VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS
Draft as of August 28, 2014

M&E-1 (NCQA HEDIS; NQF# 0036): Appropriate Medications for People with Asthma

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The measure assesses the percentage of members 5-64 years of age during the measurement year who were identified as having moderate to severe persistent asthma and who were appropriately prescribed medication during the measurement year.

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
All health plan members 5–64 years of age during the measurement year who were identified as having moderate to severe persistent asthma.

NUMERATOR:
The number of members who were dispensed at least one prescription for a preferred therapy during the measurement year.

EXCLUSIONS:
Exclude any members who had at least one encounter, in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis, or acute respiratory failure (Table ASM-E) any time on or prior to December 31 of the measurement year.

LOOK BACK PERIOD: Measurement year and the year prior to the measurement year.

CONTINUOUS ENROLLMENT: The measurement year and the year prior to the measurement year. No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year.

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-2 (NCQA HEDIS; NQF# 0055): Comprehensive Diabetes Care: Eye Exams for Diabetics

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a retinal or dilated eye exam during the measurement year or a negative retinal or dilated eye exam in the year prior to the measurement year.

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

NUMERATOR:
Members who received an eye screening for diabetic retinal disease. This includes diabetics who had the following:
- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
OR

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

For exams performed in the year prior to the measurement year, a result must be available.

EXCLUSIONS:
Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

LOOK BACK PERIOD: For the numerator, the measurement year. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

CONTINUOUS ENROLLMENT: Measurement year. No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-3 (NCQA HEDIS; NQF# 0062): Comprehensive Diabetes Care: Medical Attention for Nephropathy

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

NUMERATOR:
Members who received a nephropathy screening test or had evidence of nephropathy during the measurement year.

EXCLUSIONS:
Exclude members with a diagnosis of polycystic ovaries who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the

year prior to the measurement year. Diagnosis may occur at any time in the member's history, but must have occurred by the end of the measurement year.

Exclude members with gestational or steroid-induced diabetes who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by the end of the measurement year.

LOOK BACK PERIOD: For the numerator, the measurement year. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

CONTINUOUS ENROLLMENT: Measurement year. No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-4 (NCQA HEDIS; NQF# 0577): Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: This measure assesses the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
Any health plan member 42 years or older as of December 31 of the measurement year, who had a diagnosis of COPD during the Intake Period.

NUMERATOR:
The measure looks at the number of health plan members whose initial diagnosis of COPD is being confirmed using spirometry.

EXCLUSIONS:
Members are excluded from the denominator if they had a claim/encounter with a COPD diagnosis during the 730 days (2 years) prior to the index episode start date (IESD).

LOOK BACK PERIOD: A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year for the Intake Period captures the first COPD diagnosis. The index episode start date is the first date of service for a COPD diagnosis during the intake period. A negative diagnosis history for two years prior to the index episode start date is required to be included in the denominator.

CONTINUOUS ENROLLMENT: 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD.

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-5 (NCQA HEDIS; NQF# 0108): Follow-up Care for Children Prescribed ADHD Medication

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.
• Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
• Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
Initiation Phase: 6-12 years of age (6 as of March 1 of the year prior to the measurement year; 12 years as of February 28 of the measurement year), AND

Medical and pharmacy benefit, AND
Dispensed an ADHD medication during the 12-month Intake Period.

Continuation and Management Phase: Eligible Population (see details)
6-12 years of age (6 as of March 1 of the year prior to the measurement year; 12 years as of February 28 of the measurement year), AND
Medical and pharmacy benefit, AND
Had continuous treatment for at least 210 days out of the 300-day period

NUMERATOR:
Initiation Phase: One face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD.
Note: Do not count a visit on the IPSD as the Initiation Phase visit.

C&M Phase: Identify all members who meet the following criteria.
An Initiation Phase Visit in the first 30 days, and
At least two follow-up visits from 31–300 days (10 months) after the IPSD
One of the two visits (during days 31–300) may be a telephone visit with practitioner.

EXCLUSIONS:
Initiation Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis or DRG for mental health or substance abuse during the 30 days after the IPSD.

Continuation and Management Phase: Exclude members who had an acute inpatient claim/encounter with a principal diagnosis of mental health substance abuse during the 300 days after the IPSD.

Patients diagnosed with narcolepsy (ICD-9-CM Code: 347) should be excluded from the denominators.

LOOK BACK PERIOD: The intake period is the 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year. The patient must have a negative medication history 120 days before the index prescription start date, which is the earliest prescription during the intake period.

CONTINUOUS ENROLLMENT:

Initiation Phase: Must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD through 30 days after the IPSD with no gaps.

Continuation Phase: Must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. Members who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1. One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-6 (NCQA HEDIS; NQF# 0105): Antidepressant Medication Management

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: __X__ State Level: ____

Name and date of specifications used:
HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.
a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).

FREQUENCY OF REPORTING: Annual

DENOMINATOR:
Diagnosed with a new episode of major depression and treated with antidepressant medication.

NUMERATOR:
a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

   Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

EXCLUSIONS:
Exclude members who have antidepressant prescriptions filled during the Negative Medication History period 90 days (3 months) prior to the IPSD.

Exclude members who had a claim/encounter for any diagnosis of major depression or prior episodes of depression during the Negative Diagnosis History period during the 120 days (4 months) prior to the IPSD.

LOOK BACK PERIOD: The intake period is the 12-month window starting May 1 of the year prior to the measurement year and ending April 30 of the measurement year. The patient must have a negative medication history 105 days before the index prescription start date, which is the earliest prescription during the intake period.

CONTINUOUS ENROLLMENT: 105 days prior to the IPSD through 231 days after the IPSD. One gap in enrollment of up to 45 days is allowed. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

MEASURE DETAILS: See HEDIS® 2015 Technical Specifications for Health Plans (Volume 2) for details.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-7: Family Evaluation of Hospice Care Survey Questions

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: __X__ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: 2011 Family Evaluation of Hospice Care (FEHC) Survey

URL of Specifications: www.nhpco.org/fehc-survey-materials

DESCRIPTION: The Family Evaluation of Hospice Care (FEHC) is a post-death survey designed to yield actionable information that reflects the quality of hospice care delivery from the perspective of family caregivers. The GMCB's Analytics Contractor will collect this measure information from the Vermont Assembly of Home Health & Hospice Agencies and the Visiting Nurse Association of Vermont and New Hampshire (VNA/VNH). The VNA/VNH will provide Vermont-specific results for their hospice program. Together with the Vermont Assembly of Home Health and Hospice Agencies' results, Analytics Contractor will receive results for all of Vermont's not-for-profit hospice agencies.

FREQUENCY OF REPORTING: Annual

DENOMINATOR: as defined by the Vermont Assembly of Home Health & Hospice Agencies and the VNA/VNH.

NUMERATOR: as defined by the Vermont Assembly of Home Health & Hospice Agencies and the VNA/VNH.

EXCLUSIONS: as defined by the Vermont Assembly of Home Health & Hospice Agencies and the VNA/VNH.

MEASURE DETAILS: See the National Hospice and Palliative Care Organization (NHPCO) website for more information: www.nhpco.org/performance-measures/family-evaluation-hospice-care-fehc

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-8: School Completion Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: ____ Other (specify): __X__

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: Four Year-cohort graduation rate as defined by the Vermont Agency of Education

URL of Specifications: http://education.vermont.gov/documents/EDU-Data_2010_2011_Dropout_and_High_School_Completion.pdf

DESCRIPTION: The Vermont Agency of Education will collect the data, calculate and report the school completion rate results at the state level. The GMCB's Analytics Contractor will collect this measure information from the Vermont Agency of Education.

FREQUENCY OF REPORTING: Annual

DENOMINATOR: as defined by the Vermont Agency of Education

NUMERATOR: as defined by the Vermont Agency of Education

EXCLUSIONS: as defined by the Vermont Agency of Education

MEASURE DETAILS: See the Vermont Agency of Education website for more information: http://education.vermont.gov/data/dropout-and-high-school-completion

MONITORING AND EVALUATION MEASURE
SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-9: Unemployment Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: ____ Clinical data: ____ Survey: ____ Other (specify): __X__

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: __X__ Evaluation: ____

Level of Measurement for 2014:

ACO Level: ____ Plan Level: ____ State Level: __X__

Name and date of specifications used: Annual average statewide unemployment rate calculated by the Local Area Unemployment Statistics (LAUS) program through the Vermont Department of Labor.

URL of Specifications: www.vtlmi.info/unemp.cfm

DESCRIPTION: The Vermont Department of Labor will collect the data, calculate and report the Annual average unemployment rate at the state level. The GMCB's Analytics Contractor will collect this measure information from the Vermont Department of Labor.

Monthly unemployment data is available on the Vermont Department of Labor website (by state, labor market, county, and town) at www.vtlmi.info/unemp.cfm. Annual unemployment information is available by state and county on the Vermont Department of Labor website at www.vtlmi.info/detftp.htm#laus.

FREQUENCY OF REPORTING: Annual

DENOMINATOR: as defined by the Vermont Department of Labor.

NUMERATOR: as defined by the Vermont Department of Labor.

EXCLUSIONS: as defined by the Vermont Department of Labor.

MEASURE DETAILS: See the Vermont Department of Labor website for more information: www.vtlmi.info/unemp.cfm.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-10: Health Partners TCOC: Total Cost Index (TCI)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HealthPartners technical guidelines updated 10/3/2013.

URL of Specifications:
www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057425.pdf

DESCRIPTION: Health Partners Total Cost of Care Calculation: Total Cost Index. Total Cost of Care (TCOC) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. The HealthPartners Total Cost of Care measure is built off of the **allowed** amounts (all payments to the provider for medical services rendered, all pharmacy payments, plan and member liability). These amounts are subject to a member-level truncation factor of $100,000 and the amounts are risk adjusted using the Johns Hopkins ACG algorithm.

FREQUENCY OF REPORTING: Quarterly

HealthPartners offers two licensing agreements free of charge to external users implementing Total Cost of Care and Resource Use in their organizations. TCOC measures can be used by SAS users and non-SAS users.

DENOMINATOR: Peer Group Risk-Adjusted PMPM

NUMERATOR: Risk adjusted PMPM = (Total PMPM/Risk Score)

EXCLUSIONS: N/A

ENROLLMENT REQUIREMENT: Minimum of 9 months enrollment during performance measurement period; does not have to be continuous.

MEASURE DETAILS: See the Health Partners website for more information: www.healthpartners.com/public/tcoc/toolkit/

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-11: Health Partners TCOC: Resource Use Index (RUI)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HealthPartners technical guidelines updated 10/3/2013.

URL of Specifications:
www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057425.pdf

DESCRIPTION: Health Partners Total Cost of Care Calculation: Resource Use Index. The Resource Use Index is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. Both the TCOC and Resource Use measures are based on a risk adjusted PMPM relative to a specified peer group or benchmark. The resource use measure is the risk adjusted total resources divided by the sum of the member months attributed to the provider. The total resources are the sum of the Total Care Relative Resource Values, which are a standardized price value that acts in the same fashion as a dollar (as described in the TCRRV™ Methodology).

HealthPartners offers two licensing agreements free of charge to external users implementing Total Cost of Care and Resource Use in their organizations. TCOC measures can be used by SAS users and non-SAS users.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Peer Group Risk-Adjusted Resource Use PMPM

NUMERATOR: Risk-Adjusted Resource Use PMPM = (Total Resource PMPM/Risk Score)

EXCLUSIONS: N/A

ENROLLMENT REQUIREMENT: Minimum of 9 months enrollment during performance measurement period; does not have to be continuous.

MEASURE DETAILS: See the Health Partners website for more information: www.healthpartners.com/public/tcoc/toolkit/.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-12: Ambulatory Surgery/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: N/A

DESCRIPTION: The rate of outpatient ambulatory surgeries. (unique cases / member months) * 12000

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: unique cases of outpatient ambulatory surgeries

EXCLUSIONS: Rolled up to a hierarchy that makes an entire claim one type of OP Claim. Second behind Outpatient Emergency Department (ED) visits.

MEASURE DETAILS:

CPT Codes:

between 10021 and 36410
between 36420 and 55920
between 56405 and 58301
between 58340 and 58960

between 59100 and 62365
between 63001 and 69020
between 69100 and 69990
between 92920 and 92944
between 92973 and 92974
between 93451 and 93462
between 93501 and 93533
between 93580 and 93581
between 99141 and 99150
between G0104 and G0105
between G0168 and G0173
between G0289 and G0291
between G0297 and G0305
between G0338 and G0343
between G0392 and G0393
between G0413 and G0419
between G0440 and G0441
between S2053 and S2118
between S2135 and S2152
between S2205 and S2900
59899, G0127, G0251, G0259, G0267, G0269, G0364, G0455, M0301, S0199, S0400, S0601, S9034

Revenue Codes:

between 360 and 369
481
between 490 and 499
between 750 and 759
between 790 and 799

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-13: Average Number of Prescriptions PMPM

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: N/A

DESCRIPTION: The rate of prescriptions per member per month.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: total prescriptions (in any setting)

EXCLUSIONS: N/A

MEASURE DETAILS: N/A

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-14: Avoidable ED Visits (NYU algorithm)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: Version 21 of the NYU ED Algorithm. Code Sets source: Milliman HCG Grouper, 2013 version 3

URL of Specifications: http://wagner.nyu.edu/faculty/billings/nyued-download

DESCRIPTION: With support from the Commonwealth Fund, the Robert Wood Johnson Foundation, and the United Hospital Fund of New York, the NYU Center for Health and Public Service Research has developed an algorithm to help classify ED utilization. The algorithm was developed with the advice of a panel of ED and primary care physicians, and it is based on an examination of a sample of almost 6,000 full ED records. Data abstracted from these records included the initial complaint, presenting symptoms, vital signs, medical history, age, gender, diagnoses, procedures performed, and resources used in the ED.

The NYU Center for Health and Public Service Research has developed software for applying the algorithm using three different software applications: SAS, SPSS, and ACCESS. Detailed instructions on how to use the algorithm are included in Download section of their website. All three applications produce an output data set that adds a new set of variables to your original data set.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: N/A

NUMERATOR: N/A

EXCLUSIONS:

MEASURE DETAILS:
Each case is classified into one of the following categories:

- Non-emergent - The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours;
- Emergent/Primary Care Treatable - Based on information in the record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CT scan or certain lab tests)
- Emergent - ED Care Needed - Preventable/Avoidable - Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.); and
- Emergent - ED Care Needed - Not Preventable/Avoidable - Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).
- Injury
- Mental health diagnosis
- Alcohol-related health principal diagnosis
- Drug-related health principal diagnosis (excluding alcohol).
- Not classified - not in one of the above categories

CPT codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

See the NYU Center for Health and Public Service Research website for more information: http://wagner.nyu.edu/faculty/billings/nyued-background.

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-15: Ambulatory Care (ED rate only)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on: HEDIS® 2015 Technical Specifications for Health Plans (Volume 2), Report ED visit rate only. Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: This measure summarizes utilization of ambulatory care in the following categories: ED Visits. Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: 1,000 Member Months

NUMERATOR: ED Visits

EXCLUSIONS: The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency (AMB Exclusions Value Set).

MEASURE DETAILS:

CPT Codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room - hospital

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-16: ED Utilization for Ambulatory Care-Sensitive Conditions

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on ahrq.gov Archive Appendix B and Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: http://archive.ahrq.gov/data/safetynet/billappb.htm

DESCRIPTION: The number of ED visits for Ambulatory Care-Sensitive Conditions compared to all ED visits. Ambulatory Care Sensitive conditions such as asthma, diabetes or dehydration are hospitalization conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or conditions, controlling an acute episode of an illness or managing a chronic disease or condition. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Total ED Visits

NUMERATOR: Ambulatory Care-Sensitive Condition ED Visits

EXCLUSIONS: Please see table below for details.

MEASURE DETAILS:

CPT Codes:

between 99281 and 99288
between G0378 and G0384
G0244

Revenue Codes:

between 450 and 459

Place of Service Code:

23 - Emergency Room - hospital

The table below is taken from the AHRQ website and lays out the Ambulatory Care-Sensitive conditions that were identified in the Billings algorithm and used in the following paper: "Using Administrative Data to Monitor Access, Identify Disparities, and Assess Performance of the Safety Net" in Billings J, Weinick R. Eds A Tool Kit for Monitoring the Local Safety Net. Agency for Health Care Research and Quality. July 2003. This algorithm is available in SAS, SPSS and MS Access formats.

Ambulatory Care-Sensitive Conditions

Source: http://archive.ahrq.gov/data/safetynet/billappb.htm

Appendix B. Ambulatory Care-Sensitive Conditions

List of ACS Condition and ICD-9-CM Code(s)

Where only three digits are listed, all diagnoses at the 4th and 5th digit should be included (e.g., asthma is listed as 493, but you should include 493.00, 493.01, 493.1, 493.10, 493.11, etc.). Where only four digits are listed, all diagnoses at the 5th digit should also be included.

All diagnoses refer to principal diagnosis, unless otherwise specified (e.g., dehydration, iron deficiency, nutritional deficiency, etc.). Where exclusions of surgical patients are specified (e.g., hypertension), search all procedure fields for excluded procedures.

List of ACS Condition and ICD-9-CM Code(s)		
ACS Number	**Ambulatory Care-Sensitive conditions and ICD-9 CM Code(s)**	**Comments**
1	Congenital syphilis [090]	Secondary diagnosis for newborns only
2	Immunization-related and preventable conditions [033, 037, 045, 320.0, 390, 391]	Hemophilus meningitis [320.2] age 1-5 only
3	Grand mal status and other epileptic convulsions [345]	

List of ACS Condition and ICD-9-CM Code(s)		
ACS Number	**Ambulatory Care-Sensitive conditions and ICD-9 CM Code(s)**	**Comments**
4	Convulsions "A" [780.3]	Age 0-5
5	Convulsions "B" [780.3]	Age >5
6	Severe ear, nose, and throat infections [382, 462, 463, 465, 472.1]	Exclude otitis media cases [382] with myringotomy with insertion of tube [20.01]
7	Pulmonary tuberculosis [011]	
8	Other tuberculosis [012-018]	
9	Chronic obstructive pulmonary disease [491, 492, 494, 496, 466.0]	Acute bronchitis [466.0] only with secondary diagnosis of 491, 492, 494, 496
10	Bacterial pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486]	Exclude case with secondary diagnosis of sickle cell [282.6] and patients <2 months
11	Asthma [493]	
12	Congestive heart failure [428, 402.01, 402.11, 402.91, 518.4]	Exclude cases with the following surgical procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7
13	Hypertension [401.0, 401.9, 402.00, 402.10, 402.90]	Exclude cases with the following procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7
14	Angina [411.1, 411.8, 413]	Exclude cases with a surgical procedure [01-86.99]
15	Cellulitis [681, 682, 683, 686]	Exclude cases with a surgical procedure [01-86.99], except incision of skin and subcutaneous tissue [86.0] where it is the only listed surgical procedure
16	Skin grafts with cellulitis [DRG 263, DRG 264]	Exclude admissions from skilled nursing facility/intermediate care facility
17	Diabetes "A" [250.1, 250.2, 250.3]	
18	Diabetes "B" [250.8, 250.9]	

List of ACS Condition and ICD-9-CM Code(s)		
ACS Number	**Ambulatory Care-Sensitive conditions and ICD-9 CM Code(s)**	**Comments**
19	Diabetes "C" [250.0]	
20	Hypoglycemia [251.2]	
21	Gastroenteritis [558.9]	
22	Kidney/urinary infection [590, 599.0, 599.9]	
23	Dehydration - volume depletion [276.5]	Examine principal and secondary diagnoses separately
24	Iron deficiency anemia [280.1, 280.8, 280.9]	Age 0-5 only, and examine principal and secondary diagnoses separately
25	Failure to thrive [783.4]	Age <1 only
26	Pelvic inflammatory disease [614]	Women only denominator - exclude cases with a surgical procedure of hysterectomy [68.3-68.8]
27	Dental Conditions [521, 522, 523, 525, 528]	

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-17: Generic Dispensing Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The number of generic prescriptions compared to the overall number of prescriptions.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: total prescriptions

NUMERATOR: generic prescriptions

EXCLUSIONS: remove prescriptions from denominator with Claim Dispense as Written Product Selection Code = 1 (Substitution not allowed by prescriber),
7 (Substitution not allowed – Brand drug mandated by law), 8 (Substitution allowed – Generic drug not available in marketplace)

MEASURE DETAILS: N/A

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-18: High-end Imaging/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications based on Code Sets Source: Milliman HCG Grouper 2013 version 3

URL of Specifications: n/a

DESCRIPTION: The rate of high-end image visits (image visits / member months) * 12000. Count multiple CPTs from an image type on same visit date as one image visit.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: High-end imaging visits

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:
Outpatient Radiology - High-end Imaging

CT
0066T

between 70450 and 70498
between 71250 and 71275
between 72125 and 72133
between 72191 and 72194
72292
between 73200 and 73206
between 73700 and 73706
between 74150 and 74178
between 74261 and 74263
between 75571 and 75574
75635
between 76070 and 76071
between 76355 and 76370
76380
73497
between 77011 and 77014
between 77078 and 77079
G0288
between S8092 and S8093

MRI

70336
between 70540 and 70559
between 71550 and 71555
between 72141 and 72159
between 72195 and 72198
between 73218 and 73225
between 73718 and 73725
between 74181 and 74185
between 75552 and 75565
between 76093 and 76094
between 76390 and 76400
76498
between 77021 and 77022
between 77058 and 77059
77084
between S8035 and S8037
S8042

PET

78459
between 78491 and 78492
between 78608 and 78609

between 78810 and 78816
between G0030 and G0047
G0125
between G0210 and G0235
between G0252 and G0254
G0296
between G0330 and G0331
G0336
S8085

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-19: (NCQA HEDIS) Inpatient Utilization - General Hospital/Acute Care

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HEDIS® 2015 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION: The rate of General Hospital/Acute Care inpatient discharges (discharges/ member months) * 12000.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: acute inpatient stays with a discharge date during the measurement period

EXCLUSIONS: Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set), a principal diagnosis of live-born infant (Deliveries Infant Record Value Set) or an MS-DRG for mental health, chemical dependency or rehabilitation (IPU Exclusions MS-DRG Value Set).

MEASURE DETAILS: N/A

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-20: Primary Care Visits/1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications

URL of Specifications: n/a

DESCRIPTION: The rate of primary care visits (unique visits/ member months) * 12000. Roll up multiple visits on the same day to count as one visit.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: unique visits with primary care

EXCLUSIONS: N/A

MEASURE DETAILS:
CPT Codes:

between 99201 and 99205
between 99211 and 99215
between 99241 and 99245
between 99304 and 99310
between 99315 and 99316
99318

between 99324 and 99328
between 99334 and 99337
between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally Qualified Health Center
72 - Rural Health Clinic

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-21: Skilled Nursing Facility (SNF) Days /1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The rate of days spent in skilled nursing facilities (SNF days/ member months) * 12000. Include all claims within the stay as one SNF stay then calculate patient days from admission through discharge.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: days spent in a skilled nursing facility

EXCLUSIONS: N/A

MEASURE DETAILS:
Place of Service Codes:
31 - Skilled Nursing Facility
Medicare or Medicaid Claim Type Code = 20 or 30

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-22: Specialty Visits /1000

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: OneCare Vermont Proposed Utilization Measure Specifications.

URL of Specifications: n/a

DESCRIPTION: The rate of specialty visits (unique specialty visits/ member months) * 12000. Include all providers not included in PCP provider type.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: member months

NUMERATOR: unique specialty visits

EXCLUSIONS: N/A

MEASURE DETAILS:
CPT Codes:

between 99201 and 99205
between 99211 and 99215
between 99241 and 99245
between 99304 and 99310
between 99315 and 99316
99318

between 99324 and 99328
between 99334 and 99337
between 99339 and 99345
between 99347 and 99350
between 99354 and 99355
between 99358 and 99359
between 99381 and 99387
between 99391 and 99397
between 99401 and 99404
between 99406 and 99409
between 99411 and 99412
99420
99429
between 99460 and 99465
G0402
G0404
G0438
G0439

Revenue Codes:

521
522
523
524
525

Place of Service Codes:

11 - Office
50 - Federally Qualified Health Center
72 - Rural Health Clinic

VERMONT ACO MONITORING AND EVALUATION MEASURE SET NARRATIVE SPECIFICATIONS FOR 2014

M&E-23 (NCQA HEDIS; NQF #1388): Annual Dental Visit /1000

Programs Requiring Use of the Measure for 2014:

Commercial: _____ Medicaid: __X___ Medicare: _____

Measure Type:

Claims: __X__ Clinical data: ____ Survey: ____ Other (specify): ____

Measure Purpose for 2014 (Commercial and Medicaid Only):

Monitoring: ____ Evaluation: __X__

Level of Measurement for 2014:

ACO Level: __X__ Plan Level: ____ State Level: ____

Name and date of specifications used: HEDIS® 2015 Technical Specifications for Health Plans (Volume 2).

URL of Specifications: N/A

DESCRIPTION: Percentage of patients 2-21 years of age who had at least one dental visit during the measurement year.

FREQUENCY OF REPORTING: Quarterly

DENOMINATOR: Patients 2-21 years of age as of the end of the measurement year (e.g., December 31)

NUMERATOR: Patients who had one or more dental visits with a dental practitioner during the measurement year.

EXCLUSIONS: N/A

MEASURE DETAILS:

CPT Codes:

70300
70310
70320

70350
70355

HCPCS Codes:

Between D0120 and D9999