator should include employed and contracted PCPs (MD or DO) in the following specialties: family/general practice, internal medicine and pediatrician/adolescent medicine.
- The aggregated numerator and denominator, for providers who can report the *Screening for Clinical Depression and Follow-Up Plan* e-Measure.
 - To calculate, pull the numerators and denominators from the EHR systems of all providers who can report the measures; specifications are programmed in the certified EHR systems of providers who can report. Certified EHR systems should be able to create general a report with the patient numerator and denominators for the e-Measures. Refer to pages 137–144.

Include all payer types in e-Measure reporting; do not limit to just commercial HMO/POS.

Meaningful Use of Health IT

For Value Based P4P MY 2015

Overview

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Added a time frame for the NPI file collection period.
- Added information about MUHIT training Webinars.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Clarified that for the results based on the CMS EHR Incentive programs, P4P staff will compute scores both including and excluding pediatricians; the higher of the two scores will be used.
- Added instructions for how POs must submit NPI numbers for all MDs and DOs in the following specialties: family/general practice, internal medicine and pediatrician/adolescent medicine.
- Clarified that all physicians who meet the criterion (MD or DO) in family/general practice, internal medicine or pediatrician/adolescent medicine should be included in submission, regardless of panel size.
- Added an optional exclusion for providers who are employed in an administrative-only role (e.g., medical director).
- Added an optional exclusion for providers who were employed or contracted with a PO for less than six months of the measurement year.
- Added an optional exclusion for pediatricians for the *Controlling High Blood Pressure* e-Measure denominator.
- Added an optional exclusion for providers considered hospitalists by CMS.
- Added the *Controlling High Blood Pressure* and the *Screening for Clinical Depression and Follow-Up Plan* e-Measure specifications to the MUHIT domain.

Description

To support the continued implementation of technology and eliminate redundancy, the P4P committees recommended aligning with the CMS EHR Incentive Program starting in MY 2011. Promoting health IT adoption and use will also allow the future addition of measures that require clinically enriched data from EHRs.

The CMS Meaningful Use objectives are being released in three stages, as shown in the following table.

CMS STAGE 1 Data Capture and Sharing	CMS STAGE 2 Advanced Clinical Processes	CMS STAGE 3 Improved Outcomes
Electronically capturing health information in a standardized format.	More rigorous health information exchange (HIE).	Improving quality, safety, and efficiency, leading to improved health outcomes.
Using that information to track key clinical conditions.	Increased requirements for e-prescribing and incorporating lab results.	Decision support for national high-priority conditions.
Communicating that information for care coordination processes.	Electronic transmission of patient care summaries across multiple settings.	Patient access to self-management tools.
Initiating the reporting of clinical quality measures and public health information.	More patient-controlled data.	Access to comprehensive patient data through patient-centered HIE.
Using information to engage patients and their families in their care.		Improving population health.

To compliment these objectives the MY 2015 Meaningful Use of Health IT (MUHIT) Domain for the Value Based P4P program has the following three measures:

- CMS EHR Incentive Program participation.
- POs' ability to report two Clinical Quality e-Measures (CQMs):
 - Controlling High Blood Pressure e-Measure
 - Clinical Depression and Follow-Up Plan e-Measure.

The MY 2015 P4P MUHIT Domain gives credit for participating in the CMS EHR Incentive Program. Credit will be given based on the percentage of PO's providers that have successfully attested through the Medicare or Medicaid Incentive program, for Stage 1 or Stage 2.

Credit for the CQM e-Measures will be given based on the PO's ability to report these two measures. While the data for these measures will be collected through the Physician Organization Clinical Measure File Layout, points will be assigned to the MUHIT Domain.

P4P staff will hold training Webinars for MUHIT reporting during the 2016 NPI file collection period.

Who We Measure

For the P4P MUHIT domain, IHA will score POs based on all primary care physicians (MDs and DOs) including: internists, family practitioners, GPs, and pediatricians. For the results based on the CMS EHR Incentive programs, P4P staff will compute scores both including and excluding pediatricians; the higher of the two scores will be used.

Participation in the CMS EHR Incentive Programs

Credit is given based on the percentage of a PO's providers who have successfully attested—for either Stage 1 or Stage 2—to the CMS Medicare or Medi-Cal EHR Incentive Program for Meaningful Use. Consistent with CMS criteria, only ONC-ATCB software is considered compliant with MUHIT criteria, and credit is only given for providers who have successfully attested to the CMS Medicare or Medi-Cal EHR Incentive Programs for Meaningful Use.

Health plans and POs do not submit scores for the MUHIT domain; P4P staff assign scores to POs based on data publicly available from the CMS Medicare and Medi-Cal EHR Incentive Programs for Meaningful Use. In order to assign credit for each PO, P4P staff will solicit a list of National Provider Identifiers (NPI) from POs, for all primary care physicians (MDs and DOs), including internists, family practitioners, general practitioners and pediatricians. These providers will constitute the denominator in the rate.

P4P staff will then match these NPI lists with the NPIs that have successfully attested for either Stage 1 or Stage 2 Meaningful Use of the CMS EHR Incentive Program, either through the CMS Medicare or Medi-Cal program. These files will be solicited in early 2016; requirements for the NPI lists are described below.

P4P staff intend to use the most current public files available on April 22, 2016. Data sources are:

- **Medi-Cal EHR Incentive Program:** http://www.dhcs.ca.gov/provgovpart/Pages/EHR_Incentive_Data_and_Reports.aspx
- **Medicare EHR Incentive Program:** <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html>

CMS Incentive Program Measure—Submitting NPI list

NPI files will be collected January 4–29, 2016 and scores will be reported with the clinical P4P results in May.

File Naming Convention

Files must be named according to specific logic: NPIP4PMY2015_DMHCID.csv

“DMHCID” should be the PO’s seven-digit P4P DMHC ID. If you manage more than one PO, provide a separate list for each organization. Follow the specifications below to create and submit a file.

The following fields are required and should appear in the header of the file, as follows:

1. NPI.
2. PO P4P DMHC ID.
3. PO Name.
4. Provider Last Name.
5. Provider First Name.
6. Provider Professional Suffix. *Limit providers to those with an MD or a DO.*
7. Provider Specialty. *Limit providers to the following specialties:*
 - 01 (family/general practice).
 - 02 (internal medicine)
 - 03 (pediatric/adolescent medicine).

Refer to the list of required specialty types.

Data File Specifications

Provider Data Fields	Header (should appear as follows)	Specifications	Data Format
1	NPI	10 digit National Provider Identifier for each provider. Remove duplicates.	<ul style="list-style-type: none"> Column: A Type: Numeric Code
2	PO P4P DMHC ID	PO's P4P DMHC Code. Used to organize data by participating POs. Use 7 digit P4P DMHC code.	<ul style="list-style-type: none"> Column: B Type: Numeric Code
3	PO Name	Name of Physician Organization. Exclude commas. Use organization's full name.	<ul style="list-style-type: none"> Column: C Type: Alpha
4	Provider Last Name	Last name only. Do not include professional suffix (e.g., MD, DO.) Exclude commas or suffixes (e.g., Jr., Sr., III). Delete unnecessary text appended to the last name.	<ul style="list-style-type: none"> Column: D Type: Alpha
5	Provider First Name	First name only. Exclude middle initial. Exclude commas or suffixes (e.g., Jr., Sr., III). Delete unnecessary text appended to the first name.	<ul style="list-style-type: none"> Column: E Type: Alpha
6	Provider Professional Suffix	Include only MD and DOs. Do not include periods.	<ul style="list-style-type: none"> Column: F Type: Alpha
7	Provider Specialty	Include only providers from the List of Required Specialty Types table. Use 2-digit code to identify the specialty type. Do not include text.	<ul style="list-style-type: none"> Column: G Type: Numeric Code

List of Required Specialty Types

Required Specialty Types listed below must be represented in the data submission, using the codes in the left column.

Code	Specialty Type
01	Family/General Practice
02	Internal Medicine
03	Pediatrician/Adolescent Medicine

Note: A sample data file will be provided for POs at the time of the NPI file submission period. POs that do not follow the instructions and submit the file in the incorrect format will not receive credit.

Optional Exclusions

- Providers who were employed or contracted with a PO for less than six months of the measurement year.
- Providers who meet the criterion but are employed in an administrative-only role (e.g., medical director).
- Providers who meet the criterion but are considered hospitalists by CMS may be excluded.

Clinical Quality Measures

Clinical Quality Measures (CQM) are clinical measures that have specifications for calculation from EHR data. P4P committees added *Controlling High Blood Pressure* and *Screening for Clinical Depression and Follow-Up Plan* CQMs to the MUHIT Domain starting in MY 2014.

Controlling High Blood Pressure and *Screening for Clinical Depression and Follow-Up Plan* are part of the nine recommended 2014 core measures for adult populations. (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_AdultRecommend_CoreSetTable.pdf)

Submitting Results

These measures will be part of the MUHIT domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout.

These measures are a part of the MUHIT domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout.

For self-reporting POs, these measures are reported via the PO Clinical File Layout.

A separate layout is provided for non-self-reporting PO submission.

For each measure, collect two metrics:

- The percentage of providers who can report the *Screening for Clinical Depression and Follow-Up Plan* e-Measure (i.e., report a numerator and denominator to the PO).
 - POs should use the same definition of “PCP” outlined in the NPI data file specification instructions. Providers in your denominator should include employed and contracted PCPs (MD or DO) in the following specialties: family/general practice, internal medicine and pediatric/adolescent medicine.
- The aggregated numerator and denominator, for providers who can report the *Screening for Clinical Depression and Follow-Up Plan* e-Measure.
 - To calculate, pull the numerators and denominators from the EHR systems of all providers who can report the measures; specifications are programmed in the certified EHR systems of providers who can report. Certified EHR systems should be able to create general a report with the patient numerator and denominators for the e-Measures.

Example

- The PO has 50 PCPs in its NPI file.
- 40 of the PCPs have an EHR and have the *Controlling High Blood Pressure* e-Measure activated in their EHRs.
 - These 40 PCPs can report an individual performance rate to the PO, with patient numerators and denominators, for this measure.
- The total number of patients in the rates reported by these PCPs (aggregated, across-PO denominator) is 1,000. Of those 1000 patients, 450 have a controlled blood pressure.

Measure	Denominator	Numerator	Rate
MU_CBPH_RPT	50	40	80%
MU_CBPH	1,000	450	45%

Optional Exclusions

- Pediatricians can be excluded from the *Controlling High Blood Pressure* e-Measure denominator.
- Providers who were employed or contracted with a PO for less than six months of the measurement year.
- Providers who meet the criterion but are employed in an administrative-only role (e.g., medical director).
- Providers who meet the criterion but are considered hospitalists by CMS.

Measures in Meaningful Use of Health IT

Table 1 lists the core measures in the CMS EHR Incentive Programs for Stage 1 and Stage 2 Meaningful Use. The measures below make up the core measures required for the program. More detailed information on the measures, menu measures and the CMS EHR Incentive Program, go to:

- Stage 1: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html
- Stage 2: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Table 2 below lists the two CQM e-Measures included in the MY 2014 MUHIT Domain.

Table 1: CMS Stage 1 and Stage 2 Meaningful Use Core Objectives

MEANINGFUL USE OBJECTIVE	
STAGE 1 MEANINGFUL USE MEASURES	STAGE 2 MEANINGFUL USE MEASURES
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local and professional guidelines.	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders.
Implement drug-drug and drug-allergy interaction checks.	Generate and transmit permissible prescriptions electronically (eRx).
Maintain an up-to date problem list of current and active diagnoses.	Record the following demographics: preferred language, gender, race, ethnicity, date of birth.
Generate and transmit permissible prescriptions electronically (eRx).	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

MEANINGFUL USE OBJECTIVE	
STAGE 1 MEANINGFUL USE MEASURES	STAGE 2 MEANINGFUL USE MEASURES
Maintain active medication list.	Record smoking status for patients 13 years old or older.
Maintain active medication allergy list.	Use clinical decision support to improve performance on high-priority health conditions.
Record all of the following demographics: <ul style="list-style-type: none"> • Preferred language. • Gender. • Race. • Ethnicity. • Date of birth. 	Provide patients the ability to view online, download and transmit their health information.
Record and chart changes in the following vital signs: <ul style="list-style-type: none"> • Height. • Weight. • Blood pressure. • Calculate and display body mass index (BMI). • Plot and display growth charts for children 2–20 years, including BMI. 	Provide clinical summaries for patients for each office visit.
Record smoking status for patients 13 years old or older	Protect electronic health information created or maintained by the Certified EHR Technology.
Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the states	Incorporate clinical lab-test results into Certified EHR Technology.
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
Provide patients with an electronic copy of their health information	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.
Provide clinical summaries for patients for each office visit	Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources.
Protect electronic health information created or maintained by the certified EHR technology.	Perform medication reconciliation.
	Provide summary of care record for each transition of care or referral.
	Submit electronic data to immunization registries.
	Use secure electronic messaging to communicate with patients on relevant health information.

Table 2: CQMs included in the P4P MUHIT Domain

CQM E-MEASURES
<i>Controlling High Blood Pressure e-Measure</i>
<i>Screening for Clinical Depression and Follow Up Plan e-Measure</i>

Controlling High Blood Pressure (e-Measure) (ECBP)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added e-Measure identifier and version number to the measure specification.

Note: This Meaningful Use of Health IT (MUHIT) measure is collected with the Clinical measures. The measure specification is provided for reference. **POs are not expected to program this measure.** If a provider's EHR system already has this measure programmed, the provider should be able to report this measure. The PO should aggregate the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.

Specifications

e-Measure identifier	165	e-Measure version number⁷	4.0.000
NQF number	0018	GUID	abdc37cc-bac6-4156-9b91-d1be2c8b7268
Measurement period	January 1–December 31, 2015.		
Measure steward	National Committee for Quality Assurance.		
Measure developer	National Committee for Quality Assurance.		
Endorsed by	National Quality Forum.		
Description	Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.		
Initial patient population	Patients 18–85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period		
Denominator	Equals initial patient population.		
Denominator exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.		
Numerator	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure <140 mmHg; diastolic blood pressure <90 mmHg) during the measurement period.		

⁷This measure specification is based on the most recent version of the *2014 eCQM Specifications for Eligible Professionals Update*, published by CMS in June 2015. These specifications are available on the *eCQM Library* page of the CMS Web site (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html). P4P does not specify which version of the measure specification POs comply with.

Screening for Clinical Depression and Follow-Up Plan (e-Measure) (ESCD)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added eMeasure Identifier and Version number to the measure specification.
- Added additional Screening Tools, under Guidance.

Note: This Meaningful Use of Health IT (MUHIT) measure is collected with the Clinical measures. The measure specification is provided for reference. **POs are not expected to program this measure.** If a provider's EHR system already has this measure programmed, the provider should be able to report this measure. The PO should aggregate the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.

Specifications

e-Measure identifier	2	e-Measure version number⁷	5.0.000
NQF number	0418	GUID	9a031e24-3d9b-11e1-8634-00237d5bf174
Measurement period	January 1–December 31, 2015.		
Measure steward	Centers for Medicare & Medicaid Services.		
Measure developer	Quality Insights of Pennsylvania.		
Endorsed by	National Quality Forum.		
Description	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter, using an age appropriate standardized depression screening tool, and , if positive, a follow-up plan is documented on the date of the positive screen.		

Definitions

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized depression screening tool	<p>A normalized and validated depression screening tool developed for the patient population in which it is being utilized.</p> <p>Examples of depression screening tools include, but are not limited to:</p> <ul style="list-style-type: none"> • Adolescent screening tools (12–17 years): <ul style="list-style-type: none"> – Patient Health Questionnaire for Adolescents (PHQ-A). – Beck Depression Inventory-Primary Care Version (BDI-PC). – Mood Feeling Questionnaire. – Center for Epidemiologic Studies Depression Scale (CES-D). – PRIME MD-PHQ2.

- Adult screening tools (18 years and older):
 - Patient Health Questionnaire (PHQ9).
 - Beck Depression Inventory (BDI or BDI-II).
 - Center for Epidemiologic Studies Depression Scale (CES-D).
 - Depression Scale (DEPS).
 - Duke Anxiety-Depression Scale (DADS).
 - Geriatric Depression Scale (SDS).
 - Cornell Scale Screening.
 - PRIME MD-PHQ2.

Follow-up plan Documented follow-up for a positive depression screening must include one or more of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Guidance

A clinical depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool **and**, if positive, a follow-up plan is documented on the date of the positive screen.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter.
 - The screening and encounter must occur on the same date.
- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record.

Follow-Up Plan:

- This follow-up plan must be related to a positive depression screening; for example: "Patient referred for psychiatric evaluation due to positive depression screening."

Initial patient population	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.
Denominator	Equals initial patient population.
Denominator exclusions	Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.
Numerator	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND , if positive, a follow-up plan is documented on the date of the positive screen.
Numerator exclusions	NA

**Denominator
exceptions**

Patient reason

- Patient refuses to participate, **or**

Medical reason

- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status, **or**
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools; for example, certain court-appointed cases or cases of delirium.

Patient Experience Domain

**For Value Based P4P MY 2015
Self-Reporting POs**

Overview

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Updated the contact information for PAS.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a link for the PAS registration site.
- New for this year, there is a short- and long-form option for doctor surveys.
- Added a timeline for the first wave of e-mail surveys in the fielding surveys section.

Description

This section includes the P4P guidelines and specifications for POs that participate in the Patient Experience domain for MY 2015. Health plans do not submit data for the Patient Experience domain; POs voluntarily self-report this domain. P4P uses the **Patient Assessment Survey (PAS)** to assess PO performance.

Beginning in 2001, the California Cooperative Healthcare Reporting Initiative (CCHRI), a statewide collaborative of health plans, POs and purchasers, conducted an annual survey to assess patient experience with the care delivered by the patient's PO. The PAS was conducted under the auspices of the CCHRI, until CCHRI's dissolution in 2012. The Pacific Business Group on Health (PBGH) continued to manage the PAS survey after that point, and as of June 2013, the PAS is now a program of the California Healthcare Performance Information System (CHPI). The PAS is still managed by CHPI with guidance provided by the PAS Committee—composed of representatives of each participating health plan and 10 physician organizations—under the authority of the CHPI Board of Directors. Each P4P measurement year, a subset of questions from the PAS survey is selected for inclusion in the Patient Experience domain.

Survey instrument	Starting in MY 2012, the PAS will be the national standard CG-CAHPS Patient Experience survey, which has been endorsed by the National Quality Forum. It was developed by the Agency for Healthcare Research and Quality (AHRQ) and its research partners in the CAHPS consortium. The survey has both PCP and specialist versions of the survey, which overlap substantially.
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Participation

For MY 2015, CHPI will invite all POs that operate in California and serve commercially insured HMO and POS patients to participate in PAS. Invitations will be distributed electronically by early September, and POs will be required to register formally by September 30, 2015.

Registration will be online; registration forms can be found at <http://pas-registration.chpis.org>. The PAS Registration site can be found at <https://www.cssresearch.org/pas/>. POs that do not receive an e-mail invitation by September 2, 2015, should contact Meghan Hardin by e-mail at mhardin@pbgh.org.

During the registration process, POs will be given information on various survey options and the associated fees. POs will be required to provide up-to-date contact information and data on member enrollment, geographic locations served and other PO characteristics, and must agree to the terms outlined in the PAS Participation Agreement.

POs will have the option to download and sign off on the terms outlined in the Business Associate Agreement with the survey vendor for the project, the Center for the Study of Services (CSS).

In addition to participating in the PAS Physician Group Survey, POs may elect supplemental survey options that include:

- Surveys of distinct subunits or practice sites of the PO as separate reporting units, each with a unique sample of 900 patients.
- Alternative-language surveys, in which POs “double-stuff” patient survey packages with a survey translated into one of three alternative languages (i.e., Spanish, Chinese or Vietnamese). Double-stuffing facilitates responses by patient populations that may not be fluent in English.
- Doctor surveys, in which POs conduct additional surveys at the physician level using the PAS survey instrument, processes and methods. This supplemental project is designed to facilitate quality improvement **and will be offered in short- and long-form options for MY 2015**. Pediatricians may be included in the survey process.

PO Requirements

In addition to formal registration, POs must adhere to the following requirements.

- Meet deadlines that will be specified during the registration process.
 - Failure to meet deadlines will result in forfeiture of the PO's participation in the PAS project and eligibility for P4P bonus dollars associated with PAS performance measures.
- Sign up for the PAS at the same reporting level at which the PO will be reported for P4P. All P4P domains must be reported at the same level.
 - The data aggregator cannot separate results for groups who have not registered sub-units, nor can the data aggregator roll up PAS scores for groups with different five-digit DMHC codes.
- Sign off on the PAS Participation Agreement at the time of registration.
- Submit (or confirm) the PO logo and executive (i.e., medical director) signature, which will be printed on the survey cover letter and instrument.
 - POs will be given instructions for submitting these items after registration.
- Provide accurate information on the PO's coding practices and provider specialties, as requested in an online survey to be hosted by the survey vendor.
 - POs will be given instructions for providing this information after registration.
- Submit data files on all eligible patients, patient visits and providers, from which the patient sample will be drawn.
 - POs will be given a set of data specifications that define the layout of the files and the information required within each field. All data submissions must meet the data quality criteria identified by PAS.
- Submit National Provider Identifier (NPI) for each physician in their provider file.
 - Understanding that not all groups will be able to provide 100% of their physician NPIs, it is expected that groups provide at least 80% of physician NPIs. Failure to meet the 80% threshold may result in forfeiture of PAS participation.
- Pay participation fees associated with the survey options elected by the PO.
 - Fees are listed on the registration site.

Performance Areas

The following key performance areas are recommended for payment in P4P:

- Doctor-Patient Interaction Composite for PCPs and Specialists (combined).
- Coordination of Care Composite.
- Timely Care and Service Composite for PCPs and Specialists (combined).
- Overall Rating of Care Composite
- Office Staff Composite.
- Health Promotion Composite.

The following key performance areas are recommended for internal reporting only:

- Doctor-Patient Interaction Composite for PCPs.
- Doctor-Patient Interaction Composite for Specialists.
- Timely Care and Service Composite for PCPs.
- Timely Care and Service Composite for Specialists.

P4P Measurement Year 2015 Patient Experience Questions From 2016 PAS

Performance Area	Primary Care and Specialist Version
Doctor-Patient Interaction Composite	• In the last 12 months, how often did this doctor listen carefully to you? (Q18)
	• In the last 12 months, how often did this doctor explain things in a way that was easy to understand? (Q17)
	• In the last 12 months, how often did this doctor spend enough time with you? (Q23)
	• In the last 12 months, how often did this doctor show respect for what you had to say? (Q22)
	• In the last 12 months, how often did this doctor give you easy to understand information about these health questions or concerns? (Q20)
	• In the last 12 months, how often did this doctor seem to know the important information about your medical history? (Q21)
Coordination of Care Composite	• In the last 12 months, when this doctor ordered a blood test, x-ray, or other test for you, how often did someone from the doctor's office follow up to give you those results? (Q30)
	• In the last 12 months, how often did this doctor seem informed and up-to-date about the care you got from specialists/other doctors? (Q28)
Timely Care and Service Composite	• In the last 12 months, when you contacted this doctor's office to get an appointment for <u>care you needed right away</u> , how often did you get an appointment as soon as you needed? (Q6)
	• In the last 12 months, when you contacted this doctor's office during regular office hours, how often did you get an answer to your medical question that same day? (Q10)
	• In the last 12 months, when you made an appointment for <u>a check-up or routine care</u> with this doctor, how often did you get an appointment as soon as you needed? (Q8)
	• In the last 12 months, when you contacted this doctor's office <u>after</u> regular office hours, how often did you get an answer to your medical question as soon as you needed? (Q12)
	• Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this doctor <u>within 15 minutes</u> of your appointment time? (Q13)

Performance Area	Primary Care and Specialist Version
Overall Ratings of Care Composite	<ul style="list-style-type: none"> Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate this doctor? (Q33) Using any number from 0 to 10, where 0 is the worst <u>care</u> possible and 10 is the best <u>care</u> possible, what number would you use to rate all your health care from <u>all doctors and other health providers</u> that you have seen in the last 12 months? (Q39)
Office Staff Composite	<ul style="list-style-type: none"> In the last 12 months, how often were clerks and receptionists at this doctor's office as helpful as you thought they should be? (Q37) In the last 12 months, how often did clerks and receptionists at this doctor's office treat you with courtesy and respect? (Q38)
Health Promotion Composite	<ul style="list-style-type: none"> In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits? (Q31) In the last 12 months, did you and this doctor talk about the exercise or physical activity you get? (Q32)

Note: The total weight for the Patient Experience domain is 20 percent. Each measure is weighted equally.

Specifications: Patient Population Surveyed

Only adults are surveyed for multispecialty POs. There are two options for assessing pediatric performance.

1. Conduct a second group-level survey process for pediatric patients, which would be sent to the parent of the patient sample.
2. Select the doctor-level survey of pediatricians when completing the registration process.

For more information on assessing pediatric performance, contact **Meghan Hardin** by e-mail at mhardin@pbgh.org.

Sampling

A sample of 900 commercially-insured HMO and POS patients who had at least one visit between January and October of the measurement year and were enrolled in the PO as of October 31 of the measurement year are randomly selected from each PO. The sample is stratified, with 450 patients drawn from patients who had visits with their assigned PCPs and the remaining patients drawn from those who had a specialist visit.

Only one eligible patient from each household is included in the patient sample. To increase the likelihood of responses, sampling is prioritized by the most recent date of visit. Patient visits are grouped into three periods during 2014: January–April, May–July and August–October. Visits are selected randomly from the enrollment files of each PO, starting with the most recent period (August–October).

Fielding Surveys

The standard survey protocol consists of two mailed surveys and includes a cover letter outlining an option to complete the survey via the survey vendor Web site, using a unique Web ID contained in the letter. The cover letter is printed with the logo of the patient's PO and is signed by the PO's medical director.

The first mailing occurs in late January 2016; the second occurs in late February and is sent only to patients who did not respond to the first mailing. Patients who do not respond to the second mailing are contacted by phone in late March. Mail, Web and phone interviews are available in English and Spanish for all patients, and all mailed cover letters include a message in Spanish inviting patients to request a Spanish version of the survey via a toll-free number.

POs are also given the option to field the survey in English and an alternative language (Chinese, Spanish or Vietnamese). Patients receiving the alternative language survey receive a cover letter in English, with a translation in the alternative language printed on the back of the letter, and a copy of the survey instrument in the alternative language.

As of PAS 2013 (MY 2012), groups that register for the e-mail option and confirm that e-mail surveys are consistent with their privacy policies may include e-mail addresses in the patient file. Sampled patients will be sent an e-mail invitation prior to the first mailing to complete the survey on the CSS Web site. Patients who complete the survey online within a week of the invitation will not be sent a mailed survey or called during the phone follow-up period. **The first wave of e-mail surveys is sent in early January and cost savings associated with participation in the e-mail option are shared with the groups.**

Response File Preparation

When survey fielding is complete, the survey vendor cleans the data (e.g., removes duplicate interviews, merges response data with the original sample data, conducts consistency checks between question items). Response data files from mail, Web and telephone interview sources are cleaned for out-of-range responses for each question. All responses are kept where the patient either confirms a physician visit or—for PCP patient interviews—provides the name of another PCP in the PO *and* confirms a visit with the physician in the past year. The respondent's survey is dropped from analysis if the respondent indicates a physician who cannot be matched to the PO's provider file.

Analysis of Survey Data

Each PO's results are adjusted for patient case-mix to control for differences across POs. In MY 2015, the case-mix adjustment model will control for the following.

- Age.
- Gender.
- Education level.
- Race/ethnicity—primary language of respondent.
- Single-item physical health status.
- Single item mental health status.
- Specialty type of physician that patient rated (44 categories).
- Survey response mode (mail/Internet, phone).
- Language in which survey was completed.
- Obesity **indicator (derived from Body Mass Index).**

Reports

POs receive the following reports of their results.

- *Provider Group Summary PAS P4P Report* (May 2016): question and composite level scores.
- *PAS Provider Group Report* (June 2016): group detailed results including benchmarks, trending, PCP/Specialist scores, and a comparison of provider groups' question and composite level scores within geographic region.
- *Provider Group Response-level Report* (June 2016): Excel dataset contains de-identified patient-level records for Provider Group's patients only; records include physician identifier.

Survey results are made publicly available for consumers through the California Department of Managed Health Care's Office of the Patient Advocate consumer Web site (www.opa.ca.gov/report_card), and the California HealthCare Foundation's Web site at CalQualityCare.org.

Note: Performance results will not be publicly reported for any question or composite that achieves a reliability score of <0.70.

Key Dates for PAS

Activity or Milestone	Time Frame or Deadline
POs receive invitation to participate in PAS.	September 2, 2015
PAS Registration Site Live.	September 15, 2015
Deadline to register for 2016 PAS. Participation agreement between PO and CHPI due (via electronic consent during the registration process).	September 30, 2015
Submit Signed Business Associates Agreement (BAA) to CSS.	October 23, 2015
<ul style="list-style-type: none"> • Use Data Checking Tool (via downloadable tool). • Submit Data for Survey Sampling. 	November 2–18, 2015
Data corrections due.	November 23, 2015
Survey fielding period.	December 8, 2015–April 7, 2016
Group and Doctor survey results sent to groups.	June 22, 2016

For More Information

Visit the CHPI Web site at <http://www.chpis.org/programs/pas.aspx> after September 15, 2015, or contact Meghan Hardin by e-mail at mhardin@pbgh.org.

Resource Use Domain Technical Specifications

For Value Based P4P MY 2015

Overview

In recognition of the growing issue of affordability of the HMO product in California and the consequent potential demise of the delegated model, the P4P Governance Committee (the former P4P Executive and Steering Committees) charged IHA with developing standardized resource use measures to be implemented as part of the Pay for Performance program. Resource use measures were already being used for incentive payments by individual plans and physician groups. Incorporating them into P4P aligns measurement across plans for consistent identification of unwarranted variation in care delivery, and provides an opportunity to address these areas to ensure appropriate use of limited health care dollars in delivering quality care. The Resource Use domain includes the *Appropriate Resource Use* and *Total Cost of Care* measures.

Measures

- *Inpatient Utilization—Acute Care Discharges.*
- *Inpatient Utilization—Bed Days.*
- *Outpatient Procedures Utilization—Percentage Done in Preferred Facility.*
- *Frequency of Selected Procedures.*
- *Emergency Department Visits.*
- *Generic Prescribing.*
- *Total Cost of Care.*
- *Cesarean Section Rate for Low-Risk Birth.*
- *Vaginal Birth After Cesarean Delivery Rate.*
- *All-Cause Readmissions.*

Measure Development and Testing

The Resource Use measures were selected by a multi-stakeholder group of P4P Committee and IHA board members, based on resource use measures currently in use and their potential to improve efficient delivery of appropriate, quality care. The detailed specifications on the following pages were developed by a workgroup of participating POs and health plans, with technical support from Truven and NCQA.

These measures are calculated by Truven from claims, encounter and eligibility data submitted by participating health plans. POs do not self-report Resource Use measures.

Calculating Measure Results

Each measure is calculated in two ways.

1. **Results for each contracted health plan.** Rates are run on each health plan's data for each contracted PO. Each plan applies its actual costs for the PO to the utilization results provided, and shares savings generated by a PO's improvement over the previous year's performance.
2. **Results aggregated across all contracted health plans.** A PO's results for each measure is aggregated across all contracted plans. This lets POs understand how their utilization compares with that of other POs.

A confidence interval of 95 percent is provided for all measures, representing the range within which the true rate would appear 95 percent of the time.

Enrollment in Plan and PO

For the service to be counted for any measure, members must be enrolled in the plan and the PO on the date of service. For example, for *Outpatient Procedures Utilization—Percentage Done in Preferred Facility*, the procedure is attributed to the PO and plan where the member was enrolled on the date of the procedure. The service is not counted in the measure if an enrollment record does not identify a PO in which a member was enrolled on the date of service.

Which Services Count?

Report all services for which the organization actually paid or expects to pay. *Do not include* services or days denied for any reason. If a member is enrolled retroactively, count all services for which the organization has paid or expects to pay. Services should be included regardless of provider location (e.g. in-state or out-of-state) and a health plan's status as primary or secondary coverage for the member.

Risk Adjustment

The selected risk-adjustment methodology is indicated in each measure's specification. Risk adjustment was determined to be unnecessary for two measures:

- For *Outpatient Procedures Utilization*, a standard list of outpatient procedures is used, which CMS has determined can be done in an ambulatory outpatient setting, independent of member risk.
- For *Generic Prescribing*, specific therapeutic areas are measured, which makes the eligible population more homogenous.

Observed-to-Expected Ratio

A common characteristic of the measures that includes risk adjustment is the use of an “observed-to-expected” ratio (also known as an observed/expected [O/E] ratio). In all calculations, the observed rate (per the specifications) is divided by an expected rate, which considers the risk or illness burden of the PO's population. POs with higher-risk (i.e., sicker) members are expected to have higher utilization and, therefore, have higher expected rates. Similarly, POs with lower risk scores are expected to have lower utilization and have lower expected rates. It is important to note that the calculation of the expected rate is based on utilization and risk patterns in the P4P population, not on national or other external benchmarks. Specifically, to calculate the expected rate, a statistical model is developed that summarizes the relationship between observed rates and relative risk scores across the P4P population and provides an expected rate for a given level of risk. Because the distribution of observed rates by relative risk score varies by measure, the specific statistical model used to fit the data depends on the measure.

The O/E ratio compares the PO's observed rate to the expected rate and allows straightforward interpretation of how the PO's performance compared with the performance of the P4P population:

- An O/E ratio of 1.0 means the PO's rate was the same as expected, based on the risk of its population.
- An O/E ratio of 1.1 means the rate was 10 percent higher than expected.
- An O/E ratio of 0.9 means the rate was 10 percent lower than expected.

Small PO Pools

Although the P4P Committees expressed a commitment to ensuring that all POs are able to participate in Value Based P4P, POs with low enrollment (“small POs” with fewer than 1,500 members) with a contracted plan generally have less reliable ARU measure results. To address this concern, a “Small PO Pooled Rate” will be calculated on a plan-specific basis for small POs.

All small POs within each plan are pooled and a rate is calculated based on the pool. A weighted average, based on enrollment, is then used to blend the pooled result with each small PO’s own measure result. The weighting placed on the PO’s own result increases proportionally with membership, from 0 member years up to 1,500 members. At enrollment of 750 member years, 50 percent of the Small PO Pooled Rate will be based on the PO’s own rate and 50 percent will be based on the plan’s small PO pool rate.

Timeline

The Resource Use measures are part of the MY 2015 P4P measure set. Calculation of improvement results is based on changes between MY 2014 and MY 2015 performance.

Inpatient Utilization—Acute Care Discharges (IPU)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added a note to part D of Discharge Identification Methodology and Coding.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Utilization specifications.
- Added risk adjustment.

Description

This measure summarizes utilization of non-maternity-related acute inpatient services. The final reported metrics are:

- Risk adjusted non-maternity-related inpatient discharges PTMY (by plan).
- Risk adjusted non-maternity-related inpatient discharges PTMY (aggregated).

Risk adjustment is performed using the concurrent DxCG Relative Risk Score (RRS), which is generated from Sightlines DxCG Risk Solutions software, Version 3.1.0, Model 18: All Medical Predicting Concurrent Total Risk. This model does not include diagnosis information from pharmacy, lab, radiology, DME and transportation claims and encounters in the determination of a member's relative risk score.

Note

- *Truven will run this measure for MY 2015. Health plans and POs are not expected to report the measure.*

Eligible Population

Product lines	Commercial HMO and POS.
Ages	All ages.
Member years	Determine the PO's total member years of enrollment in a health plan as the sum of the number of days during the measurement year when each eligible member was enrolled in the health plan and PO, divided by 365.
Continuous enrollment	Date of admission through discharge in the health plan and in the PO (parent level).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.

Discharge Identification Methodology and Coding

- A.** Identify all acute inpatient discharges from January 1–December 31 of the measurement year. A claim with a code from any of the following value sets meet the criteria for acute inpatient stay (regardless of principal diagnosis or MS-DRG on the claim).

- Total Inpatient UBTOB Value Set.
- Total Inpatient POS Value Set.
- Total Inpatient UBREV Value Set.

- B.** *Skilled nursing facility.* Exclude discharges from a skilled nursing facility (Skilled Nursing Facility Value Set).

Note: Do not exclude discharges to a skilled nursing facility.

- C.** *Discharged to another acute care hospital.* Count transfers to another acute facility as one stay and extend the discharge date to include the transfer stay.

- D.** *Readmissions within 30 days.* Exclude discharges that are qualifying readmissions within 30 days.

Note: The PCR readmissions measure is not used to identify readmissions for this purpose. Instead, an alternative methodology is used that identifies readmissions for any cause within 30 days of discharge. Transfers to SNF and acute facilities and members who are discharged as “deceased” are not included in the set of admissions for which readmissions are identified.

- E.** *Maternity/newborn care exclusion.* Exclude maternity and newborn care discharges. Refer to the following value sets:

- Maternity Value Set .
- Maternity Diagnosis Value Set.
- Maternity MS-DRG Value Set
- Newborns/Neonates MS-DRG Value Set.

Exclude discharges with a principal diagnosis of live-born infant (Deliveries Infant Record Value Set).

- F.** *Mental health/chemical dependency.* Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) or an MS-DRG for mental health, chemical dependency or rehabilitation (IPU Exclusions MS-DRG Value Set).

- G.** Apply MS DRG grouper to the inpatient claims data.

Inpatient Discharges Calculation

Step 1 Identify qualifying discharges, as defined in A, above.

Step 2 Remove exclusions. Remove skilled nursing facility discharges and readmissions within 30 days. Refer to B–D, above.

Step 3 Remove maternity discharges. Refer to E, above.

Note: The maternity discharges PTMY is calculated separately for each PO by plan and is provided to POs and plans for information purposes.

Step 4 Remove mental health/chemical dependency discharges. Refer to F, above.

Step 5 Calculate the observed discharges PTMY for each PO.

Observed rate = [sum of qualifying discharges excluding maternity / total PO member years] * 1000.

Step 6 Remove outliers. Remove any plan results for a PO below the outlier threshold—fewer than 15 discharges PTMY. Members from these POs will be excluded from the pool of members used in the risk adjustment calculation. In addition, expected and risk adjusted rates will not be calculated for these POs.

Step 7 Calculate risk scores. Member-level relative risk scores (RRS) will be calculated by running the DxCG Relative Risk software. Appropriate RRS “bins,” which define members of similar risk, are calculated by running a logistic regression model to identify bin cut points. Collect members into appropriate bins based on RRS value.

Step 8 Calculate the expected inpatient discharges PTMY for each PO (expected rate). The expected rate for each member is the arithmetic mean of all rates for members attributed to each bin, based on qualifying discharges across all plans and POs (excluding outlier POs). Sum expected rates across all members in PO, within each contracted health plan and aggregated across health plans.

Step 9 Calculate the O/E inpatient discharges ratio for each PO.

O/E ratio = Observed discharges PTMY / Expected discharges PTMY

Step 10 Calculate the population rate PTMY. Across all members (i.e., across all plans and POs),

Population rate = [sum of discharges] / [sum of member years] * 1,000

Step 11 Calculate risk adjusted inpatient discharges PTMY for each PO.

Risk-adjusted rate = [O/E ratio] * population rate

Note: All expected rates are based on the performance of the entire P4P population (i.e., across all plans and POs, excluding outlier POs). However, a PO's expected rate will be estimated for the relative risk score specific to the PO's members reflected in the measure. For example, a PO's expected rate for a specific plan will use only the risk of the PO's members enrolled in that plan to estimate the expected rate. Similarly, the all-plan rate will use the risk of the PO's members across the plans to estimate the expected rate.

Inpatient Utilization—Bed Days (IPBD)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Utilization specifications.
- Added risk adjustment.

Description

This measure reports total bed days-associated discharges, after exclusions, including maternity exclusions. The final reported metrics are:

- Risk-adjusted bed days per 1,000 member years (PTMY) (by plan).
- Risk-adjusted bed days PTMY (aggregated).

Risk adjustment for total bed days will be performed using the concurrent DxCG Relative Risk Score (RRS), which is generated from Sightlines DxCG Risk Solutions software, Version 3.1.0, Model 18: All Medical Predicting Concurrent Total Risk. Risk adjustment for ALOS will be performed using CMS-DRG mix. This model does not include diagnosis information from pharmacy, lab, radiology, DME and transportation claims and encounters in the determination of a member's relative risk score.

Note

- *Truven will run this measure for MY 2015. Health plans and POs are not expected to report the measure.*

Eligible Population

Product lines	Commercial HMO and POS.
Ages	All ages.
Member years	Determine the PO's total member years of enrollment in a health plan as the sum of the number of days during the measurement year when each eligible member was enrolled in the health plan and PO, divided by 365.
Continuous enrollment	Date of admission through discharge in the health plan and in the PO (parent level).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.

Bed Days Calculation

Step 1 *Identify qualifying discharges from the IPU measure.* This excludes maternity discharges, mental health/chemical dependency discharges and readmissions within 30 days. It also excludes discharges from POs that are identified as outliers.

Step 2 *Sum bed days.* For each qualifying discharge, calculate the number of days hospitalized during the measurement year. Winsorize (i.e., truncate) each stay at 30 days.

Step 3 *Calculate observed bed days PTMY for each PO.*

Observed rate = [number of bed days / total PO member years] * 1,000

Step 4 *Calculate risk scores.* Member-level RRS will be calculated by running the DxCG Relative Risk software. Appropriate RRS “bins,” which define members of similar risk, are calculated by running a logistic regression model to identify bin cut points. Collect members into appropriate bins based on RRS value.

Step 5 *Calculate expected bed days PTMY for each PO (expected rate).* The expected rate for each member is the arithmetic mean of all rates for members attributed to each bin, based on qualifying discharges across all plans and POs (excluding outlier POs). Sum expected rates across all members in PO, within each contracted health plan and aggregated across health plans.

Step 6 *Calculate the O/E inpatient bed days ratio for each PO.*

O/E ratio = Observed bed days PTMY / Expected bed days PTMY

Step 7 *Calculate population rate PTMY across all members (i.e., across all plans and POs).*

Population rate = [sum of all bed days] / [sum of all member years] * 1,000

Step 8 *Calculate risk-adjusted bed days PTMY for each PO.*

Risk-adjusted rate = [O/E ratio] * population rate

Note: All expected rates are based on the performance of the entire P4P population (i.e., across all plans and POs, excluding outlier POs). However, a PO's expected rate will be estimated for the relative risk score specific to the PO's members reflected in the measure. For example, a PO's expected rate for a specific plan will use only the risk of the PO's members enrolled in that plan to estimate the expected rate. Similarly, the all-plan rate will use the risk of the PO's members across the plans to estimate the expected rate.

Average Length of Stay Calculation

Step 1 *Calculate observed ALOS.* For members with a qualifying discharge, the ALOS is the mean Winsorized LOS of all member level discharges. Winsorization bounds are set at 30 bed days.

Step 2 *Calculate expected ALOS for each CMS-DRG.* Collect member-level ALOS values into CMS-DRG-specific “bins.” The expected ALOS for each DRG is the arithmetic mean of all ALOS values attributed to that DRG-bin, based on discharges across all plans and POs (excluding outlier POs).

Step 3 *Calculate population-level ALOS.* The population level ALOS is defined as the arithmetic mean of ALOS scores across all members, within each DRG bin.

Step 4 Calculate risk-adjusted ALOS for each PO.

Risk-adjusted ALOS = [O/E ALOS] * population ALOS.

The same process is followed for the maternity ALOS calculations, but DRGs are limited to maternity DRGs during the DRG case-mix adjustment (step 2).

Note: All expected rates are based on the performance of the entire P4P population (i.e., across all plans and POs, excluding outlier POs). However, a PO's expected rate will be estimated for the relative risk score specific to the PO's members reflected in the measure. For example, a PO's expected rate for a specific plan will use only the risk of the PO's members enrolled in that plan to estimate the expected rate. Similarly, the all-plan rate will use the risk of the PO's members across the plans to estimate the expected rate.

Outpatient Procedures Utilization— Percentage Done in Preferred Facility (OSU)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- Based on a former HEDIS Utilization measure.

Description

This measure summarizes utilization of preferred facilities for outpatient/ambulatory procedures. (Outpatient surgeries are included in the definition of “procedures.”) One metric will be reported for each PO:

- Percentage of outpatient procedures performed in a preferred facility (by plan).

No risk adjustment will be applied.

Note: Truven will run this measure for MY 2015. Health plans and POs are not expected to report it.

Eligible Population

Product lines	Commercial HMO and POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.
Total outpatient procedures	<p>Count the total number of ambulatory surgery/procedure encounters/claims. A claim with a code from any of the following value set combinations meet the criteria.</p> <ul style="list-style-type: none"> • <u>Ambulatory Surgery Option A Value Set</u> with <u>Ambulatory Surgery POS Value Set</u>. • <u>Ambulatory Surgery Option A Value Set</u> with <u>Ambulatory Surgery UBTOB Value Set</u>. <p>Report only outpatient procedures performed at a hospital outpatient facility or at a free-standing surgery center. Use only facility claims that are flagged as either preferred or not preferred by the health plan.</p>

Professional claims are not used to identify outpatient procedures.

Count multiple outpatient procedures on the same date of service as one ambulatory procedure.

Exclusions (required)

- Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria.
 - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
 - Psychiatry (Psychiatry Value Set).
 - Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
 - Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set).
- ED visits are not included in the measure. Identify ED visits using either of the following:
 - An ED visit (ED Value Set).
 - An ED procedure code (ED Procedure Code Value Set) **with** an ED place of service code (ED POS Value Set).

Outpatient Procedures Calculation

Step 1 *Identify the denominator.* The denominator is the total outpatient procedures identified above.

Step 2 *Identify the numerator.* The numerator is the number of denominator qualifying procedures that were conducted in preferred facilities. Health plans provide a flag on the outpatient facility claim to indicate whether the procedure was carried out in a preferred facility.

Step 3 *Calculate the observed rate for each PO.*

Observed rate = number of outpatient procedures in preferred facility / total outpatient procedures.

Separate rates will be calculated for each health plan and aggregated across all contracted health plans.

Emergency Department Visits (EDV)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Utilization specifications.
- Added risk adjustment.

Description

This measure summarizes the utilization of emergency department (ED) visits. The final reported metrics for each PO are:

- Risk-adjusted ED visits PTMY (by plan).
- Risk-adjusted ED visits PTMY (aggregated).

Risk adjustment is performed using the concurrent DxCG Relative Risk Score (RRS), which is generated from Sightlines DxCG Risk Solutions software, Version 3.1.0, Model 18: All Medical Predicting Concurrent Total Risk. This model does not include diagnosis information from pharmacy, lab, radiology, DME and transportation claims and encounters in the determination of a member's relative risk score.

Note: Truven will run this measure for MY 2015. Health plans and POs are not expected to report it.

Eligible Population

Product lines	Commercial HMO and POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.
Member years	Determine the PO's total member years of enrollment in a health plan as the sum of the number of days during the measurement year when each eligible member was enrolled in the health plan and PO, divided by 365.

ED visits Use the following value sets to identify qualifying ED visits:

- An ED visit (ED Value Set).
- An ED procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Count each visit to an ED that does not result in an inpatient stay once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Both professional and facility claims are used to identify ED visits.

Exclusions (required)

Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria.

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
- Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set).
- ED visits that result in an inpatient admission.

ED Utilization Calculation

Step 1 *Identify ED Visits.* Use the following value sets to identify qualifying ED visits.

- An ED visit (ED Value Set).
- An ED procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Step 2 *Calculate observed ED visits PTMY for each PO.*

Observed rate = [sum qualifying ED visits from step 1 / total PO member years] *1,000.

Step 3 *Remove outliers.* Identify POs with an ED utilization rate of <60 or >250 PTMY. Members from these POs will be excluded from the pool of members used in the risk-adjustment calculation. In addition, expected and risk-adjusted rates will not be calculated for these POs.

Step 4 *Calculate risk scores.* Member-level RRS will be calculated by running the DxCG Relative Risk software. Appropriate RRS “bins,” which define members of similar risk, are calculated by running a logistic regression model to identify bin cut points. Collect members in appropriate bins by RRS value.

Step 5 *Calculate expected ED visits PTMY for each PO (expected rate).* The expected rate for each member is the arithmetic mean of all rates for members attributed to each bin, based on qualifying discharges across all plans and POs (excluding outlier POs). Sum expected rates across all members in PO, within each contracted health plan and aggregated across health plans.

Step 6 *Calculate the O/E ED visits ratio for each PO.*

O/E ratio = Observed ED Visits PTMY / Expected ED Visits PTMY.

Step 7 Calculate population ED utilization rate PTMY across all members (i.e., across all plans and POs).

Population rate = [sum of all ED visits / sum of all member years] *1,000.

Step 8 Calculate risk adjusted ED visits PTMY for each PO.

Risk-adjusted rate = O/E ratio * population rate

Note: All expected rates are based on the performance of the entire P4P population (i.e., across all plans and POs, excluding outlier POs). However, a PO's expected rate will be estimated for the relative risk score specific to the PO's members reflected in the measure. For example, a PO's expected rate for a specific plan will use only the risk of the PO's members enrolled in that plan to estimate the expected rate. Similarly, the all-plan rate will use the risk of the PO's

Generic Prescribing (GRX)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- Non-HEDIS measure.

Description

The level of generic prescribing will be measured as a simple prescription rate for seven groups of therapeutic areas and for all prescriptions:

Generic Prescribing Rate	Description
Antidepressants	SSRIs and SNRIs
Antihyperlipidemics	Statins
Anti-ulcer agents	Proton pump inhibitors (PPIs)
Cardiac—Hypertension and cardiovascular	Angiotensin II receptor blockers (ARBs)
Nasal steroids	Nasal steroids
Diabetes	Oral and self-injected antidiabetic agents, excluding insulin
Anxiety/sedation—sleep aids	Nonbenzodiazepine sedative hypnotics
Antimigraine	Oral and self-injected triptans
Overall	All drugs, excluding injectables

Plan-defined definitions of “brand” and “generic” will be used to calculate the measure, based on how a prescription was paid, and will accommodate plan-specific contracting arrangements that price brand-name drugs at generic rates.

Note

- *Truven will run this measure for MY 2015. Health plans and POs are not expected to report the measure.*

Eligible Population

Product line	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None. Because the denominator of this measure is based on prescriptions, not on members, there is no continuous enrollment requirement.

Benefit	Members must have pharmacy benefits coverage on the fill date of the prescription. The measure is based on all pharmacy claims received by participating health plans for members enrolled in the PO at any point in the measurement year. Pharmacy claims are attributed to a PO if the member was enrolled in the PO on the fill date on the pharmacy claim.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.

Measure Definition 1: Therapeutic Area Generic Prescribing Rate

Measures in seven therapeutic areas will be calculated and used for P4P reporting, and all except anxiety/sedation—sleep aids are recommended for incentive payment purposes.

Therapeutic Area Generic Prescribing Rate =

$$\frac{\text{Number of Prescriptions for Generic Drugs in Therapeutic Area X}}{\text{Number of Prescriptions for All Drugs in Therapeutic Area X}}$$

A prescription reflects a 30 day supply or less. To account for multi-month fills (i.e. days supplied exceeds 30 days) divide the days supply by 30 and round down to the nearest whole number. For example, a 100-day supply is equal to three prescriptions (100/30 = 3.33, rounded down to 3).

Denominator

- Step 1** Identify all *paid* pharmacy claims for members enrolled in the PO at any point during the measurement year.
- Step 2** Ensure that the member was enrolled in the PO on the fill date and had pharmacy benefits coverage.
- Step 3** Identify NDC codes of prescriptions belonging to one of the seven therapeutic areas. These are the prescriptions counted in the denominator.
- Step 4** Exclude prescriptions with any other NDCs.

Numerator

- Step 1** For all prescriptions in the denominator, determine whether the prescription was filled with a generic version of the drug or with a brand drug priced as a generic for that therapeutic area. This is determined by a flag supplied by the health plan on the pharmacy claim, indicating whether the drug was a generic or a brand drug priced as a generic.
- Step 2** Count the prescription in the numerator if it was filled with a generic drug or a brand drug priced as a generic.

Measure Definition 2: Overall Generic Prescribing Rate

This measure is provided to physician organizations for internal use, but is not intended for P4P reporting or incentive payment purposes.

Overall Generic Prescribing Rate =

Number of Prescriptions for All Generic Drugs

Number of Prescriptions for All Drugs

A prescription reflects a 30 day supply or less. To account for multi-month fills (i.e. days supplied exceeds 30 days) divide the days supply by 30 and round down to the nearest whole number. For example, a 100-day supply is equal to three prescriptions ($100/30 = 3.33$, rounded down to 3).

Denominator

- Step 1** Identify all *paid* pharmacy claims for members enrolled in the PO at any point during the measurement year.
- Step 2** Ensure that the member was enrolled in the PO on the fill date and had pharmacy benefits coverage.
- Step 3** Identify the NDC code for the drug filled on the prescription.
- Step 4** Identify and exclude claims for self-injectable drugs.
- Step 5** All other paid pharmacy claims are included in the denominator.

Numerator

- Step 1** For all prescriptions in the denominator, determine whether the prescription was filled with a generic version of the drug or with a brand drug priced as a generic for that therapeutic area. This is determined by a flag supplied by the health plan on the pharmacy claim, indicating whether the drug was a generic or a brand drug priced as a generic.
- Step 2** Count the prescription in the numerator if it was filled with a generic drug.

Total Cost of Care (TCC)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Removed information about which metrics POs report from the description.
- Added a step to the Total Cost of Care Calculation for geography adjustment.

MODIFICATIONS FROM HEDIS

- Non-HEDIS measure.

Description

This measure is based on actual costs associated with care for members attributed to a PO, including all covered professional, pharmacy, hospital and ancillary care, as well as administrative payments and adjustments. It *does not* include costs associated with mental health/chemical dependency, chiropractic, acupuncture, vision or dental services.

Participating health plans provide to Truven member-level total payments for each contracted PO. Payment includes both capitation payments and FFS payments, including member copayments, paid to the PO or other providers caring for members of the PO. Per member costs above \$100,000 are truncated.

Risk adjustment will be performed using concurrent DxCG Relative Risk Score, which is generated from Sightlines DxCG Risk Solutions software, Version 3.1.0, Model 19: All Medical Predicting \$100K Concurrent Total Risk. This model does not include diagnosis information from pharmacy, lab, radiology, DME and transportation claims and encounters in the determination of a member's relative risk score.

Geographic adjustment is performed using the geographic adjustment factors published by CMS and based on the hospital wage index.

Note: Truven will run this measure for MY 2015. Health plans and POs are not expected to report it.

Eligible Population

Product line	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None. Include all members who are enrolled in a PO and the health plan for one day or more during the measurement year.
Allowable gap	NA.
Anchor date	None.
Benefit	Medical and pharmacy.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015. Include services with a date of service between January 1 and December 31, 2015, and a date of payment between January 1, 2015, and March 31, 2016.

- Member years** Determine the member-level enrollment in a PO as the sum of the number of days during the measurement year for which each eligible member was enrolled in the health plan and PO.
- For each member, calculate member years by dividing the total member days by 365. For example, a member enrolled with a PO for the entire year would have MY = 1.0.

Total Cost of Care Calculation

Step 1 *Identify the eligible population as defined above.*

Step 2 *Obtain member-level observed cost.* This is the payment supplied by the health plan for a member's cost while enrolled with a specific PO. It includes all professional, facility (inpatient and outpatient), pharmacy, and other payments for services provided to a member.

The following services and payments are excluded from the observed cost amount:

- Mental health.
- Chemical dependency.
- Dental.
- P4P quality incentive payments.
- Vision.
- Chiropractic.
- Acupuncture.

If any of these services are included in a PO's capitation agreement, the plan uses its own actuarial method to adjust for them.

The following payments made to a PO that are not directly related to the delivery of services to individuals are included and attributed to members on a prorated basis:

- Capital infusions.
- Capitation administrative fee.
- Capitation deductions and adjustments.
- Capitation floors and guarantees.
- Non-P4P incentive payments.
- Shared risk payments.
- Special case rates for particular populations.
- Stop loss provisions.
- Non-claim bulk adjustments.
- Non-claim payments other.

Costs above \$100,000 per member are truncated.

Step 3 *Calculate risk scores.* For each member in the eligible population, a member-level RRS will be calculated using DxCG Relative Risk Score software (based on the claims/encounters submitted by the health plan). The RRS are then normalized for the P4P population (i.e., across all POs and plans) to a benchmark of 1.0, incorporating partial year enrollment, to generate a member-level RRS.

Step 4 *Calculate the average population cost PMPY.*

Average population cost PMPY = sum of member-level observed costs (across all POs and plans) / total number of member years (across all POs and plans).

This average population cost PMPY will be used for both plan-specific and all-plan calculations.

Step 5 *Calculate member-level expected cost.*

Member-level expected cost PMPY = member-level RRS * average population cost PMPY.

Step 6 Calculate PO-level observed/expected cost ratio.

Calculate the PO-level observed costs as the sum of member-level observed costs across all members attributed to the PO.

Calculate the PO-level expected costs as the sum of member-level expected costs across all members attributed to the PO.

Calculate the ratio of PO-level observed costs/PO-level expected costs

Step 7 Calculate the risk-adjusted total cost of care PMPY.

Risk-adjusted total cost of care PMPY = [PO-level observed cost PMPY/expected cost ratio] * average population cost PMPY = PO-level observed cost PMPY/PO-level average RRS.

Step 8 Calculate the geography and risk-adjusted total cost of care PMPY

Geography and risk-adjusted total cost of care PMPY = Risk adjusted total cost of care/ geographic adjustment factor, where the geographic adjustment factor is based on the CMS Hospital Wage Index (HWI) for the region in which the PO resides.

The CMS HWI is normalized by dividing it by the average PO HWI to create the geographic adjustment factor.

Two sets of risk-adjusted and geography and risk adjusted total cost of care PMPY rates are calculated per PO:

1. **Plan-specific:** Based on the PO's enrollment in each health plan. A plan-specific rate is calculated by carrying out steps 3–8 based only on members enrolled in the health plan. A plan-specific, risk-adjusted total cost of care PMPY and geography and risk adjusted total cost of care PMPY are calculated for each health plan with which the PO contracts.

Note: Plan-specific average population costs are not calculated based on the plan's population; rather, they are based on the entire P4P population (i.e., across all POs and plans).

2. **All-plan:** Based on the PO's data aggregated across all contracted health plans. In step 4, the PO-level observed costs from all contracted health plans are summed and divided by the sum of the number of member years across all health plans. An all-plan, risk-adjusted total cost of care PMPY and geography and risk adjusted total cost of care PMPY are calculated for the PO.

Frequency of Selected Procedures (FSP)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added hysterectomy, tonsillectomy, cholecystectomy, prostatectomy, mastectomy, lumpectomy to the list of selected procedures.

MODIFICATIONS FROM HEDIS

- P4P collects carotid endarterectomy, total hip replacement and total knee replacement for the commercial HMO/POS population.

Description

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. This measure is for internal reporting only.

Methodologies for adjusting for age/sex differences will be developed and tested. Adjusted rates of procedures will be reported per 1,000 member years.

Note: Truven will run this measure for MY 2015. Health plans and POs are not expected to report it.

Calculations

Product lines	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None. Include all members who are enrolled in a PO and in the health plan for one day or more during the measurement year.
Allowable gap	NA.
Anchor date	None.
Benefit	Medical.
Measurement period	Calendar year. The measurement period is January 1–December 31, 2015.
Member years	Determine the PO's total member years of enrollment in a health plan as the sum of the number of days during the measurement year when each eligible member was enrolled in the plan and the PO. For each PO, calculate member years by dividing the total member days by 365.
Procedures	Report counts for the procedures as specified regardless of the site of care (e.g., inpatient or ambulatory setting). Report the number of procedures rather than the number of members who had the procedures. Do not double-count the same procedure. The two examples below illustrate scenarios counted as one procedure.

Count as one procedure...

- If the date of service for two procedures is the same and both codes indicate CABG.
- If the date of service for a procedure falls between the admission and discharge dates for an inpatient stay where the procedure was performed.
 - For example, if a CABG was billed by a surgeon on March 4 of the measurement year and the facility bill shows a CABG for an admission that started on March 2 and lasted until March 7 of the measurement year, combine these to count one CABG.

Musculoskeletal procedures

Back surgery Back surgery (Back Surgery Value Set). Report all spinal fusion and disc surgery, including codes relating to laminectomy with and without disc removal.

Total hip replacement Total hip replacement (Total Hip Replacement Value Set). Report the number of total hip replacements.

Total knee replacement Total knee replacement (Total Knee Replacement Value Set). Report the number of total knee replacements.

Cardiovascular procedures

Bariatric weight loss surgery Bariatric weight loss surgery (Bariatric Weight Loss Surgery Value Set). Report the number of bariatric weight loss surgeries.

PCI Percutaneous coronary intervention (PCI Value Set). Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI rate or the cardiac catheterization rate; report only the CABG.

Cardiac catheterization Cardiac catheterization (Cardiac Catheterization Value Set). Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) an PCI in the cardiac catheterization rate; report only the PCI.

Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

CABG Coronary artery bypass graft (CABG Value Set). Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.

Do not report PCI or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the PCI or the cardiac catheterization rate; report only the CABG.

Carotid endarterectomy Carotid endarterectomy (Carotid Endarterectomy Value Set). Report the number of carotid endarterectomies.

Tonsillectomy Tonsillectomy (Tonsillectomy Value Set). Report tonsillectomy (with or without adenoidectomy).

Do not report adenoidectomy performed alone.

Hysterectomy Report abdominal and vaginal hysterectomy separately.

- [Abdominal Hysterectomy Value Set](#).
- [Vaginal Hysterectomy Value Set](#).

Do not double-count procedures; count multiple codes on the same date of service as one procedure.

Cholecystectomy Report open and laparoscopic cholecystectomy separately.

- [Open Cholecystectomy Value Set](#).
- [Laparoscopic Cholecystectomy Value Set](#).

Prostatectomy Prostatectomy ([Prostatectomy Value Set](#)). Report the number of prostatectomies.

Mastectomy Report the number of mastectomies. Report bilateral mastectomy procedures as two procedures, even if performed on the same date.

Identify unilateral mastectomies using any of the following:

- [Unilateral Mastectomy Value Set](#).
- [Unilateral Mastectomy Left Value Set](#).
- [Unilateral Mastectomy Right Value Set](#).

Identify bilateral mastectomies using either of the following:

- Bilateral mastectomy ([Bilateral Mastectomy Value Set](#)).
- Unilateral mastectomy ([Unilateral Mastectomy Value Set](#)) with a bilateral modifier ([Bilateral Modifier Value Set](#)).

Lumpectomy Lumpectomy ([Lumpectomy Value Set](#)). Report the number of lumpectomies. Report multiple lumpectomies on the same date of service as one lumpectomy procedure per patient.

All-Cause Readmissions (PCR)

The *All-Cause Readmission (PCR)* measure specifications are located in the *Clinical Domain* section. Although this is an Appropriate Resource Use measure, data for this measure will be collected with the Clinical measures.

Refer to page 120 for the complete measure specifications.

Unexpected Complications in Full-Term Newborns (UNC)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015.
- Changed the codes set references to "Perinatal Code Set".
- Codes to Identify Neonatal Death or Transfer changed from OSHPD Proprietary Code Set to a UB Code Set as of 1/1/2015.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure based on an NQF-endorsed measure.

Description

The rate of unexpected newborn morbidity in full-term newborns.

Note: *Truven and IHA's vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.*

Eligible Population

Product lines	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	All singleton, full-term live births (<u>Singleton, Inborn, Live Births ICD-9 Perinatal Code Set</u>) for discharges before October 1, 2015, and (<u>Singleton, Inborn, Live Births ICD-10 Perinatal Code Set</u>) for discharges on or after October 1, 2015, without conditions likely present prior to labor. Refer to <i>Exclusions</i> , below. Identify full-term infants according to gestational age and birth weight (Table UNC-A). If gestational age is missing, birth weight must be 3,000–8,165 grams.

Table UNC-A: Codes to Identify Full-Term Infants

Description	Vital Statistics		Vital Statistics
Full-term infant	Gestational age ≥ 37 and ≤ 47 weeks*	AND	Birthweight $\geq 2,500$ grams and $\leq 8,165$ grams

*Infants missing gestational age are required to have birth weight of at least 3,000 grams and no more than 8,165 grams.

Exclusions

- Exclude stillbirths in the data matching process with Vital Statistics Birth Certificate Data, which include records for live births only.
- Fetal conditions likely to be present before labor.
- Any of the following **perinatal** code sets meet the exclusion criteria:

For Discharges before October 1, 2015:

- Fetal Conditions Present Before Labor: Congenital Malformations ICD-9 Perinatal Code Set.
- Fetal Conditions Present Before Labor: Other Fetal Placental Conditions ICD-9 Perinatal Code Set.
- Fetal Conditions Present Before Labor: Maternal Drug Use ICD-9 Perinatal Code Set.

For Discharges on or after October 1, 2015:

- Fetal Conditions Present Before Labor: Congenital Malformations ICD-10 Perinatal Code Set.
- Fetal Conditions Present Before Labor: Other Fetal Placental Conditions ICD-10 Perinatal Code Set.
- Fetal Conditions Present Before Labor: Maternal Drug Use ICD-10 Perinatal Code Set.

Administrative Specification

Denominator The eligible population.

Numerator Number of newborns with either a severe or moderate complication that occurred during delivery and nursery care. Include:

- 5-minute or 10-minute Apgar score ≤ 3 .
- Neonatal transfer or neonatal death (Codes to Identify Neonatal Death or Transfer UB Code Set).

For Discharges before October 1, 2015:

- Severe complications occurring during delivery and nursery care:
 - Severe Birth Trauma ICD-9 Perinatal Code Set.
 - Severe Hypoxia Asphyxia ICD-9 Perinatal Code Set.
 - Severe Shock and Resuscitation ICD-9 Perinatal Code Set.
 - Severe Respiratory Complications ICD-9 Perinatal Code Set.
 - Severe Infection ICD-9 Perinatal Code Set.
 - Severe Neurological Complication ICD-9 Perinatal Code Set.
- Length of Stay >4 days and sepsis (Severe Septicemia (LOS >4 Days) ICD-9 Perinatal Code Set).
- Moderate complications occurring during delivery and nursery care:
 - Moderate Birth Trauma ICD-9 Perinatal Code Set.
 - Moderate Respiratory Complication ICD-9 Perinatal Code Set.
- Length of Stay >4 days for Cesarean birth **and** moderate complications **or** LOS >2 days for vaginal birth **and** moderate complications:
 - Moderate Birth Trauma with specific LOS requirement ICD-9 Perinatal Code Set.
 - Moderate Respiratory Complications with specific LOS requirement ICD-9 Perinatal Code Set.
 - Moderate Neurological Complication with specific LOS requirement ICD-9 Perinatal Code Set.

- Moderate Infection with Specific LOS requirement (< 4 Days) ICD-9 Perinatal Code Set.
- Length of Stay >5 days **without** jaundice or social problem:
 - Jaundice ICD-9 Perinatal Code Set.
 - Social Problems ICD-9 Perinatal Code Set.

For Discharges on or after October 1, 2015:

- Severe complications occurring during delivery and nursery care:
 - Severe Birth Trauma ICD-10 Perinatal Code Set.
 - Severe Hypoxia Asphyxia ICD-10 Perinatal Code Set.
 - Severe Shock and Resuscitation ICD-10 Perinatal Code Set.
 - Severe Respiratory Complications ICD-10 Perinatal Code Set.
 - Severe Infection ICD-10 Perinatal Code Set.
 - Severe Neurological Complication ICD-10 Perinatal Code Set.
- Length of Stay >4 days and sepsis (Severe Septicemia (LOS > 4 Days) ICD-10 Perinatal Code Set.)
- Moderate complications occurring during delivery and nursery care:
 - Moderate Birth Trauma ICD-10 Perinatal Code Set.
 - Moderate Respiratory Complication ICD-10 Perinatal Code Set.
- Length of Stay >4 days for Cesarean birth and moderate complications or LOS >2 days for vaginal birth and moderate complications:
 - Moderate Birth Trauma with specific LOS requirement ICD-10 Perinatal Code Set.
 - Moderate Respiratory Complications with specific LOS requirement ICD-10 Perinatal Code Set.
 - Moderate Neurological Complication with specific LOS requirement ICD-10 Perinatal Code Set.
- Moderate Infection with specific LOS requirement (< 4 Days) ICD-10 Perinatal Code Set.
- Length of Stay >5 days without jaundice or social problem:
 - Jaundice ICD-10 Perinatal Code Set.
 - Social Problems ICD-10 Perinatal Code Set.

Do not include newborn morbidities identified through a hospital readmission subsequent to the newborn's initial discharge home following delivery.

Incidence of Episiotomy (EPS)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015.
- Changed the codes set references to “Perinatal Code Set”.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure based on an NQF-endorsed measure developed by the National Perinatal Information Center.

Description

The percentage of vaginal deliveries during the measurement year with evidence of an episiotomy.

Note: *Truven and IHA's vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.*

Eligible Population

Product lines	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	All live birth vaginal deliveries without shoulder dystocia during the measurement year.

Codes to Identify Deliveries

For discharges before October 1, 2015:

- Complication Mainly Related to Pregnancy [ICD-9 Perinatal Code Set](#) (Joint Commission Table 11.01).
- Normal Delivery and Other Indications for Care [ICD-9 Perinatal Code Set](#) (Joint Commission Table 11.02).
- Complication Mainly in the Course of Labor and Delivery [ICD-9 Perinatal Code Set](#) (Joint Commission Table 11.03).
- Complication of the Puerperium [ICD-9 Perinatal Code Set](#) (Joint Commission Table 11.04).

For Discharges on or after October 1, 2015:

- [Delivery ICD-10 Perinatal Code Set](#).

Exclusions

- Exclude stillbirths in the data matching process with Vital Statistics Birth Certificate Data, which include records for live births only.
- Cesarean deliveries ([Cesarean Delivery ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Cesarean Delivery ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.
- Vaginal deliveries with shoulder dystocia ([Shoulder Dystocia ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Shoulder Dystocia ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.

Administrative Specification

Denominator The eligible population.

Numerator Number with episiotomy performed ([Episiotomy Procedure ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Episiotomy Procedure ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.

Cesarean Section Rate for Low-Risk Births (CSX)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- ICD-10 Codes Replace ICD-9 Codes for Discharge Dates from October 1, 2015.
- Changed the codes set references to “Perinatal Code Set”.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure based on an NQF-endorsed measure **utilized** by the Joint Commission.

Description

The percentage of deliveries to nulliparous women with a term, singleton baby in a vertex position (NTSV) that are delivered by cesarean section.

Note: *Truven and IHA's vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.*

Eligible Population

Product lines	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	All nulliparous single live births with gestational age of 37 weeks or more.

Codes to Identify Deliveries

For discharges before October 1, 2015:

- Complication Mainly Related to Pregnancy ICD-9 Perinatal Code Set (Joint Commission Table 11.01).
- Normal Delivery and Other Indications for Care ICD-9 Perinatal Code Set (Joint Commission Table 11.02).
- Complication Mainly in the Course of Labor and Delivery ICD-9 Perinatal Code Set (Joint Commission Table 11.03).
- Complication of the Puerperium ICD-9 Perinatal Code Set (Joint Commission Table 11.04).

For discharges on or after October 1, 2015:

- [Delivery ICD-10 Perinatal Code Set](#)

Codes to Identify Singleton Births

Singleton Birth ([Singleton Birth ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Singleton Birth ICD-9 Perinatal Code Set](#)) for discharges on or after October 1, 2015.

Exclusions

- Exclude stillbirths in the data matching process with Vital Statistics Birth Certificate Data, which include records for live births only.
- Women with contraindication to vaginal delivery ([Contraindications to Vaginal Delivery ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Multiple Gestations and Other Presentations ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.
- Women with previous births.
- Deliveries with an estimated gestational age less than 37 weeks.

Table CSX-A: Codes to Identify Previous Births

Description	Vital Statistics
Parity >0	Sum of "Total Number of prior children still living" and "Total number of prior children no longer living" >0

Table CSX-B: Codes to Identify Live Births 37 or More Weeks Gestation

Description	Vital Statistics Data
Live birth ≥37 weeks gestation	Field "Best Obstetric Estimate of Gestational Age" OR LMP-based gestational age ≥37 weeks

Administrative Specification

Denominator The eligible population.

Numerator The number of Cesarean section deliveries ([Cesarean Delivery ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Cesarean Delivery ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.

Vaginal Birth After Cesarean Delivery Rate (VBC)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- ICD-10 Codes Replace ICD-9 Codes for Discharge Dates from October 1, 2015.
- Changed the codes set references to “Perinatal Code Set”.
- Revised the eligible population criteria to include cases with prior Cesarean deliveries.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- None.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure originally developed by the Agency for Healthcare Research and Quality.

Description

The rate of vaginal deliveries during the measurement year to women with evidence of a prior Cesarean section.

Note: *Truven and IHA's vendor will run this measure using data submitted by health plans, linked with California birth certificate data. Health plans and POs are not expected to report this measure.*

Eligible Population

Product lines	Commercial HMO/POS.
Ages	All ages.
Continuous enrollment	None.
Allowable gap	NA because there is no continuous enrollment requirement.
Anchor date	Date of delivery.
Benefit	Medical.
Event/ diagnosis	All live birth deliveries with a previous Cesarean delivery diagnosis. Use the following perinatal code sets to identify the eligible population.

Codes to Identify Deliveries

For discharges before October 1, 2015

- Complication Mainly Related to Pregnancy ICD-9 Perinatal Code Set (Joint Commission Table 11.01).
- Normal Delivery and Other Indications for Care ICD-9 Perinatal Code Set (Joint Commission Table 11.02).
- Complication Mainly in the Course of Labor and Delivery ICD-9 Perinatal Code Set (Joint Commission Table 11.03).
- Complication of the puerperium ICD-9 Perinatal Code Set (Joint Commission Table 11.04).

For Discharges from October 1, 2015

- [Delivery ICD-10 Perinatal Code Set](#)

Codes to Identify Prior Cesarean Deliveries

- Identify cases with prior Cesarean deliveries ([Prior Cesarean Delivery ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Prior Cesarean Delivery ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015, and include these cases in the eligible population.

Exclusions

- Exclude stillbirths in the data matching process with Vital Statistics Birth Certificate Data, which include records for live births only.

Administrative Specification

Denominator The eligible population.

Numerator Number of vaginal deliveries, defined as all denominator cases without a cesarean delivery procedure code for current delivery ([Cesarean Delivery ICD-9 Perinatal Code Set](#)) for discharges before October 1, 2015, and ([Cesarean Delivery ICD-10 Perinatal Code Set](#)) for discharges on or after October 1, 2015.

MY 2015 Testing Measures

**For Value Based P4P MY 2015
Health Plans and Self-Reporting POs**

Overview

There will be opportunity for public comment before testing measures are finalized by the P4P Technical Measurement and Governance Committees in November 2015. Selected measures will be tested in MY 2015 and are expected to be added to the MY 2016 P4P measure set (barring problems identified during testing). The P4P Committees will confirm adoption of these measures in November 2015, with input from public comment and recommendations from the P4P Technical Measurement Committee.

All health plans and self-reporting POs are strongly encouraged to participate in testing. The MY 2015 testing measures are listed below.

Clinical	<ul style="list-style-type: none"> • <i>Statin Therapy for Patients With Diabetes (SPD).</i> • <i>Statin Therapy for Patients With Cardiovascular Disease (SPC).</i> • <i>Antidepressant Medication Management (AMM).</i>
Medicare	None.
Meaningful Use of Health IT	None.
Patient Experience	None.
Resource Use	None

Statin Therapy for Patients With Diabetes (SPD)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the allowable gap criteria.
- Revised the CABG criteria for the required exclusions of step 2 in the event/diagnosis.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added to the manual as a MY 2015 testing measure.

MODIFICATIONS FROM HEDIS

- None.

Description

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 met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	<p>If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.</p> <p>Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.</p>

Eligible Population: Rate 1—Received Statin Therapy

Product lines	Commercial
Ages	40–75 years as of December 31 of the measurement year.
Continuous enrollment	
...for self-reporting POs	The measurement year and the year prior to the measurement year in the PO (parent level).
...for health plans	The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
...for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
...for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical. Pharmacy during the measurement year.
Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	<p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or non-acute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). <p><i>Pharmacy data.</i> Members who were dispensed insulin or hypoglycemics/ anti-hyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table SPD-A).</p>

**Step 2:
Required
exclusions**

Exclude members who meet any of the following criteria:

- Members with cardiovascular disease are identified in two ways: by event or by diagnosis. The organization must use *both* methods to identify this population, but a member only needs to be identified by one method to be excluded from the measure.
 - *Event*. Any of the following during the year prior to the measurement year meet criteria:
 - *MI*. Discharged from an inpatient setting with an MI (MI Value Set). To identify discharges:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the discharge date for the stay.
 - *CABG*. Members who had CABG (CABG Value Set) in any setting.
 - *PCI*. Members who had PCI (PCI Value Set) in any setting.
 - *Other revascularization*. Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting.
 - *Diagnosis*. Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.
 - At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set), **or**
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
- Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year.
- In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year.

Table SPD-A: Prescriptions to Identify Members With Diabetes

Description	Prescription			
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol		
Amylin analogs	• Pramlintide			
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin	
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human		
Meglitinides	• Nateglinide	• Repaglinide		
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin		
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide	
Thiazolidinediones	• Pioglitazone	• Rosiglitazone		
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin		

Administrative Specification: Rate 1—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a statin medication of any intensity (Table SPD-B) during the measurement year.

Table SPD-B: High, Moderate and Low-Intensity Statin Prescriptions

Description	Prescription	
High-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Ezetimibe-atorvastatin 40–80 mg 	<ul style="list-style-type: none"> • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Ezetimibe-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg • Niacin-simvastatin 20–40 mg • Sitagliptin-simvastatin 20–40 mg 	<ul style="list-style-type: none"> • Pravastatin 40–80 mg • Aspirin-pravastatin 40–80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2–4 mg

Description	Prescription
Low-intensity statin therapy	<ul style="list-style-type: none"> • Simvastatin 10 mg • Ezetimibe-simvastatin 10 mg • Sitagliptin-simvastatin 10 mg • Pravastatin 10–20 mg • Aspirin-pravastatin 20 mg • Lovastatin 20 mg • Niacin-lovastatin 20 mg • Fluvastatin 20–40 mg • Pitavastatin 1 mg

Eligible Population: Rate 2—Statin Adherence 80%

Product lines	Commercial
Age	40–75 years as of December 31 of the measurement year.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year and the year prior to the measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
<i>...for self-reporting POs</i>	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
<i>...for health plans</i>	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical. Pharmacy during the measurement year.
Event/diagnosis	All members who meet the numerator criteria for Rate 1.

Administrative Specification: Rate 2—Statin Adherence 80%

Denominator	The Rate 2 eligible population.
Numerator	<p>The number of members who achieved a PDC of at least 80% during the treatment period.</p> <p>Follow the steps below to identify numerator compliance.</p> <p>Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any intensity statin medication (Table SPD-B) during the measurement year.</p> <p>Step 2 To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.</p> <p>Step 3 Count the days covered by at least one prescription for statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond the measurement year, subtract any days supply that extends beyond December 31 of the measurement year.</p>

Step 4 Calculate the member's PDC using the following equation. Round (using the .5 rule) to two decimal places.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is $\geq 80\%$ for the treatment period.

Exclusion (optional)

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Statin Therapy for Patients With Cardiovascular Disease (SPC)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- Revised the CABG criteria for step 1 in the event/diagnosis.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added to the manual as a MY 2015 testing measure.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	<p>If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.</p> <p>Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.</p>

Eligible Population: Rate 1—Received Statin Therapy

Product line	Commercial).
Age	Report two age/gender stratifications and a total rate. <ul style="list-style-type: none"> • Males 21–75 years as of December 31 of the measurement year. • Females 40–75 years as of December 31 of the measurement year. • Total.
Continuous enrollment	
...for self-reporting POs	The measurement year and the year prior to the measurement year in the PO (parent level).
...for health plans	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	
...for self-reporting POs	Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a P4P plan on December 31 of the measurement year.
...for health plans	Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.
Benefit	Medical. Pharmacy during the measurement year.
Event/Diagnosis	Follow the steps below to identify the eligible population. <p>Step 1: Members are identified for the eligible population in two ways: by event or by diagnosis. The organization must use <i>both</i> methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure.</p> <p><i>Event.</i> Any of the following during the year prior to the measurement year meet criteria:</p> <ul style="list-style-type: none"> • <i>MI.</i> Discharged from an inpatient setting with an MI (<u>MI Value Set</u>). To identify discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay. • <i>CABG.</i> Members who had CABG (<u>CABG Value Set</u>) in any setting. • <i>PCI.</i> Members who had PCI (<u>PCI Value Set</u>) in any setting. • <i>Other revascularization.</i> Members who had any other revascularization procedures (<u>Other Revascularization Value Set</u>) in any setting. <p><i>Diagnosis.</i> Identify members as having ischemic vascular disease (IVD) who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</p>

- At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set), **or**
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).

Step 2: Exclude members who meet any of the following criteria:
Required exclusions

- Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year.
- In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.
- Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year.

Table SPC-A: Medications to Identify Exclusions

Description	Prescription
Estrogen agonists	• Clomiphene

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Administrative Specification: Rate 1—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high or moderate-intensity statin medication (Table SPC-B) during the measurement year.

Table SPC-B: High and Moderate-Intensity Statin Medications

Description	Prescription	
High-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40-80 mg • Ezetimibe-atorvastatin 40-80 mg 	<ul style="list-style-type: none"> • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10-20 mg • Ezetimibe-atorvastatin 10-20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20-40 mg • Niacin-simvastatin 20-40 mg • Sitagliptin-simvastatin 20-40 mg 	<ul style="list-style-type: none"> • Pravastatin 40–80 mg • Aspirin-pravastatin 40-80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2–4 mg

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

Eligible Population: Rate 2—Statin Adherence 80%

Product line	Commercial
Age	Report two age/gender stratifications and a total rate. <ul style="list-style-type: none"> • Males 21–75 years as of December 31 of the measurement year. • Females 40–75 years as of December 31 of the measurement year. • Total.
Continuous enrollment	
<i>...for self-reporting POs</i>	The measurement year and the year prior to the measurement year in the PO (parent level).
<i>...for health plans</i>	The measurement year and the year prior to the measurement year in the health plan and PO (parent level).
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical. Pharmacy during the measurement year.
Event/Diagnosis	All members who meet the numerator criteria for Rate 1.

Administrative Specification: Rate 2—Statin Adherence 80%

Denominator	The Rate 2 eligible population.
Numerator	<p>The number of members who achieved a PDC of at least 80% during the treatment period.</p> <p>Follow the steps below to identify numerator compliance.</p> <p>Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high or moderate-intensity statin medication (Table SPC-B) during the measurement year.</p> <p>Step 2 To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.</p> <p>Step 3 Count the days covered by at least one prescription for statin medication (Table SPC-B) during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.</p> <p>Step 4 Calculate the member's PDC using the following equation. Round (using the .5 rule) to two decimal places.</p> $\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$ <p>Step 5 Sum the number of members whose PDC is $\geq 80\%$ for the treatment period.</p>

Antidepressant Medication Management (AMM)

MEASURE UPDATES DECEMBER 2015 FOR P4P MY 2015

- None.

MEASURE UPDATES SEPTEMBER 2015 FOR P4P MY 2015

- Added to the manual as a MY 2015 testing measure.

MODIFICATIONS FROM HEDIS

- None.

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

Product lines	Commercial
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
...for self-reporting POs	105 days prior to the IPSD through 231 days after the IPSD in the PO (parent level).
...for health plans	105 days prior to the IPSD through 231 days after the IPSD in the health plan and PO (parent level).

Allowable gap	One gap in enrollment of up to 45 days.
Anchor date	
...for self-reporting POs	IPSD in the PO (parent level, or, for eligible POs, subgroup level) and in a P4P plan.
...for health plans	IPSD in the health plan and the PO (parent level, or, for eligible POs, subgroup level).
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population, which is used for both rates.
Step 1	Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-A) during the Intake Period.
Step 2: Required exclusion	<p>Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:</p> <ul style="list-style-type: none"> • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: <ul style="list-style-type: none"> – <u>AMM Stand Alone Visits Value Set</u> with <u>Major Depression Value Set</u>. – <u>AMM Visits Value Set</u> with <u>AMM POS Value Set</u> and <u>Major Depression Value Set</u>. • An ED visit (<u>ED Value Set</u>) with any diagnosis of major depression (<u>Major Depression Value Set</u>). • An acute or nonacute inpatient discharge with any diagnosis of major depression (<u>Major Depression Value Set</u>). To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay. <p><i>For a direct transfer, use the discharge date from the last discharge.</i></p>
Step 3	Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
Step 4	Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator	The eligible population.
Numerators	
Effective Acute Phase Treatment	At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-A) beginning on the IPSD through 114 days after the IPSD (115 total days). Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table AMM-A: Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 2, 2015.

**Effective
Continuation
Phase Treatment**

At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-A) beginning on the IPSD through 231 days after the IPSD (232 total days).

Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Note

- Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.

Appendix
Summary Table of
Measure Specification Changes

For Value Based P4P MY 2015

APPENDIX 1

SUMMARY TABLE OF QUALITY MEASURES AND CHANGES

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Encounter Rate by Service Type	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
Annual Monitoring for Patients on Persistent Medications	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added value sets to identify acute and nonacute inpatient encounters for the optional exclusions.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.
Controlling High Blood Pressure for People With Hypertension	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Removed the criteria for polycystic ovaries when assigning a flag of “not diabetic” in the event/diagnosis. Clarified Step 2 in Required exclusion: Diabetes
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS Measure
Proportion of Days Covered by Medications: <ul style="list-style-type: none"> Renin Angiotensin System (RAS) Antagonists Statins Diabetes All Class 	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Clarified the percentage threshold for Step 4 of each rate. Added a Note to the denominator exclusion in the Diabetes All Class rate. Added a new class, SGL T2 Inhibitor Combinations, and medications to Table PDC-C. Added Insulin Regular (Human) Inhalation Powder to Table PDC-D.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
Diabetes Care: <ul style="list-style-type: none"> Two HbA1c Tests HbA1c Poor Control (>9.0%) HbA1c Control (<8.0%) HbA1c Control (<7.0%) Eye Exam LDL Screening and Control (<100) Nephropathy Monitoring 	December 2015	<ul style="list-style-type: none"> Revised the CABG criteria in the required exclusions for HbA1c Control <7% for a Selected Population indicator. Clarified when reporting the HbA1c Control <8% indicator using CPT Category II code 3045F that documentation must follow the requirements in General Guideline 29. Added the <u>Total Inpatient POS Value Set</u>, to Option B of the BP Control indicator.
	September 2015	<ul style="list-style-type: none"> Added a method and value sets to identify discharges for the applicable required exclusions for the <i>HbA1c Control (<7.0%) for a Selected Population</i> indicator. Added a method and value sets to identify acute discharges for <i>Option B: Exclusions to Identify Appropriate Setting</i>. Revised the requirements for urine protein testing for the <i>Medical Attention for Nephropathy</i> indicator; a screening or monitoring test meets criteria, whether the result is positive or negative. Removed the optional exclusion for polycystic ovaries.
	Modifications From HEDIS	

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1-2 Appendix 1—Summary Table of Quality Measures and Changes

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
<ul style="list-style-type: none"> Blood Pressure Control (<140/90) Optimal Diabetes Care 		<ul style="list-style-type: none"> Added a <i>Note</i> clarifying optional exclusions. Removed the indicator for a single Hemoglobin A1c (HbA1c) test. Reordered some of the exclusions and made clarifications to <i>Option B: Exclusions to Identify Appropriate Setting</i> under the BP Control Indicator.
	Modifications From HEDIS	<ul style="list-style-type: none"> Optimal Diabetes Care Combination Rate is a non-HEDIS measure that is an “all or none” combination rate composed of four indicators. Volume 2 has an indicator that looks for at least one HbA1c test, the P4P indicator looks for at least two HbA1c tests. Two HbA1c Tests is a non-HEDIS indicator used by the Wisconsin Collaborative for Healthcare Quality in their Diabetes All or None Process measure, which is the basis for the Optimal Diabetes Care Combination Rate. <i>Blood Pressure Control</i> (<140/90): POs and plans may choose to use either the requirement that the blood pressure reading must be in conjunction with an outpatient visit code or a nonacute inpatient visit code or to use optional exclusions to identify BPs taken in the appropriate setting.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
Use of Imaging Studies for Low Back Pain	Modifications From HEDIS	<ul style="list-style-type: none"> None.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added a method and value sets to identify nonacute inpatient discharges for the event/diagnosis.
	Modifications From HEDIS	<ul style="list-style-type: none"> Limited to the Medicare Advantage product line only.
Osteoporosis Management in Women Who Had a Fracture	December 2015	<ul style="list-style-type: none"> None.
		<ul style="list-style-type: none"> Defined “active prescription.” Revised the method and value sets to identify acute and nonacute inpatient events for steps 1 and 2 of the event/diagnosis.
	September 2015	<ul style="list-style-type: none"> Clarified when to use admission or discharge dates when determining Negative Diagnosis History. Clarified that bone mineral density tests that occur in an inpatient setting (either during an inpatient IESD or during the 180-day (6-month) period after the IESD) meet numerator criteria. Added long-acting osteoporosis therapy administered during an inpatient IESD to the numerator.
	Modifications From HEDIS	<ul style="list-style-type: none"> Physician organizations without access to inpatient claim/encounter data may use an alternative method to determine the IESD.
Childhood Immunization Status	December 2015	<ul style="list-style-type: none"> None.
		<ul style="list-style-type: none"> Added Influenza and Combination 10.
	September 2015	<ul style="list-style-type: none"> Added a <i>Note</i> to MMR clarifying that the “14-day rule” does not apply to this vaccine. Added a new value set to the administrative method to identify hepatitis B vaccines administered at birth.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Immunizations for Adolescents	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.
Human Papillomavirus Vaccine for Female Adolescents	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> The HEDIS HPV measure does not include male adolescents.
Chlamydia Screening in Women	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.
Evidence-Based Cervical Cancer Screening of Average-Risk, Asymptomatic Women	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Revised the service dates in the example for step 2 of Rate 2.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
Cervical Cancer Screening	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added to the MY 2015 measure set.
	Modifications From HEDIS	<ul style="list-style-type: none"> The measure exclusion is required.
Cervical Cancer Overscreening	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added to the MY 2015 measure set. Clarified the denominator for each rate in the measure description. Added a note to step 1 and step 2 to the Administrative Specifications.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
	December 2015	<ul style="list-style-type: none"> Revised the optional exclusion so that any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service meets criteria.
Breast Cancer Screening	September 2015	<ul style="list-style-type: none"> Added new value sets to identify bilateral mastectomy.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.

1-4 Appendix 1—Summary Table of Quality Measures and Changes

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Colorectal Cancer Screening	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.
Adult BMI Assessment	December 2015	<ul style="list-style-type: none"> Revised the age criteria from “21 years of age or older” to “20 years of age or older” for BMI and BMI percentile in the numerator.
	September 2015	<ul style="list-style-type: none"> Revised the age criteria for BMI and BMI percentile in the numerator.
	Modifications From HEDIS	<ul style="list-style-type: none"> Limited to the Medicare Advantage product line only.
Asthma Medication Ratio	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added the table AMR-A. Added the 65-85 age stratification. Added a total rate for ages 5-85.
	Modifications From HEDIS	<ul style="list-style-type: none"> To establish a baseline for the new 5-85 age band, P4P will collect two total rates: the total rate for ages 5-64 and the total rate for ages 5-85.
	December 2015	<ul style="list-style-type: none"> Increased the upper age limit to 3 years of age.
	September 2015	<ul style="list-style-type: none"> None. <p>Note: ICD-10 codes are not in effect during the Intake Period for the measure. To accommodate the ICD-10 codes in P4P MY 2016, we anticipate the removal of the single diagnosis code requirement from the measure specifications and the addition of comorbid conditions and competing conditions (ICD-10 coding guidelines for respiratory diagnoses encourage multiple codes on claims).</p>
Appropriate Testing for Children With Pharyngitis	Modifications From HEDIS	<ul style="list-style-type: none"> None.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None. <p>Note: ICD-10 codes are not in effect during the Intake Period for the measure. To accommodate the ICD-10 codes in P4P 2016, we anticipate the removal of the single diagnosis code requirement from the measure specifications and the addition of comorbid conditions and competing conditions (ICD-10 coding guidelines for respiratory diagnoses encourage multiple codes on claims).</p>
Appropriate Treatment for Children With Upper Respiratory Infection	Modifications From HEDIS	<ul style="list-style-type: none"> None.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis	Modifications From HEDIS	<ul style="list-style-type: none"> None.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> None.

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Unexpected Complications in Full-Term Newborns	December 2015	<ul style="list-style-type: none"> ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015. Changed the codes set references to "Perinatal Code Set". Codes to Identify Neonatal Death or Transfer changed from OSHPD Proprietary Code Set to a UB Code Set as of 1/1/2015.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
Incidence of Episiotomy	December 2015	<ul style="list-style-type: none"> ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015. Changed the codes set references to "Perinatal Code Set".
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
All-Cause Readmissions	December 2015	<ul style="list-style-type: none"> Revised the example text and table in step 4 and step 5 of the Risk Adjustment Determination section.
	September 2015	<ul style="list-style-type: none"> Added a method and value sets to identify acute inpatient discharges in step 1 of the event/diagnosis. Added instructions for identifying the transfer setting in step 2 of the event/diagnosis. Added a Note to steps 4 and 5 of the event/diagnosis. Added a method and value sets to identify acute inpatient admissions in step 1 of the numerator.
	Modifications From HEDIS	<ul style="list-style-type: none"> Age 18-64 age band not reported for Medicare. NCQA refers to this measure as <i>Plan All-Cause Readmissions</i>. Expected rates are normalized by Truven to reflect the performance of the population being measures (i.e., commercial P4P or Medicare Advantage).
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added a Note to the measure description. Added further clarification for Calculating Cumulative Days Supply and Average Dose for B) reserpine, C) digoxin, and D) doxepin. Revised the definition for "average daily dose."
High-Risk Medication	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure

1-6 Appendix 1—Summary Table of Quality Measures and Changes

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Meaningful Use of Health IT	December 2015	<ul style="list-style-type: none"> Added a time frame for the NPI file collection period. Added information about MUHIT training Webinars.
	September 2015	<ul style="list-style-type: none"> Clarified that for the results based on the CMS EHR Incentive programs, P4P staff will compute scores both including and excluding pediatricians; the higher of the two scores will be used. Added instructions for how POs must submit NPI numbers for all MDs and DOs in the following specialties: family/general practice, internal medicine and pediatric/adolescent medicine. Clarified that all physicians who meet the criterion (MD or DO) in family/general practice, internal medicine or pediatric/adolescent medicine should be included in submission, regardless of panel size. Added an optional exclusion for providers who are employed in an administrative-only role (e.g., medical director). Added an optional exclusion for providers who were employed or contracted with a PO for less than six months of the measurement year. Added an optional exclusion for providers considered hospitalists by CMS. Added the <i>Controlling High Blood Pressure</i> and the <i>Screening for Clinical Depression and Follow-Up Plan</i> e-measure specifications to the MUHIT domain.
Patient Experience	December 2015	<ul style="list-style-type: none"> Updates contact information for PAS.
	September 2015	<ul style="list-style-type: none"> Added a link for the PAS registration site. New for this year, there is a short- and long-form option for doctor surveys. Added a timeline for the first wave of e-mail surveys in the <i>Fielding Surveys</i> section. Clarified and adjusted timeline in the Key Dates for PAS table.
Inpatient Utilization—Acute Care Discharges	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> Added a note to part D of Discharge Identification Methodology and Coding.
Inpatient Utilization—Bed Days	Modifications From HEDIS	<ul style="list-style-type: none"> Based on HEDIS Use of Services specifications. Added risk adjustment.
	December 2015	<ul style="list-style-type: none"> None.
Outpatient Procedures Utilization—Percentage Done in Preferred Facility	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Based on HEDIS Use of Services specifications. Added risk adjustment.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Based on former HEDIS Utilization specifications.
	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Based on former HEDIS Utilization specifications.

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update
Emergency Department Visit	December 2015	<ul style="list-style-type: none"> None.
	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Based on HEDIS Utilization specifications. Added risk adjustment.
	December 2015	<ul style="list-style-type: none"> None.
Generic Prescribing	September 2015	<ul style="list-style-type: none"> None.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
	December 2015	<ul style="list-style-type: none"> None.
Total Cost of Care	September 2015	<ul style="list-style-type: none"> Removed information about which metrics POs report from the description. Added a step for geography adjustment to the Total Cost of Care Calculation.
	Modifications From HEDIS	<ul style="list-style-type: none"> Non-HEDIS measure.
	December 2015	<ul style="list-style-type: none"> None.
Frequency of Selected Procedures	September 2015	<ul style="list-style-type: none"> Added hysterectomy, tonsillectomy, cholecystectomy, prostatectomy, mastectomy, lumpectomy to list of selected procedures.
	Modifications From HEDIS	<ul style="list-style-type: none"> P4P collects carotid endarterectomy, total hip replacement and total knee replacement for the commercial HMO/POS.
	December 2015	<ul style="list-style-type: none"> Revised the example text and table in step 4 and step 5 of the Risk Adjustment Determination section.
All-Cause Readmissions	September 2015	<ul style="list-style-type: none"> Added a method and value sets to identify acute inpatient discharges in step 1 of the event/diagnosis. Added instructions for identifying the transfer setting in step 2 of the event/diagnosis. Added a Note to steps 4 and 5 of the event/diagnosis. Added a method and value sets to identify acute inpatient admissions in step 1 of the numerator.
	Modifications From HEDIS	<ul style="list-style-type: none"> Age 18-64 age band not reported for Medicare. NCQA refers to this measure as <i>Plan All-Cause Readmissions</i> Expected rates are normalized by Truven to reflect the performance of the population being measures (i.e., commercial P4P or Medicare Advantage).
	December 2015	<ul style="list-style-type: none"> ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015. Changed the codes set references to "Perinatal Code Set". Codes to Identify Neonatal Death or Transfer changed from OSHPD Proprietary Code Set to a UB Code Set as of 1/1/2015.
	September 2015	<ul style="list-style-type: none"> None.

1-8 Appendix 1—Summary Table of Quality Measures and Changes

MY 2015 Measures	Date of Update/ Modification From HEDIS	Measure Update	
		Measure Update	
Incidence of Episiotomy	Modifications From HEDIS	<ul style="list-style-type: none"> • Non-HEDIS measure. 	
	December 2015	<ul style="list-style-type: none"> • ICD-10 Codes replace ICD-9 Codes for discharge dates from October 1, 2015. • Changed the codes set references to "Perinatal Code Set". 	
	September 2015	<ul style="list-style-type: none"> • None. 	
	Modifications From HEDIS	<ul style="list-style-type: none"> • Non-HEDIS measure. 	
Cesarean Section Rate for Low-Risk Births	December 2015	<ul style="list-style-type: none"> • ICD-10 Codes Replace ICD-9 Codes for Discharge Dates from October 1, 2015. 	
	September 2015	<ul style="list-style-type: none"> • Changed the codes set references to "Perinatal Code Set". • None. 	
	Modifications From HEDIS	<ul style="list-style-type: none"> • Non-HEDIS measure. 	
Vaginal Birth After Cesarean Delivery Rate	December 2015	<ul style="list-style-type: none"> • ICD-10 Codes Replace ICD-9 Codes for Discharge Dates from October 1, 2015. • Changed the codes set references to "Perinatal Code Set". • Revised the eligible population criteria to include cases with prior Cesarean deliveries. 	
	September 2015	<ul style="list-style-type: none"> • None. 	
	Modifications From HEDIS	<ul style="list-style-type: none"> • Non-HEDIS measure. 	