Integrated Healthcare Association
California Value Based Pay for Performance Program

Measurement Year 2016 VBP4P Manual

Updated December 1, 2016
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Overview

VBP4P Background

The California Value Based Pay for Performance (VBP4P) 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 VBP4P 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 VBP4P 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.

VBP4P Measure Set Evolution and Priorities

Since 2003, IHA has had an established common measure set for the VBP4P program, accompanied by standard processes, procedures and timelines for updating the measure set. IHA seeks to evolve the VBP4P 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 VBP4P 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 VBP4P 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.

The 2016–2021 Measure Set Strategy (http://www.iha.org/sites/default/files/resources/2016-2021_vbp4p_measure_set_strategy.pdf) guides development and maintenance of the VBP4P measure set. Key priorities identified in the measure set strategy include supporting alignment across commonly used measure sets, targeted development of the VBP4P measure set and reducing the burden of data collection and reporting.

The primary objectives of Value Based P4P are to reorder the priorities of the VBP4P 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 VBP4P 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 VBP4P program for Medicare Advantage currently exists. The following Medicare Advantage plans participate in measurement and reporting:

- Blue Shield of California
- Kaiser Permanente
- Health Net
- SCAN Health Plan
- UnitedHealthcare
Key Organizations Involved in Data Collection, Aggregation and Reporting

**IHA**  The Integrated Healthcare Association manages VBP4P 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 Advancing Care Information domain. The majority of clinical quality measures are adapted from the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) 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.

**CHPI/PBGH**  The California Healthcare Performance Information System (CHPI) administers the Patient Assessment Survey (PAS), which is used to measure performance in VBP4P’s Patient Experience domain. CHPI reports relevant PAS results to IHA for inclusion in the VBP4P 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 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 VBP4P results as the basis of its annual Medical Group Quality of Care Report Card, at http://www.opa.ca.gov.

VBP4P Participation and Use of Results

The IHA VBP4P 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 VBP4P program to provide care for their commercial HMO or POS members.

VBP4P 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 VBP4P public recognition award winners. VBP4P produces results across four domains: Clinical, Advancing Care Information, 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.
- **Advancing Care Information Domain data** are voluntarily submitted by POs.
- **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.
- **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.

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

Although the Value Based P4P program encourages data sharing between POs and health plans, VBP4P staff are not prescriptive about how this is done. POs and health plans are expected to work together early in the process to establish a data sharing process and requirements. This may include an agreement on allowable data types, file formatting, timing, confirmation of data received and of data use in health plan reports.

Domains and Reporting Entities

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<thead>
<tr>
<th>Domain</th>
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<td>Resource Use</td>
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*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 VBP4P are eligible for VBP4P. POs must sign the VBP4P Consent to Disclosure Agreement to confirm their participation in VBP4P. 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 VBP4P for commercial and Medicare, as of the publication of this manual.

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PO and Health Plan Report Types, Content and Uses

VBP4P generates several reports of PO measurement results.

VBP4P provides health plans with aggregated VBP4P measurement results for commercial HMO or POS members, for each PO they are contracted with (if the PO signed the VBP4P Consent to Disclosure Agreement).

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

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

VBP4P 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. VBP4P staff consider all comments and discuss them with VBP4P committees, as appropriate.

Joining P4P as a New Plan

New plans that want to join the VBP4P program should send an e-mail to p4p@iha.org. VBP4P 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 VBP4P compliance audits.

A list of NCQA-Certified HEDIS and VBP4P Licensed Organizations is available here: http://www.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/LicOrgs%208.23_2016.pdf?ver=2016-08-23-204313-020 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 website 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 VBP4P 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.
**VBP4P Data Collection and Reporting Timeline**

The timeline includes major milestones in the VBP4P 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 VBP4P.

### General VBP4P Program Dates

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MY 2016 Measure Set and Summary of Changes</strong> posted to the IHA website.</td>
<td>December 15, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Calendar year 2016 Public Comment Period</strong> posted to the IHA website.</td>
<td>September 1–30, 2016</td>
<td></td>
</tr>
<tr>
<td>• Public Comment Overview document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Draft MY 2016 Manual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MY 2017 Proposed Measure Set</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MY 2016 Intentions Period:</strong> POs declare their intent to participate in the VBP4P program for MY 2016 and confirm their health plan contracts.</td>
<td>November 15–December 1, 2016</td>
<td>November 15–December 15, 2016</td>
</tr>
<tr>
<td><strong>Final MY 2016 VBP4P Manual</strong> posted to the IHA website.</td>
<td>December 1, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>MY 2017 Measure Set and Summary of Changes</strong> posted to the IHA website.</td>
<td>December 14, 2016</td>
<td></td>
</tr>
</tbody>
</table>

### Data Submission Deadlines

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PAS:</strong> Registration information e-mailed to POs.</td>
<td>September 12, 2016</td>
<td>NA</td>
</tr>
<tr>
<td><strong>NDC Lists:</strong> MY 2016 NDC lists posted to NCQA website.</td>
<td>November 1, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Auditors Guideline:</strong> VBP4P MY 2016 Auditors Guideline posted to NCQA and IHA website.</td>
<td>November 30, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Data Submission File Layout:</strong> MY 2016 data submission file layout posted to IHA website. E-mail notification will also be sent out to health plans and self-reporting POs notifying them of the most recent postings.</td>
<td>Preliminary File: January 13, 2017</td>
<td>Final File: February 1, 2017</td>
</tr>
<tr>
<td><strong>Q1-Q4 Encounter Data:</strong> POs that use TransUnion HealthCare as the encounter data intermediary must submit all remaining Q4 2016 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 VBP4P reporting.</td>
<td>February 17, 2017</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Supplemental Data Collection Deadline:</strong> Organization completes and stops all nonstandard supplemental data collection and entry.</td>
<td>February 16, 2017</td>
<td>March 1, 2017</td>
</tr>
<tr>
<td><strong>Supplemental Data Validation Deadline</strong></td>
<td>March 15, 2017</td>
<td>March 31, 2017</td>
</tr>
<tr>
<td>• For POs: Auditor finalizes approval of all supplemental data for POs. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to February 16, unless the PO finished all supplemental data processes, collection and entry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• For Health Plans: Auditor finalizes approval of all supplemental data for health plans. Primary source verification (PSV) for nonstandard supplemental data must not occur prior to March 1, unless the health plan finished all supplemental data processes, collection and entry.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Measure certification deadline:</strong> NCQA sends final certification reports to auditors.</td>
<td>March 15, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Data Layout Test Files:</strong> Self-reporting POs and health plans submit data layout test files to TransUnion HealthCare.</td>
<td>March 21–May 2, 2017</td>
<td></td>
</tr>
<tr>
<td><strong>Supplemental Data to Health Plans:</strong> VBP4P health plans receive the audited supplemental data files and audit results from the PO.</td>
<td>March 31, 2017</td>
<td></td>
</tr>
</tbody>
</table>
Report Release Dates and Review Periods

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>PO Deadline</th>
<th>Health Plan Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Reports Timeline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preliminary Reports Release: IHA posts preliminary quality reports for POs and health plans.</td>
<td>May 25, 2017</td>
<td></td>
</tr>
<tr>
<td>Questions and Appeals Period: VBP4P staff work 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.</td>
<td>May 25–June 15, 2017</td>
<td></td>
</tr>
<tr>
<td>Appeals Hearing: The VBP4P Appeals Panel reviews and decides on all appeals to change quality results, if needed.</td>
<td>June 29, 2017</td>
<td></td>
</tr>
<tr>
<td>Resubmission of Auditor-Locked VBP4P Results: Self-reporting POs and health plans submit auditor-locked VBP4P clinical results to TransUnion HealthCare, if needed.</td>
<td>July 6, 2017</td>
<td></td>
</tr>
<tr>
<td>Final Reports Released: IHA releases final quality reports to POs and health plans.</td>
<td>July 13, 2017</td>
<td></td>
</tr>
</tbody>
</table>

Resource Use Reports Timeline

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Time Frame or Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary Reports Released: IHA posts preliminary quality reports for PO and Health Plan's Appropriate Resource Use and Total Cost of Care preliminary reports.</td>
<td>June 29, 2017</td>
</tr>
<tr>
<td>Review Period: IHA and Truven work with POs and health plans to address any questions or issues related to Appropriate Resource Use &amp; Total Cost of Care results.</td>
<td>June 29–July 20, 2017</td>
</tr>
<tr>
<td>Final Reports Released: IHA releases Appropriate Resource Use &amp; Total Cost of Care final reports to POs and health plans.</td>
<td>August 17, 2017</td>
</tr>
</tbody>
</table>

Key Dates for Review and Correction of MY 2016 Results

IHA is committed to providing POs and health plans an opportunity to review their VBP4P results and to submit questions and requests for changes if they believe any of their results are in error.

The full timeline for reviewing VBP4P results and requesting corrections or changes is documented in the Data Collection and Reporting Timeline. VBP4P program staff encourage participants to seek corrections and additional information throughout the measurement cycle.
Organizations have 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, 2017**, and the final date to submit an appeal is **June 15, 2017**. VBP4P staff work 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, 2017**, and the final date to submit an appeal is **July 20, 2017**. 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 Panel is made up of seven members: three representatives from participating health plans, three representatives from participating physician organizations, and one at-large member. The panel receives blinded appeal requests, supporting documentation and a summary from the VBP4P 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 Advancing Care Information) 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 VBP4P 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.


Specifications in the **MY 2016 Value Based P4P Manual** that are posted to the IHA website on December 1, 2016, are frozen. The National Drug Code (NDC) lists are published on the NCQA website 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

VBP4P 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 2016) 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 VBP4P specifications, and are posted to the NCQA website (www.ncqa.org) on the 15th of each month, and on the IHA website (www.iha.org), as needed.

What's in VBP4P MY 2016?

Clinical Domain

The VBP4P 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 VBP4P clinical measures is based on NCQA's HEDIS Compliance Audit™ program. NCQA staff work with VBP4P 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 VBP4P audit review. The *MY 2016 VBP4P Audit Review Guidelines* for Measurement Year (MY) 2016 is scheduled for release in November 2016.

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 2016 Clinical Measures.
Advancing Care Information 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 providers’ ability to generate clinical e-Measure results directly from their systems. POs may voluntarily participate in the domain by submitting e-Measure results in the clinical file submission.

Refer to Advancing Care Information Domain (previously 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® 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. VBP4P 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 2016 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. Refer to Resource Use Domain for a list of the MY 2016 appropriate Resource Use measures.

Testing Measures

The VBP4P measure set includes testing measures for voluntary data collection and submission. VBP4P 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 VBP4P Technical Measurement and Governance Committees. Selected measures will be tested in MY 2016 and added to the MY 2017 P4P measure set (barring problems identified during testing). The VBP4P Governance Committee will confirm adoption of these measures in fall 2016, with input from Public Comment and recommendations from the VBP4P Technical Measurement Committee.

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CAHPS® 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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Specification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td>None.</td>
</tr>
<tr>
<td>Medicare</td>
<td>None.</td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>None.</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>None.</td>
</tr>
<tr>
<td>Resource Use</td>
<td>None.</td>
</tr>
</tbody>
</table>

Read the entire guidelines section and measure specifications before implementing the VBP4P MY 2016 measures.
General Guidelines for Data Collection and Reporting

For Value Based P4P MY 2016
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 VBP4P 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 VBP4P clinical specifications and submit results for all clinical measures on behalf of all contracted POs with commercial HMO/POS contracts that have signed the VBP4P Consent to Disclosure Agreement, regardless of PO eligibility for VBP4P 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 VBP4P Consent to Disclosure Agreement, regardless of PO eligibility for VBP4P 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 VBP4P clinical results based on all commercial HMO/POS members belonging to a participating health plan, regardless of its eligibility for VBP4P 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 VBP4P compliance audits. A list of NCQA-Certified HEDIS and VBP4P Licensed Organizations is available here: http://www.ncqa.org/Portals/0/HEDISQM/Programs/CompAud/LicOrgs%208.23_2016.pdf?ver=2016-08-23-204313-020 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 website 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 VBP4P. All reported clinical measure results must be validated through a VBP4P Audit Review, described in Audit Review.
2. Reporting Level

VBP4P aggregates data at either the PO “parent” level or the PO “subgroup” level. For VBP4P to report data at the subgroup level for a PO, all of the PO’s contracted VBP4P 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 VBP4P health plans must report the PO’s data at the PO parent level (i.e., the “00” level). Additionally, to report final VBP4P data at the PO subgroup level, the PO must have separate PAS surveys and Advancing Care Information 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).

3. Submitting Data

All POs eligible for VBP4P (i.e., with a commercial HMO/POS contract during 2016, with any VBP4P participating health plan) —self-reporting or not—must submit encounter data to their contracted VBP4P 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 VBP4P 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.

Although the Value Based P4P program encourages data sharing between POs and health plans, VBP4P staff are not prescriptive about how this is done. POs and health plans are expected to work together early in the process to establish a data sharing process and requirements. This may include an agreement on allowable data types, file formatting, timing, confirmation of data received and of data use in health plan reports.

4. VBP4P 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 VBP4P policy for handling mergers and acquisitions accommodates a variety of circumstances and ensures a consistent and fair process.

5. VBP4P Consent to Disclosure Agreement

POs must sign the VBP4P Consent to Disclosure Agreement to confirm their participation in VBP4P. No data are collected or reported for POs that have not signed a Consent to Disclosure Agreement. VBP4P posts reports for all POs that sign the Consent to Disclosure Agreement.

6. Attribution

VBP4P 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

VBP4P defines peer groups as “all POs participating in the VBP4P program.” POs eligible to participate in the P4P program have a commercial HMO/POS contract with any VBP4P 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 VBP4P clinical quality measures; therefore, VBP4P 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.

Advancing Care Information  Advancing Care Information measures are not risk adjusted.

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

VBP4P 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, VBP4P 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 VBP4P 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

VBP4P 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.

*Note:* For VBP4P 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 VBP4P health plan, regardless of product line, should be included in all VBP4P 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 VBP4P 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 health plan/PO VBP4P reports. Health plans/POs may exclude only ASO members from VBP4P reports in only either of the following situations and only with auditor approval.

- The contract prohibits the health plan/PO from contacting members for any reason.
  - This 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 health plan/PO may not contact these ASO members under any circumstances.
  - The agreement to exclude members in the reporting year is in place (i.e., fully executed by both parties, in the case of a contract, or communicated, in the case of a written agreement) by January 1 of the measurement year.

- The health plan/PO is not responsible for administering both in-network and out-of-network claims for ASO members (i.e., employer carve-out for both in-network and out-of-network claims).
  - If claims are administered through a third party on behalf of the plan/PO (i.e., claims delegation arrangement), the plan/PO is considered responsible for administering claims and may not exclude members.

A health plan/PO may not exclude members who cannot be reached (e.g., overseas military or Foreign Service members), unless one of these situations applies. Non-ASO members may not be excluded under this guideline. Federal government instructions and guidance supersede the requirements in this guideline.

18. Members Who Switch Products/Product Lines

Measures with a continuous enrollment requirement

Members enrolled in different products or 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 VBP4P 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.

Organizations 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.
19. Members in Hospice

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include, but are not limited to, enrollment data, medical record and claims/encounter data (Hospice Value Set).

Organizations should attempt to remove these members prior to determining a measure’s eligible population.

The exclusion of members in hospice is subject to auditor review.

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 VBP4P 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 VBP4P measures require calculation of continuous enrollment at the PO parent level. POs that self-report VBP4P 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 VBP4P 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. VBP4P 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 VBP4P 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.
29. 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).

30. Supplemental Data

*Supplemental data uses*  To supplement claims data for calculating VBP4P 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:*  
- Numerators (that are labeled as numerators in the specifications).
- Observed events in the All-Cause Readmissions measure.
- Optional exclusions.
- Eligible-population required exclusions (labeled as required exclusions in the
  specification). For example:
  - *Asthma Medication Ratio.* Organizations may use supplemental data for
    members who have any condition in step 3, Required Exclusions for the
    event/diagnosis.

*Supplemental data may not be used for:*  
- Denominator events. Organizations may not create and use records to identify
denominator events, other than for optional exclusions and appropriate required
exclusions. For example:
  - *Appropriate Testing for Children With Pharyngitis.* 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 may not create and use records, on an ongoing basis, for
exclusions for clinical conditions that change.
- Correcting bills or identifying valid data errors. Organizations may not 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:
  - Organizations may not exclude a member from the Osteoporosis Management
    in Women Who Had a Fracture 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.
- Measures with no numerators. Organizations may not use supplemental data to
  identify events in measures with no numerators. For example:
  - Organizations may not use supplemental data to identify procedures in the
    Frequency of Selected Procedures measure.
• Risk adjustment. Organizations may not 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.
- Data from certified e-Measure vendors.

**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 VBP4P 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., uncertified eMeasure modules).
- Provider portals (i.e., electronic systems providers use to enter information about services rendered).
- Health Information registries.
- Provider abstraction forms.
- Member-reported services.
  – Refer to General Guideline 38 for requirements for member-reported services abstracted during medical record review.
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 documentation that is allowed for primary source verification:

- 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 documentation that is 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.

Required Data Elements

<table>
<thead>
<tr>
<th>Standard supplemental data</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonstandard supplemental data</td>
<td>Nonstandard supplemental data files must have all the data elements required to meet the criteria specified by the measure specifications.</td>
</tr>
</tbody>
</table>

Electronic sources (i.e., portal, uncertified 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).

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.

Member-reported services. 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).

All supplemental data

All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to General Guideline 32 for date specificity requirements).

If a VBP4P health plan uses audited PO supplemental data to report HEDIS results to NCQA, any VBP4P measure that can be reported using the hybrid methodology for HEDIS must contain all hybrid data elements.
For all measures, the organization must be able to determine that a test or service was performed within the period specified, not merely ordered.

When pharmacy data are classified as supplemental data, all data elements from the NDC lists must be present: the generic name, strength/dose, route and date when the medication was dispensed to the member. Generic documentation in the medical record (e.g., that a patient “was prescribed” or “is taking” a medication) that does not include drug name, strength/dose and dispense date, does not meet criteria.

All supplemental data used to show eligibility for exclusion must follow the requirements for exclusion in each measure.

**Supplemental data sharing between POs and health plans**

VBP4P health plans that use supplemental data collected for VBP4P 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.

**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 supplemental data must be completed by the deadlines listed in the VBP4P 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.

VBP4P 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 VBP4P 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 VBP4P Data Collection and Reporting timeline for all deadline requirements.

**Identifying and Validating Supplemental Data**

All supplemental data (standard and nonstandard) must be identifiable. Because supplemental data can affect reporting and incentives, POs, plans or vendors that include supplemental data files for VBP4P 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 Supplemental Data and e-Measure section of the 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.
- For supplemental data from a certified eMeasure vendor, the auditor must receive a final certification report.
Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate VBP4P 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 VBP4P MY 2016 Audit Review Guidelines, released each November.

**Note:** Only health plans that participate in the VBP4P 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 VBP4P health plans are not required to also collect the proof-of-service documents for these audited and approved PO data. Refer to the VBP4P Audit Review Guidelines, released each November.

### 31. 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 VBP4P reporting. To be eligible for use, documentation must include the collection date or the reported date.
32. Date Specificity

VBP4P 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.

33. 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.**
- **Immunizations 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.

34. Measures That Use Pharmacy Data

Some measures require the use of available pharmacy data. Self-reporting POs must have pharmacy data from all contracted VBP4P 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 website at [http://www.ncqa.org](http://www.ncqa.org). Select HEDIS 2017 for VBP4P MY 2016. NCQA posts the final NDC lists for pharmacy-related measures on the NCQA website on November 1, 2016.
35. 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 LOINC 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. Claims with a code from the Independent Laboratory Value Set are considered laboratory claims. Organizations may need to use other methods 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.

36. Facility Data

With the exception of ARU and certain maternity measures, VBP4P 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.

37. 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 VBP4P reporting.

38. Member-Reported Services

Member-reported services are acceptable only if the information is collected by a primary care practitioner, or by a specialist who is providing a primary care service related to the condition being assessed, while taking a patient’s history. The information must be recorded, dated and maintained in the member’s legal health record.

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.

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^3LOINC® is a registered trademark of the Regenstrief Institute.
Coding Conventions

39. Coding Systems Included in VBP4P

VBP4P includes codes from the following coding systems.

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).\(^5\)
- CVX—Vaccines Administered.
- 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).

40. Presentation of Codes in VBVP4P Value Sets


Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

The American Medical Association holds a copyright to the CPT® codes contained in the measures specifications.

The American Hospital Association holds a copyright to the Uniform Bill Codes (“UB”) contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@healthforum.com.

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\(^6\)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 VBP4P specifications before they are frozen at the end of November. Consequently, AHA’s coding updates are not included in the final VBP4P specifications for that year, and should not be used for VBP4P reporting. This policy ensures consistency in reporting across health plans and POs and reduces burden by eliminating updates to the VBP4P specifications after the freeze date. The codes will be considered for the following VBP4P cycle.
41. Using Claims to Identify Events in Conjunction With Diagnoses

Many measures require that a visit code or procedure code be used in conjunction with a diagnosis code. Unless otherwise stated in a measure specification, the codes must be on the same claim or be found on the same date of service.

If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes may be on the same claim or same date of service). For example, the Comprehensive Diabetes Care measure identifies members with at least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). The Acute Inpatient Value Set includes both CPT and UB Revenue codes; therefore, use both facility and professional claims to identify the acute inpatient visit diagnosis and the diabetes diagnosis.

If a value set includes codes used only on facility claims (e.g., UB), only use facility claims to identify services and diagnoses (the codes must be on the same claim). For example, the Persistence of Beta-Blocker Treatment After a Heart Attack measure identifies members who had an inpatient discharge (Inpatient Stay Value Set; Nonacute Inpatient Stay Value Set) with any diagnosis of AMI (AMI Value Set). The Inpatient Stay Value Set and Nonacute Inpatient Stay Value Set include only codes used on facility claims (UB Revenue and UB Type of Bill); therefore, use only facility claims to identify the discharge and the AMI diagnosis.

42. 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.
43. 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 VBP4P specifications that appears in the organization’s database with any modifier other than those specified above may be counted in the HEDIS measure.

44. Uniform Bill Codes Specificity

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

The VBP4P 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.

45. 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 website (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.
46. 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 VBP4P measures. Codes designated obsolete are not deleted from the VBP4P 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.

47. 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. |

VBP4P Data Submission

48. 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.”

49. Reporting Date

The previous calendar year is the standard measurement year for VBP4P 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 Q1–Q4 2016 encounter data to TransUnion HealthCare by February 18, 2017. 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 VBP4P reporting.

- Self-reporting POs and health plans must submit auditor-locked VBP4P clinical results by May 9, 2017. Health plans must submit results for all clinical measures for each contracted PO with a signed VBP4P Consent to Disclosure Agreement.
50. 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).
- VBP4P 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 VBP4P Audit Review

51. Audit Review Principles

VBP4P 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 VBP4P Audit Review incorporates VBP4P-relevant components of the HEDIS Compliance Audit described in the current volume, *HEDIS Compliance Audit™: Standards, Policies and Procedures*. A separate manual with VBP4P Audit Specifications will be posted to the IHA website in November 2016.

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 VBP4P 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.
52. Audit Components

VBP4P audit review components depend on the reporting option.

**Health plan reporting**  
A health plan that undergoes a HEDIS Compliance Audit and also reports VBP4P 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:

- 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 VBP4P measures according to VBP4P specifications.
- The algorithms and source code used to report rates by PO.

**PO self-reporting**  
A PO that collects and reports VBP4P 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 VBP4P Audit Review Guidelines.

*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 VBP4P Audit Review Guidelines, released in November 2016.

53. Audit Results

VBP4P Audit Reviews result in audited rates at the measure level and indicate if a measure can be publicly reported. All VBP4P 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.

<table>
<thead>
<tr>
<th>Rate/Result</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–XXX</td>
<td>Reportable</td>
<td>Reportable rate for VBP4P 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.</td>
</tr>
<tr>
<td>BR</td>
<td>Biased Rate</td>
<td>The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.</td>
</tr>
<tr>
<td>NR</td>
<td>Not Reported</td>
<td>The health plan did not report the measure (may only be used for testing measures).</td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th>Rate/Result</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–XXX</td>
<td>Reportable</td>
<td>Reportable rate for VBP4P 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.</td>
</tr>
<tr>
<td>BR</td>
<td>Biased Rate</td>
<td>The calculated rate was materially biased. The auditor determines a result is not reportable due to material bias.</td>
</tr>
<tr>
<td>SD</td>
<td>Small Denominator</td>
<td>The PO calculated the result, but the denominator was too small to report a valid rate (denominator between 1 and 29 members).</td>
</tr>
<tr>
<td>NB</td>
<td>No Benefit</td>
<td>The health plan did not offer the health benefit required by the measure (e.g., pharmacy).</td>
</tr>
<tr>
<td>NR</td>
<td>Not Reported</td>
<td>The PO did not report the measure.</td>
</tr>
</tbody>
</table>

54. 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.

55. 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.

56. Marketing

Release of VBP4P Audit results must be in accordance with NCQA’s Guidelines for Advertising and Marketing, posted on the NCQA website 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 VBP4P audit or to VBP4P data audited by a Certified HEDIS Compliance Auditor must adhere to the guidelines.
Clinical Domain Technical Specifications

For Value Based P4P MY 2016
Health Plans and Self-Reporting POs
Overview

This section includes the VBP4P technical specifications for use in collecting California PO clinical performance data in 2017 for MY 2016. 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 2016 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.

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Clinical Measures</th>
<th>Commercial</th>
<th>Medicare</th>
<th>Non-HEDIS</th>
<th>Differs From HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Rate for Clinical Measures</td>
<td>Encounter Rate by Service Type</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Controlling High Blood Pressure for People With Hypertension</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of Days Covered by Medications— Renin Angiotensin System (RAS) Antagonists</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statin Therapy for Patients With Diabetes (SPD)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of Days Covered by Medications—Statins</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Proportion of Days Covered by Medications—Diabetes All Class</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—Two HbA1c tests</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—HbA1c Poor Control (9.0%)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—HbA1c Control (&lt;8.0%)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—Eye Exam</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—Nephropathy Monitoring</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—BP Control (&lt;140/90)</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diabetes Care—Optimal Diabetes Care Combination Rate</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statin Therapy for Patients With Cardiovascular Disease (SPC)</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Priority Area</td>
<td>Clinical Measures</td>
<td>Commercial HMO/POS</td>
<td>Medicare*</td>
<td>Non-HEDIS</td>
<td>Differs From HEDIS</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Prevention</td>
<td>Childhood Immunization Status</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Immunizations for Adolescents</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Human Papillomavirus Vaccine for Female Adolescents</td>
<td>✔</td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td></td>
<td>Human Papillomavirus Vaccine for Male Adolescents</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chlamydia Screening in Women</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Screening</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Overscreening</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Colorectal Cancer Screening</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adult BMI Assessment</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>Asthma Medication Ratio</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appropriate Treatment for Children With Upper Respiratory Infection</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization</td>
<td>All-Cause Readmissions</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Other Medicare Measures</td>
<td>High-Risk Medications</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>E-Clinical Measures</td>
<td>Controlling High Blood Pressure (e-Measure)</td>
<td>✔</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Screening for Clinical Depression and Follow-Up Plan (e-Measure)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

*All Medicare measures are CMS Stars measures.
Encounter Rate by Service Type (ENRST)

**Measure Updates December 2016 for P4P MY 2016**
- Added to the MY 2016 Medicare measure set.

**Measure Updates September 2016 for P4P MY 2016**
- 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**

<table>
<thead>
<tr>
<th>Definitions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member years</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td>For each PO, calculate member years by dividing total member months by 12. X member months/12 months = Y member years</td>
</tr>
<tr>
<td><strong>Encounter</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
Determine encounters/claims

Count any code that represents a unique date of service, a unique provider identifier and a unique patient.

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).

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 2016.

Report services without regard to practitioner type, training or licensing. Include after-hours, nonemergency urgent care, nursing home visits and outpatient surgical procedures.

IHA encourages detailed service reporting to facilitate comparability and complete reporting, even when the financial reimbursement arrangement does not require it.

Overall encounter rate

Sum of the numerators for rates 1, 2, 3, 4a, 5a and 6, divided by member years for the PO.

Product lines

Commercial HMO/POS, Medicare.

Encounter Rate 1: Office and Other Outpatient Services

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

Note

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

Encounter Rate 2: Preventive Medicine

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Member years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Count the total number of preventive medicine encounters/claims using the (Preventive Medicine Services Value Set).</td>
</tr>
</tbody>
</table>

Encounter Rate 3: Ophthalmology and Optometry

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Member years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Count the total number of ophthalmology or optometry encounters/claims (Ophthalmological Services Value Set). Report services without regard to practitioner type, training or licensing.</td>
</tr>
</tbody>
</table>
### Encounter Rate 4: Laboratory/Pathology Services

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Member years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td></td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Member years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td></td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Member years</th>
</tr>
</thead>
</table>
| 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.

---

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Annual Monitoring for Patients on Persistent Medications (MPM)

Measure Updates December 2016 for P4P MY 2016

- Added Amlodipine-perindopril to Table MPM-A.

Measure Updates September 2016 for VBP4P MY 2016

- None.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

Product lines
Commercial HMO/POS.

Ages
18 years and older 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 VBP4P 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 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin converting enzyme inhibitors</td>
<td>• Benazepril  • Enalapril  • Lisinopril  • Moexipril  • Quinapril  • Rampir  • Trandolapril</td>
</tr>
<tr>
<td>Angiotensin II inhibitors</td>
<td>• Azilsartan  • Eprosartan  • Losartan  • Telmisartan</td>
</tr>
<tr>
<td>Antihypertensive combinations</td>
<td>• Aliskiren-valsartan  • Amlodipine-benazepril  • Amlodipine-chlorthalidone  • Benazepril-hydrochlorothiazide  • Candesartan-hydrochlorothiazide  • Captopril-hydrochlorothiazide  • Enalapril-hydrochlorothiazide  • Eprosartan-hydrochlorothiazide  • Felodipine-hydrochlorothiazide  • Nifedipine-hydrochlorothiazide  • Olmesartan-hydrochlorothiazide  • Telmisartan-hydrochlorothiazide  • Verapamil-hydrochlorothiazide  • Valsartan-hydrochlorothiazide  • Verapamil-hydrochlorothiazide  • Valsartan-hydrochlorothiazide</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.
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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inotropic agents</td>
<td>• Digoxin</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antihypertensive combinations</strong></td>
<td></td>
</tr>
<tr>
<td>Aliskiren-hydrochlorothiazide</td>
<td>Fosinopril-hydrochlorothiazide</td>
</tr>
<tr>
<td>Aliskiren-hydrochlorothiazide-amlodipine</td>
<td>Hydrochlorothiazide-irbesartan</td>
</tr>
<tr>
<td>Amlodipine-hydrochlorothiazide</td>
<td>Hydrochlorothiazide-lisinopril</td>
</tr>
<tr>
<td>Amlodipine-hydrochlorothiazide-olmesartan</td>
<td>Hydrochlorothiazide-losartan</td>
</tr>
<tr>
<td>Amlodipine-hydrochlorothiazide-valsartan</td>
<td>Hydrochlorothiazide-metoloprolol</td>
</tr>
<tr>
<td>Atenolol-chlorthalidone</td>
<td>Hydrochlorothiazide-moexipril</td>
</tr>
<tr>
<td>Azilsartan-chlorthalidone</td>
<td>Hydrochlorothiazide-olmesartan</td>
</tr>
<tr>
<td>Benazepril-hydrochlorothiazide</td>
<td>Hydrochlorothiazide-propranolol</td>
</tr>
<tr>
<td>Bendroflumethiazide-nadolol</td>
<td>Hydrochlorothiazide-quinapril</td>
</tr>
<tr>
<td>Bisoprolol-hydrochlorothiazide</td>
<td>Hydrochlorothiazide-spiroolactone</td>
</tr>
<tr>
<td>Candesartan-hydrochlorothiazide</td>
<td>Hydrochlorothiazide-telmisartan</td>
</tr>
<tr>
<td>Captopril-hydrochlorothiazide</td>
<td>Hydrochlorothiazide-triamterene</td>
</tr>
<tr>
<td>Chlorthalidone-clonidine</td>
<td>Hydrochlorothiazide-valsartan</td>
</tr>
<tr>
<td>Enalapril-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Eprosartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td><strong>Loop diuretics</strong></td>
<td></td>
</tr>
<tr>
<td>Bumetanide</td>
<td>Furosemide</td>
</tr>
<tr>
<td>Ethacrynic acid</td>
<td>Torsemide</td>
</tr>
<tr>
<td><strong>Potassium-sparing diuretics</strong></td>
<td></td>
</tr>
<tr>
<td>Amiloride</td>
<td>Spironolactone</td>
</tr>
<tr>
<td>Eplerenone</td>
<td>Triamterene</td>
</tr>
<tr>
<td><strong>Thiazide diuretics</strong></td>
<td></td>
</tr>
<tr>
<td>Chlorothiazide</td>
<td>Hydrochlorothiazide</td>
</tr>
<tr>
<td>Chlorthalidone</td>
<td>Indapamide</td>
</tr>
<tr>
<td><strong>Note:</strong> NCQA will post a comprehensive list of medications and NDC codes to <a href="http://www.ncqa.org">www.ncqa.org</a> by November 1, 2016.</td>
<td></td>
</tr>
</tbody>
</table>

#### 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 2016 for VBP4P MY 2016**

- Added nonacute inpatient visits as an appropriate setting for identifying the most recent BP reading.
  - As a reminder the mapping of proprietary and other codes is allowed under current guidelines (see General Guideline 45 on page 30) as permitted by audit approval.
- Added new medications to Table CBPH-A:
  - Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the "Antidiabetic combinations" row.
  - Added Insulin degludec and Insulin human inhaled to the "Insulin" row.
  - Added Dulaglutide to the "Glucagon-like peptide-1 (GLP1) agonists" row.

**Measure Updates September 2016 for VBP4P MY 2016**

- Clarified the description.

**Modifications From HEDIS**

- This is a non-HEDIS measure adapted from the VBP4P Comprehensive Diabetes Care: Blood Pressure Control measure.

**Description**

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age without a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Report each of the two rates separately and as a total rate (members 18-85 years of age adequately controlled based on their age).

**Eligible Population**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

- **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 VBP4P 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

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

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 1, 2016.

Administrative Specification

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td></td>
</tr>
</tbody>
</table>

**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) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

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.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Less Than 140 Value Set</td>
<td>Systolic compliant</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal To 140 Value Set</td>
<td>Systolic not compliant</td>
</tr>
<tr>
<td>Diastolic Less Than 80 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic 80–89 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal To 90 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
</tbody>
</table>

**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) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

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.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Less Than 140 Value Set</td>
<td>Systolic compliant</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal To 140 Value Set</td>
<td>Systolic not compliant</td>
</tr>
<tr>
<td>Diastolic Less Than 80 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic 80–89 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal To 90 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
</tbody>
</table>

*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 VBP4P 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.

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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.
Statin Therapy for Patients With Cardiovascular Disease (SPC)

**Measure Updates December 2016 for P4P MY 2016**
- Removed Aspirin-pravastatin 40–80 mg from Table SPC-B.

**Measure Updates September 2016 for VBP4P MY 2016**
- Added to the MY 2016 commercial measure set.
- Added a Note section.

**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**

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.

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.

Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.
Eligible Population: Rate 1—Received Statin Therapy

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

**Product line** Commercial.

**Age** Report two age/gender stratifications and a total rate.
- 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 VBP4P 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:** Members are identified for the eligible population in two ways: by event or by diagnosis. 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.

*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 procedures (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).

Step 2: Required exclusions

Exclude members who meet any of the following criteria:

- 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estrogen agonists</td>
<td>Clomiphene</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>• Atorvastatin 40–80 mg&lt;br&gt;• Amlodipine-atorvastatin 40-80 mg&lt;br&gt;• Ezetimibe-atorvastatin 40-80 mg&lt;br&gt;• Rosuvastatin 20–40 mg&lt;br&gt;• Simvastatin 80 mg&lt;br&gt;• Ezetimibe-simvastatin 80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>• Atorvastatin 10–20 mg&lt;br&gt;• Amlodipine-atorvastatin 10-20 mg&lt;br&gt;• Ezetimibe-atorvastatin 10-20 mg&lt;br&gt;• Rosuvastatin 5–10 mg&lt;br&gt;• Simvastatin 20–40 mg&lt;br&gt;• Ezetimibe-simvastatin 20-40 mg&lt;br&gt;• Niacin-simvastatin 20-40 mg&lt;br&gt;• Sitagliptin-simvastatin 20-40 mg&lt;br&gt;• Pravastatin 40–80 mg&lt;br&gt;• Lovastatin 40 mg&lt;br&gt;• Niacin-lovastatin 40 mg&lt;br&gt;• Fluvastatin XL 80 mg&lt;br&gt;• Fluvastatin 40 mg bid&lt;br&gt;• Pitavastatin 2–4 mg</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.
Eligible Population: Rate 2—Statin Adherence 80%

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

Product line  
Commercial.

Age  
Report two age/gender stratifications and a total rate.
  - 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  
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  
The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

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.

Step 2  
To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

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.

Step 4  
Calculate the member’s PDC using the following equation. Round (using the .5 rule) to two decimal places.

\[
\text{PDC} = \frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}
\]

Step 5  
Sum the number of members whose PDC is ≥80% for the treatment period.
**Note**

- All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.
Proportion of Days Covered by Medications (PDC)

**Measure Updates December 2016 for P4P MY 2016**

- Added the combination product, Valsartan-Nebivolol to the “Antihypertensive combinations” row of Table PDC-A.
- Corrected the table names for Statin Medications, Diabetes All Class Medications, and Insulin Medication in alignment with the final version of the MY 2015 VBP4P Manual.
  - Table PDC-C changed to Table PDC-B.
  - Table PDC-D changed to Table PDC-C.
  - Table PDC-E changed to Table PDC-D.

**Modifications Updates September 2016 for VBP4P MY 2016**

- Added a denominator exclusion for renin angiotensin system (RAS) antagonists.
- Added table PDC-E to identify Renin Angiotensin System (RAS) antagonists denominator exclusions.
- Removed Aliskiren-valsartan from the “Direct renin inhibitor combination products” row and “Antihypertensive combinations” row of Table PDC-A
- Added Perindopril-amlodipine to the “Antihypertensive combinations” row of Table PDC-A
- Removed empagliflozin from the “DPP-IV inhibitor combinations” row of Table PDC-C and added Linagliptin-empagliflozin.
- Added Empagliflozin-metformin to the “SGLT2 Inhibitor Combinations” row of Table PDC-C
- Added Insulin degludec 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—Diabetes All-Class Medications is the same as the CMS Stars measure Medication Adherence for Diabetes All-Class 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**
- Proportion of Days Covered by Medications: RAS antagonists (ACEI, ARB, direct renin inhibitors).
- Proportion of Days Covered by Medications: HMG-CoA inhibitors (i.e., statins).

**Diabetes**
- Proportion of Days Covered by Medications: Diabetes All-Class 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 September 2016 NDC List). Do not distribute NDC lists outside your organization.

### Definitions

**IPD**
Index prescription date. The date of the first fill of the target medication that meets the following criteria:
- 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.
- The member’s treatment period begins on this date. Only paid, nonreversed claims for target medications count for this measure.

**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**

*...for self-reporting POs*
Treatment period: 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.

*...for health plans*
Treatment period: 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.

**Allowable gap**
No gaps in enrollment.
Anchor date

...for self-reporting POs None.

...for health plans None.

Benefit Medical, Pharmacy.

Event/diagnosis Refer to Additional Eligible Population Criteria 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.

Patients dispensed at least one prescription for an ARB/Neprilysin Inhibitor Combination Medication (Table PDC-E).

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

<table>
<thead>
<tr>
<th>Direct renin inhibitor medications</th>
<th>Aliskiren</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin receptor blockers (ARB) medications</td>
<td>Candesartan</td>
</tr>
<tr>
<td>Eprosartan</td>
<td>Losartan</td>
</tr>
<tr>
<td>Angiotensin converting enzyme inhibitors (ACEI) medications</td>
<td>Benazepril</td>
</tr>
<tr>
<td>Captopril</td>
<td>Fosinopril</td>
</tr>
<tr>
<td>Antihypertensive combinations</td>
<td>Amlodipine-benazepril</td>
</tr>
<tr>
<td></td>
<td>Fosinopril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>Perindopril-amlodipine</td>
</tr>
<tr>
<td>Medication Combination Products</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Benazepril-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Candesartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Captopril-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Enalapril-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Eprosartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Losartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Moexipril-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Olmesartan-amlodipine-</td>
<td></td>
</tr>
<tr>
<td>hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Telmisartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Trandolapril-verapamil HCL</td>
<td></td>
</tr>
<tr>
<td>Valsartan-nebivolol</td>
<td></td>
</tr>
<tr>
<td>Valsartan-hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Direct renin inhibitor</td>
<td></td>
</tr>
<tr>
<td>combination products</td>
<td></td>
</tr>
<tr>
<td>Aliskiren-amlodipine</td>
<td></td>
</tr>
<tr>
<td>Aliskiren-amlodipine-</td>
<td></td>
</tr>
<tr>
<td>hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Aliskiren-hydrochlorothiazide</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Active ingredients are limited to oral formulations only.

### Table PDC-E: Exclusion

**ARB/Neprilysin Inhibitor Combination Medication**

- Sacubitril/valsartan

**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

<table>
<thead>
<tr>
<th>Statins</th>
<th>Statins and Statin Combinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lovastatin</td>
<td>Pravastatin</td>
</tr>
<tr>
<td>Rosuvastatin</td>
<td>Pitavastatin</td>
</tr>
<tr>
<td>Fluvastatin</td>
<td>Simvastatin</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>Ezetimibe-simvastatin</td>
</tr>
<tr>
<td>Pravastatin</td>
<td>Sitagliptin-simvastatin</td>
</tr>
<tr>
<td>Pitavastatin</td>
<td></td>
</tr>
</tbody>
</table>

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.

Note: 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 Diabetes All-Class 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

| 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 • Glyburide |
| • Glimepiride • Tolazamide |
| • Glipizide • Tolbutamide |
| Sulfonylurea and thiazolidinedione combinations | • Rosiglitazone-glimepiride • Pioglitazone-glimepiride |
| Thiazolidinediones | • Pioglitazone • Rosiglitazone |
| DPP-IV inhibitors | • Sitagliptin • Saxagliptin |
| • Linagliptin • Alogliptin |
| DPP-IV inhibitor combinations | • Alogliptin-metformin • Saxagliptin-metformin SR |
| • Alogliptin-pioglitazone • Sitagliptin-simvastatin |
| • Sitagliptin-metformin (IR and SR) • Linagliptin-empagliflozin |
| • Linagliptin-metformin |
| Incretin mimetic agents | • Exenatide • Liraglutide |
| • Albiglutide • Dulaglutide |
| Meglitinides | • Nateglinide • Repaglinide |
| • Repaglinide • Repaglinide-metformin |
| Sodium glucose co-transporter 2 (SGLT2) inhibitor | • Canagliflozin • Dapagliflozin |
| • Empagliflozin |
| SGLT2 Inhibitor Combinations | • Dapagliflozin-metformin • Empagliflozin-linagliptin |
| • Cagliflozin-metformin • Empagliflozin-metformin |

Note: Active ingredients are limited to oral formulations only.

Table PDC-D: Insulin Medications

| Human insulin | • Insulin aspart • Insulin isophane (human N) |
| • Insulin aspart protamine-aspart | • Insulin lispro |
| • Insulin detemir | • Insulin lispro protamine-insulin lispro |
| • Insulin glargine | • Insulin regular (human R) |
| • Insulin glulisine | • Insulin regular (human) inhalation powder |
| • Insulin isophane and regular human insulin | • Insulin degludec |

**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%), Eye Exam, Medical Attention for Nephropathy, Blood Pressure Control (<140/90), ODC: Optimal Diabetes Care

MEASURE UPDATES DECEMBER 2016 FOR VBP4P MY 2016

• Removed Option B from the blood pressure indicator.
  – As a reminder the mapping of proprietary and other codes is allowed under current guidelines (see General Guideline 45 on page 30) as permitted by audit approval.

• Made changes to Table CDC-A:
  – Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the “Antidiabetic combinations” row.
  – Added Insulin degludec and Insulin human inhaled to the “Insulin” row.
  – Added Dulaglutide to the “Glucagon-like peptide-1 (GLP1) agonists” row.

• Added Amlodipine-perindopril to the “Antihypertensive Combinations” row of Table CDC-B.

MEASURE UPDATES SEPTEMBER 2016 FOR VBP4P MY 2016

• Added a method and new value set to identify negative eye exams in the year prior to the measurement year.

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 VBP4P 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%).
• Eye exam (retinal) performed.
• Medical attention for nephropathy.
• BP control (<140/90 mm Hg).
Also 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.

*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

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

**Product line** Report each product line separately.

<table>
<thead>
<tr>
<th>Clinical Measures</th>
<th>Commercial HMO/POS</th>
<th>Medicare</th>
<th>Non-HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care—Two Hemoglobin A1c (HbA1c) Tests</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes Care—HbA1c Poor Control (&gt;9.0%)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care—HbA1c Control (&lt;8.0%)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care—Eye Exam (Retinal) Performed</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care—Medical Attention for Nephropathy</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Care—Optimal Diabetes Care</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

**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 VBP4P 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-glucosidase inhibitors</td>
<td>Acarbose, Miglitol</td>
</tr>
<tr>
<td>Amylin analogs</td>
<td>Pramlinitide</td>
</tr>
<tr>
<td>Antidiabetic combinations</td>
<td>Alogliptin-metformine, Alogliptin-pioglitazone, Dapagliflozin-metformin,</td>
</tr>
<tr>
<td></td>
<td>Empagliflozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone,</td>
</tr>
<tr>
<td></td>
<td>Metformin-saxagliptin, Metformin-sitagliptin, Metformin-repaglinide</td>
</tr>
<tr>
<td>Insulin</td>
<td>Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec,</td>
</tr>
<tr>
<td></td>
<td>Insulin detemir, Insulin glargine, Insulin glulisine, Insulin human inhaled,</td>
</tr>
<tr>
<td></td>
<td>Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro,</td>
</tr>
<tr>
<td></td>
<td>Insulin lispro-insulin lispro protamine, Insulin regular human</td>
</tr>
<tr>
<td>Meglitinides</td>
<td>Nateglinide, Repaglinide</td>
</tr>
<tr>
<td>Glucagon-like peptide-1 (GLP1)</td>
<td>Dulaglutide, Exenatide, Liraglutide, Albiglutide</td>
</tr>
<tr>
<td>agonists</td>
<td>Canagliflozin, Dapagliflozin</td>
</tr>
<tr>
<td>Sodium glucose cotransporter 2</td>
<td>Canagliflozin, Dapagliflozin</td>
</tr>
<tr>
<td>(SGLT2) inhibitor</td>
<td>Tolazamide, Tolbutamide</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>Chlorpropamide, Glipizide, Glyburide, Glimepiride</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>Pioleprazine, Rosiglitazone</td>
</tr>
<tr>
<td>Dipeptidyl peptidase-4 (DPP-4)</td>
<td>Alogliptin, Saxagliptin, Linagliptin, Sitagliptin</td>
</tr>
</tbody>
</table>

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 1, 2016.
Administrative Specification

**Denominator**
The eligible population.

**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.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Not compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Level Less Than 7.0 Value Set</td>
<td>Compliant</td>
</tr>
<tr>
<td>HbA1c Level 7.0–9.0 Value Set</td>
<td>Not compliant*</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0 Value Set</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>

*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 31 (i.e., the dates of service for the code and the test result must be no more than seven days apart).
**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 Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set). All codes must be on the same claim.
- 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE inhibitors</td>
<td>- Benazepril</td>
</tr>
<tr>
<td></td>
<td>- Captopril</td>
</tr>
<tr>
<td></td>
<td>- Enalapril</td>
</tr>
<tr>
<td></td>
<td>- Fosinopril</td>
</tr>
<tr>
<td></td>
<td>- Lisinopril</td>
</tr>
<tr>
<td></td>
<td>- Perindopril</td>
</tr>
<tr>
<td></td>
<td>- Ramipril</td>
</tr>
<tr>
<td>Angiotensin II</td>
<td>- Azilsartan</td>
</tr>
<tr>
<td>inhibitors</td>
<td>- Candesartan</td>
</tr>
<tr>
<td></td>
<td>- Eprosartan</td>
</tr>
<tr>
<td></td>
<td>- Losartan</td>
</tr>
<tr>
<td></td>
<td>- Olmesartan</td>
</tr>
<tr>
<td></td>
<td>- Telmisartan</td>
</tr>
<tr>
<td>Antihypertensive</td>
<td>- Amlodipine-valsartan</td>
</tr>
<tr>
<td>combinations</td>
<td>- Amlodipine-benazepril</td>
</tr>
<tr>
<td></td>
<td>- Amlodipine-hydrochlorothiazide-valsartan</td>
</tr>
<tr>
<td></td>
<td>- Amlodipine-hydrochlorothiazide-olmesartan</td>
</tr>
<tr>
<td></td>
<td>- Amlodipine-olmesartan</td>
</tr>
<tr>
<td></td>
<td>- Amlodipine-perindopril</td>
</tr>
<tr>
<td></td>
<td>- Amlodipine-telmisartan</td>
</tr>
<tr>
<td></td>
<td>- Amiodipine-valsartan</td>
</tr>
<tr>
<td></td>
<td>- Azilsartan-chlorthalidone</td>
</tr>
<tr>
<td></td>
<td>- Benazepril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Candesartan-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Enalapril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Fosinopril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Eprosartan-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Fosinopril-hydrochlorothiazide</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-valsartan</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-losartan</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-moexipril</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-olmesartan</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-quenapril</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-telmisartan</td>
</tr>
<tr>
<td></td>
<td>- Hydrochlorothiazide-valsartan</td>
</tr>
<tr>
<td></td>
<td>- Trandolapril-verapamil</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

**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 VBP4P 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.

Note: BP readings taken by the member may not be used for this measure.

<table>
<thead>
<tr>
<th>Value Set</th>
<th>Numerator Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Less Than 140 Value Set</td>
<td>Systolic compliant</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal To 140 Value Set</td>
<td>Systolic not compliant</td>
</tr>
<tr>
<td>Diastolic Less Than 80 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic 80–89 Value Set</td>
<td>Diastolic compliant</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal To 90 Value Set</td>
<td>Diastolic not compliant</td>
</tr>
</tbody>
</table>

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**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.

- 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 is 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

**STEP 1:**
Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy, dialysis or renal transplant?

YES → STOP! Member is compliant

NO →

**STEP 2:**
Was a urine test for albumin or protein performed during the measurement year?

YES → STOP! Member is compliant

NO →

**STEP 3:**
Review for evidence of ACE inhibitor/ARB therapy. Is there evidence of therapy in the measurement year?

YES → STOP! Member is compliant

NO →

STOP! Member is not compliant
**Statin Therapy for Patients With Diabetes (SPD)**

**MEASURE UPDATES DECEMBER 2016 FOR VBP4P MY 2016**

- Made changes to Table SPD-A:
  - Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the “Antidiabetic combinations” row.
  - Added Insulin degludec and Insulin human inhaled to the “Insulin” row.
  - Added Dulaglutide to the “Glucagon-like peptide-1 (GLP1) agonists” row.

- Made changes to Table SPD-B:
  - Removed Aspirin-pravastatin 40–80 mg from the Moderate-intensity statin therapy row.
  - Removed Aspirin-pravastatin 20 mg from the “Low-intensity statin therapy” row.

**MEASURE UPDATES SEPTEMBER 2016 FOR VBP4P MY 2016**

- Added to the MY 2016 commercial measure set.
- Clarified that optional exclusions are excluded from the denominator for both rates.
- Added a *Note*.

**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**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPSD</td>
<td>Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year.</td>
</tr>
<tr>
<td>Treatment period</td>
<td>The period of time beginning on the IPSD through the last day of the measurement year.</td>
</tr>
<tr>
<td>PDC</td>
<td>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.</td>
</tr>
<tr>
<td>Calculating number of days covered for multiple prescriptions</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

Use the drug ID provided by the NDC to determine if the prescriptions are the same
or different.

### Eligible Population: Rate 1—Received Statin Therapy

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>40–75 years as of December 31 of the measurement year.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td></td>
</tr>
<tr>
<td>...for self-reporting POs</td>
<td>The measurement year and the year prior to the measurement year in the PO (parent level).</td>
</tr>
<tr>
<td>...for health plans</td>
<td>The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.</td>
</tr>
</tbody>
</table>

**Anchor date**

| ...for self-reporting POs | Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P 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**

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 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).

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 SPD-A).

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-glucosidase inhibitors</td>
<td>• Acarbose • Miglitol</td>
</tr>
<tr>
<td>Amylin analogs</td>
<td>• Pramlintide</td>
</tr>
<tr>
<td>Antidiabetic combinations</td>
<td>• Alogliptin-metformin • Alogliptin-pioglitazone • Dapagliflozin-metformin • Empagliflozin-linagliptin • Empagliflozin-metformin • Glimepiride-pioglitazone • Metformin-pioglitazone • Metformin-repaglinide</td>
</tr>
<tr>
<td>Insulin</td>
<td>• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin human inhaled • Insulin glargine • Insulin glulisine • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human</td>
</tr>
<tr>
<td>Meglitinides</td>
<td>• Nateglinide • Repaglinide</td>
</tr>
<tr>
<td>Glucagon-like peptide-1 (GLP1) agonists</td>
<td>• Dulaglutide • Exenatide • Liraglutide • Albiglutide</td>
</tr>
<tr>
<td>Sodium glucose cotransporter 2 (SGLT2) inhibitor</td>
<td>• Canagliflozin • Dapagliflozin</td>
</tr>
<tr>
<td>Sulfonylureas</td>
<td>• Chlorpropamide • Glimepiride • Glyburide • Tolazamide • Tolbutamide</td>
</tr>
<tr>
<td>Thiazolidinediones</td>
<td>• Pioglitazone • Rosiglitazone</td>
</tr>
<tr>
<td>Dipeptidyl peptidase-4 (DDP-4) inhibitors</td>
<td>• Alogliptin • Saxagliptin • Linagliptin • Sitaglipin</td>
</tr>
</tbody>
</table>

**Note:** Glucophage/metformin as a solo agent 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 1, 2016.

**Administrative Specification: Rate 1—Received Statin Therapy**

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>• Atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>• Atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 5–10 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin XL 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 40 mg bid</td>
</tr>
<tr>
<td></td>
<td>• Pitavastatin 2–4 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 40–80 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 80 mg</td>
</tr>
<tr>
<td>Low-intensity statin therapy</td>
<td>• Simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 10–20 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 20–40 mg</td>
</tr>
<tr>
<td></td>
<td>• Pitavastatin 1 mg</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

Eligible Population: Rate 2—Statin Adherence 80%

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>40–75 years as of December 31 of the measurement year.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>The measurement year and the year prior to the measurement year in the PO (parent level).</td>
</tr>
<tr>
<td>...for self-reporting POs</td>
<td>The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P plan on December 31 of the measurement year.</td>
</tr>
<tr>
<td>...for self-reporting POs</td>
<td>Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical. Pharmacy during the measurement year.</td>
</tr>
<tr>
<td>Event/diagnosis</td>
<td>All members who meet the numerator criteria for Rate 1.</td>
</tr>
</tbody>
</table>
Administrative Specification: Rate 2—Statin Adherence 80%

**Denominator**
The Rate 2 eligible population.

**Numerator**
The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

**Step 1** Identify the IPSD. The IPSD is the earliest dispensing event for any intensity statin medication (Table SPD-B) during the measurement year.

**Step 2** To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

**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.

**Step 4** Calculate the member’s PDC using the following equation. Round (using the .5 rule) to two decimal places.

\[
\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)} / \text{Total Days in Treatment Period (step 2)}
\]

**Step 5** Sum the number of members whose PDC is ≥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.

Organizations that apply optional exclusions must exclude members from the denominator for both rates.

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**
- All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.
Use of Imaging Studies for Low Back Pain (LBP)

**MEASURE UPDATES DECEMBER 2016 FOR P4P MY 2016**

- None.

**MEASURE UPDATES SEPTEMBER 2016 FOR VBP4P MY 2016**

- Made changes to step 1 of the event/diagnosis:
  - Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set.
  - Added instructions to identify ED visits and observation visits that result in an inpatient stay.
  - Renamed the Osteopathic Manipulative Treatment Value Set to Osteopathic and Chiropractic Manipulative Treatment Value Set.
  - Added the Physical Therapy Value Set.
  - Added the Telehealth Value Set.
- Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in step 3 of the event/diagnosis.
- Made changes to step 4 of the event/diagnosis:
  - Revised the look back period from 12 months to 3 months, to exclude members with recent trauma.
  - Added required exclusions and the HIV Value Set, Spinal Infection Value Set, Organ Transplant Other Than Kidney Value Set and Kidney Transplant Value Set.
  - Added a required exclusion for prolonged use of corticosteroids.
- Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in the numerator.
- Added a requirement to not include denied claims in the numerator.

**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**

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

**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**

...for self-reporting POs 180 days (6 months) prior to the IESD through 28 days after the IESD in the PO (parent level).

...for health plans 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 VBP4P plan.

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

**Benefit** Medical.

**Event/diagnosis**

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:

- Outpatient visit (Outpatient Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

- Observation visit (Observation Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Do not include observation visits that result in an inpatient stay (Inpatient Stay Value Set). An observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

- ED visit (ED Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visit (Physical Therapy Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telehealth visit (Telehealth Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

**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 uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) 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:

- **Cancer.** Cancer any time during the member’s history through 28 days after the IESD. Any of the following meet criteria:
  - Malignant Neoplasms Value Set.
  - Other Neoplasms Value Set.
  - History of Malignant Neoplasm Value Set.
- **Recent trauma.** Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- **Intravenous drug abuse.** IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **Neurologic impairment.** Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **HIV.** HIV (HIV Value Set) any time during the member’s history through 28 days after the IESD.
- **Spinal infection.** Spinal Infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **Major organ transplant.** Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set) any time in the member’s history through 28 days after the IESD.
- **Prolonged use of corticosteroids.** 90 consecutive days of corticosteroid treatment any time during the 12 months (1 year) prior to and including the IESD.
  - To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Table LBP-A). For overlapping prescriptions, assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).
— Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).
— No gaps are allowed.

Table LBP-A: Corticosteroid Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
</table>
| Corticosteroid | • Hydrocortisone  
• Cortisone   
• Prednisone   
• Prednisolone | • Methylprednisolone  
• Triamcinolone   
• Dexamethasone   
• Betamethasone |

**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 uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Do not include denied claims.

**Note**

— Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

**Measure Updates December 2016 for P4P MY 2016**
- None.

**Measure Updates September 2016 for VBP4P MY 2016**
- Added the HIV Type 2 Value Set to the optional exclusions.

**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**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

- **Product line**: Medicare.
- **Ages**: 18 years and older 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 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 VBP4P plan on December 31 of the measurement year.
  - *...for health plans*: Enrolled in the health plan and PO (parent level, or, for eligible POs, subgroup level) and in a VBP4P 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

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

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.
Exclusions (optional)

- A diagnosis of HIV (HIV Value Set; HIV Type 2 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 2016 for P4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- Added a requirement to not include ED visits and observation visits that result in an inpatient stay in steps 1 and 2 of the event/diagnosis.
- Added instructions to identify direct transfers.
- Clarified that for direct transfers, the first admission date should be used when determining the number of days prior to the IESD in step 4.
- Removed the Note regarding inpatient claim/encounter data.

Modifications From HEDIS

- None.

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

<table>
<thead>
<tr>
<th><strong>Intake Period</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IESD</td>
<td>Index Episode Start Date. The earliest date of service for any encounter during the Intake Period with a diagnosis of fracture. For an outpatient, observation 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 last admission.</td>
</tr>
<tr>
<td>Negative Diagnosis History</td>
<td>A period of 60 days (2 months) prior to the IESD when the member had no diagnosis of fracture. For fractures requiring an inpatient stay, use the date of admission to determine Negative Diagnosis History. For direct transfers, use the first admission date to determine the Negative Diagnosis History.</td>
</tr>
<tr>
<td>Direct transfer</td>
<td>A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example: An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</td>
</tr>
</tbody>
</table>
• An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

Product line
Medicare.

Ages
Women 67-85 years of age and older as of December 31 of the measurement year.

Continuous enrollment
...for self-reporting POs
12 months (1 year) before the IESD through 180 days (6 months) after the IESD in the PO (parent level).

...for health plans
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
...for self-reporting POs
IESD in the PO (parent level, or, for eligible POs, subgroup level) and in a VBP4P plan.

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

Benefit
Medical and pharmacy.

Event/diagnosis
The earliest fracture during the Intake Period.

Step 1
Identify all members who had either of the following during the Intake Period.

• 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).
  – Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.
• An acute or nonacute inpatient discharge for a fracture (Fractures Value Set).
  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.

If the member had more than one fracture, include only the first fracture.

**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).
  – Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit that results in an inpatient stay is when the ED/observation date of service and the admission date are one calendar day apart or less.

• 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.*

*For direct transfers, use the first admission date 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biphosphonates</td>
<td></td>
</tr>
<tr>
<td>Alendronate</td>
<td>Ibendronate</td>
</tr>
<tr>
<td>Alendronate-cholecalciferol</td>
<td>Risedronate</td>
</tr>
<tr>
<td>Calcium carbonate-risedronate</td>
<td>Zoledronic acid</td>
</tr>
<tr>
<td>Other agents</td>
<td></td>
</tr>
<tr>
<td>Calcitonin</td>
<td>Teriparatide</td>
</tr>
<tr>
<td>Denosumab</td>
<td>Raloxifene</td>
</tr>
</tbody>
</table>

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

**Note**

- Fractures of finger, toe, face and skull are not included in this measure.
Childhood Immunization Status (CIS)

Measure Updates December 2016 for P4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- Added CVX codes to the measure.
- Added HIV Type 2 Value Set to the optional exclusions.
- Added optional exclusions for the rotavirus vaccine.

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 one separate combination rate.

- 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 10.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

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 VBP4P plan on the child’s second birthday.
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 33 (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 31.
  - 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 10.

<table>
<thead>
<tr>
<th>Combination</th>
<th>DTaP</th>
<th>IPV</th>
<th>MMR</th>
<th>HiB</th>
<th>HepB</th>
<th>VZV</th>
<th>PCV</th>
<th>HepA</th>
<th>RV</th>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination 10</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
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 and influenza**
- Immunodeficiency ([Disorders of the Immune System Value Set](#)).
- HIV ([HIV Value Set](#): [HIV Type 2 Value Set](#)).
- Lymphoreticular cancer, multiple myeloma or leukemia ([Malignant Neoplasm of Lymphatic Tissue Value Set](#)).
- Anaphylactic reaction to neomycin.

**Rotavirus**
- Severe combined immunodeficiency ([Severe Combined Immunodeficiency Value Set](#)).
- History of intussusception ([Intussusception Value Set](#)).

**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 2016 for P4P MY 2016**

- None.

**Measure Updates September 2016 for VBP4P MY 2016**

- Added the HPV vaccine.
- Added Combination 2 (meningococcal, Tdap, HPV).
- Removed the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines.
- Added CVX codes to the measure.

**Modifications from HEDIS**

- None.

**Description**

The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

**Eligible Population**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

- **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 VBP4P 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 conjugate, Tdap and HPV count only evidence of the antigen or combination vaccine.

**Meningococcal** At least one meningococcal conjugate vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the member’s 11th and 13th birthdays.

**Tdap/** At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set), with a date of service on or between the member’s 10th and 13th birthdays.

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

**Combination 1 (Meningococcal, Tdap)** Adolescents who are numerator compliant for both the meningococcal conjugate and Tdap indicators.

**Combination 2 (Meningococcal, Tdap, HPV)** Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Exclusion (optional)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. 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 2016 for P4P MY 2016

• None.

Measure Updates September 2016 for VBP4P MY 2016

• None.

Modifications From Hedis

• The HEDIS HPV measure is included as an antigen under the Immunization for Adolescents (IMA) measure. VBP4P will collect HPV separately for trending purposes.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

Product lines
Commercial HMO/POS.

Age
Adolescents who turn 13 years of age during the measurement year. Report males and females separately.

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 VBP4P 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

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerators</td>
<td></td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Males</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

### 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 2016 for P4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- 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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

Product line

Commercial HMO/POS.

Ages

Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 16–20 years.
- 21–24 years.
- Total.

The total is the sum of the age stratifications.

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 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

...for self-reporting POs

Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P plan on 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) on December 31 of the measurement year.

Benefit

Medical.
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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>Desogestrel-ethinyl estradiol</td>
</tr>
<tr>
<td></td>
<td>Drospirenone-ethinyl estradiol</td>
</tr>
<tr>
<td></td>
<td>Drospirenone-ethinyl estradiol-levoestradiol</td>
</tr>
<tr>
<td></td>
<td>Estradiol-medroxyprogesterone</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-ethynodiol</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-etonogestrel</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-levonorgestrel</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-norelgestromin</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-norethindrone</td>
</tr>
<tr>
<td></td>
<td>Ethinyl estradiol-norgestimate</td>
</tr>
<tr>
<td></td>
<td>Etonogestrel</td>
</tr>
<tr>
<td></td>
<td>Levonorgestrel</td>
</tr>
<tr>
<td></td>
<td>Medroxyprogesterone</td>
</tr>
<tr>
<td></td>
<td>Mestranol-norethindrone</td>
</tr>
<tr>
<td></td>
<td>Norethindrone</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>Diaphragm</td>
</tr>
<tr>
<td>Spermicide</td>
<td>Nonxynol 9</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retinoid</td>
<td>Isotretinoin</td>
</tr>
</tbody>
</table>

*Note:* An NDC list for isotretinoin will be available on [www.ncqa.org](http://www.ncqa.org) by November 1, 2016.
Cervical Cancer Screening (CCS)

**Measure Updates December 2016 for P4P MY 2016**
- None.

**Measure Updates September 2016 for VBP4P MY 2016**
- Added a clarification to step 2 of the numerator.
- Added a Note.

**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**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>Women 24–64 years as of December 31 of the measurement year.</td>
</tr>
</tbody>
</table>

**Continuous enrollment**

<table>
<thead>
<tr>
<th>...for self-reporting POs</th>
<th>The measurement year and the two years prior to the measurement year in the PO (parent level).</th>
</tr>
</thead>
<tbody>
<tr>
<td>...for health plans</td>
<td>The measurement year and the two years prior to the measurement year in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.</td>
</tr>
</tbody>
</table>

**Anchor date**

<table>
<thead>
<tr>
<th>...for self-reporting POs</th>
<th>Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P plan on December 31 of the measurement year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>...for health plans</td>
<td>Enrolled in the health plan and the PO (parent level, or, for eligible POs, subgroup level) on December 31 of the measurement year.</td>
</tr>
</tbody>
</table>

**Benefit**

- Medical.

**Event/diagnosis**

- None.
Administrative Specification

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The eligible population.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.</td>
</tr>
</tbody>
</table>

**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. There is flexibility in the date of service (i.e., four days or fewer apart) to allow for lab processing that may result in separate billing of the two tests.

**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 Screening (CCU) is the inversion of the CCS measure and represents cervical cancer underscreening; it is calculated by the VBP4P data aggregator and will appear on your VBP4P reports. The CCU measure is the percentage of women 21–64 years of age who were not screened for cervical cancer using either of the following criteria: 1.) women age 21–64 who had cervical cytology performed every three years, or 2.) women age 30–64 who had cervical cytology/HPV co-testing performed every five years.
Cervical Cancer Overscreening (CCO)

Measure Updates December 2016 for P4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- Added a Note.
- Changed the name of the ECS Exclusions Group 1 Value Set and ECS Exclusions Group 2 Value Set to CCO Exclusions Group 1 Value Set and CCO Exclusions Group 2 Value Set.

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

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

- 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 VBP4P 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 33.

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 33.

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 *(CCO 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 *(CCO Exclusions Group 2 Value Set)* any time during the member’s history through December 31 of the measurement year.

**Note:** Current cervical cancer screening guidelines for average-risk women do not state that women 30–64 years of age with a “cervical cytology” in 3 years and a “cervical cytology and HPV co-test” in 5 years are considered overscreened. For VBP4P reporting, we look only at cases of overscreening as explicitly outlined by the guidelines. VBP4P staff and committees will continue to review clinical practices and cervical cancer screening guidelines.
Breast Cancer Screening (BCS)

**Measure Updates December 2016 for VBP4P MY 2016**

- Clarified the optional exclusions.
- Revised the *Note* section.

**Measure Updates September 2016 for VBP4P MY 2016**

- Clarified that diagnostic screenings are not included in the measure.

**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**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial HMO/POS, Medicare (report each product line separately).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td><em>Medicare and commercial product lines:</em> 52–74 years.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td><strong>...for self-reporting POs</strong> October 1 two years prior to the measurement year through December 31 of the measurement year in the PO (parent level).</td>
</tr>
<tr>
<td></td>
<td><strong>...for health plans</strong> 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).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Anchor date</td>
<td><strong>...for self-reporting POs</strong> Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P plan on December 31 of the measurement year.</td>
</tr>
<tr>
<td></td>
<td><strong>...for health plans</strong> Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical.</td>
</tr>
<tr>
<td>Event/diagnosis</td>
<td>None.</td>
</tr>
</tbody>
</table>
Administrative Specification

**Denominator**
The eligible population.

**Numerator**
One or more mammograms (Mammography Value Set) 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). Codes must be on the same claim.
- 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.

<table>
<thead>
<tr>
<th>Left Mastectomy (any of the following)</th>
<th>Right Mastectomy (any of the following)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same claim)</td>
<td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same claim)</td>
</tr>
<tr>
<td>Absence of the left breast (Absence of Left Breast Value Set)</td>
<td>Absence of the right breast (Absence of Right Breast Value Set)</td>
</tr>
<tr>
<td>Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td>
<td>Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td>
</tr>
</tbody>
</table>

**Note:** This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, MRIs or tomosynthesis (3D mammography) because they are not appropriate methods for primary breast cancer screening.
Colorectal Cancer Screening (COL)

**Measure Updates December 2016 for VBP4P MY 2016**

- Revised the numerator criteria to include CT colonography and the FIT-DNA test.

**Measure Updates September 2016 for VBP4P MY 2016**

- 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**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial HMO/POS, Medicare (report each product line separately).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>51–75 years as of December 31 of the measurement year.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>The measurement year and the year prior to the measurement year in the PO (parent level).</td>
</tr>
<tr>
<td>...for self-reporting POs</td>
<td>The measurement year and the year prior to the measurement year in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>Enrolled in the PO (parent level, or subgroup level, for eligible POs) and in a VBP4P plan on December 31 of the measurement year.</td>
</tr>
<tr>
<td>...for self-reporting POs</td>
<td>Enrolled in the health plan and the PO (parent level, or subgroup level, for eligible POs) on December 31 of the measurement year.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical.</td>
</tr>
<tr>
<td>Event/diagnosis</td>
<td>None.</td>
</tr>
</tbody>
</table>
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.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT-DNA Value Set) during the measurement year or the two 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 2016 for P4P MY 2016
• None.

Measure Updates September 2016 for VBP4P MY 2016
• None.

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
Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

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...for self-reporting P0s 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, for eligible POs, subgroup level) and in a VBP4P 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 2016 for P4P MY 2016**
- Added Fluticasone-vilanterol to the Inhaled steroid combinations row of Table AMR-A and AMR-B.

**Measure Updates September 2016 for VBP4P MY 2016**
- None.

**Modifications From HEDIS**
- None.

**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.

<table>
<thead>
<tr>
<th>Units of Controller</th>
<th>Units of Controller+ Units of Reliever</th>
</tr>
</thead>
</table>

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**

*Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.*

**Product lines**

Commercial HMO/POS.

**Ages**

5–85 years by December 31 of the measurement year. Report five age stratifications and one total rate.

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

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 VBP4P 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

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

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

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.

\[
\text{Units of Controller Medications (step 1)} / \text{Units of Total Medications (step 3)}
\]

Step 5: Calculate performance rate

Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Table AMR-B: Asthma Controller and Reliever Medications

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

Note: NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2016.
Appropriate Testing for Children With Pharyngitis (CWP)

**Measure Updates December 2016 for P4P MY 2016**
- None.

**Measure Updates September 2016 for VBP4P MY 2016**
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.

**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**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake Period</td>
<td>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.</td>
</tr>
<tr>
<td>Episode Date</td>
<td>The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of pharyngitis. Exclude claims/encounters with more than one diagnosis.</td>
</tr>
<tr>
<td>IESD</td>
<td>Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date.</td>
</tr>
<tr>
<td></td>
<td>• A 30-day Negative Medication History prior to the Episode Date.</td>
</tr>
<tr>
<td></td>
<td>• The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date.</td>
</tr>
<tr>
<td>Negative Medication History</td>
<td>To qualify for Negative Medication History, the following criteria must be met:</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>
Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

**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 VBP4P 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 or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

**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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminopenicillins</td>
<td>• Amoxicillin</td>
</tr>
<tr>
<td></td>
<td>• Ampicillin</td>
</tr>
<tr>
<td>Beta-lactamase inhibitors</td>
<td>• Amoxicillin-clavulanate</td>
</tr>
<tr>
<td>First generation cephalosporins</td>
<td>• Cefadroxil</td>
</tr>
<tr>
<td></td>
<td>• Cefazolin</td>
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<tr>
<td>Folate antagonist</td>
<td>• Trimethoprim</td>
</tr>
<tr>
<td>Lincomycin derivatives</td>
<td>• Clindamycin</td>
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<tr>
<td>Macrolides</td>
<td>• Azithromycin</td>
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<td></td>
<td>• Clarithromycin</td>
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<td>• Erythromycin</td>
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<td></td>
<td>• Erythromycin ethylsuccinate</td>
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<td></td>
<td>• Erythromycin lactobionate</td>
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<tr>
<td></td>
<td>• Erythromycin stearate</td>
</tr>
<tr>
<td>Miscellaneous antibiotics</td>
<td>• Erythromycin-sulfisoxazole</td>
</tr>
<tr>
<td>Natural penicillins</td>
<td>• Penicillin G potassium</td>
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<tr>
<td></td>
<td>• Penicillin G sodium</td>
</tr>
<tr>
<td>Penicillinase-resistant penicillins</td>
<td>• Dicloxacillin</td>
</tr>
<tr>
<td>Quinolones</td>
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<td>• Ofloxacin</td>
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<tr>
<td>Sulfonamides</td>
<td>• Sulfamethoxazole-trimethoprim</td>
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<td>• Sulfisoxazole</td>
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<tr>
<td>Tetracyclines</td>
<td>• Doxycycline</td>
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<td></td>
<td>• Minocycline</td>
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<td></td>
<td>• Tetracycline</td>
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<tr>
<td>Third generation cephalosporins</td>
<td>• Cefdinir</td>
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<td></td>
<td>• Cefixime</td>
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<td>• Cefpodoxime</td>
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<td></td>
<td>• Cefibuten</td>
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<tr>
<td></td>
<td>• Cefditoren</td>
</tr>
<tr>
<td></td>
<td>• Ceftriaxone</td>
</tr>
</tbody>
</table>

Note: NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 1, 2016.

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 2016 for P4P MY 2016**
- None.

**Measure Updates September 2016 for VBP4P MY 2016**
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added a requirement to not include denied claims in the numerator.

**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 \[1 \text{ – } \frac{\text{numerator}}{\text{eligible population}}\]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

**Definitions**

<table>
<thead>
<tr>
<th><strong>Intake Period</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode Date</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **IESD**          | Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:  
  - 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

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

**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 VBP4P 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 or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

**Step 2**

Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits 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.

*Do not include denied claims.*

#### Table URI-A: Antibiotic Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
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<tbody>
<tr>
<td>Aminopenicillins</td>
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<td>• Cefpodoxime</td>
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<td>• Cefitubutin</td>
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<td></td>
<td>• Cefitoren</td>
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<tr>
<td></td>
<td>• Cefitaxone</td>
</tr>
</tbody>
</table>

**Note:** NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2016.
Note

- Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis (AAB)

**Measure Updates December 2016 for P4P MY 2016**

- None.

**Measure Updates September 2016 for VBP4P MY 2016**

- Revised the allowable gap and anchor date criteria.
- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added two value sets to step 3 of the event/diagnosis criteria (HIV Type 2 Value Set; Disorders of the Immune System Value Set).
- Added a requirement to not include denied claims in the numerator.

**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 \(1 – \frac{\text{numerator}}{\text{eligible population}}\). A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

**Definitions**

<table>
<thead>
<tr>
<th>Intake Period</th>
<th>January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episode Date</td>
<td>The date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.</td>
</tr>
<tr>
<td>IESD</td>
<td>Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• A 30-day Negative Medication History prior to the Episode Date.</td>
</tr>
<tr>
<td></td>
<td>• A 12-month Negative Comorbid Condition History prior to and including the Episode Date.</td>
</tr>
<tr>
<td></td>
<td>• A Negative Competing Diagnosis during the 30 days prior to the Episode Date through 7 days after the Episode Date (inclusive).</td>
</tr>
<tr>
<td></td>
<td>• The member was continuously enrolled 1 year prior to the Episode Date through 7 days after the Episode Date.</td>
</tr>
</tbody>
</table>
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

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

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 during the 365 days (1 year) prior to the Episode Date.

No gaps in enrollment are allowed on the IESD through 7 days after the IESD.

**....for self-reporting POs**

Episode Date in the PO (parent level, or, for eligible POs, subgroup level) and in a VBP4P 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 or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

**Step 2** Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits 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.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Cystic Fibrosis Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System 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. Do not include denied claims.

## Table AAB-A: Antibiotic Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminoglycosides</td>
<td></td>
</tr>
<tr>
<td>• Amikacin</td>
<td>• Kanamycin</td>
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<tr>
<td>• Gentamicin</td>
<td>• Streptomycin</td>
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<td>• Tobramycin</td>
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<td>Aminopenicillins</td>
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<td>• Amoxicillin</td>
<td>• Ampicillin</td>
</tr>
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<td>Antipseudomonal penicillins</td>
<td>• Piperacillin</td>
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<td>Betalactamase inhibitors</td>
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</tr>
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<td>• Ticarcillin-clavulanate</td>
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<tr>
<td>First-generation cephalosporins</td>
<td>• Cefadroxil</td>
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<td>• Cefazolin</td>
<td>• Cephalexin</td>
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<td>• Cefepime</td>
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<td>Ketolides</td>
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<td>• Dalfopristin-quinupristin</td>
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<td>• Metronidazole</td>
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<td>• Vancomycin</td>
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</tr>
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<td>• Penicillin G sodium</td>
<td>• Penicillin V potassium</td>
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<td>• Penicillin G benzathine</td>
<td>• Penicillin G potassium</td>
</tr>
<tr>
<td>Penicillinase resistant penicillins</td>
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<td>• Nafcillin</td>
<td>• Oxacillin</td>
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<td>• Ciprofloxacin</td>
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<td>• Levofoxacin</td>
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<td>• Moxifloxacin</td>
<td>• Norfloxacin</td>
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<td>• Ofloxacin</td>
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<tr>
<td>Rifamycin derivatives</td>
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<td>Second generation cephalosporin</td>
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<td>Sulfonamides</td>
<td>• Sulfadiazine</td>
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<td>• Sulfamethoxazole-trimethoprim</td>
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<td>• Cefpodoxime</td>
</tr>
<tr>
<td>• Ceftazidime</td>
<td>• Cefixime</td>
</tr>
<tr>
<td>• Ceftixime</td>
<td>• Cefotaxime</td>
</tr>
<tr>
<td>• Ceftuzidime</td>
<td>• Cefiximex</td>
</tr>
<tr>
<td>• Ceftriaxone</td>
<td>• Ceftobuten</td>
</tr>
<tr>
<td>• Ceftriaxone</td>
<td>• Cefiximex</td>
</tr>
<tr>
<td>Urinary anti-infectives</td>
<td>• Fosfomycin</td>
</tr>
<tr>
<td>• Nitrofurantoin</td>
<td>• Nitrofurantoin macrystals-monohydrate</td>
</tr>
<tr>
<td>• Trimethoprim</td>
<td>• Nitrofurantoin macrystals</td>
</tr>
</tbody>
</table>

**Note:** NCQA will post a comprehensive list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2016.
Note

- Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
All-Cause Readmissions (PCR)

Measure Updates December 2016 for P4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- Clarified that organizations may not consolidate stays into a single stay if the discharge date from the first setting and the admission date of the second setting are two or more calendar days apart.
- Added instructions to identify direct transfers.
- Changed the reference of “discharges” to “admissions” in step 3 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 VBP4P 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:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of 30-Day Readmissions (numerator).
3. 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 VBP4P 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 Eligible Population.

**Classification Period**

365 days prior to and including an Index Discharge Date.

---

### Risk Adjustment Tables

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

**Note:** The risk adjustment tables will be released on November 1, 2016, and posted to www.ncqa.org.

---

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 19: Members in Hospice.

- **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

An acute inpatient discharge on or between January 1 and December 1 of the measurement year.

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.

Follow the steps below to identify acute inpatient stays.

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.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

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

**Step 2**
Acute-to-acute direct transfers: Keep the original admission date as the Index Admission Date, but use the direct transfer’s discharge date as the Index Discharge Date.

A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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 and discharge dates for the stay.

**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 direct transfer (identified in step 2), use both the original stay and the direct 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 planned hospital stays, identify all acute inpatient discharges on or between January 3 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 direct 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 or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute direct transfers, use the direct 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**

<table>
<thead>
<tr>
<th>Ranking Group</th>
<th>CC</th>
<th>Description</th>
<th>Rank</th>
<th>HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>CC-85</td>
<td>Congestive Heart Failure</td>
<td>NA</td>
<td>HCC-85</td>
</tr>
<tr>
<td>Diabetes 1</td>
<td>CC-17</td>
<td>Diabetes With Acute Complications</td>
<td>1</td>
<td>HCC-17</td>
</tr>
<tr>
<td></td>
<td>CC-18</td>
<td>Diabetes With Chronic Complications</td>
<td>2</td>
<td>HCC-18</td>
</tr>
<tr>
<td></td>
<td>CC-19</td>
<td>Diabetes Without Complications</td>
<td>3</td>
<td>HCC-19</td>
</tr>
</tbody>
</table>

**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.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, only the diabetes/CHF/renal combination is counted.

If there are overlapping combinations, use both sets of combinations. 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**

<table>
<thead>
<tr>
<th>Comorbid HCC</th>
<th>Comorbid HCC</th>
<th>Comorbid HCC</th>
<th>Combination HCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC-17</td>
<td>HCC-85</td>
<td>NA</td>
<td>HCC-901</td>
</tr>
<tr>
<td>HCC-18</td>
<td>HCC-85</td>
<td>NA</td>
<td>HCC-901</td>
</tr>
<tr>
<td>HCC-19</td>
<td>HCC-85</td>
<td>NA</td>
<td>HCC-901</td>
</tr>
</tbody>
</table>
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 1, 2016.

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.

\[
\text{Adjusted probability of readmission} = \frac{\exp(\sum \text{Weights for IHS})}{1 + \exp(\sum \text{Weights for IHS})}
\]

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

<table>
<thead>
<tr>
<th>Member ID</th>
<th>Admiss. Counter</th>
<th>Base Risk Weight</th>
<th>Age</th>
<th>Gender</th>
<th>Age, Gender, Weight</th>
<th>Surgical Weight</th>
<th>ICD-9 Diagnosis Code</th>
<th>Discharge CC Category</th>
<th>HCC-PCR Category</th>
<th>Weight</th>
<th>Weight</th>
<th>Sum of Weights</th>
<th>Adjusted Probability</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1250</td>
<td>1</td>
<td>-1.08883</td>
<td>67</td>
<td>Female</td>
<td>0.1000</td>
<td>-0.2800</td>
<td>250.4</td>
<td>15</td>
<td>0.0700</td>
<td>-0.8600</td>
<td>0.2976</td>
<td>0.2090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4010</td>
<td>1</td>
<td>-1.08883</td>
<td>50.00</td>
<td>Male</td>
<td>0.1200</td>
<td>NA</td>
<td>007.4</td>
<td>5</td>
<td>0.0300</td>
<td>NA</td>
<td>-0.9400</td>
<td>0.2811</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4010</td>
<td>2</td>
<td>-1.08883</td>
<td>50.00</td>
<td>Male</td>
<td>0.1200</td>
<td>NA</td>
<td>298.00</td>
<td>77</td>
<td>0.0600</td>
<td>NA</td>
<td>-0.5700</td>
<td>0.3615</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 3 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.
   - Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

**Step 2** Acute-to-acute direct transfers: Keep the original admission date as the Index Admission Date, but use the direct transfer’s discharge date as the Index Discharge Date.

A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.
Use the following method to identify acute-to-acute direct transfers:

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 and discharge dates for the stay.

**Step 3** Exclude acute inpatient hospital admissions 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.
### Table PCR-A-2: Plan All-Cause Readmission Rates by Age, and Risk Adjustment (for the commercial product line)

<table>
<thead>
<tr>
<th>Age</th>
<th>Count of Index Stays (Denominator)</th>
<th>Count of 30-Day Readmissions (Numerator)</th>
<th>Observed Readmission (Num/Den)</th>
<th>Average Adjusted Probability</th>
<th>Total Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-44</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55-64</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table PCR-B-3: Plan All-Cause Readmission Rates by Age, and Risk Adjustment (for the Medicare product line)

<table>
<thead>
<tr>
<th>Age</th>
<th>Count of Index Stays (Denominator)</th>
<th>Count of 30-Day Readmissions (Numerator)</th>
<th>Observed Readmission (Num/Den)</th>
<th>Average Adjusted Probability</th>
<th>Total Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75-84</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**High-Risk Medication (HRM)**

**MEASURE UPDATES DECEMBER 2016 FOR P4P MY 2016**

- None.

**MEASURE UPDATES SEPTEMBER 2016 FOR VBP4P MY 2016**

- Made changes to Table HRM-A:
  - Added Guanabenz to the “Cardiovascular, alpha blockers, central” row.
  - Added Mephobarbital to the “Central nervous system, barbiturates” row.

**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 September 2016 NDC List). Do not distribute NDC lists outside your organization.

**Definitions**

<table>
<thead>
<tr>
<th>Treatment period</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk medication</td>
<td>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.</td>
</tr>
<tr>
<td>Fill</td>
<td>A unique prescription drug claim.</td>
</tr>
</tbody>
</table>

**Eligible Population**

<table>
<thead>
<tr>
<th>Product line</th>
<th>Medicare.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>66 years and older as of December 31 of the measurement year.</td>
</tr>
</tbody>
</table>

**...for self-reporting POs**

*Treatment period*: 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  
**Treatment period:** 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

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticholinergics (excludes TCAs), first-generation antihistamines</strong></td>
<td><strong>Anticholinergics (excludes TCAs), first-</strong></td>
</tr>
<tr>
<td>(as single agent or as part of combination products)—<strong>excludes OTC products</strong></td>
<td><strong>generation antihistamines (as single agent or</strong></td>
</tr>
<tr>
<td></td>
<td><strong>as part of combination products)</strong></td>
</tr>
<tr>
<td></td>
<td>• Brompheniramine</td>
</tr>
<tr>
<td></td>
<td>• Carboxinamine</td>
</tr>
<tr>
<td></td>
<td>• Chlorpheniramine</td>
</tr>
<tr>
<td></td>
<td>• Clemastine</td>
</tr>
<tr>
<td></td>
<td>• Cyproheptadine</td>
</tr>
<tr>
<td></td>
<td>• Dextchlorpheniramine</td>
</tr>
<tr>
<td></td>
<td>• Diphenhydramine (oral)</td>
</tr>
<tr>
<td></td>
<td>• Doxylamine</td>
</tr>
<tr>
<td></td>
<td>• Hydroxyzine</td>
</tr>
<tr>
<td></td>
<td>• Promethazine</td>
</tr>
<tr>
<td></td>
<td>• Triprolidine</td>
</tr>
<tr>
<td></td>
<td>• Benztropine (oral)</td>
</tr>
<tr>
<td></td>
<td>• Trihexyphenidyl</td>
</tr>
<tr>
<td><strong>Anticholinergics (excludes TCAs), anti-Parkinson agents</strong></td>
<td><strong>Antithrombotics</strong></td>
</tr>
<tr>
<td></td>
<td>• Dipyridamole, oral short-acting</td>
</tr>
<tr>
<td></td>
<td>(does not apply to the extended-release combination with aspirin)</td>
</tr>
<tr>
<td></td>
<td>• Ticlopidine*</td>
</tr>
<tr>
<td><strong>Anti-infective</strong></td>
<td><strong>Cardiovascular, alpha blockers, central</strong></td>
</tr>
<tr>
<td></td>
<td>• Guanfacine*</td>
</tr>
<tr>
<td></td>
<td>• Methyldopa*</td>
</tr>
<tr>
<td></td>
<td>• Reserpine (&gt;0.1mg/day)* (B)</td>
</tr>
<tr>
<td></td>
<td>• Guanabenz*</td>
</tr>
<tr>
<td></td>
<td>• Disopyramide*</td>
</tr>
<tr>
<td></td>
<td>• Digoxin (&gt;0.125mg/day) (C)</td>
</tr>
<tr>
<td></td>
<td>• Nifedipine, immediate release*</td>
</tr>
<tr>
<td><strong>Cardiovascular, other</strong></td>
<td><strong>Central nervous system, tertiary TCAs (as a</strong></td>
</tr>
<tr>
<td></td>
<td><strong>single agent or as part of a combination</strong></td>
</tr>
<tr>
<td></td>
<td><strong>product)</strong></td>
</tr>
<tr>
<td></td>
<td>• Amitriptyline</td>
</tr>
<tr>
<td></td>
<td>• Clomipramine</td>
</tr>
<tr>
<td></td>
<td>• Doxepin (&gt;6mg/day) (D)</td>
</tr>
<tr>
<td></td>
<td>• Imipramine</td>
</tr>
<tr>
<td></td>
<td>• Trimipramine</td>
</tr>
<tr>
<td><strong>Central nervous system, antipsychotics, first-generation</strong> (conventional)</td>
<td><strong>Central nervous system, barbiturates</strong></td>
</tr>
<tr>
<td></td>
<td>• Thioridazine</td>
</tr>
<tr>
<td></td>
<td>• Amobarbital*</td>
</tr>
<tr>
<td></td>
<td>• Butabarbital*</td>
</tr>
<tr>
<td></td>
<td>• Butalbital</td>
</tr>
<tr>
<td></td>
<td>• Pentobarbital*</td>
</tr>
<tr>
<td></td>
<td>• Phenobarbital</td>
</tr>
<tr>
<td></td>
<td>• Secobarbital*</td>
</tr>
<tr>
<td></td>
<td>• Mepobarbital**</td>
</tr>
<tr>
<td><strong>Central nervous system, other</strong></td>
<td><strong>Central nervous system, other</strong></td>
</tr>
<tr>
<td></td>
<td>• Chloral hydrate</td>
</tr>
<tr>
<td></td>
<td>• Meprobamate</td>
</tr>
<tr>
<td><strong>Central nervous system, Nonbenzodiazepine hypnotics</strong> (include when**</td>
<td><strong>Central nervous system, Nonbenzodiazepine</strong></td>
</tr>
<tr>
<td>cumulative day supply is &gt;90 days) <strong>(E)</strong></td>
<td><strong>hypnotics</strong></td>
</tr>
<tr>
<td></td>
<td>• Eszopiclone</td>
</tr>
<tr>
<td></td>
<td>• Zolpidem</td>
</tr>
<tr>
<td></td>
<td>• Zaleplon</td>
</tr>
<tr>
<td><strong>Central nervous system, vasodilators for dementia</strong></td>
<td><strong>Central nervous system, vasodilators for</strong></td>
</tr>
<tr>
<td></td>
<td><strong>dementia</strong></td>
</tr>
<tr>
<td></td>
<td>• Ergot mesylates*</td>
</tr>
<tr>
<td></td>
<td>• Isoxsuprine</td>
</tr>
<tr>
<td><strong>Endocrine system</strong></td>
<td><strong>Endocrine system</strong></td>
</tr>
<tr>
<td></td>
<td>• Desiccated thyroid</td>
</tr>
<tr>
<td></td>
<td>• Estrogens** with or without progesterone</td>
</tr>
<tr>
<td></td>
<td>(oral and topical patch products only)</td>
</tr>
<tr>
<td></td>
<td>• Megestrol</td>
</tr>
<tr>
<td><strong>Endocrine system, sulfonylureas, long-duration</strong></td>
<td><strong>Gastrointestinal system</strong></td>
</tr>
<tr>
<td></td>
<td>• Chlorpropamide</td>
</tr>
<tr>
<td></td>
<td>• Glyburide</td>
</tr>
<tr>
<td><strong>Gastrointestinal system</strong></td>
<td><strong>Pain medications</strong></td>
</tr>
<tr>
<td></td>
<td>• Trimethobenzamide</td>
</tr>
<tr>
<td><strong>Pain medications</strong></td>
<td><strong>Pain medications</strong></td>
</tr>
<tr>
<td></td>
<td>• Meperidine</td>
</tr>
<tr>
<td></td>
<td>• Pentazocine*</td>
</tr>
<tr>
<td><strong>Pain medications, non-COX-selective NSAIDS</strong></td>
<td><strong>Pain medications, non-COX-selective NSAIDS</strong></td>
</tr>
<tr>
<td></td>
<td>• Indomethacin</td>
</tr>
<tr>
<td></td>
<td>• Ketrolarol</td>
</tr>
<tr>
<td><strong>Skeletal muscle relaxants (as a single agent or as part of a combination</strong></td>
<td><strong>Skeletal muscle relaxants (as a single agent or</strong></td>
</tr>
<tr>
<td>product)**</td>
<td><strong>as part of a combination product)</strong></td>
</tr>
<tr>
<td></td>
<td>• Carisoprodol</td>
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<td></td>
<td>• Chlorzoxazone</td>
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<tr>
<td></td>
<td>• Cyclobenzaprine</td>
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<tr>
<td></td>
<td>• Metaxalane</td>
</tr>
<tr>
<td></td>
<td>• Methocarbamol</td>
</tr>
<tr>
<td></td>
<td>• Orphenadrine</td>
</tr>
</tbody>
</table>

*Infrequently used drugs. Abbreviations: TCAs, tricyclic antidepressants; OTC, over the counter.

** Conjugated estrogen, esterified estrogen, estradiol, estropipate (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.
Advancing Care Information
For Value Based P4P MY 2016
Overview

**Measure Updates December 2016 for VBP4P MY 2016**

- Changed the name of the MUHIT domain to Advancing Care Information domain in alignment with CMS Merit-Based Incentive Payment System (MIPS).

**Measure Updates September 2016 for VBP4P MY 2016**

- Removed the CMS EHR Incentive Program measure from the MUHIT domain.
- Revised the domain description.
- Added a Data Collection section.

**Description**

To support the continued implementation of technology and eliminate redundancy, the VBP4P 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.

Starting in MY 2014, VBP4P began collecting two e-Measures as part of the Advancing Care Information domain.

- **Controlling High Blood Pressure**.
- **Clinical Depression and Follow-Up Plan**.

These e-Measures are currently included in the CMS set of electronic specifications for clinical quality measures (eCQMs) for eligible professionals and eligible hospitals for use in the EHR Incentive program for electronic reporting.

*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](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_AdultRecommend_CoreSetTable.pdf)).

For VBP4P, credit is 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 Advancing Care Information Domain.

A list of all the CMS eCQMs and measure specifications can be found on the CMS website at: [https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/ecqm_library.html)

VBP4P staff will hold training Webinars for e-Measure reporting in early 2017.

**Who We Measure**

For the VBP4P **Advancing Care Information** domain, IHA will score POs based on all primary care physicians (MDs and DOs), including internists, family practitioners, GPs and pediatricians who can report the e-Measures to the PO.
Data Collection

Clinical Quality Measures (eCQMs) are measures that have specifications for calculation from EHR data. Measures are already programmed into the ONC-ATCB certified EHR systems of providers who can report the measures.

For each measure, report two metrics:

- **Rate 1: Percent Reportable**: The percentage of providers who can report the e-Measure (i.e., report a numerator and denominator to the PO).
  - Providers in your denominator should include all employed and contracted PCPs (MD or DO) in the following specialties: family/general practice, internal medicine and pediatric/adolescent medicine.

- **Rate 2: PO-level aggregated performance**: The aggregated patient numerator and denominator, for those providers who can report the e-Measure.
  - To calculate, pull the numerators and denominators from the EHR systems of all providers who can report the measures. Certified EHR systems should be able to create general a report with the patient numerator and denominators for the e-Measures.

VBP4P staff is not prescriptive about how POs collect e-Measure data, and assume that POs use different methods to collect data. POs using one integrated EHR system may be able to create a global report to generate numerators and denominators for providers across the PO. Organizations not using one centralized EHR system may need to collect numerators and denominators from individual providers and aggregate across the PO. Methods for collecting this data may include, but are not limited to, surveys or direct correspondence with the practice or provider.

Submitting Results

These e-Measures are included in the Advancing Care Information domain, but the numerators and denominators will be collected as part of the Physician Organization Clinical Measure File Layout and submitted to TransUnion. All participating POs, regardless of whether or not they self-report, may participate in e-Measure reporting. Non-self-reporting POs complete a separate file layout provided for non-self-reporting PO submission of e-Measures.

**Note**

- To receive credit, POs must submit both rates for each e-Measure.
- The PO-level aggregated patient numerator and denominator for Rate 2 are only for those PCPs that can report the e-Measure in Rate 1; the patient denominator in Rate 2 are the patients of those PCPs counted in the numerator for Rate 1.
- Include all payer types in e-Measure reporting; do not limit to commercial HMO/POS.
Example

• The PO has 50 PCPs that meet the measure criteria.

• 40 of the PCPs have an EHR and have the *Controlling High Blood Pressure* e-Measure activated in their EHRs, and the PO can collect the e-Measure from those PCPs.
  – These 40 PCPs can report an individual performance rate to the PO, with patient numerators and denominators, for this measure. This is Rate 1: Percent Reportable.

• The total number of patients in the rates reported by these 40 PCPs (aggregated, across-PO denominator) is 1,000. Of those 1,000 patients, 450 have a controlled blood pressure. This is Rate 2: PO-Level Aggregated Performance.

<table>
<thead>
<tr>
<th>e-Measure Name</th>
<th>Measure ID</th>
<th>Measure Rate</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Controlling High Blood Pressure</em></td>
<td>MU_CBPH_RPT</td>
<td>Rate 1: Percent Reportable</td>
<td>50</td>
<td>40</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>MU_CBPH</td>
<td>Rate 2: PO-Level Aggregated Performance</td>
<td>1,000</td>
<td>450</td>
<td>45%</td>
</tr>
</tbody>
</table>

**Optional Exclusions for Rate 1 of each e-Measure**

• Pediatricians may 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).
Controlling High Blood Pressure (e-Measure) (ECBP)

**Measure Updates December 2016 for VBP4P MY 2016**

- Changed the name of the MUHIT domain to Advancing Care Information.

**Measure Updates September 2016 for VBP4P MY 2016**

- Updated the version number of the measure specifications.
- Added full detail of the measure specifications from the CMS eCQM Library.

**Note:** This Advancing Care Information 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 report the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.

### Specifications

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<td>National Quality Forum.</td>
<td></td>
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<tr>
<td>Description</td>
<td>Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period.</td>
<td></td>
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</tr>
</tbody>
</table>

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1This measure specification is based on the most recent version of the eCQM Specifications for Eligible Professionals Update, published by CMS in April 2016. These specifications are available on the eCQM Library page of the CMS website (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.
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**Measure scoring**

Proportion.

**Measure type**

Process.

**Stratification**

None.

**Risk adjustment**

None.

**Rate aggregation**

None.

**Rationale**

Hypertension, or high blood pressure, is a very common and dangerous condition that increases risk for heart disease and stroke, two of the leading causes of death for Americans (Farley et al., 2010). Compared with other dietary, lifestyle, and metabolic risk factors, high blood pressure is the leading cause of death in women and the second-leading cause of death in men, behind smoking (Danaei et al., 2011).

Approximately 1 in 3 U.S. adults, or about 70 million people, have high blood pressure but only about half (52%) of these people have their high blood pressure under control. Additionally, data from NHANES 2011–2012 found that 17.2% of U.S. adults are not aware they have hypertension (Nwankwo et al., 2013). Projections show that by 2030, approximately 41.4% of U.S. adults will have hypertension, an increase of 8.4% from 2012 estimates (Heidenreich et al., 2011).

The estimated direct and indirect cost of high blood pressure for 2011 was $46.4 billion. This total includes direct costs, such as the cost of physicians and other health professionals, hospital services, prescribed medications and home health care, as well as indirect costs due to loss of productivity from premature mortality (Mozaffarian et al., 2015). Projections show that by 2030, the total cost of high blood pressure could increase to an estimated $274 billion (Heidenreich et al., 2011).

Better control of blood pressure has been shown to significantly reduce the probability that undesirable and costly outcomes will occur. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40%), myocardial infarction (20%–25%) and heart failure (>50%) (Chobanian et al., 2003). Thus, the relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established.
Clinical recommendation statement

The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003): Treating systolic blood pressure and diastolic blood pressure to targets that are <140/90 mmHg is associated with a decrease in cardiovascular disease complications.

Improvement notation

Higher score indicates better quality.

Reference


Reference


Reference


Reference


Reference


Reference


Reference


Reference


Reference


Definition

None.
Guidance
In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Blood pressure readings from the patient’s home (including readings directly from monitoring devices) are not acceptable.

If no blood pressure is recorded during the measurement period, the patient’s blood pressure is assumed “not controlled.”

If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Transmission format
TBD.

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.

Numerator exclusions
NA

Denominator exceptions
None.

Supplemental data elements
For every patient evaluated by this measure, also identify payer, race, ethnicity and sex.


### Screening for Clinical Depression and Follow-Up Plan (e-Measure) (ESCD)

**Measure Updates December 2016 for VBP4P MY 2016**

- Changed the name of the MUHIT domain to Advancing Care Information domain.

**Measure Updates September 2016 for VBP4P MY 2016**

- Updated the Version number of the measure specification.
- Added full detail of the measure specification from CMS eCQM Library.

**Note:** This Advancing Care Information 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 report the percentage of its providers who can report the measure, and the aggregated numerator and denominator for those providers across the PO.

### Specifications

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<tr>
<td>Description</td>
<td>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.</td>
<td></td>
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</tr>
<tr>
<td>Copyright</td>
<td>Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications. CPT (R) contained in the Measure specifications is copyright 2007-2016 American Medical Association. LOINC (R) copyright 2004-2015 [2.50] Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms (R) (SNOMED CT [R]) copyright 2004-2015</td>
<td></td>
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</tr>
</tbody>
</table>

²This measure specification is based on the most recent version of the eCQM Specifications for Eligible Professionals Update, published by CMS in April 2016. These specifications are available on the eCQM Library page of the CMS website (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.
Disclaimer

These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

Measure scoring

Proportion

Measure type

Process

Stratification

None

Risk adjustment

None

Rate aggregation

None

Rationale

In 2008, the Geriatric Mental Foundation reported that of the population aged 65 and older in the United States, 15%–20% of adults had experienced depression (Geriatric Mental Health Foundation, 2008), while 7 million of the same population were affected by depression (Steinman, 2007, p. 175) and accounted for 16% of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The World Health Organization (WHO), as cited by Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. “Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms” (Pratt & Brody, 2008, p.2). Pratt & Brody (2008) found that depression rates were higher in the 40-59 age brackets, is more common in females than in males, and higher in non-Hispanic black persons than in their non-Hispanic white counterparts (Pratt & Brody, 2008, p. 2). Disparities due to income have also been observed, as those with lower income (below the federal poverty line) in the 18-39 and 40-59 age brackets, whom experience higher depression rates than those with higher income. This disparity is not observable in other age categories (Pratt & Brody, 2008, p. 2).

Among children, the rate of current or recent depression stands at 3% and at 6% for adolescents, whose lifetime incidence rate of major depressive disorder (MDD) could be as high as 20% (Williams et al., 2009, p. e716). Bomer (2010), states that 20% of adolescents are likely to have experienced depression by the time they are 18 years old and that there is an observed increased onset around puberty. Onset of MDD during adolescence is particularly significant because it is associated with higher risks of suicide attempt, death by suicide and MDD recurrence in young adulthood. Additionally MDD is “associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood” (Williams et al., 2009, p. e716). According to Zalsman et al., (2006) as reported in Bomer et al. (2010), “depression ranks among the most commonly reported mental health problems in adolescent girls” (p. 947).

“The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages” (Bomer, 2010, p. 948). While
Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments" (Borner, 2010, p. 948). “Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated” (Borner, 2010, p. 948).

The substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. This measure seeks to achieve this goal and aligns with the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014). The measure makes important contribution to the quality domain of community and population health.

Adolescent Recommendation (12–18 years):

“The USPSTF recommends screening of adolescents (12-18 years of age), for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up” (AHRQ, 2010, p.141).

“Clinicians and health care systems should try to consistently screen adolescents, ages 12-18, for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up” (ICSI, 2013, p. 16).

Adult Recommendation (18 years and older):

“The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up” (AHRQ, 2010, p.136).

“A system that has embedded the elements of best practice and has capacity to effectively manage the volume, should consider routine screening of all patients based on the recommendations of the U.S. Preventive Services Task Force” (ICSI, 2013, p. 7). “Clinicians should use a standardized instrument to screen for depression if it is suspected, based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women” (ICSI, 2013, p. 4).

Higher score indicates better quality.


Reference

Reference

Reference

Reference

Reference

Reference

Reference

Reference

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**

A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of depression screening tools include, but are not limited to:

- Adolescent screening tools (12–17 years):
  - Patient Health Questionnaire for Adolescents (PHQ-A).
  - Beck Depression Inventory-Primary Care Version (BDI-PC).
  - Mood Feeling Questionnaire (MFQ).
  - Center for Epidemiologic Studies Depression Scale (CES-D).
  - Patient Health Questionnaire (PHQ-9).
  - Pediatric Symptom Checklist (PSC-17).
  - 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 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.”
Transmission format | TBD
--- | ---
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(s)
• Patient refuses to participate, or
Medical reason(s)
• 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.
Supplemental data elements | For every patient evaluated by this measure, also identify payer, race, ethnicity and sex.
Patient Experience Domain

For Value Based P4P MY 2016
Self-Reporting POs
Overview

MEASURE UPDATES DECEMBER 2016 FOR VBP4P MY 2016

- Removed the Health Promotion Composite from the VBP4P measure set.
- Patient-Doctor Interaction Composite has been renamed to Provider Communication Composite.
- Coordination of Care Composite has been renamed to Care Coordination Composite.
- Moved to a 6-month lookback period. For groups with results that are too small using the 6 month look back, two years of results will be rolled up.
- Removed height and weight question from the demographic section, which were previously used in the case mix adjustment.

MEASURE UPDATES SEPTEMBER 2016 FOR VBP4P MY 2016

- CHPI updated the PAS instrument to align with the CAHPS 3.0 version of the survey instrument.
- Removal of the Health Promotion Composite is under discussion by PAS Committee.
- Removed two questions from the Patient-Doctor Interaction Composite.
- Added two questions to the Coordination of Care Composite.
- Timely Care and Service Composite has been renamed Access to Care Composite.
- Removed two questions from the Access to Care Composite.

Description

This section includes the VBP4P guidelines and specifications for POs that participate in the Patient Experience domain for MY 2016. Health plans do not submit data for the Patient Experience domain; POs voluntarily self-report this domain. VBP4P 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 7 participating health plans and 8 physician organizations—under the authority of the CHPI Board of Directors. Each VBP4P measurement year, a subset of questions from the PAS survey is selected for inclusion in the Patient Experience domain.

Survey instrument

In MY 2012, the PAS began to use 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. In 2017, PAS will align with CAHPS 3.0 instrument as the basis for the PAS survey instrument.

Participation

For MY 2016, CHPI invites all POs that operate in California and serve commercially insured HMO and POS patients to participate in PAS. Invitations were distributed electronically mid-September, and opened October 3, 2016.
Registration was completed online at https://www.cssresearch.org/pas/.

During the registration process, POs were given information on various survey options and the associated fees. POs were required to provide up-to-date contact information and data on member enrollment, geographic locations served and other PO characteristics, and must have agreed to the terms outlined in the PAS Participation Agreement.

POs had 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 have added supplemental survey options. These are not required for VBP4P.

**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 VBP4P 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 VBP4P. All VBP4P domains must be reported at the same level.
  - The survey vendor may not separate results for groups who have not registered sub-units.

- At the time of registration, 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.

- 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.

- 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 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.

- 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 VBP4P:

- Access to Care Composite.
- Provider Communication Composite.
- Care Coordination Composite.
- Overall Rating of Care Composite.
- Office Staff Composite.
The following key performance areas are recommended for internal reporting only:

- Provider Communication Composite for PCPs.
- Provider Communication Composite for Specialists.
- Access to Care Composite for PCPs.
- Access to Care Composite for Specialists.
- Overall Rating of Doctor for PCPs.
- Overall Rating of Doctor for Specialists.

**VBP4P Measurement Year 2016 Patient Experience Questions From 2017 PAS**

The transition to CAHPS 3.0 included some changes to the questions included in the composites used for VBP4P. Please see the composites collected and recommended for payment for VBP4P in MY 2016, below, as well as in the MY 2016 measure set. Questions regarding the survey instrument and CAHPS 3.0 changes can be directed to Emily London at elondon@pbgh.org.

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Primary Care and Specialist Version</th>
</tr>
</thead>
</table>
| **Access to Care Composite** | Patient got appointment for urgent care as soon as needed  
|                         | Patient got appointment for non-urgent care as soon as needed  
|                         | Patient got answer to medical question the same day he/she contacted provider’s office |
| **Provider Communication Composite** | Provider explained things in a way that was easy to understand  
|                         | Provider listened carefully to patient  
|                         | Provider showed respect for what patient had to say  
|                         | Provider spent enough time with patient |
| **Care Coordination Composite** | Provider knew important information about patient's medical history  
|                         | Someone from provider's office followed up with patient to give results of blood test, x-ray or other test  
|                         | Someone from provider's office talked about all prescription medications being taken |
| **Office Staff Composite** | Clerks and receptionists helpful  
|                         | Clerks and receptionists courteous and respectful |
| **Overall Ratings of Care** | Overall rating of provider  
|                         | Overall rating of care |

**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 Emily London by e-mail at elondon@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. Visits in August to October are prioritized, but July visits are included if necessary. Visits from January to June are excluded from the sample.

Fielding Surveys

The standard survey protocol consists of three e-mails (where e-mail addresses are available) to complete the survey via website; two mailed surveys with a cover letter option to complete the survey via the survey website using a unique webID; and up to four attempts by Computer Assisted Telephone Interview (CATI), where phone numbers are available. The cover letter is printed with the logo of the patient’s PO and is signed by the PO’s medical director or other executive signatory.

The e-mails occur over at least one week in early December. The first mailing occurs in mid-January 2017; the second occurs in mid-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 mid-March. As patients respond to the survey, they are removed from further contact attempts.

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.

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 confirms a visit with the physician in the past year. Respondents to the PCP survey must also confirm that the doctor named on the survey is their PCP.

Analysis of Survey Data

If any POs do not have a sufficient number of survey responses to meet the reliability threshold for P4P reporting (overall ratings and composites), CSS will combine your 2016 and 2017 responses together into a two-year rollup. A similar two-year rollup was previously used in 2013 on the Health Promotion composite for groups with low levels of responses.
Each PO’s results are adjusted for patient case-mix to control for differences across POs. In MY 2016, 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.

## Reports

POs receive the following reports of their results.

- **PAS Provider Group Report** (June 2017): 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 2017): 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 website ([www.opa.ca.gov/report_card](http://www.opa.ca.gov/report_card)).

## Key Dates for PAS

<table>
<thead>
<tr>
<th>Activity or Milestone</th>
<th>Time Frame or Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAS Registration Information e-mailed to POs.</td>
<td>September 12, 2016</td>
</tr>
<tr>
<td>PAS Registration Site Live.</td>
<td>October 3, 2016</td>
</tr>
<tr>
<td>Deadline to register for 2017 PAS. Participation agreement between PO and CHPI due (via electronic consent during the registration process).</td>
<td>October 14, 2016</td>
</tr>
<tr>
<td>Submit Signed Business Associates Agreement (BAA) to CSS.</td>
<td>October 21, 2016</td>
</tr>
<tr>
<td>• Use Data Checking Tool (via downloadable tool).</td>
<td>November 1–17, 2016</td>
</tr>
<tr>
<td>• Submit Data for Survey Sampling.</td>
<td></td>
</tr>
<tr>
<td>Data corrections due.</td>
<td>November 22, 2016</td>
</tr>
<tr>
<td>Survey fielding period.</td>
<td>January 12, 2016 – April 6, 2017</td>
</tr>
<tr>
<td>Participation fees due to PAS.</td>
<td>March 4, 2017</td>
</tr>
<tr>
<td>Group survey results sent to groups.</td>
<td>June 8, 2017</td>
</tr>
<tr>
<td>Doctor survey results sent to groups.</td>
<td>Mid-July, 2017</td>
</tr>
</tbody>
</table>

## For More Information

Visit the CHPI website at [http://www.chpis.org/programs/pas.aspx](http://www.chpis.org/programs/pas.aspx) or contact Emily London by e-mail at elondon@pbgh.org.
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 VBP4P Governance Committee (the former VBP4P 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 VBP4P 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.
- All-Cause Readmissions.

Measure Development and Testing

The Resource Use measures were selected by a multi-stakeholder group of VBP4P 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 VBP4P 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 VBP4P 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 VBP4P 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 VBP4P Committees expressed a commitment to ensuring that all POs are able to participate in Value Based VBP4P, POs with low enrollment ("small POs" with fewer than 1,500 member years) 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 member years. 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 2016 VBP4P measure set. Calculation of improvement results is based on changes between MY 2015 and MY 2016 performance.
**Inpatient Utilization—Acute Care Discharges (IPU)**

**Measure Updates December 2016 for VBP4P MY 2016**
- None.

**Measure Updates September 2016 for VBP4P MY 2016**
- None.

**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 4.1.1, 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 2016. Health plans and POs are not expected to report the measure.*

**Eligible Population**

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial HMO and POS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>All ages.</td>
</tr>
<tr>
<td>Member years</td>
<td>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.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>Date of admission through discharge in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No gaps in enrollment.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>None.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical.</td>
</tr>
<tr>
<td>Measurement period</td>
<td>Calendar year. The measurement period is January 1–December 31, 2016.</td>
</tr>
</tbody>
</table>
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 = \[\text{sum of qualifying discharges from step 4 / total PO member years}\] * 1,000.

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. However, Small PO Pooled Observed Rates will be calculated for outlier 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 = \[\text{sum of discharges} / \text{sum of member years}\] * 1,000

Step 11  Calculate risk adjusted inpatient discharges PTMY for each PO.

Risk-adjusted rate = \[\text{O/E ratio} \times \text{population rate}\]

Note: All expected rates are based on the performance of the entire VBP4P 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 2016 for VBP4P MY 2016

• None.

Measure Updates September 2016 for VBP4P MY 2016

• 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 4.1.1, 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 2016. Health plans and POs are not expected to report the measure.

Eligible Population

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial HMO and POS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>All ages.</td>
</tr>
<tr>
<td>Member years</td>
<td>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.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>Date of admission through discharge in the health plan and in the PO (parent level).</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>No gaps in enrollment.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>None.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical.</td>
</tr>
<tr>
<td>Measurement period</td>
<td>Calendar year. The measurement period is January 1–December 31, 2016.</td>
</tr>
</tbody>
</table>
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.

\[
\text{Observed rate} = \frac{\text{number of bed days}}{\text{total PO member years}} \times 1,000
\]

**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.

\[
\text{O/E ratio} = \frac{\text{Observed bed days PTMY}}{\text{Expected bed days PTMY}}
\]

**Step 7** Calculate population rate PTMY across all members (i.e., across all plans and POs).

\[
\text{Population rate} = \left[ \frac{\text{sum of all bed days}}{\text{sum of all member years}} \right] \times 1,000
\]

**Step 8** Calculate risk-adjusted bed days PTMY for each PO.

\[
\text{Risk-adjusted rate} = \left[ \text{O/E ratio} \right] \times \text{population rate}
\]

**Note:** All expected rates are based on the performance of the entire VBP4P 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 = \( \frac{O}{E} \) 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 VBP4P 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 2016 for VBP4P MY 2016

• None.

Measure Updates September 2016 for VBP4P MY 2016

• Changed the definition of “preferred facility” to be consistent across health plans: a preferred facility is a contracted freestanding ambulatory surgery center.

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 2016. Health plans and POs are not expected to report it.

Eligible Population

<table>
<thead>
<tr>
<th>Product lines</th>
<th>Commercial HMO and POS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>All ages.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>None.</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>NA because there is no continuous enrollment requirement.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>None.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical.</td>
</tr>
<tr>
<td>Measurement period</td>
<td>Calendar year. The measurement period is January 1–December 31, 2016.</td>
</tr>
<tr>
<td>Total outpatient procedures</td>
<td>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.</td>
</tr>
</tbody>
</table>

- 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 only outpatient procedures performed at a hospital outpatient facility or at a free-standing surgery center.

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. A preferred facility is a contracted, free-standing ambulatory surgery center (ASC).

Hospital outpatient facilities will be considered “non-preferred”.

Health plans will provide a flag on the outpatient facility claim to indicate whether the facility was contracted.

A freestanding ambulatory surgery center will be identified by Bill Type = 83x on the claim/encounter.

**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 2016 for VBP4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- 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 4.1.1, 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 2016. 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, 2016.
- **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 VBP4P 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.
Generic Prescribing (GRX)

**Measure Updates December 2016 for VBP4P MY 2016**

- None.

**Measure Updates September 2016 for VBP4P MY 2016**

- 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:

<table>
<thead>
<tr>
<th>Generic Prescribing Rate</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>SSRIs and SNRIs</td>
</tr>
<tr>
<td>Antihyperlipidemics</td>
<td>Statins</td>
</tr>
<tr>
<td>Anti-ulcer agents</td>
<td>Proton pump inhibitors (PPIs)</td>
</tr>
<tr>
<td>Cardiac—Hypertension and cardiovascular</td>
<td>Angiotensin II receptor blockers (ARBs)</td>
</tr>
<tr>
<td>Nasal steroids</td>
<td>Nasal steroids</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Oral and self-injected antidiabetic agents, excluding insulin</td>
</tr>
<tr>
<td>Anxiety/sedation—sleep aids</td>
<td>Nonbenzodiazepine sedative hypnotics</td>
</tr>
<tr>
<td>Antimigraine</td>
<td>Oral and self-injected triptans</td>
</tr>
<tr>
<td>Overall</td>
<td>All drugs, excluding injectables</td>
</tr>
</tbody>
</table>

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 2016. 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, 2016.

**Measure Definition 1: Therapeutic Area Generic Prescribing Rate**

Measures in seven therapeutic areas will be calculated and used for VBP4P 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 VBP4P reporting or incentive payment purposes.

Overall Generic Prescribing Rate =

\[
\frac{\text{Number of Prescriptions for All Generic Drugs}}{\text{Number of Prescriptions for All Drugs}}
\]
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 2016 for VBP4P MY 2016**

- None.

**Measure Updates September 2016 for VBP4P MY 2016**

- Added service category breakdowns.

**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 4.1.1, 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 2016. Health plans and POs are not expected to report it.*

**Eligible Population**

<table>
<thead>
<tr>
<th>Product line</th>
<th>Commercial HMO/POS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>All ages.</td>
</tr>
<tr>
<td>Continuous enrollment</td>
<td>None. Include all members who are enrolled in a PO and the health plan for one day or more during the measurement year.</td>
</tr>
<tr>
<td>Allowable gap</td>
<td>NA.</td>
</tr>
<tr>
<td>Anchor date</td>
<td>None.</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical and pharmacy.</td>
</tr>
<tr>
<td>Measurement period</td>
<td>Calendar year. The measurement period is January 1–December 31, 2016. Include services with a date of service between January 1 and December 31, 2016, and a date of payment between January 1, 2016, and March 31, 2017.</td>
</tr>
</tbody>
</table>
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 by service category. 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.
- VBP4P 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-VBP4P quality 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 VBP4P 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 VBP4P 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 2016 for VBP4P MY 2016

- None.

Measure Updates September 2016 for VBP4P MY 2016

- None.

Modifications From HEDIS

- None.

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 2016. 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, 2016.

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 PCI.

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 127 for the complete measure specifications.
Appendix
Summary Table of Measure Specification Changes
For Value Based P4P MY 2016
## APPENDIX 1
### SUMMARY TABLE OF QUALITY MEASURES AND CHANGES

<table>
<thead>
<tr>
<th>MY 2016 Measures</th>
<th>Date of Update/Modification From HEDIS</th>
<th>Measure Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Rate by Service Type</td>
<td>December 2016</td>
<td>• Added to the MY 2016 Medicare measure set</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Non-HEDIS measure.</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>December 2016</td>
<td>• Added Amlodipine-perindopril to Table MPM-A.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
</tbody>
</table>
| Controlling High Blood Pressure for People With Hypertension                     | December 2016                        | • Added nonacute inpatient visits as an appropriate setting for identifying the most recent BP reading.  
                                                                                            • As a reminder the mapping of proprietary and other codes is allowed under current guidelines (see General Guideline 45 on page 30) as permitted by audit approval.  
                                                                                            • Added new medications to Table CBPH-A:  
                                                                                            • Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the "Antidiabetic combinations" row.  
                                                                                            • Added Insulin degludec and Insulin human inhaled to the “Insulin” row.  
                                                                                            • Added Dulaglutide to the “Glucagon-like peptide-1 (GLP1) agonists” row.  
                                                                                            • Made clarifications to the description.  
|                                                                                  | September 2016                       | • None.                                                                                                                                                                                                       |
|                                                                                  | Modifications From HEDIS             | • Non-HEDIS Measure                                                                                                                                                                                           |
| Statin Therapy for Patients With Cardiovascular Disease                          | December 2016                        | • Removed Aspirin-pravastatin 40-80 mg from table SPC-B.                                                                                                                                                      |
|                                                                                  | September 2016                       | • Added to the MY 2016 Commercial measure set  
                                                                                            • Added a Note section.                                                                                                                                                                                          |
|                                                                                  | Modifications From HEDIS             | • None.                                                                                                                                                                                                       |
| Proportion of Days Covered by Medications:                                       | December 2016                        | • Added the combination product, Valsartan-Nebivolol to the “Antihypertensive combinations” row of Table PDC-A.  
                                                                                            • Corrected the table names for Statin Medications, Diabetes All Class Medications, and Insulin Medication in alignment with the final version of the MY 2015 VBP4P Manual.  
                                                                                            • Table PDC-C changed to Table PDC-B.  
                                                                                            • Table PDC-D changed to Table PDC-C.  
                                                                                            • Table PDC-E changed to Table PDC-D.                                                                                                                                                                          |
### Appendix 1—Summary Table of Quality Measures and Changes

<table>
<thead>
<tr>
<th>MY 2016 Measures</th>
<th>Date of Update/Modification From HEDIS</th>
<th>Measure Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added a denominator exclusion for Renin Angiotensin System (RAS) Antagonists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added table PDC-E to identify Renin Angiotensin System (RAS) Antagonists denominator exclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed Aliskiren-valsartan from the Direct renin inhibitor combination products row and Antihypertensive combinations row of Table PDC-A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added Perindopril – amlodipine to the Antihypertensive combinations row of Table PDC-A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed empagliflozin from DPP-IV inhibitor combinations row of Table PDC-C and added the Linagliptin-empagliflozin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added empagliflozin- metformin to the SGLT2 Inhibitor Combinations row of Table PDC-C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added Insulin degludec Table PDC-D.</td>
</tr>
<tr>
<td>Diabetes Care:</td>
<td>December 2016</td>
<td>• Non-HEDIS measure.</td>
</tr>
<tr>
<td>• Two HbA1c Tests</td>
<td></td>
<td>• Removed Option B from the blood pressure indicator.</td>
</tr>
<tr>
<td>• HbA1c Poor Control (&gt;9.0%)</td>
<td></td>
<td>– As a reminder the mapping of proprietary and other codes is allowed under current guidelines (see General Guideline 45 on page 30) as permitted by audit approval.</td>
</tr>
<tr>
<td>• HbA1c Control (&lt;8.0%)</td>
<td></td>
<td>• Made changes to Table CDC-A:</td>
</tr>
<tr>
<td>• Eye Exam</td>
<td></td>
<td>– Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the “Antidiabetic combinations” row.</td>
</tr>
<tr>
<td>• LDL Screening and Control (&lt;100)</td>
<td></td>
<td>– Added Insulin degludec and Insulin human inhaled to the “Insulin” row.</td>
</tr>
<tr>
<td>• Nephropathy Monitoring</td>
<td></td>
<td>– Added Dulaglutide to the “Glucagon-like peptide-1 (GLP1) agonists” row.</td>
</tr>
<tr>
<td>• Blood Pressure Control (&lt;140/90)</td>
<td></td>
<td>• Added Amlodipine-perindopril to the “Antihypertensive Combinations” row of Table CDC-B.</td>
</tr>
<tr>
<td>• Optimal Diabetes Care</td>
<td>September 2016</td>
<td>• Added a method and new value set to identify negative eye exams in the year prior to the measurement year.</td>
</tr>
<tr>
<td>Modifications From HEDIS</td>
<td>December 2016</td>
<td>• Optimal Diabetes Care Combination Rate is a non-HEDIS measure that is an “all or none” combination rate composed of four indicators.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Volume 2 has an indicator that looks for at least one HbA1c test, the VBP4P 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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Blood Pressure Control (&lt;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.</td>
</tr>
<tr>
<td>MY 2016 Measures</td>
<td>Date of Update/ Modification From HEDIS</td>
<td>Measure Update</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Statin Therapy for Patients With Diabetes</td>
<td>December 2016</td>
<td>Made changes to Table SPD-A:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Added Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin to the “Antidiabetic combinations” row.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Added Insulin degludec and Insulin human inhaled to the “Insulin” row.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Added Dulaglutide to the “Glucagon-like peptide-1 (GLP1) agonists” row.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Made changes to Table SPD-B:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Removed Aspirin-pravastatin 40–80 mg from the Moderate-intensity statin therapy row.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Removed Aspirin-pravastatin 20 mg from the “Low-intensity statin therapy” row.</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>September 2016</td>
<td>Added to the MY 2016 Commercial measure set</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clarified that optional exclusions are excluded from the denominator for both rates.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added a Note.</td>
</tr>
<tr>
<td>Modifications From HEDIS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>December 2016</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in step 1 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added instructions to identify ED visits and observation visits that result in an inpatient stay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renamed the Osteopathic Manipulative Treatment Value Set to Osteopathic and Chiropractic Manipulative Treatment Value Set in step 1 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added the Physical Therapy Value Set to step 1 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added the Telehealth Value Set to step 1 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in step 3 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revised the look back period to exclude members with recent trauma from 12-months to 3-months in step 4 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added required exclusions and the following value sets: HIV Value Set, Spinal Infection Value Set, Organ Transplant Other Than Kidney Value Set, Kidney Transplant Value Set to step 4 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added a required exclusion for prolonged use of corticosteroids to step 4 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Replaced the Low Back Pain Value Set with the Uncomplicated Low Back Pain Value Set in the numerator.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added a requirement to not include denied claims in the numerator.</td>
</tr>
<tr>
<td>Modifications From HEDIS</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>MY 2016 Measures</td>
<td>Date of Update/Modification From HEDIS</td>
<td>Measure Update</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added the HIV Type 2 Value Set to the optional exclusions.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Limited to the Medicare Advantage product line only.</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added a requirement to not include ED visits and observation visits that result in an inpatient stay in steps 1 and 2 of the event/diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added instructions to identify direct transfers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarified that for direct transfers, the first admission date should be used when determining the number of days prior to the IESD in step 4.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed Note regarding inpatient claim/encounter data.</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added CVX codes to the measure.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added HIV Type 2 Value Set to the optional exclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added optional exclusions for the rotavirus vaccine.</td>
</tr>
<tr>
<td>Immunizations for Adolescents</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added the HPV vaccine.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added Combination 2 (meningococcal, Tdap, HPV).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added CVX codes to the measure.</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine for Female Adolescents</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• The HEDIS HPV measure is included as an antigen under the Immunization for Adolescents (IMA) measure. VBP4P will collect HPV separately for trending purposes.</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>MY 2016 Measures</td>
<td>Date of Update/Modification From HEDIS</td>
<td>Measure Update</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added a clarification to Step 2 of the numerator.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added a Note.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• The measure exclusion is required.</td>
</tr>
<tr>
<td>Cervical Cancer Overscreening</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• No Added a Note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Changed the name of the ECS Exclusions Group 1 Value Set and ECS Exclusions Group 2 Value Set to CCO Exclusions Group 1 Value Set and CCO Exclusions Group 2 Value Set.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Non-HEDIS measure.</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>December 2016</td>
<td>• Clarified the optional exclusions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Revised the Note section.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Clarified that diagnostic screenings are not included in the measure.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>December 2016</td>
<td>• Revised the numerator criteria to include CT colonography and the FIT-DNA test.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Limited to the Medicare Advantage product line only.</td>
</tr>
<tr>
<td>Asthma Medication Ratio</td>
<td>December 2016</td>
<td>• Added Fluticasone-vilanterol to the Inhaled steroid combinations row of Table AMR-A and AMR-B.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added instructions to identify ED visits and observation visits that result in an inpatient stay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added a requirement to not include denied claims in the numerator.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>Appropriate Treatment for Children With Upper Respiratory Infection</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added instructions to identify ED visits and observation visits that result in an inpatient stay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added a requirement to not include denied claims in the numerator.</td>
</tr>
</tbody>
</table>
## Appendix 1—Summary Table of Quality Measures and Changes

<table>
<thead>
<tr>
<th>MY 2016 Measures</th>
<th>Date of Update/ Modification From HEDIS</th>
<th>Measure Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
</tbody>
</table>
|                  | September 2016 | • Revised the allowable gap and anchor date criteria.  
|                  |              | • Added instructions to identify ED visits and observation visits that result in an inpatient stay.  
|                  |              | • Added two value sets to step 3 of the event/diagnosis criteria (HIV Type 2 Value Set; Disorders of the Immune System Value Set).  
|                  |              | • Added a requirement to not include denied claims in the numerator.  
| Modifications From HEDIS | | |
| All-Cause Readmissions | December 2016 | • None. |
|                      | September 2016 | • Clarified that organizations may not consolidate stays into a single stay if the discharge date from the first setting and the admission date of the second setting are two or more calendar days apart.  
|                      |              | • Added instructions to identify direct transfers.  
|                      |              | • Changed the reference of "discharges" to "admissions" in step 3 of the Numerator.  
| Modifications From HEDIS | | • Age 18-64 age band 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 measures (i.e., commercial VBP4P or Medicare Advantage).  
| High-Risk Medication | December 2016 | • None. |
|                      | September 2016 | • Added Guanabenz* to the Cardiovascular, alpha blockers, central row of Table HRM- A.  
|                      |              | • Added Mephobarbital* to the Central nervous system, barbiturates row of Table HRM- A.  
| 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.  
| Advancing Care Information | December 2016 | • Changed the name of the MUHIT domain to Advancing Care Information domain in alignment with CMS Merit-Based Incentive Payment System (MIPS).  
|                      | September 2016 | • Removed the CMS EHR Incentive Program measure from the MUHIT domain.  
|                      |              | • Revised the domain description.  
|                      |              | • Added a Data Collection section.  
| Patient Experience | December 2016 | • Removed the Health Promotion Composite from the VBP4P measure set.  
|                      |              | • Patient-Doctor Interaction Composite has been renamed to Provider Communication Composite.  
|                      |              | • Coordination of Care Composite has been renamed to Care Coordination Composite.  
|                      |              | • Moved to a 6-month lookback period. For groups with results that are too small using the 6 month lookback, two years of results will be rolled up.  

---

Measurement Year 2016 VBP4P Manual
<table>
<thead>
<tr>
<th>MY 2016 Measures</th>
<th>Date of Update/ Modification From HEDIS</th>
<th>Measure Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Removed height and weight question from the demographic section, which were previously used in the case mix adjustment.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• CHPI updated the PAS instrument to align with the CAHPS 3.0 version of the survey instrument.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removal of Health Promotion Composite currently under discussion by PAS Committee.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed two questions from Patient-Doctor Interaction Composite.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added two questions to the Coordination of Care Composite.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Timely Care and Service Composite has been renamed Access to Care Composite.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed two questions from the Access to Care Composite.</td>
</tr>
<tr>
<td>Inpatient Utilization—Acute Care Discharges</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Based on HEDIS Use of Services specifications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added risk adjustment.</td>
</tr>
<tr>
<td>Inpatient Utilization—Bed Days</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Based on HEDIS Use of Services specifications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added risk adjustment.</td>
</tr>
<tr>
<td>Outpatient Procedures Utilization—Percentage Done in Preferred Facility</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Changed the definition of preferred facility to be consistent across health plans: a preferred facility is a contracted freestanding ambulatory surgery center.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Based on former HEDIS Utilization specifications.</td>
</tr>
<tr>
<td>Emergency Department Visit</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Based on HEDIS Utilization specifications.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Added risk adjustment.</td>
</tr>
<tr>
<td>Generic Prescribing</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Non-HEDIS measure.</td>
</tr>
<tr>
<td>Total Cost of Care</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• Added service category breakdowns.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• Non-HEDIS measure.</td>
</tr>
<tr>
<td>MY 2016 Measures</td>
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<td>Measure Update</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Frequency of Selected Procedures</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>September 2016</td>
<td>• None.</td>
</tr>
<tr>
<td></td>
<td>Modifications From HEDIS</td>
<td>• None.</td>
</tr>
<tr>
<td>All-Cause Readmissions</td>
<td>December 2016</td>
<td>• None.</td>
</tr>
</tbody>
</table>
|                                 | September 2016                          | • Clarified that organizations may not consolidate stays into a single stay if the discharge date from the first setting and the admission date of the second setting are two or more calendar days apart.  
• Added instructions to identify direct transfers.  
• Changed the reference of “discharges” to “admissions” in step 3 of the Numerator. |
|                                 | Modifications From HEDIS                | • Age 18-64 age band 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 measures (i.e., commercial VBP4P or Medicare Advantage). |