ATTACHMENT B
Care Management Organization (CMO) Quality Incentive Payment Methodology

This attachment describes the CMO program period cost reduction guarantees as follows: 1. Fees-at-Risk; 2. Reconciliation Methodology and Holdback Calculation; 3. Operational and Reconciliation Data Requirements; 4. Data Extract and Reconciliation Timeframes; 5. Pay-for-Performance Methodology; and 6. CMO Quality Measures Chart.

1. Fees-at-Risk

The CMO is placing 25 percent of its monthly care management fees at risk based on annual net cost reduction. The State of Nevada will hold back 25 percent of the monthly care management fees due to the CMO. The CMO will receive up to 100 percent of this holdback based on each program year's net reduction in costs.

2. Reconciliation Methodology and Holdback Calculation

The reconciliation methodology and holdback calculation described in this document are approved for the first two demonstration years (DY), from July 1, 2013 – June 30, 2015. During this period the state shall work with CMS to refine or develop a new methodology for evaluating the effectiveness of the CMO and making incentive payments. The new reconciliation methodology and holdback calculation must be completed and approved by CMS for implementation in DY s 3-5, July 1, 2015 – June 30, 2018.

The method for the annual financial reconciliation is based on the recommendation of the Care Continuum Alliance (CCA) in its Outcomes Guidelines (Volume 5). The goal of these guidelines is to balance suitability, rigor and precisions against acceptability, ease of use, and simplicity.

This method is an actuarially sound, population based pre-post study. The goal of this type of study is to provide symmetry between the baseline and program period - thus minimizing bias in the study.

A. Methodology Used to Calculate Program Net Reduction in Costs

Reconciliation Population

This population includes all Medicaid recipients meeting the eligibility and condition requirements to be eligible to receive care management services. This is the population where program net reduction in costs will occur.

Includes: The Medicaid eligibility categories of Aged, Blind and Disabled, Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) assistance groups. This population served by the CMO will encompass Medicaid recipients who have at least one chronic condition and/or a serious and persistent mental health condition as defined by the following criteria based on the CCA Guidelines as well as the CMO's own clinical standards:

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Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Heart Disease criteria are contained in the CCA Outcomes Guidelines Report Volume 5.

Additional condition inclusion criteria are as follows:

- End Stage Renal Disease: ICD-9-CM codes 585.6, V45.11, V56; ICD-9 Procedure codes 38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98; CPT-4 codes 36145, 36147, 36148, 36800, 36810, 36815, 36819, 36820-36821, 36831-36833, 90935, 90937, 90940, 90945, 90947, 90989, 90993, 90951, 90953, 90954, 90956, 90957, 90959, 90960, 90962-90970, 99512; HCPCS codes G0257, G0311, G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- Cancer: ICD-9-CM codes 140-165, 170-176, 179-209, 230-239, 285.3; Diagnosis Rule: One face-to-face encounter/visit, in any setting, with any diagnosis of cancer (ICD9 diagnosis) in conjunction with any cancer treatment code, as identified in CPT/Rev/ICD-9 Procedures Code in Table RDI-A on page 23 of the 2011 Cost of Care Specifications PDF document.. The presence of both the ICD9 diagnosis and treatment code can occur at any time during the 1 year time period for identification.
- Obesity: ICD-9-CM codes 278.0, V85.3, V85.4; Diagnosis Rule: 2 face to face visits in a 12 month period any position
- Mental Health: ICD-9-CM codes 293.84, 295-298, 300.00-300.4, 307.1, 307.5, 308.0, 309.1-309.9, 311-314; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- Substance Abuse: ICD-9-CM codes 291, 292.0-292.2, 292.8-292.9, 303.0, 303.9, 304-305, 535.3, 571.1; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- HIV/AIDS: ICD-9-CM codes 042, 079.53, 969, V08;
- Chronic Kidney Disease: ICD-9 CM codes 585; Diagnosis Rule: 1 acute inpatient visit with diagnosis in 1st or 2nd position (primary or secondary) or 2 visits in a year any position
- High Risk Maternity/Neonatal: ICD-9 CM codes 638, 640-642, 643.1-643.9, 644.0-644.1, 646-649, 651, 653.5-653.7, 654.5, 655-656, 657.0, 658.0, 658.1, 658.4, 658.8, 658.9, 659.4-659.7, V23, V91; Diagnosis Rule: Frequency of 1 face to face visits for any code in first or second position (primary or secondary diagnosis) within defined 9 month period
- Care Transition IP Admissions: Person must have had an IP Admission with the following codes as primary or secondary diagnoses; ICD-9 CM codes 250, 295, 296, 298, 300.4, 309, 311, 345, 357.2, 362.01-362.07, 366.41, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 410-413, 415.12, 415.19, 416.2, 427-428, 430-432, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 438.13, 438.14, 440, 441.1-441.7, 441.9. 442, 443.1, 443.81, 443.89, 443.9, 444, 445.01, 445.02, 445.81, 445.89, 453.4, 453.5, 453.72-453.79, 466, 480-483, 484.1, 484.3, 484.5-484.8, 485-487, 490-492, 496, 514, 648.01-648.04, 671.4, 715, 721, 722.1-722.6, 722.73, 722.8-722.9, 723-724, 738.4, 739.1,

739.2, 739.4, 756.11, 756.12, 820, 846, 997.02; ICD-9 Procedure codes 36.01, 36.02, 36.05-36.07, 36.09, 36.1, 36.2; CPT-4 codes 32491, 33140, 33510-33514, 33516-33519, 33521-33523, 33533-33536, 33572, 35600, 92980-92982, 92984, 92986, 92995, 92996; HCPCS codes G0302-G0305, S2205-S2209;

To determine visit types, the CMO uses HEDIS guidelines. When counting visits, only one visit per day is included.

Once an individual has been identified under the inclusion criteria above, that individual will remain eligible for the program, and therefore in the reconciliation population, for the duration of that individual's Medicaid eligibility. The two exceptions are:

- The individual is identified under the pregnancy criteria, in which case eligibility will be limited to the earlier of a medical claim for delivery or nine months from initial qualification, and

The individual meets one or more of the criteria listed in "Excluded Population" below. The Division of Health Care Financing and Policy (DHCFP) currently uses ICD-9 codes, but will begin using ICD-10 codes in October, 2014. The CMO must use the current version of the International Classification of Diseases (ICD) being used by the DHCFP. The State's contracted actuary and/or External Quality Review Organization (EQRO) will work with the CMO to transition and update the contract from ICD-9 to ICD-10 prior to October, 2014.

Trend Population

This population includes all Medicaid recipients meeting the eligibility but not the condition requirements to be eligible to receive care management services. This population should not experience program related net reduction in costs, and will be used to approximate population per-member-per-month annual cost trends. In the state's analysis of actual historical data, the difference between the annual cost trends of the reconciliation and trend populations must be no greater than plus or minus 2 percent. If the analysis produces cost trends that differ by more than 2 percent, then the state must propose and make adjustments to the assignment process (or other technical modifications that may be appropriate) to be reviewed and approved by CMS. Any adjustments to the assignment process made during the analysis to achieve an acceptable cost trend must be reflected in the description of the reconciliation and trend populations.

Excluded Population

All Medicaid recipients that either fail to meet the care management program eligibility requirements or meet one of the exclusion criteria (listed below) are to be excluded from both the Reconciliation and Trend Populations.

The following types of members are excluded:

- Recipients who are dually eligible for Medicaid and Medicare coverage (i.e. dual eligibles);

- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act;
- Recipients of Medicaid home and community-based services (HCBS) waiver case management services;
- Recipients of Medicaid covered targeted case management;
- TANF and CHAP recipients in services areas that require enrollment in a Medicaid Managed Care Organization (MCO);
- Those who reside in a full-time Skilled Nursing Facility;
- Recipients enrolled in the state's Intellectual Disabilities/Developmental Disabilities (ID/DD or (MR/DD) Section 1915 (c) Waiver;
- Recipients of the Title XXI Children's Health Insurance Program (CHIP) entitled Nevada Check Up;
- Recipients receiving emergency Medicaid; and
- Recipients residing in Intermediate Care Facilities for individuals with Intellectual Disabilites (ICF/ID).

Eligible Months
Eligible months are defined as members meeting the necessary Reconciliation or Trend Population eligibility and condition requirements, and not meeting any of the Excluded Population criteria as of the 15th day of the measurement month. If the requirements are met, the member's month is counted (one member month) and all of that member's claims incurred during the month are included. If the requirements are not met, the member's month is not counted (no member month) and all of the member's claims incurred during the month are excluded.

Calculation Steps
The process for calculating the program net reduction in costs for the care management population consists of the following steps:

1) Calculate an initial baseline Reconciliation Population Per Member Per Month (PMPM) cost using claims data net of exclusions.
2) Trend this baseline PMPM cost forward to the appropriate program period using the annual cost trend experienced by the Trend Population during this same period.
3) Calculate actual program period Reconciliation Population PMPM cost using claims data for each program year.
4) Calculate PMPM gross reduction in costs by subtracting the actual program period Reconciliation PMPM cost from the trended baseline Reconciliation Population PMPM cost.
5) Calculate total program period gross reduction in costs by multiplying the PMPM gross reduction in costs by the total program period Reconciliation Member Months.
6) Calculate total program period net reduction in costs by subtracting total program period care management fees from total program period gross reduction in costs.

Steps 2 – 6 would be repeated for each program period.

In order to calculate PMPM cost, the population must be appropriately identified using identification and exclusion criteria that apply equally to both baseline and program periods. The identification and exclusion process is as follows:

Baseline Establishment
The baseline period includes the eligibility and incurred costs from the 12 months immediately prior to the beginning of program period 1 and will not be recalculated through the term of the contract (unless significant programmatic eligibility or identification criteria changes occur, which would need to be agreed upon by the State and the CMO before any recalculations would occur). Condition identification to determine members included in the Reconciliation Population uses claim diagnosis from claims incurred during the 36 months immediately prior to the beginning of program period 1. For cost calculations and condition identification, a 12 month claim payment lag (or run-out) is included in the final calculation to allow claim adjudication and payment to complete.

Identical client identification and eligibility methodologies are used for both the baseline and program periods to eliminate selection bias between periods. Claims (net of exclusions outlined below) for Reconciliation and Trend Population members are totaled in the baseline period to create the baseline PMPM costs for both populations.

The benchmark numbers to be used must be in the PCCM contract that is subject to review and approval by the CMS Regional Office.

Program Period Calculations
Program period calculations include the eligibility and incurred costs from the 12 months during each given program period (program periods consist of 12 months). Condition identification to determine members included in the Reconciliation Population uses claim diagnosis from claims incurred during the 12 months of the program period and 24 months immediately preceding the program period. For cost calculations and condition identification, a 12 month claim payment lag (or run-out) is included in the final calculation to allow claim adjudication and payment to complete.

Claims (net of exclusions outlined below) for Reconciliation and Trend Population members are totaled in the program period to create the program period PMPM costs for both populations.

Exclusions
All claims incurred during the baseline or program periods during months where the member does not meet the Reconciliation or Trend Population eligibility criteria.

Trauma claims during the baseline or program periods are excluded from claim cost/PMPM cost calculations as they are random in nature and therefore non-manageable. This does not imply that clients with trauma claims will be removed from the reduction in costs calculation, but rather **only the claims for traumatic injuries will be excluded**.

Trauma claims are defined as claims with one or more of the ICD-9 codes listed in the CMO contract Attachment AA.1, Table 4, "Master Code List: Trauma"

Outlier claim costs (excluding non-eligible and trauma claims) for an individual are capped at $500,000 for any annual period (baseline or program periods). These claims tend to be random or one-time events, and add volatility to the measurement.

Exclusions apply equally to the Reconciliation and Trend Population and to the baseline or program periods.

Trend
The trend factors used are calculated as the measurement program period Trend Population PMPM cost divided by the baseline Trend Population PMPM cost. The Reconciliation Population PMPM cost is multiplied by the trend factor to calculate the expected program period Reconciliation PMPM cost, if no care management program were in place.

For example:

> Trend Population baseline PMPM cost = $100
> Trend Population program period one PMPM cost = $110
> Trend factor for program period one = $110/100 = 1.10
> Reconciliation Population baseline PMPM cost = $1,000
>
> Reconciliation Population expected program period one PMPM cost
> = $1,000*1.10 = $1,100

Risk Adjustment
A member month weighted risk score will be calculated separately for the Trend and Reconciliation populations for the baseline period and all program periods. Program period costs will be adjusted to account for changes in this risk score. This adjusted cost will be used in the determination of final reduction in costs.

The risk score will be calculated using the most recent available version of the Chronic Disability Payment System (CDPS) concurrent model.

For example:

> Trend Population baseline risk score = 1.000
> Trend Population program period one CDPS risk score = 1.100
> Trend Population program period one PMPM cost = $110
> Trend Population period one adjusted PMPM cost = $110 x (1.000 / 1.100) =
> $100

In order to ensure that the calculated risk scores are consistent with expected costs as defined by this calculation, the following rules will be adhered to in the calculation:

- Claims containing diagnosis codes found in Attachment AA.1 of the CMO Contract will be excluded from the risk score calculation.
- Diagnosis codes associated with claim lines covering testing procedures will be excluded from the risk score calculation to ensure that the presence of testing procedures alone does not cause "false positives" for chronic conditions. Testing lines are defined in Tables 5 and 6 in Attachment AA.1 of the CMO Contract.
- Children under age 21 are classified as "Child" for purposes of the CDPS risk adjustment methodology. All others are classified as "Adult."
- Aged/Blind/Disabled beneficiaries are classified as "Disabled" for purposes of the risk adjustment methodology. All others are classified as "AFDC/TANF."

B. Holdback Calculation

The CMO is placing 25 percent of its monthly care management fees at risk based on annual net reduction of costs. The State of Nevada will hold back 25 percent of the monthly care management fees due to the CMO. The CMO will receive up to 100 percent of this holdback based on each program year's net reduction of costs. The CMO is guaranteeing annual care management program net reduction of costs of $5,100,000.

- If the reconciliation process described above produces a total net reduction in costs amount exceeding $5,100,000, the CMO will receive all of the fees-at-risk.
- If the reconciliation results in no reduction in costs (care management program period fees equal or exceed program period gross reduction in costs), the CMO does not recover any of the fees-at-risk.
- If the reconciliation results in net reduction in costs between $0 and $5,100,000, DHCFP holds back the proportion of net reduction in costs short of the $5,100,000 guarantee. For example: if net reduction in costs for the program period was $4,000,000, then DHCFP would holdback = 1 – (4,000,000/5,100,000) = 21.57 percent of fees-at-risk, or 21.57 percent*25 percent = 5.39 percent of total fees.

3. **Operational and Reconciliation Data Requirements**

The State of Nevada agrees to provide timely, accurate, and complete data for the CMO to be able to meet the net reduction in costs guarantee.

A. Timely data is data that is delivered on the dates specified in the file transfer calendar that will be finalized by mutual agreement and included in the Data Management Manual.
B. Accurate data is data that reflects the best-available information in the State of Nevada data systems and that is organized according to the data file layouts as documented in the Data Management Manual.
C. Complete data is data that is in the format as specified in the Data Management Manual and includes values in all required fields for which Nevada has data, or

contains all of the information from Nevada's data warehouse, and contains the processed data that Nevada agrees to provide to the CMO as specified in the Data Management Manual.

D. Unless otherwise mutually agreed upon, data provided on a monthly basis during the program period are the data-of-record for the program and the program guarantees. All performance measurement calculations will be based upon monthly eligibility and claims activity during ongoing program operations.

E. The CMO is not required to independently verify the accuracy or completeness of data supplied by Nevada.

4. **Data Extract and Reconciliation Timeframes**

The reconciliation process will be conducted through claims and eligibility data extracts covering the time periods shown in Table 1 below. The compilation of these reconciliation data extracts allow for eligibility and claim adjustments to be compiled and for the State of Nevada and the CMO to have the same data starting points in completing reconciliations. The parties agree that all data received by the CMO from the State of Nevada in the reconciliation data extracts shall be the same data utilized to provide services and operate the Program during the performance periods.

These dates allow for 3 month interim reconciliations to be completed for quarterly program period performance evaluations. Only full 12 month periods will be used in fees-at-risk/final holdback calculations. The dates in the table below may be adjusted to correspond with contract start date. However, this will not change the frequency of the performance evaluations.

Table 1. Time Frames for State of Nevada Data Extracts

Deliverable File	Eligibility Period Begins	Eligibility Period Ends	Incurred Dates of Extracted Claims Used To Identify Target Population	Paid Date Cut-Off Of Claims Extract	Submittal Date to The CMO
Baseline	01/01/12	12/31/12	01/01/11 – 12/31/12	6/30/13	8/15/2013
Program Period 1 – 3 Month	01/01/13	03/31/13	01/01/12-03/31/13	8/31/13	10/15/2013
Program Period 1 – 6 Month	01/01/13	06/30/13	01/01/12-06/30/13	12/31/13	2/15/2014
Program Period 1 – 9 Month	01/01/13	09/30/13	01/01/12-09/30/13	03/31/14	5/15/2014
Program Period 1	01/01/13	12/31/13	01/01/12-12/31/13	06/30/14	8/15/2014
Program Period 2 – 3 Month	01/01/14	03/31/14	01/01/13-03/31/14	8/31/14	10/15/2014
Program Period 2 – 6 Month	01/01/14	06/30/14	01/01/13-06/30/14	12/31/14	2/15/2015
Program Period 2 – 9 Month	01/01/14	09/30/14	01/01/13-09/30/14	03/31/15	5/15/2015
Program Period 2	01/01/14	12/31/14	01/01/13-12/31/14	06/30/15	8/15/2015

5. **Pay-for-Performance Methodology**

Description of Methodology

In addition to the fixed PMPM that will be paid to the selected Care Management Organization(s), an annual pay-for-performance payment will be made based on a reduction in costs, if the CMO meets the criteria outlined in this section. It is a requirement that each year's reduction in costs must meet or exceed the prior year's reduction in costs to qualify for any portion of the pay-for-performance payment. The value of this payment will be calculated as follows:

Bonus = Reduction in Costs above Cost Reduction Guarantee x [66% - (100% - Overall Quality Score)]

Note that, under this formula, the maximum bonus is equal to 66 percent of total cost reductions above the Cost
Reduction Guarantee; the ratio of 66 percent is reduced by a function of quality unattained (100 percent less the quality score); and no bonus will be paid for a quality score of less than 34 percent.

The various components of the formula are built up as follows:

Reduction in Costs

The methodology and calculations to determine the achieved reduction in costs are defined in Sections 1 through 4 of this appendix.

Reduction in Costs Guarantee

The Reduction in Costs Guarantee has been defined as $5,100,000, per program year.

Condition Specific Quality Scores (used to develop the Overall Quality Score)

The chart contained at the end of this attachment lists, by condition, the quality measures that will be used in the calculation of the condition scores.

The quality improvement target for each quality measure will be equal to 10 percent of the difference between 100 percent and the value of the measurement during the baseline period for the eligible population. In subsequent years, the quality measurement score must sustain or exceed the prior year's improvement in order to qualify for a pay-for-performance bonus. For example, if the value of a given quality measure during the baseline period was 60 percent, the Care Management Organization would be expected to increase the measure by 4 percent, to 64 percent. This is calculated as 4 percent = 10 percent x (100 percent – 60 percent). Each measure that shows improvement equal to or greater than the targeted improvement is considered "achieved."

For each condition, the Condition Specific Quality Score would be calculated as the number of "achieved" targets divided by the total number of quality measures for that condition. As an example, if a particular condition has 4 quality measures, and the CMO achieved the required target for 3 of those measures, the condition score would be 0.75, or 75 percent. For single measures that require the reporting of multiple rates, that are not subsets of one another, all targets must be met in order for that condition's improvement to be considered "achieved."

Overall Quality Score

The value of "Overall Quality Score" included in the formula above will be calculated as a weighted average of Condition Specific Quality Scores (described below). The weights used for each Condition Specific Quality Score would be the proportion of individuals in the eligible population with that condition. The proportion would be calculated using member months, not unique individuals.

As an example, assume the following:

- Condition 1 score: 75 percent
- Condition 2 score: 100 percent
- Condition 3 score: 50 percent
- Prevalence of condition 1 in the eligible population (member months basis): 50 percent
- Prevalence of condition 2 in the eligible population (member months basis): 40 percent
- Prevalence of condition 3 in the eligible population (member months basis): 30 percent

Under this scenario, Overall Quality Score would equal:

$$\frac{75\% \times 50\% + 100\% \times 40\% + 50\% \times 30\%}{50\% + 40\% + 30\%} = 77.1\%$$

Note that the total of all prevalence amounts is greater than 100 percent. This is to be expected, as many individuals in the eligible population will have more than one condition.

The quality measures to be used in the pay for performance calculation are listed at the end of this attachment.

Any changes to payment methodologies, is subject to CMS approval.

ATTACHMENT B

Care Management Organization (CMO) Quality Incentive Payment Methodology

Number	Short Name or Condition	Measure Steward	Performance Measure Definition
1	ASM.1 (Asthma)	HEDIS	Percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma who were appropriately prescribed medication during the measurement period
2	ASM.2 (Asthma)	AHRQ/ NQMC: 001614	Percent of patients who have a record of influenza immunization in the past 12 months
3	ASM.3 (Asthma)	NQF (1381) AL Medicaid Agency	Percentage of members enrolled during the measurement period with at least one emergency department visit or an urgent care visit for an asthma related event
4	ASM.4 (Asthma)	State-devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary dis-charge diagnosis of asthma and had a follow-up ambulatory care visit within 7 days of discharge
5	SPR.1 (Chronic Obstructive Pulmonary Disease)	HEDIS	Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis
6	SPR.2 (Chronic Obstructive Pulmonary Disease)	NQMC: 002443	Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months
7	SPR.3 (Chronic Obstructive Pulmonary Disease)	State-devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge
8	CDC.1 (Diabetes)	HEDIS	Percentage of members 18 – 75 years of age, with diabetes, who had an HbA1c test performed in the measurement period
9	CDC.2 (Diabetes)	HEDIS	Percentage of members 18 through 75 years of age with diabetes mellitus (type 1 and type 2) who had low-density lipoprotein cholesterol (LDL-C) test performed in the measurement period
10	CDC.3 (Diabetes)	HEDIS	Percentage of members 18 – 75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy

11	CDC.4 (Diabetes)	HEDIS	Percentage of members 18 – 75 years of age, with diabetes, who had an eye screening for diabetic retinal disease in the measurement period
12	CDC.5 (Diabetes)	NQMC: 001605	Percentage of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period
13	CDC.6 (Diabetes)	HEDIS-LIKE	Percentage of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period
14	CAD.1 (Coronary Artery Disease)	State-devised, Actuary confirmed	Percentage of members identified with coronary artery disease (CAD) who were prescribed a lipid lowering medication during the measurement period
15	CAD.2 (Coronary Artery Disease)	State-devised, Actuary confirmed	Percentage of members identified with a coronary artery disease (CAD) who had an LDL-C screen performed during the measurement period
16	CAD.3 (Coronary Artery Disease))	State-devised, Actuary confirmed	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge
17	HF.1 (Heart Failure)	NQMC: 007086	Percent of members 18 years and older who were hospitalized in the intake period with a diagnosis of acute myocardial infarction (AMI) and received persistent beta-blocker treatment for six months after being discharged alive
18	HF.2 (Heart Failure)	NQMC: 001399	Percent of members with heart failure who had at least one ED visit for acute exacerbation
19	HF.3 (Heart Failure)	HEDIS	Percent of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACEIs or ARBs during the measurement period and at least one serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement period
20	HF.4 (Heart Failure)	JAMA; Pub Med.gov published study	Percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge
21	HPTN.1 (Hypertension)	State-devised, Actuary confirmed	Percentage of members with hypertension who were on an antihypertension multi-drug therapy regimen, during the measurement period, that included a thiazide diuretic
22	HIV.1 (HIV/AIDS)	NQF-2079 Health Resources and Services Admin.- HIV/AIDS	Percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit

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23	MH.1 (Mental Health)	State-devised, Actuary confirmed	Percentage of members with bipolar I disorder treated with mood stabilizers at least 80% of the time during the measurement period
24	MH.2 (Mental Health)	NQF-0105 National Committee for Quality Assurance	Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days
25	MH.3 (Mental Health)	State-devised, Actuary confirmed	Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported: MH.3.1 – rate for 6 months of medication adherence MH.3.2 – rate for one year of medication adherence
26	MH.4 (Mental Health)	NQMC: 7104 NQMC: 7105	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:MH.4.1 – percentage of discharges for which the member received follow-up within 30 days of discharge (not used for P4P); MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge (used for P4P).
27	S.A.1 (Substance Abuse)	NQMC: 007135 NQMC: 007136	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported: S.A.1.1 – The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis S.A.1.2 – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.