2014 CORE MEASURE SET NARRATIVE SPECIFICATIONS
As of July 10, 2015

The specifications for the ACO core measures used for Payment or Reporting are below. The specifications for the pending measures will be determined by the VHCIP Quality and Performance Measures Work Group or its successor entity at the time when the measures are ready to be used for Payment or Reporting. The VHCIP Quality and Performance Measures Work Group or its successor entity by policy intends to publish revised specifications in advance of each pilot year that detail the specifications for any new measures and any changes from the previous year. Measures in the core measure set will be reported by ACOs on an annual basis.

Core-1 (NCQA HEDIS; NQF # 1768): ACO All-Cause Readmission

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

DESCRIPTION:
For attributed individuals 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an 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
4. Observed Readmission (Numerator/Denominator)
5. Total Variance

DENOMINATOR:
All acute inpatient discharges for attributed individuals who had one or more discharges on or between January 1 and December 1 of the measurement year.

NUMERATOR:
At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

EXCLUSIONS:
Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date and any inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

LOOK BACK PERIOD: 365 days prior to the index discharge date. Discharge is on or between January 1 and December 1 of the measurement year.

CONTINUOUS ENROLLMENT: 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. 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.

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Rather than applying this measure at the plan level, this measure will be applied to the ACO. Therefore the title of the measure has been changed from "Plan All-Cause Readmission" to "ACO All-Cause Readmission."
3. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-2 (NCQA HEDIS): Adolescent Well-Care Visit

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

DESCRIPTION:

The percentage of attributed individuals 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

DENOMINATOR:

The eligible population.

NUMERATOR:

At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the attributed individual.

EXCLUSIONS: None

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: Measurement year. Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member 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.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-3 (NCQA HEDIS): Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening 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):

Payment: __X__ Reporting: ____

Name and date of specifications used:
HEDIS® 2014 Technical Specifications for Health Plans (Volume 2)

URL of Specifications: n/a

DESCRIPTION:

The percentage of attributed individuals 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the year prior to the measurement year, *or* who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:

- LDL-C screening.

DENOMINATOR:
The eligible population.

NUMERATOR:
An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data. The organization may use a calculated or direct LDL for LDL-C screening and control indicators

EXCLUSIONS: None

LOOK BACK PERIOD: Measurement year.[1]

[1] In June 2015, GMCB modified the specification for Core-3 for Year 1 only so that the look back period is the measurement year, as opposed to the measurement year *and* year prior to the measurement year. Without this specification adjustment, the denominator for this measure is quite low. A June 2015 Bailit Health analysis compared the newly-generated rate to the BCBSVT PPO HEDIS rate, as reported in Quality Compass 2014 (performance year 2013) and Quality Compass 2013 (performance year 2012). The analysis found that for Core-3, ACO rates were generally comparable to the benchmark, suggesting that calculating the rate with a modified methodology would be acceptable for CY2014 performance evaluation.

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 (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

MEASURE DETAILS: See HEDIS® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

NOTE: Please note that Core-3 is counted in both the "payment" and "pending" categories since the claims-based LDL-screening will be used for payment until the clinical data-based NQF#0075/ MSSP-29 "Complete Lipid Panel and LDL Control" are ready to be used for payment, at which point, it will replace LDL screening.

Core-4 (NCQA HEDIS; NQF #0576): Follow-up After Hospitalization for Mental Illness, 7-day

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

DESCRIPTION:

The percentage of discharges for attributed individuals 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. One rate is reported:

- The percentage of discharges for which the attributed individual received follow-up within 7 days of discharge.

DENOMINATOR:
The eligible population.

NUMERATOR:

An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set ***and*** FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set ***and*** FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the attributed individual was discharged with a principal diagnosis of mental illness.

EXCLUSIONS: None

LOOK BACK PERIOD: January 1 through December 1 of the measurement year.

CONTINUOUS ENROLLMENT: Date of discharge through 30 days after discharge. No gaps in enrollment.

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-5 (NCQA HEDIS; NQF #0004): Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

DESCRIPTION:

The percentage of adolescent and adult attributed individuals with a new episode of alcohol or other drug (AOD) dependence who received the following:

- *Initiation of AOD Treatment.* The percentage of attributed individuals who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of attributed individuals who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

DENOMINATOR:
The eligible population.

NUMERATOR:

***Initiation of AOD Treatment*:** Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the attributed individual is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the attributed individual must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a diagnosis of AOD, within 14 days of the IESD (inclusive). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:

- An inpatient admission with a diagnosis of AOD (AOD Dependence Value Set).

- IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.

If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).

Do not count Index Episodes that include inpatient detoxification or detoxification codes (Detoxification Value Set) as initiation of treatment. Exclude attributed individuals from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria:

- An inpatient admission with a diagnosis of AOD (AOD Dependence Value Set).
- IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.

For attributed individuals who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).

Do not count engagement encounters that include inpatient detoxification or detoxification codes (Detoxification Value Set).

EXCLUSIONS: None

LOOK BACK PERIOD: January 1–November 15 of the measurement year.

CONTINUOUS ENROLLMENT: 60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-6 (NCQA HEDIS; NQF #0058): Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

DESCRIPTION:
The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

DENOMINATOR:
The eligible population.

NUMERATOR:
Dispensed prescription for antibiotic medication (Table AAB-D) on or three days after the IESD.

EXCLUSIONS: None

LOOK BACK PERIOD: The intake period is January 1–December 24 of the measurement year. A negative medication history is required 30 days prior to the first episode date, and a negative comorbid condition history 12 months prior to and including the episode date.

CONTINUOUS ENROLLMENT: Continuously enrolled 1 year prior to the Episode Date through 7 days after the Episode Date.

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

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-7 (NCQA HEDIS; NQF #0033): Chlamydia Screening in Women

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):

Payment: __X__ Reporting: ____

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

URL of Specifications: n/a

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.

DENOMINATOR:
The eligible population.

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

EXCLUSIONS: None

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: The 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® 2014 Technical Specifications for Health Plans (Volume 2) for details.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-8 (NCQA; NQF #1448): Developmental Screening in the First Three Years of Life

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):

Payment: __X__ Reporting: ____

Name and date of specifications used: The Center for Medicare and Medicaid Services. Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resources Manual for Federal Fiscal Year 2012 Reporting. Updated November 2012.

URL of Specifications: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf

DESCRIPTION:
The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

DENOMINATOR:
Indicator 1: Attributed individuals who turn 12 months of age between January 1 of the measurement year and December 31 of the measurement year
Indicator 2: Attributed individuals who turn 24 months of age between January 1 of the measurement year and December 31 of the measurement year
Indicator 3: Attributed individuals who turn 36 months of age between January 1 of the measurement year and December 31 of the measurement year

Claims data: CPT codes 96110 (Developmental testing, with interpretation and report)

NUMERATOR:
The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators.

Indicator 1: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age
Indicator 2: Children who had screening for risk of developmental, behavioral and social

delays using a standardized screening tool that was documented by 24 months of age
Indicator 3: Children who screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 36 months of age

EXCLUSIONS: None

LOOK BACK PERIOD: One year prior to the measurement year

CONTINUOUS ENROLLMENT: Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.

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 beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).

MEASURE DETAILS:
See page 53 of The Center for Medicare and Medicaid Services. Initial Core Set of Children's Health Care Quality Measures: Technical Specifications and Resources Manual for Federal Fiscal Year 2012 Reporting. Updated November 2012.

Current recommended tools:
- Ages and Stages Questionnaire (ASQ) - 2 months to 5 years
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to 2 years
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) - 18 months to 6 years
- Infant Development Inventory – Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

NOTE: Important Note About Appropriate Use of Claims Data: This measure is anchored to standardized tools that meet four criterion specified above. States that have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

MODIFICATIONS TO MEASURE SPECIFICATIONS:
Claims NOT Included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

Future efforts should be made to develop complimentary measures focused specifically on

autism screening (for which national recommendations exist) and a measure on social-emotional screening (for which a large number of ABCD states have been focused, are implementing and for which growing evidence supports).

Core-9 was not approved by the GMCB and has been removed from the Core Measure Set

Core-10 (NQF #0275; AHRQ PQI #05; MSSP-9): Ambulatory Care-Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

Name and date of specifications used: AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

URL of Specifications:
www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2005%20COPD%20or%20Asthma%20in%20Older%20Adults%20Admission%20Rate.pdf

DESCRIPTION:
Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.

DENOMINATOR:
Population ages 40 years and older attributed to the ACO.

NUMERATOR:
Discharges, for patients ages 40 years and older with either:

- A principal ICD-9-CM diagnosis code for COPD (excluding acute bronchitis)
- A principal ICD-9-CM diagnosis code for asthma; or
- A principal ICD-9-CM diagnosis code for acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD (excluding acute bronchitis)

EXCLUSIONS: Exclude cases:

- With any listed ICD-9_CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system
- Transfer from a hospital (different facility)
- Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender, age, quarter, year, principal diagnosis, or county

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: This specification is based on clinical practice data and not health plan data. Patient enrollment in health plans is not used, and therefore there is no requirement for continuous enrollment.

MEASURE DETAILS:
Please see AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013 for technical specifications.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a metropolitan area or county.

Core-11 (NCQA HEDIS; NQF #2372; MSSP-20):
Preventive Care and Screening: Breast Cancer Screening

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

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

URL of Specifications: n/a

DESCRIPTION:
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

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.

EXCLUSIONS: (optional exclusions)
Bilateral mastectomy any time during the attributed individual's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) on different dates of service.
- Both of the following (on the same or a different date of service):
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same date of service).
  - Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same date of service).

NOTE:

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

LOOK BACK PERIOD: October 1 two years prior to the measurement year through December 31 of the measurement year.

CONTINUOUS ENROLLMENT: October 1 two years prior to the measurement year through December 31 of 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 (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

MEASURE DETAILS:

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individual."

Core-12 (PQI #92): Prevention Quality Chronic Composite (Rate of Hospitalization for Ambulatory Care-Sensitive Conditions: PQI Composite)

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):

Payment: ____Reporting: __X__

Name and date of specifications used: AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

URL of Specifications:
www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/TechSpecs/PQI%2092%20Prevention%20Quality%20Chronic%20Composite.pdf

DESCRIPTION:
Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population ages 18 and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower- extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.

DENOMINATOR:
Population ages 18 years and older attributed to the ACO.

NUMERATOR:
Discharges, for patients 18 years and older that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI #1 Diabetes with short-term complications admission rate
- PQI #3 Diabetes with long-term complications admission rate
- PQI# 5 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate
- PQI # 7 Hypertension admission rate
- PQI #8 Heart failure admission rate
- PQI #13 Angina without a cardiac procedure admission rate
- PQI #14 Uncontrolled diabetes admission rate
- PQI #15 Asthma in younger adults admission rate
- PQI #16 Lower- extremity amputation among patients with diabetes

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of

the above PQIs are counted only once in the composite numerator.

EXCLUSIONS: none

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: This specification is based on clinical practice data and not health plan. Patient enrollment in health plans is not used, and therefore there is no requirement for continuous enrollment

MEASURE DETAILS:
AHRQ QI Version 4.5, Prevention Quality Indicators #5, May 2013

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a metropolitan area or county.

Core-13 (NCQA HEDIS; NQF #0002): Appropriate Testing for Children with Pharyngitis

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):

Payment: ____Reporting: __X__

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 2–18 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).

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.

EXCLUSIONS: none

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. The Intake Period captures eligible episodes of treatment. Must have a negative medication history 30 days prior to the episode date.

CONTINUOUS ENROLLMENT: 30 days prior to the Episode Date through 3 days after the Episode Date (inclusive). No gaps in enrollment during the continuous enrollment period.

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-14 (NCQA HEDIS; NQF #0038): Childhood Immunization Status (Combo 10)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

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

URL of Specifications: n/a

DESCRIPTION:
The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Report Combination 10 only.

DENOMINATOR:
The eligible population.

NUMERATOR:

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.

[2] GMCB and DVHA will permit ACOs to modify the specifications to remove the restriction excluding vaccinations prior to 42 days after the child's birth. The GMCB and DVHA will annually obtain reports from the Vermont Department of Health's Immunization Registry to determine the number of vaccinations administered prior to 42 days after birth, and evaluate whether this variation from HEDIS® specifications should be continued.

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.
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. • 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 Two-Dose Schedule Administered Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus Three-Dose Schedule Administered Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (Rotavirus Two-Dose Schedule Administered Value Set) ***and*** at least two doses of the three-dose rotavirus vaccine (Rotavirus Three-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 six months (180 days) after birth.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	Hep A	RV	Influenza
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Medical record For immunization evidence obtained from the medical record, organizations may count attributed individuals where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the attributed individual's second birthday.

Notes in the medical record indicating that the attributed individual received the immunization
"at delivery" or "in the hospital" may be counted toward the numerator *only*

for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "attributed individual is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

EXCLUSIONS: (optional)

- Exclude children 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.
- 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 attributed individual'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, VZV and influenza	• Immunodeficiency (Immunodeficiency Value Set). • HIV (HIV Value Set). • Lymphoreticular cancer, Multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue r Value Set). • (Anaphylactic reaction to neomycin.
IPV	• Anaphylactic reaction to streptomycin, polymyxin B or neomycin.
Hepatitis B	• Anaphylactic reaction to common baker's yeast.

NOTE: Report Combination 10 only.

LOOK BACK PERIOD: 12 months prior to the child's second birthday.

CONTINUOUS ENROLLMENT: 12 months prior to the child's second birthday. No more

than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. 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 continuously enrolled).

MEASURE DETAILS:

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

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-15 (NCQA HEDIS; NQF #0024): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: _____

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

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

URL of Specifications: n/a

DESCRIPTION:
The percentage of attributed individuals 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

DENOMINATOR:
The eligible population.

NUMERATOR:

BMI Percentile	BMI percentile (BMI Percentile Value Set) during the measurement year.
Counseling for Nutrition	Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.
Counseling for Physical Activity	Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.
Medical record	Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile.
- BMI percentile plotted on age-growth chart.

For attributed individuals who are younger than 16 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.

For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m^2 is acceptable.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile or value, if applicable, is required for numerator compliance.

Counseling for Nutrition Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Attributed individual received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.

- Attributed individual received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance for physical activity.
- Weight or obesity counseling.

EXCLUSIONS: (optional)
Attributed individuals who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these attributed individuals must do so for all rates.

- **NOTE:** *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI or BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to an acute or chronic condition do not count toward the Counseling for nutrition and Counseling for physical activity indicators.*

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: The measurement year. No more than one gap in continuous 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.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-16 (MN Community Measurement; NQF #0024; MSSP 22-26):
Optimal Diabetes Care (Diabetes Composite (D4))

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

Name and date of specifications used: MN Community Measurement, revised 4/16/2014

URL of Specifications:
www.health.state.mn.us/healthreform/measurement/adoptedrule/msr12fnl01odc.pdf
http://mncm.org/wp-content/uploads/2014/05/Cholesterol-Components-for-Diabetes-and-Vascular-Measures-4-15-2014.pdf

DESCRIPTION:
Please note that this measure is in a transition phase due to changes in national guidelines for cholesterol management.

For the 2014 reporting year, dates of service between 1/1/2013 – 12/31/2013, the measure is: the percentage of adult diabetes patients who have optimally managed modifiable risk factors (A1c, LDL, blood pressure, tobacco non-use and daily aspirin usage for patients with diagnosis of ischemic vascular disease) with the intent of preventing or reducing future complications associated with poorly managed diabetes.

Patients ages 18 - 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure: A1c < 8.0, LDL < 100, Blood Pressure < 140/90, Tobacco non-user and for patients with diagnosis of ischemic vascular disease daily aspirin use unless contraindicated.

For the 2015 reporting year, dates of service 1/1/2014 – 12/31/2014, the cholesterol component (LDL<100) is temporarily removed from the numerator.

For the 2016 reporting year, dates of service 1/1/2015 – 12/31/2015, there are plans for a new cholesterol component to be added.

DENOMINATOR:
Patients ages 18 to 75 with diabetes who have at least two visits for this diagnosis in the last two years (established patient) with at least one visit in the last 12 months.

NUMERATOR:
Patients ages 18 to 75 with diabetes who meet all of the following targets from the most recent visit during the measurement year:
A1c less than 8.0, Blood Pressure less than 140/90, Tobacco non-user and Daily aspirin for patients with diagnosis of ischemic vascular disease use unless contraindicated.

EXCLUSIONS: Valid exclusions include patients who only had one visit to the clinic with diabetes codes during the last two years, patients who were pregnant, died or were in hospice or a permanent resident of a nursing home during the measurement year.

NOTE: Please note that while the all-or-none composite measure is considered to be the gold standard, reflecting best patient outcomes, the individual components may be measured as well. This is particularly helpful in quality improvement efforts to better understand where opportunities exist in moving the patients toward achieving all of the desired outcomes. Please refer to the additional numerator logic provided for each component.

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: The specification is based on practice clinical data and not health plan data. Patient enrollment in health plans is not used, and therefore there is no requirement for continuous enrollment.

MEASURE DETAILS:
See Minnesota Community Measurement, revised 4/16/2014.

Core-17 (NCQA HEDIS; NQF #0059; MSSP-27):
Diabetes Mellitus: Hemoglobin A1c Poor Control (>9 percent)

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

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

URL of Specifications: n/a

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

- HbA1c poor control (>9.0%).

DENOMINATOR:
The eligible population.

NUMERATOR:

HbA1c Poor Control >9% Use codes in the HbA1c Tests Value Set to identify the *most recent* HbA1c test during the measurement year. The attributed individual 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 attributed individual 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 attributed individual is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

HbA1c Poor Control >9%	The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The attributed individual is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The attributed individual is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%. *Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.*

EXCLUSIONS: (optional)

Identify attributed individuals who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the attributed individual's history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes (Gestational or Steroid-Induced Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year.

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

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

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.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-18 (NCQA HEDIS; NQF #0034; MSSP-19): Colorectal Cancer Screening

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____ Reporting: __X__

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

URL of Specifications: n/a

DESCRIPTION:
The percentage of attributed individuals 50–75 years of age who had appropriate screening for colorectal cancer.

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.

Medical record

Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record; if this
is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to

determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The attributed individual meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the attributed individual meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the attributed individual does not meet the screening criteria for inclusion.
- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the attributed individual meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.

– *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The attributed individual meets the screening criteria for inclusion in the numerator.

– *If the medical record indicates that three or more samples were returned,* the attributed individual meets the screening criteria for inclusion in the numerator.

– *If the medical record indicates that fewer than three samples were returned,* the attributed individual does not meet the screening criteria.

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

EXCLUSIONS: (optional)
Either of the following any time during the attributed individual's history through December 31 of the measurement year:

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

LOOK BACK PERIOD: Fecal occult blood test during the measurement year. For administrative data, assume the required number of samples was returned regardless of FOBT type. Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. Colonoscopy during the measurement year or the nine years prior to the measurement year.

CONTINUOUS ENROLLMENT: The measurement year and the year prior to the measurement year. No more than one gap in continuous 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 (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.

MODIFICATIONS TO MEASURE SPECIFICATIONS:

1. This measure will be used to assess quality in the ACO population rather than in a health plan population.
2. Since the measure will be applied at the ACO level, we have replaced the term "members" with the term "attributed individuals."

Core-19 (CMS; NQF #0418; MSSP-18): Screening for Clinical Depression and Follow-up Plan

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

Name and date of specifications used: Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012.

URL of Specifications:
www.acr.org/~/media/ACR/Documents/P4P/Resources/2013/2013_PQRS_MeasureSpecManual.pdf

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression during the measurement period using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period.

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION: (Exclusions only applied if patient did not receive screening for clinical depression using an age appropriate standardized tool)

- Documentation of medical reason(s) for not having screening for clinical depression performed during the measurement period (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, 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], or patient has an active diagnosis of depression or bipolar disorder)
- Documentation of patient reason(s) for not having screening for clinical depression performed during the measurement period (e.g., patient refuses to participate)

NUMERATOR:
Patients screened for clinical depression during the measurement period using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Clinical Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population where 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, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ 2

Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ-9), 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 (GDS), Cornell Scale Screening and PRIME MD-PHQ 2

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening *must* include one or more of the following:

- Additional evaluation
- 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

LOOK BACK PERIOD: Measurement year.

CONTINUOUS ENROLLMENT: The specification is based on practice clinical data and not health plan data. Patient enrollment in health plans is not used, and therefore there is no requirement for continuous enrollment.

MEASURE DETAILS:

See Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012 for details.

Core-20 (CMS; NQF #0421; MSSP-16): Body Mass Index (BMI) Screening and Follow-up

Programs Requiring Use of the Measure for 2014:

Commercial: __X___ Medicaid: __X___ Medicare: __X___

Measure Type:

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

Measure Purpose for 2014 (Commercial and Medicaid Only):

Payment: ____Reporting: __X__

Name and date of specifications used: Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012.

URL of Specifications:
www.acr.org/~/media/ACR/Documents/P4P/Resources/2013/2013_PQRS_MeasureSpecManual.pdf

DESCRIPTION:
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is **outside of normal parameters**, a follow-up plan is documented within the past six months or during the current visit.

Normal Parameters: Age 65 years and older BMI $\geq$ 23 and $<$ 30
Age 18 – 64 years BMI $\geq$ 18.5 and $<$ 25

DENOMINATOR:
All patients aged 18 years and older at the beginning of the measurement period.

EXCLUDED FROM PERFORMANCE DENOMINATOR POPULATION:
(Exclusion only applied if a calculated BMI was not documented as normal OR was outside parameters with a follow-up not performed during the measurement period)

- Documentation of medical reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient is receiving palliative care, patient is pregnant or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status)
- Documentation of patient reason(s) for not having a BMI measurement performed during the measurement period (e.g., patient refuses BMI measurement or if there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate)

NUMERATOR:
Patients with BMI calculated within the past six months or during the current visit and a follow-up plan is documented within the last six months or during the current visit if the BMI is outside of normal parameters.

Definitions:
BMI – Body mass index (BMI) is expressed as weight/height (BMI; kg/m^2) and is commonly used to classify weight categories.
Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.
Follow-up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional or surgeon), pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.
Not Eligible/Not Appropriate for BMI Measurement or Follow-Up Plan – A patient is **not** eligible if one or more of the following reasons exists:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

NOTE: *Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility or if obtained by the provider from outside medical records within the past six months.*

The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters"

LOOK BACK PERIOD: Six months.

CONTINUOUS ENROLLMENT: The specification is based on practice clinical data and not health plan data. Patient enrollment in health plans is not used, and therefore there is no requirement for continuous enrollment.

MEASURE DETAILS:

See Centers for Medicare and Medicaid Services (CMS) 2013 Physician Quality Reporting System (PQRS) Claims/Registry Measure Specifications Manual, Version 7.1, revised 11/16/2012 for details.

Core-21 (NQCA HEDIS CAHPS PCMH Survey): Access to Care Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, when you phoned this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
2. In the last 12 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
3. In the last 12 months, how often were you able to get the care you needed from this provider's office during evenings, weekends, or holidays?
4. In the last 12 months, when you phoned this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
5. In the last 12 months, when you phoned this provider's office during after office hours, how often did you get an answer to your medical question as soon as you needed?
6. Wait time includes time spent in the waiting room and exam room. In the last 12 months, how often did you see this provider within 15 minutes of your appointment time?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-22 (NQCA HEDIS CAHPS PCMH Survey): Communications Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, how often did this provider explain things in a way that was easy to understand?
2. In the last 12 months, how often did this provider listen carefully to you?
3. In the last 12 months, how often did this provider give you easy to understand information about your health questions or concerns?
4. In the last 12 months, how often did this provider seem to know the important information about your medical history?
5. In the last 12 months, how often did this provider show respect for that you had to say?
6. In the last 12 months, how often did this provider spend enough time with you?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR:
For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.
Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-23 (NQCA HEDIS CAHPS PCMH Survey): Shared Decision-making Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might want to take a medicine?
2. When you talked about starting or stopping a prescription medicine, how much did this provider talk about the reasons you might not want to take a medicine?
3. When you talked about starting or stopping a prescription medicine, did this provider ask you what you thought was best for you?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined. For the Shared Decision Making composite, pair "Yes" responses to Q3 with "A lot" responses from Q1/Q2 and pair "No" responses to Q3 with "Not at all" responses from Q1/Q2.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-24 (NQCA HEDIS CAHPS PCMH Survey): Self-Management Support Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, did anyone in this provider's office talk with you about specific goals for your health?
2. In the last 12 months, did anyone in this provider's office ask you if there are things that make it hard for you to take care of your health?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-25 (NQCA HEDIS CAHPS PCMH Survey): Comprehensiveness Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty, or depressed?
2. In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?
3. In the last 12 months, did you and anyone in this provider's office talk about a personal problem, family problem, alcohol use, drug use, or a mental or emotional illness?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in

the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-26 (NQCA HEDIS CAHPS PCMH Survey): Office Staff Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?
2. In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-27 (NQCA HEDIS CAHPS PCMH Survey): Information Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?
2. Some offices remind patients between visits about tests, treatment or appointments. In the last 12 months, did you get any reminders from this provider's office between visits?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR:
For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See NCQA CAHPS PCMH Survey 2014

Core-28 (NQCA HEDIS CAHPS PCMH Survey): Coordination of Care Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: NCQA CAHPS PCMH Survey 2014

URL of Specifications: N/A

DESCRIPTION:

1. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
2. In the last 12 months, how often did the provider seem informed and up-to-date about the care you got from specialists?
3. In the last 12 months, did you and anyone in this provider's office talk at each visit about all the prescription medicines you were taking?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion in CAHPS PCMH survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See: NCQA CAHPS PCMH Survey 2014

Core-29 (Adapted from CMS' National Implementation Survey): Specialist Care Composite

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):

Payment: ____Reporting: __X__

Name and date of specifications used: These questions are adapted from CMS' National Implementation Survey (time frame changed from 6 months to 12 months).

URL of Specifications: N/A

DESCRIPTION:

All respondents who answer "yes" to the following question complete questions #1 and #2 below:
In the last 12 months, did you try to make any appointments with specialists?

1.	In the last 12 months, how often was it easy to get appointments with specialists?
2.	In the last 12 months, how often did the specialist you saw most seem to know the important information about your medical history?

DENOMINATOR: Attributed ACO members that responded to the CAHPS survey. ACO members will be flagged prior to the fielding of the survey. Each specific question must be appropriately answered for inclusion survey results calculations. An appropriately answered question is one that complies with survey and skip-pattern instructions. The denominator for a composite is the average number of responses across all questions in the composite, rounded to the nearest whole number.

NUMERATOR: For each individual question, count the number of patients who selected each response choice.

To calculate the Composite Global Proportions, use the following method for combining questions 1&2:

Step 1: For each question, count the number of patients who selected each response choice. For composites with response choices of "Never," "Sometimes," "Usually," and "Always," response choices of "Never" and "Sometimes" are combined.

Step 2: For each question, determine the proportion selecting each response choice.

Step 3: Calculate the average proportion responding to each choice across all the questions in the composite; these are the Composite Global Proportions.

Each question in a composite is weighted equally.

MEASURE DETAILS: See CMS' National Implementation Survey

CORE MEASURES THAT WERE PENDING AS OF 8-20-14:

The specifications for the following Pending measures will be determined by the Quality and Performance Measures Work Group or its successor entity at the time that the Work Group recommends the measures to be ready to be used for Payment or Reporting. Please note that measures in *italics* were previously recommended to be employed as Medicaid-only measures.

a. **Pending claims-based measures (1 measure):**
   - (Core-49) *Use of High Risk Medications in the Elderly (Medicaid-only, duals-specific measure)*

b. **Pending clinical data-based measures (19 measures):**
   - (Core- 3/ MSSP-29) Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control (<100 mg/dL)[3]
   - (Core-30) Cervical Cancer Screening
   - (Core-31/ MSSP-30) Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
   - (Core-32) Proportion not admitted to hospice (cancer patients)
   - (Core-33) Elective delivery before 39 weeks
   - (Core-34) Prenatal and Postpartum Care
   - (Core-35/ MSSP-14) Influenza Immunization
   - (Core-36/ MSSP-17) Tobacco Use Assessment and Tobacco Cessation Intervention
   - (Core-37) Care Transition-Transition Record Transmittal to Health Care Professional
   - (Core-38/ MSSP-32-33) Coronary Artery Disease (CAD) Composite
   - (Core-39/ MSSP-28) Hypertension (HTN): Controlling High Blood Pressure
   - (Core-40/ MSSP-21) Screening for High Blood Pressure and follow-up plan documented
   - (Core-43) *Frequency of Ongoing Prenatal Care (Medicaid only)*
   - (Core-44) *Percentage of Patients with Self-Management Plans (Medicaid only)*
   - (Core-45) *Screening, Brief Intervention, and Referral to Treatment (Medicaid only)*
   - (Core-46) *Trauma Screen Measure (Medicaid only)*
   - (Core-47/ MSSP-13) *Falls: Screening for Future Fall Risk (Medicaid-only, duals-specific measure)*
   - (Core-48/ MSSP-15) *Pneumococcal Vaccination for Patients 65 Years and Older (Medicaid only, duals-specific measure)*
   - (Core-50) *Persistent Indicators of Dementia without a Diagnosis (Medicaid-only, duals-specific measure)*

[3] Core-3 is counted in both the "payment" and "pending" categories since the claims-based LDL-screening will be used for payment until the clinical data-based Complete Lipid Panel and LDL Control are ready to be used for payment, at which point, it will replace LDL screening.

c. Pending survey-based measures (2 measures):

- (Core-41) How's Your Health?
- (Core-42) Patient Activation Measure