

Health Insurance Marketplace<sup>SM</sup>

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## 2017 Quality Rating System Measure Technical Specifications

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September 2016

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## Technical Assistance and Contact Information

The following links and contact information should be used to obtain additional details and technical assistance related to the Quality Rating System (QRS) measure set for 2017.

### Website Links

- Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>
- CMS Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) website: <http://qhpcahps.cms.gov>
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup> Compliance Audit™ website: <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISComplianceAuditProgram.aspx>

### Contact Information

- For questions regarding the QRS clinical measure specifications, please contact the appropriate measure steward:
  - NCQA for the HEDIS® measures: via the Policy Clarification Support (PCS) system available at <http://pcs.ncqa.org>
  - Pharmacy Quality Alliance (PQA) for the *Proportion of Days Covered* measure: <http://pqaalliance.org/measures/qrs.asp>
- For questions regarding QRS survey measures, the QHP Enrollee Survey, or QRS requirements, please contact the Exchange Operations Support Center (XOSC) Help Desk via email at [CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov) or via phone at 1-855-CMS-1515 (1-855-267-1515). Reference the “Marketplace Quality Initiative (MQI)-QRS”.

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<sup>1</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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# Table of Contents

1 Introduction.....1

2 QRS Measure Set .....5

3 QRS Clinical Measure Specifications.....9

    3.1 NCQA Measure Specifications .....9

    3.2 PQA Measure Specifications .....207

4 QRS Survey Measure Specifications .....219

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# **1. Introduction**

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# Introduction

## Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2017 Quality Rating System (QRS) measure set. Qualified Health Plan (QHP) issuers will need to reference this document in order to collect and submit QRS measure data to the Centers for Medicare & Medicaid Services (CMS) in accordance with the QRS 2017 requirements. The document specifically details the following:

- *QRS measure set.* This section includes a list of the QRS measures and a brief background on the QRS measure set. The QRS measure set is comprised of clinical quality measures, including the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Information and Data Set (HEDIS) measures and a Pharmacy Quality Alliance (PQA) measure. The measure set also includes survey measures based on questions from the Qualified Health Plan Enrollee Experience Survey (QHP Enrollee Survey).
- *QRS clinical measure technical specifications.* This section includes measure specifications and data collection guidelines for NCQA's HEDIS measures and the PQA measure in the QRS measure set. For the PQA measure, QHP issuers should refer to NCQA's "General Guidelines for Data Collection" (see Section 3.1 for guidance related to data collection protocols, with the exception of a few guidelines specific to the PQA measure as noted in Section 3.2).
- *QRS survey measure technical specifications.* This section includes descriptions for the survey measures in the QRS measure set that will be collected as part of the QHP Enrollee Survey.

CMS anticipates updating this document on an annual basis to reflect any changes to the measure set, including changes to the measure specifications or data collection guidelines.

## Background

In accordance with the requirements specified in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017*, QHP issuers and Multi-State Plan (MSP) issuers<sup>2</sup> that offered coverage through a Health Insurance Marketplace (Marketplace) in the prior year are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification.<sup>3</sup> CMS will calculate the quality performance ratings for QHPs offered through all Marketplaces, regardless of the Marketplace model. CMS will apply the QRS rating methodology to validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures) to produce quality ratings on a 5-star rating scale.<sup>4</sup> CMS will collect data and calculate quality ratings for each QHP issuer's product type (e.g., health maintenance organization [HMO]) within each state and apply these ratings to each product type's QHPs in that State.

<sup>2</sup> A Multi-State Plan, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP per 45 CFR § 155.1010. Therefore, when describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSPs, unless otherwise noted by OPM in guidance issued to MSP issuers.

<sup>3</sup> 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.

<sup>4</sup> The QHP Enrollee Survey includes a core question set that will be used to assess enrollee experience with health care services. Specific questions are grouped to form survey measures that will be used in the QRS.

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## **2. QRS Measure Set**

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## QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 1 includes the list of QRS measures required for 2017.

The measure set includes a subset of NCQA's HEDIS measures and one PQA measure. The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems<sup>5</sup> (CAHPS®) surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to <https://ghpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system>.

Some measures have multiple indicators (or rates). QHP issuers are required to collect and submit validated data for every indicator associated with a measure, unless a specific indicator is shown in parentheses next to the measure, in which case only the indicator must be reported (e.g., for Childhood Immunization Status [Combination 3], only Combination 3 must be reported).

Exhibit 1. 2017 QRS Measures

Measure Title	Measure Steward	National Quality Forum (NQF) ID <sup>6</sup>
<i>QRS Clinical Measures</i>		
Adult BMI Assessment	NCQA	Not Endorsed
Annual Dental Visit	NCQA	Not Endorsed
Annual Monitoring for Patients on Persistent Medications	NCQA	2371
Antidepressant Medication Management	NCQA	0105
Appropriate Testing for Children With Pharyngitis	NCQA	0002
Appropriate Treatment for Children With Upper Respiratory Infection	NCQA	0069
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	0058
Breast Cancer Screening	NCQA	2372
Cervical Cancer Screening	NCQA	0032
Childhood Immunization Status (Combination 3)	NCQA	0038
Chlamydia Screening in Women	NCQA	0033
Colorectal Cancer Screening	NCQA	0034
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	0055
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA	0575
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	NCQA	0057
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	0062
Controlling High Blood Pressure	NCQA	0018
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	NCQA	0576
Follow-Up Care for Children Prescribed ADHD Medication	NCQA	0108
Immunizations for Adolescents (Combination 2)	NCQA	1407
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	0004
Medication Management for People With Asthma (75% of Treatment Period)	NCQA	1799
Plan All-Cause Readmissions	NCQA	1768

<sup>5</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The surveys are available at <https://cahps.ahrq.gov>.

<sup>6</sup> Definitions of NQF-endorsed measures can be found here: <http://www.qualityforum.org/Home.aspx>

## 2. QRS Measure Set

Measure Title	Measure Steward	National Quality Forum (NQF) ID <sup>6</sup>
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541
Relative Resource Use for People with Diabetes (Inpatient Facility Index)	NCQA	1557
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	NCQA	1392
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA	1516
<b>QRS Survey Measures</b>		
Access to Care	AHRQ, CMS	Not Endorsed
Access to Information	AHRQ, CMS	Not Endorsed
Aspirin Use and Discussion	NCQA	Not Endorsed
Care Coordination	AHRQ, CMS	Not Endorsed
Cultural Competence	AHRQ, CMS	Not Endorsed
Flu Vaccinations for Adults Ages 18-64	NCQA	0039
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS <sup>7</sup>	Not Endorsed
Rating of All Health Care	AHRQ	0006 <sup>7</sup>
Rating of Health Plan	AHRQ	0006 <sup>7</sup>
Rating of Personal Doctor	AHRQ	0006 <sup>7</sup>
Rating of Specialist	AHRQ	0006 <sup>7</sup>

<sup>7</sup> Measure consists of CAHPS survey items and a survey item developed for purposes of the QHP Enrollee Survey.

## **3. QRS Clinical Measure Specifications**

### **3.1 NCQA Measure Specifications**

### **3.2 PQA Measure Specifications**

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# **2017 HEDIS® General Guidelines for the QRS Measure Technical Specifications**

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NCQA Customer Support: 888-275-7585

NCQA Fax: 202-955-3599

NCQA Web site: [www.ncqa.org](http://www.ncqa.org)

NCQA Policy Clarification Support: <http://my.ncqa.org>

# Table of Contents

<b>Overview.....</b>	<b>15</b>
HEDIS 2017 .....	17
How HEDIS Is Developed .....	17
Additional Resources .....	17
If You Have Questions About the Specifications .....	17
FAQs and Policy Updates .....	18
Reporting Hotline for Fraud and Misconduct.....	18
Reporting Data Errors to NCQA .....	18
<b>General Guidelines for Data Collection.....</b>	<b>19</b>
General Guidelines for Data Collection .....	20
2017 HEDIS for QRS Data Collection .....	20
Definitions.....	21
The NCQA HEDIS Compliance Audit™ .....	22
For Performance Measures.....	24
In Which Reports Do Marketplace Members Remain?.....	24
Membership Changes.....	25
Required Enrollment Periods and Benefits .....	26
HEDIS for QRS Data Submission and Reporting to NCQA.....	27
Data Collection Methods and Data Sources .....	28
Supplemental Data Definitions .....	29
Required Data Elements.....	30
Supplemental Data Timeline and Systematic Sample Requirements .....	31
Identifying and Validating Supplemental Data.....	31
HEDIS Coding Conventions .....	35
<b>Guidelines for Calculations and Sampling .....</b>	<b>39</b>
Guidelines for Calculations and Sampling.....	40
How to Use the Administrative Method.....	40
Guidelines for the Hybrid Method .....	40
Systematic Sampling Methodology.....	45
Complex Probability Sampling .....	48
Substituting Medical Records.....	49
Hybrid Method: Three Approaches.....	50
References .....	50
<b>Guidelines for HEDIS Effectiveness of Care Measures .....</b>	<b>51</b>
Guidelines for HEDIS Effectiveness of Care Measures .....	52
Description .....	52
<b>Guidelines for HEDIS Access/Availability of Care Measures.....</b>	<b>55</b>
Guidelines for HEDIS Access/Availability of Care Measures .....	56
Continuous Enrollment.....	56
Which Services Count.....	56
Hybrid Methodology .....	56
<b>Guidelines for HEDIS Relative Resource Use Measure.....</b>	<b>57</b>
Guidelines for HEDIS Relative Resource Use Measure .....	58
Description .....	58
Definitions.....	58
Overview .....	60
Guidelines .....	61
RRU Risk Adjustment .....	63

## Table of Contents

---

Steps for Calculating Service Categories.....	65
Relative Resource Use Results .....	68
Data Elements for Reporting .....	69
<b>Guidelines for Risk Adjusted Utilization .....</b>	<b>71</b>
Guidelines for Risk Adjusted Utilization Measures.....	72
Specific Instructions for Utilization Tables.....	72
Utilization Risk Adjustment Determination .....	73
<b>2017 HEDIS for QRS Measure Technical Specifications (Alphabetical Order).....</b>	<b>73</b>
<i>Adult BMI Assessment (ABA)</i> .....	62
<i>Annual Dental Visit (ADV)</i> .....	65
<i>Antidepressant Medication Management (AMM)</i> .....	67
<i>Annual Monitoring for Patients on Persistent Medications (MPM)</i> .....	71
<i>Appropriate Testing for Children With Pharyngitis (CWP)</i> .....	75
<i>Appropriate Treatment for Children With Upper Respiratory Infection (URI)</i> .....	79
<i>Aspirin Use and Discussion (ASP)</i> .....	82
<i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)</i> .....	86
<i>Breast Cancer Screening (BCS)</i> .....	91
<i>Cervical Cancer Screening (CCS)</i> .....	93
<i>Childhood Immunization Status (CIS)</i> .....	97
<i>Chlamydia Screening in Women (CHL)</i> .....	102
<i>Colorectal Cancer Screening (COL)</i> .....	105
<i>Comprehensive Diabetes Care (CDC)</i> .....	109
<i>Controlling High Blood Pressure (CBP)</i> .....	118
<i>Flu Vaccinations for Adults Ages 18–64 (FVA)</i> .....	124
<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i> .....	126
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i> .....	129
<i>Immunizations for Adolescents (IMA)</i> .....	134
<i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</i> .....	137
<i>Medical Assistance With Smoking and Tobacco Use Cessation (MSC)</i> .....	142
<i>Medication Management for People With Asthma (MMA)</i> .....	145
<i>Plan All-Cause Readmissions (PCR)</i> .....	150
<i>Prenatal and Postpartum Care (PPC)</i> .....	159
<i>Relative Resource Use for People With Diabetes (RDI)</i> .....	167
<i>Use of Imaging Studies for Low Back Pain (LBP)</i> .....	171
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i> .....	175
<i>Well-Child Visits in the First 15 Months of Life (W15)</i> .....	180
<i>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)</i> .....	182

### **Appendix 1: Practitioner Types**

### **Appendix 2: Data Element Definitions**

# Overview

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## HEDIS 2017

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used set of health care performance measures in the United States. The term “HEDIS” originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations.

### How HEDIS Is Developed

NCQA’s Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, health care providers and policy makers, oversees the evolution of the measurement set. Multiple Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

### Additional Resources

#### QRS and QHP Enrollee Survey Technical Guidance

**Technical specification updates.** The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHPs) in the Marketplace to specify requirements for participating in the Quality Rating System (QRS), including the clinical and survey measures that must be reported. The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017* is posted to the CMS MQI Web site (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>).

NCQA will freeze the specifications on October 3, 2016, with the release of the 2017 *HEDIS for QRS Technical Update*:

- **HEDIS for QRS Technical Update** will be posted to the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)).
- **HEDIS for QRS Value Set Directory (10/3/2016 Release)** will be posted to the NCQA Download Center (<http://store.ncqa.org/index.php/catalog/product/view/id/2479/s/2017-quality-rating-system-qrs-hedis-value-set-directory/>).

Organizations are accountable for all changes included in the *Technical Update*, but are not required to use information posted after the freeze date, with the exception of NDC codes, Standard Pricing Tables (SPT) and HCC Risk Adjustment tables.

- **Value Set Directory. HEDIS for QRS Value Set Directory (9/1/2016 Release)** will be posted to the NCQA Download Center and will be updated on October 3, 2016.
- The final **NDC codes, SPTs and HCC Risk Adjustment Tables** will be posted to the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)) by November 1, 2016.

### If You Have Questions About the Specifications

#### Policy Clarification Support

NCQA provides different types of policy support to customers, including a function that allows customers to submit specific HEDIS for QRS policy interpretation questions to NCQA staff: the Policy Clarification Support (PCS) system. The PCS system can be accessed on the NCQA Web site at <http://my.ncqa.org>.

### FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS for QRS uses and specifications, and are posted to the NCQA Web site on the 15th of each month.

### Reporting Hotline for Fraud and Misconduct

NCQA does not tolerate submission of fraudulent, misleading or improper information by organizations as part of their survey process or for any NCQA program.

NCQA has created a confidential and anonymous Reporting Hotline to provide a secure method for reporting perceived fraud or misconduct, including submission of falsified documents or fraudulent information to NCQA that could affect NCQA-related operations (including, but not limited to, the survey process, the HEDIS measures and determination of NCQA status and level).

#### How to Report

- **Toll-Free Telephone:**
  - English-speaking USA and Canada: **855-840-0070** (not available from Mexico).
  - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Web Site:** <https://www.lighthouse-services.com/ncqa>.
- **E-Mail:** [reports@lighthouse-services.com](mailto:reports@lighthouse-services.com) (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

### Reporting Data Errors to NCQA

Because audited HEDIS data are used to establish plans' accreditation status and in many state and federal programs, NCQA must be made aware of data problems in any previously reported rate.

Organizations must immediately report any error in a measure rate or in its component (in any previous submission, regardless of timing) that is >5% higher or lower than what was reported originally. The report to NCQA must include:

- A description of the issue that includes:
  - The correct rate.
  - The error's cause.
  - How the error was discovered.
  - How the error was corrected.
- The HEDIS measure year and the measures affected.
- The submissions affected.
- The impact on reported rates.

Auditors must document all findings for the year in question and the current year's corrections. Findings must be included in the work papers and must be noted in detail in the organization's Final Audit Report.



# **General Guidelines for Data Collection**

## General Guidelines for Data Collection

These 2017 HEDIS for QRS General Guidelines for the *2017 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Marketplace and participating in the CMS Quality Rating System (QRS).<sup>1,2</sup>

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### SUMMARY OF CHANGES TO HEDIS FOR QRS 2017

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- Revised *General Guideline 1* to clarify product line use.
- Added a minimum enrollment threshold for the ratings year (i.e., 2017) for *General Guideline 2* and *General Guideline 3*.
- Updated deadlines in *General Guideline 6*.
- Added *General Guideline 10*; renumbered subsequent guidelines.
- Clarified *General Guideline 13* (combined former *General Guidelines 12* and *13*).
- Updated the “plan-lock” deadline in *General Guideline 19*.
- Clarified in the Note in *General Guideline 22* that any data found in a supplemental data source are considered a supplemental data hit.
- Clarified requirements for *General Guideline 23*.
- Replaced the *Human Papillomavirus Vaccine for Female Adolescents* measure with the *Immunizations for Adolescents* measures in *General Guideline 28*.
- Added requirement for the Independent Laboratory Value Set in *General Guideline 30*.
- Added *General Guideline 32*.
- Added CVX—Vaccines Administered to *General Guideline 33* (formerly *General Guideline 32*).
- Added *General Guideline 35*.

### 2017 HEDIS for QRS Data Collection

#### 1. Marketplace Product Line

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QHP issuers (“organizations”) must collect HEDIS for QRS measure data separately for the Marketplace population. The HEDIS for QRS specifications are for reporting the Marketplace product line only.

#### 2. Reporting Units (Product)

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Organizations must collect HEDIS for QRS measure data for each product (i.e., EPO, HMO, POS, PPO) offered through a Marketplace in 2017 that had more than 500 enrollees as of July 1, 2016 and more than 500 enrollees as of January 1 of the ratings year (i.e., 2017). Reporting units that are decertified or discontinued before June 15, 2017, are exempt.

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<sup>1</sup> The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–309) (collectively referred to as the Affordable Care Act) established an Affordable Insurance Exchange (or Exchange) within each state. Exchanges are commonly known as Health Insurance Marketplaces (or Marketplaces).

<sup>2</sup> A QHP issuer has a certification issued by or recognized by a Marketplace to demonstrate that each health plan offered in the Marketplace is a QHP and meets the requirements described in 45 CFR 155.2. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIO) Issuer ID. Each QHP issuer is defined by a state geographic unit. A QHP issuer must operate on a Marketplace for at least one year before it is required to collect QRS measure data. Final rule—<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf>

All enrollees in QHPs offered on the Marketplace and provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *2017 Quality Rating System Measure Technical Specifications*). At this time, organizations should not include child-only plans or stand-alone dental plans in the reporting unit. Organizations should not include any enrollees from health plans offered outside of the Marketplace or non-QHPs. Non-QHPs are health plans that are offered outside of the Marketplace and designated with a HIOS variant ID -00.

Additionally, sampling for QRS measures that specify a hybrid method for data collection will occur at the product level.

Combining products into one reporting unit is not allowed.

## Definitions

**EPO** Exclusive provider organization. A managed care plan that covers network providers and in-network services, except in an emergency.

**HMO** Health maintenance organization. An organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Practitioners affiliated with the health care system render health care services. In this type of organization, members must obtain all services from affiliated practitioners and must usually comply with a predefined authorization system to receive reimbursement.

A **practitioner** is a professional who provides health care services and is usually required to be licensed as defined by law.

**POS** Point of Service. An HMO with an opt-out option. In this type of organization, members may choose to receive services either with the organization's health care system (e.g., an in-network practitioner) or outside the organization's health care delivery system (e.g., an out-of-network practitioner.)

The level of benefits or reimbursement is generally determined by whether the member uses the in-network or out-of-network services. Common uses of the "POS" include references to products that enroll each member in both an HMO (or HMO-like) system in the indemnity.

A POS product is also referred to as an "HMO swing-out organization," an "out-of-organization benefits rider to an HMO" or an "open-ended HMO."

**PPO** Preferred provider organization. PPOs are responsible for providing health benefits-related services to covered individuals and for managing a practitioner network. They may administer health benefits programs for employers by assuming insurance risk or by providing only administrative services.

## 3. Minimum Enrollment Threshold

Organizations are required to submit data for each product offered through a Marketplace in 2017 that had more than 500 enrollees as of July 1, 2016 and more than 500 enrollees as of January 1 of the ratings year (i.e., 2017).

## 4. Individual and Small Business Health Options Program (SHOP) Members

An organization's Small Business Health Options Program (SHOP) and individual Marketplace members should be included in the same Marketplace reporting unit (not separated).

## **5. Multi-State Plan (MSP) Members**

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Multi-State Plan (MSP)<sup>3</sup> members should be included in the corresponding organization's Marketplace reporting units (not separated).

### **The NCQA HEDIS Compliance Audit™**

The HEDIS Compliance Audit is required for all HEDIS for QRS measures in 2017, including the sampling frame used to administer the QHP Enrollee Survey. The HEDIS audit runs concurrently with 2017 HEDIS for QRS measure set data collection. The audit allows comparability across organizations and ensures validity and integrity of HEDIS data.

## **6. Audit Preparation**

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**Contract with an audit firm.** The organization requests an application for a HEDIS for QRS Audit from an NCQA Licensed Organization ([www.ncqa.org/audit.aspx](http://www.ncqa.org/audit.aspx)), and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations for bids and selects a firm to conduct the HEDIS audit.

The contracting phase includes assessing measures to report, executing the contract with all the necessary ancillary agreements (e.g., confidentiality and conflict of interest) and negotiating a timeline.

All Licensed Organizations employ or contract with Certified HEDIS Compliance Auditors (CHCA) and select an audit team for the organization.

**HEDIS Roadmap.** Each organization must complete the HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap contains detailed questions about all audit standards and describes the operational and organizational structure of the organization. Auditors use the HEDIS Roadmap to review information about an organization's systems for collecting and processing data to produce HEDIS reports and to organize the site visit.

**Medical record review validation.** The medical record review validation (MRRV) process uses like-measure groupings for measure validation; includes hybrid measure exclusions; applies a different statistical test to the process; and defines MRR milestones clearly to ensure consistency across organizations. Refer to *HEDIS 2017: Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, released in November.

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<sup>3</sup>A Multi-State Plan, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP per 45 CFR §155.1010.

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization contracts with an NCQA Licensed Organization.	December 1
Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor.	December 1
Onsite visits begin. Onsite visits are not to be held prior to the start of the reporting year.	After January 2
Organization submits the completed current year's Roadmap to the auditor. <i>Note: The auditor must receive the Roadmap by January 31 or at least two weeks before the site visit, whichever is earlier.</i>	January 16–31
Auditor completes the survey sample frame validation.	January 31
Auditor selects a core set of noncertified measures for code review.	February 13
Measure certification deadline. NCQA sends final certification reports to auditors.	February 15
Organization submits completed source code for auditor review (for noncertified measures).	March 1
Organization completes and stops all nonstandard supplemental data collection and entry. No exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates.	March 1
Auditor finalizes approval of <i>all</i> supplemental data. PSV for nonstandard supplemental data must not occur prior to March 1, unless the organization finished all supplemental data processes, collection and entry.	March 31
Onsite visits completed.	April 28
Preliminary rate review and feedback completed. This date is the latest when this review should happen. NCQA encourages preliminary rate review to take place earlier in the audit process.	May 1
Organization completes the medical record abstraction process for all measures; sends final numerator-compliant counts for all measures and exclusions for MRRV. No exceptions! Failure to meet this deadline could result in inability to use medical record data to report rates.	May 15
Auditor picks measures from the measure groups and exclusions, selects 16 records from each for MRRV review, and informs the plan of the selections.	May 19
Organization sends selected records to the auditor for validation.	May 26
Auditor begins communicating MRRV results, including MRRV corrective actions, with the organization.	May 31
Organization completes all corrective actions and follow-up requests and submits the plan-locked Marketplace submission and patient-level data file to auditor.	June 8
Auditor performs final rate review and ensures that the MRR numerator counts entered in the IDSS match the lists submitted on May 15.	June 15
Organization submits the auditor-locked Marketplace IDSS submission, with attestation, to NCQA.	June 15
Licensed Organization submits Marketplace Final Audit Reports to NCQA.	July 17

## 7. Reporting

**Audit results.** HEDIS Compliance Audits result in audited rates or calculations at the measure and indicator level, and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The auditor approves the rate or report status of each measure and survey included in the audit, as shown below.

**For Performance Measures**

Rate/Result	Comment
R	<i>Reportable.</i> A reportable rate was submitted for the measure.
NA	<i>Small Denominator.</i> The organization followed the specifications, but the denominator was too small (<30) to report a valid rate. <i>Note: Organizations should report their data regardless of denominator size.</i>
NB	<i>Benefit Not Offered.</i> The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	<i>Not Reported.</i> The organization chose not to report the measure.
BR	<i>Biased Rate.</i> The calculated rate was materially biased.

**Material bias.** Bias differs by measure and domain and is determined by the degree of data completeness for the data collection method used. Organizations may not report a rate for a measure that the auditor determines is biased. Auditors use a standardized set of bias assessments found in the Bias Determination appendix in *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

**In Which Reports Do Marketplace Members Remain?****8. Eligible Population**

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The **eligible population** for any measure is all members who satisfy all specified criteria, including age, continuous enrollment, benefit, event and the anchor date enrollment requirement. Organizations must include all members (regardless of benefit type) in the appropriate Marketplace report.

- *For the Administrative Method*, calculate the rate using the eligible population after exclusions are removed.
- *For the Hybrid Method*, calculate the rate using the denominator (i.e., the systematic sample drawn from the eligible population) after exclusions are removed.

**Note:** Refer to the measurement specifications for eligible population criteria.

**9. The “Working Aged” and Retirees**

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Include employees 65 years of age and older and retirees if the Marketplace QHP provides their primary coverage as opposed to the Medicare product line.

**10. Members in Hospice**

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

Organizations should attempt to remove these members prior to determining a measure’s eligible population and drawing the sample for hybrid measures. If a member is found to be in hospice or using hospice services during medical record review, the member is removed as a valid data error from the sample and replaced by a member from the oversample.

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

## Membership Changes

### 11. Members Who Switch Organizations

Members who switch to different organizations or to a sister organization may be counted as continuously enrolled if they joined an organization that assumes ownership of or responsibility for members' administrative data and medical records for the entire period of continuous enrollment specified in the measure.

If an organization reports these members as continuously enrolled, it follows the definition of "continuous enrollment" in *General Guideline 14: Continuous Enrollment*, and all other guidelines affecting continuous enrollment (i.e., allow switching between products [HMO, POS, PPO, EPO] or product lines [Medicaid, commercial, Medicare, Marketplace]) consistently, across all measures.

### 12. Members Who Switch Organizations as a Result of a Merger or Acquisition

**Measures with a continuous enrollment period.** Members who switch organizations because of a merger that occurred during the measurement year may be counted as continuously enrolled.

**Measures without a continuous enrollment period.** The surviving organization may include members from the nonsurviving entity in the eligible population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the nonsurviving entity from the eligible population for January and February.

This guideline must be used consistently across all measures.

### 13. Members Who Switch Products/Product Lines

#### Measures with a continuous enrollment requirement

Members who enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS report.

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

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

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

#### Measures without a continuous enrollment requirement

Members who enrolled in different products or product lines are reported in the product and product line-specific HEDIS report in which they were enrolled on the date of service (outpatient, ED or observation visits) or date of discharge (inpatient stays).

## Required Enrollment Periods and Benefits

### 14. Continuous Enrollment

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**Continuous enrollment** specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap.

A **gap** is the time when a member is not covered by the organization (i.e., the time between disenrollment and re-enrollment). For example, if a member disenrolls on June 30 and re-enrolls on July 1, there is no gap because the member is covered by the organization on both June 30 and July 1. If the member disenrolls on June 30 and re-enrolls on July 2, there is a 1-day gap because the member is without coverage on July 1.

An **allowable gap** can occur any time during continuous enrollment. For example, the *Comprehensive Diabetes Care* measure requires continuous enrollment throughout the measurement year (i.e., January 1–December 31) and allows one gap in enrollment of up to 45 days. A member who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year. The member has one 38-day gap (January 1–February 7).

### 15. Continuous Enrollment Over Multiple Years

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Unless otherwise specified, for measures that span more than 1 year, members are allowed one gap in enrollment of up to 45 days during each year of continuous enrollment. A gap in enrollment that extends over multiple years of a continuous enrollment period may exceed 45 days. For example, in the *Colorectal Cancer Screening* measure (which requires 2 years of continuous enrollment), a member who disenrolls on November 30 of the year prior to the measurement year and re-enrolls on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment during either year. The member has one gap of 31 days (December 1–31) in the year prior to the measurement year and one gap of 31 days (January 1–31) in the measurement year.

### 16. Anchor Dates

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If a measure requires a member to be enrolled and to have a benefit on a specific date, the allowable gap must not include that date; the member must also have the benefit on that date. For example, a 30-year-old woman who has only one gap in enrollment from November 30 of the measurement year throughout the remainder of the year is not eligible for the *Cervical Cancer Screening* measure. Although she meets the continuous enrollment criteria, she does not meet the anchor date criteria, which requires her to be enrolled as of December 31 of the measurement year.

### 17. Required Benefits

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HEDIS for QRS measures evaluate performance and hold organizations accountable for services provided in their members' benefits package. Measure specifications include benefits (i.e., medical, pharmacy, mental health, chemical dependency) required during the continuous enrollment period. HEDIS for QRS measures do not define benefits at the service or metal level (e.g., if the organization offers a pharmacy benefit but does not cover a specific medication class, the member has a pharmacy benefit and is included in the applicable measures requiring this benefit).

**At the organization level:** Organizations report HEDIS for QRS measures requiring a specific benefit provided to members directly or through a contractor. Organizations are not required to report HEDIS for QRS measures specifying a benefit that it does not offer.



**At the member level:** Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit.

**Exhausted benefits (optional).** Members who do not have a specified benefit are not counted in the measure.

*For measures without a continuous enrollment criterion,* include only services or procedures that occurred while the member had a benefit. For a member whose benefit is lost or exhausted during the time specified in the measure, include services or procedures that occurred while the member had the benefit.

*For measures with a continuous enrollment criterion,* the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap or anchor date. For example, the *Medication Management for People With Asthma* measure requires a pharmacy benefit during the measurement year. Exclude a member whose pharmacy benefit is exhausted in September of the measurement year, because this exceeds the 45-day allowable gap period.

**Carved-out benefits (optional).** Some organizations can obtain the necessary information from a carved-out entity and may include these members in their measures. For example, an employer contracts directly with a pharmacy benefit manager (PBM), which shares pharmacy information with the organization. The employer's members may be included in the measure.

This guideline must be used consistently across all measures.

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## 18. Accessing Medical Records Prior to Enrollment

Data that can be accessed from a complete medical record are used to calculate a measure. If data from a medical record cannot be accessed because data were updated before the member was enrolled, the organization calculates the measure with the data that are available.

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## HEDIS for QRS Data Submission and Reporting to NCQA

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### 19. Reporting Date

The previous calendar year is the standard measurement year for HEDIS for QRS data. For HEDIS for QRS, reporting units must submit data to NCQA on or before **June 15, 2017**.

**Note:** Organizations must submit and “plan-lock” HEDIS for QRS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For HEDIS for QRS reporting, organizations are required to “plan-lock” HEDIS for QRS data no later than June 8, 2017.

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### 20. Required Data Elements

Organizations that submit HEDIS for QRS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid measures and administrative measures. Refer to *Appendix 2: Data Element Definitions*.

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### 21. Small Numbers

All organizations must report all HEDIS for QRS measures and associated data elements to NCQA regardless of the measure's denominator size.

## Data Collection Methods and Data Sources

### 22. Data Collection Methods

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HEDIS for QRS measures are specified for one or more data collection methods:

- Administrative Method.
- Hybrid Method.
- Survey Method.

Each measure specifies the data collection method(s) that must be used. If a measure includes both the Administrative and Hybrid Methods, either method may be used.

**Administrative Method:** Transaction data or other administrative data are used to identify the eligible population and numerator. The reported rate is based on all members who meet the eligible population criteria (after optional exclusions, if applicable) and who are found through administrative data to have received the service required for the numerator.

**Hybrid Method:** Organizations look for numerator compliance in both administrative and medical record data. The denominator consists of a systematic sample of members drawn from the measure's eligible population. Organizations review administrative data to determine if members in the systematic sample received the service, and review medical record data for members who do not meet the numerator criteria through administrative data. The reported rate is based on members in the sample who received the service required for the numerator.

**Survey Method:** Requires organizations to collect data through the QHP Enrollee Survey. HEDIS for QRS materials include the specifications for NCQA clinical survey measures. For additional details on the QHP Enrollee Survey data collection protocols, refer to the *2017 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*, which is available on the CMS QHP Enrollee Survey Web site (<https://qhpcahps.cms.gov>).

**Note:** *Supplemental data are considered an administrative data source; however, for all nonsurvey measures, numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/encounter) and medical record data, as indicated in the applicable Data Elements for Reporting tables. Any data found in a supplemental data source are considered a supplemental data hit because the member would not be compliant for the measure/indicator without the data source. If supplemental data are not used, report zero in the "Numerator events by supplemental data" element. For all other measures, numerator events identified using supplemental data are reported in the "Numerator events by administrative data" element. Refer to General Guideline 23 for supplemental data requirements.*

### 23. Supplemental Data

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**Supplemental data uses.** When administrative or medical record data are not available, organizations may use other sources to collect data about their members and about delivery of health services to their members. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the HbA1c control indicators in the *Comprehensive Diabetes Care* measure, the most recent test must be used regardless of data source).

For administrative-only measures, medical record data are considered supplemental data. Supplemental data may help determine:

- Numerators (that are labeled as *numerators* in the specification).
- Observed Events in the Risk Adjusted Utilization measures.
- Optional exclusions.

- Eligible-population required exclusions not related to timing of the denominator event or diagnosis. For example:
  - *Medication Management for People With Asthma*. Organizations may use supplemental data for members who have any condition in step 3, *Required Exclusions* for the event/diagnosis.

Supplemental data may not be used for:

- Denominator events. Organizations may not create and use records to identify denominator events, other than for optional exclusions and appropriate required exclusions. For example:
  - *Appropriate Testing for Children With Pharyngitis*. Organizations may not use supplemental data to find additional diagnoses for any claim that qualifies for the eligible population. Exclude “claims” with multiple diagnoses only.
- Clinical conditions that change. Organizations may not create and use records, on an ongoing basis, for exclusions for clinical conditions that change.
- Correcting bills or identifying valid data errors. Organizations *may not* use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed. For example:
  - Organizations may not exclude a member from the *Use of Imaging Studies for Low Back Pain* measure if the medical record shows that a diagnosis of back pain did not occur in the timeframe required by the measure but was billed by a provider for ongoing therapy.
- Measures with no numerators. Organizations may not use supplemental data to identify events in measures with no numerators. For example:
  - Organizations may not use supplemental data to categorize inpatient stays and pricing for the *Relative Resource Use for People With Diabetes* measure.
- Risk adjustment. Organizations may not use supplemental data sources when applying the risk adjustment methodology to the *Plan All-Cause Readmissions* and *Relative Resource Use for People With Diabetes* measures.

**Note:** Refer to “Substituting Medical Records” in the *Guidelines for Calculations and Sampling for additional information and examples of valid data errors*.

## Supplemental Data Definitions

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

Electronic files that may be used as standard supplemental data:

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

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

**Note:** Prior year’s validated historic hybrid medical record result files are reviewed as part of the *Data Integration* section of the *HEDIS Roadmap*.

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

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

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

Examples of nonstandard supplemental data:

- EHR modules (e.g., uncertified eMeasure modules).
- Provider portals (i.e., electronic systems providers use to enter information about services rendered).
- Health Information registries.
- Provider abstraction forms.
- Member reported services.
  - Refer to *General Guideline 32* for requirements for member-reported services abstracted during medical record review.

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

Proof-of-service documentation that *is allowed* for primary source verification:

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

Proof-of-service documentation that *is not allowed*:

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

## Required Data Elements

**Standard supplemental data.** Organizations must have policies and procedures for using data files as standard supplemental data. Files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by measure specifications. If the measure has a hybrid specification, the supplemental data source must contain all data elements required by the hybrid specification regardless of the method (administrative or hybrid) the plan chooses to use when reporting the measure.

**Nonstandard supplemental data.** Nonstandard supplemental data files must have all data elements required to meet criteria specified by the measure specifications. If the measure has a hybrid specification, the supplemental data source must contain all data elements required by the hybrid specification.

- Electronic sources (i.e., portal, uncertified eMeasure module). Data collected or reported from the practitioner who renders the clinical service must have evidence of accountability by the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/PIN data in each session or header record).
- Provider-abstracted forms. Provider forms may not be simple “yes or no” responses as evidence of member compliance. Provider forms must have all necessary data elements required by the measure and are signed by the rendering practitioner, attesting to the accuracy of the information.
- Member-reported services. Proof-of-service documents required for member-reported services must include all data elements required by the measure (i.e., date and place of service, procedure, prescription, test result or finding, practitioner type). If the measure has a hybrid specification, the proof-of-service documents must contain all data elements required by the hybrid specification.

**All supplemental data.** All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to *General Guideline 26* for date specificity requirements).

For all measures (including administrative-only measures), organizations must determine that a test or service was *performed* within the period specified, not merely ordered.

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

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

### **Supplemental Data Timeline and Systematic Sample Requirements**

Supplemental data may be collected during the measurement year and into the beginning of the reporting year, but data collection for nonstandard and member-reported files must be completed by the deadline listed in the Audit Timeline in *General Guideline 6*.

Supplemental data must follow the specifications for each measure. If the measure has a hybrid specification, the data elements used must comply with the hybrid requirements of the measure; however, supplemental data are used to calculate the administrative portion of the measure.

For hybrid measures, after the sample is pulled, organizations must follow the policies for collecting information for the systematic sample described in *General Guideline 24*. Supplemental data collection may not be targeted only at members selected for the systematic sample.

Data pulled from medical records for chart review for a hybrid measure may be used as supplemental data in *subsequent* HEDIS for QRS reporting years if they comply with the guidelines for data element requirements and audit review.

Refer to the Audit Timeline in *General Guideline 6* for additional deadline requirements.

### **Identifying and Validating Supplemental Data**

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

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

- A completed current year's Supplemental Data and eMeasure section of the HEDIS Roadmap, including all attachments.
- Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data.)
- Primary source verification where required or requested by the auditor.
- For supplemental data from a certified eMeasure vendor, the auditor must receive a final certification report.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate HEDIS for QRS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

For additional information about audit requirements for supplemental data, refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, released each November.

## 24. Obtaining Information for the Systematic Sample

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Organizations (and their contractors) that use the Hybrid Method are responsible for determining compliance with HEDIS for QRS measurement specifications.

Information may be abstracted from the member's legal health record by designated medical record review (MRR) staff. Abstraction of data for members in the systematic sample is performed by entities or vendors who adhere to training, policies and procedures, use of appropriate tools, oversight and all other audit components.

MRR abstractors count a service if the legal health record contains the date of the service and evidence that the service occurred. All services must be rendered and documented in the medical record by the deadline established in the measure (e.g., by the child's second birthday, for the *Childhood Immunization Status* measure).

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward HEDIS for QRS compliance. Some EHRs record CPT<sup>4</sup> codes when the practitioner enters a service order in the "order" screen. A CPT code found on the "order" list alone does not comply with the numerator criteria.

After the systematic sample is determined, supplemental data collection may not be used only for noncompliant members selected in the sample. Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard tests, are reviewed by the certified HEDIS Compliance Auditor.

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<sup>4</sup>CPT codes copyright 2016 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

**Data refresh for the systematic sample.** Because the NCQA HEDIS Compliance Audit requires that the systematic sample be stable and reproducible, organizations may not change the sample after it is created. If an organization refreshes the HEDIS repository after the sample is drawn and chart review is in progress, it should follow the guidelines below to use the newer administrative data for all hybrid measures.

**Note:** Organizations may elect to refresh data for administrative-only measures, but must apply the refresh to all applicable measures.

- Manually updating the sample. Organizations may compare only the numerator-negative members in the sample to screen shots of the refreshed data; they are not required to update every measure manually or to reassess denominator compliance for every member in the sample.  
Records used for numerator compliance are subject to medical record review validation.
- Automated updates to the sample. Organizations may use an automated process that loads the entire sample for each measure and compares it to the refreshed data. All data must be used consistently in the samples.
  - If recent data contradict numerator compliance, those data must be used.
  - If recent data exclude a member, those data must be used and the oversample must provide a substitute member.
  - If the oversample is exhausted, the organization must use the Sampling Guidelines to ensure a denominator of 411.
  - The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation.

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## **25. Measures That Require Results From the Most Recent Test**

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

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

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

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

Undated lab results in medical records may not be used for HEDIS for QRS reporting. To be eligible for use, medical record documentation must include the collection date or the reported date.

## **26. Date Specificity**

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HEDIS for QRS requires that a date be specific enough to determine that an event occurred during the time established in the measure. For example, in the *Childhood Immunization Status* measure, members must receive three hepatitis B vaccines. Assume a member was born on February 5, 2014. Documentation in the medical record that the first hepatitis B vaccine was given “at birth” is specific enough to determine that it was given prior to the deadline for this measure (i.e., the child’s second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2016, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member’s second birthday.

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

For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the *Childhood Immunization Status* measure, undated documentation on an immunization chart stating “chicken pox at age 1” is specific enough to determine that it occurred prior to the child’s second birthday. Similarly, for the *Breast Cancer Screening* measure, undated documentation on a problem list stating “bilateral mastectomy in 1999” is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.

## **27. Indicators That Require the Same Data Collection Method**

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Organizations must use the same data collection method (Administrative or Hybrid) to report the following indicators in each measure.

- *Comprehensive Diabetes Care:*
  - HbA1c Testing.
  - HbA1c Control <8%.

## **28. Collecting Data for Measures With Multiple Numerator Events**

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

- *Childhood Immunization Status.*
- *Well-Child Visits in the First 15 Months of Life.*
- *Immunizations for Adolescents*

For only the measures listed above, the organization may use a single data source or a combination of administrative data, which may include audited supplemental data, and medical record data to determine numerator compliance for members in the denominator. To avoid double counting events, when only assessing administrative data or when combining administrative and medical record data, all events must be at least 14 days apart.

For example, the organization may count two influenza vaccines identified through administrative data if the dates of service are at least 14 days apart; if the service date for the first vaccine was February 1, then the service date for the second vaccine must be on or after February 15. When combining administrative and medical record data, the dates of service must also be at least 14 days apart in order to count toward numerator compliance.

If the organization has one event from the medical record and one from administrative data but cannot determine if the dates are at least 14 days apart, it must use only the medical record event.

This rule does not apply when using only medical record data. For example, the organization may count two influenza vaccines identified through medical record data that are not 14 days apart.



## 29. Measures That Use Pharmacy Data

Some measures require the use of pharmacy data. The specifications include medication tables that must be referenced in conjunction with the National Drug Code (NDC) lists posted to NCQA's Web site. The tables include a *Description* column that indicates the therapeutic category, and a *Prescription* column that includes all appropriate medications in their generic form. Organizations must use the NDC lists for each pharmacy-dependent measure. Final NDC lists for pharmacy-related measures will be posted to the NCQA Web site on November 1, 2016.

## 30. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Laboratory claims and data may only be used for the Lab Panel Value Set, the Obstetric Panel Value Set, the Pregnancy Tests Value Set, the Sexual Activity Value Set (which do not contain LOINC<sup>5</sup> codes) and value sets that contain LOINC codes.

Claims data indicating a member had a laboratory test during a visit with a provider are not considered laboratory data. Laboratory data are claims or lab result data for the sole purpose of a laboratory test performed outside of a visit with a provider. Claims with a code from the Independent Laboratory Value Set are considered laboratory claims. Organizations may need to use other methods to differentiate between laboratory claims data and clinical/provider claims that may include a laboratory test. Diagnosis codes on pharmacy claims may not be used.

## 31. Member-Collected Samples and Biometric Values

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

Other member-collected biometric values (i.e., blood pressure [BP], body mass index [BMI], height and weight) may not be used for QRS reporting.

## 32. Member Reported Services

Member reported services are acceptable only if the information is collected by a primary care practitioner (refer to Appendix 1 for the definition of "PCP") or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated and maintained in the member's legal health record.

## HEDIS Coding Conventions

## 33. Coding Systems Included in HEDIS

HEDIS includes codes from the following coding systems:

- CMS Place of Service (POS).
- Current Dental Terminology (CDT).
- Current Procedural Terminology (CPT<sup>6</sup>).
- CVX—Vaccines Administered. Medicare Severity Diagnosis-Related Group (MS-DRG).
- Healthcare Common Procedure Coding System (HCPCS) Level II.

<sup>5</sup>LOINC<sup>®</sup> is a registered trademark of the Regenstrief Institute.

<sup>6</sup>Current Procedural Terminology © 2016 American Medical Association. All rights reserved.

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).<sup>7</sup>
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).<sup>7</sup>
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).<sup>7</sup>
- Observation Identifiers Names and Codes (LOINC).
- Uniform Bill (UB) revenue and Type of Bill (TOB).

### 34. Presentation of Codes in HEDIS for QRS Value Set

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Measure specifications reference value sets that must be used for HEDIS for QRS reporting. In the specifications, value set references are capitalized and underlined (e.g., Essential Hypertension Value Set). A **value set** is the complete set of codes used to identify the service or condition included in the measure. Only use the codes included in the value sets for HEDIS for QRS reporting.

Value sets used for HEDIS for QRS reporting are included in the HEDIS for QRS Value Set Directory.

### 35. Using Claims to Identify Events in Conjunction With Diagnoses

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

If a value set includes codes used on professional claims (e.g., CPT,<sup>6</sup> HCPCS) **and** includes codes used on facility claims (e.g., Uniform Bill), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service). For example, the Comprehensive Diabetes Care measure identifies members with at least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). The Acute Inpatient Value Set includes both CPT and UB Revenue codes. Therefore, use both facility and professional claims to identify the acute inpatient visit and the diabetes diagnosis.

If a value set includes codes used only on facility claims (e.g., Uniform Bill) then only use facility claims to identify services and diagnoses (the codes must be on the same claim). For example, the *Follow-Up After Hospitalization for Mental Illness* measure identifies members who had an inpatient discharge (Inpatient Stay Value Set; Nonacute Inpatient Stay Value Set) with a principal diagnosis of mental illness (Mental Illness Value Set). The Inpatient Stay Value Set and Nonacute Inpatient Stay Value Set include only codes used on facility claims (UB Revenue and UB Type of Bill). Therefore, use only facility claims to identify the discharge and the mental illness diagnosis.

### 36. Principal vs. Secondary Diagnosis

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Principal and secondary diagnoses are mentioned throughout HEDIS for QRS. Generally, a **principal diagnosis** or **primary diagnosis** is the diagnosis given at discharge and the one listed first on a claim form. A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis is the **secondary diagnosis**. A claim form can contain several secondary diagnoses. Organizations follow the measure specifications to determine whether a diagnosis must be principal or can be secondary. If the specification does not specify that the principal or primary diagnosis must be used, any applicable diagnosis is used.

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<sup>7</sup>Updates to the International Classification of Diseases diagnosis and procedure codes are released annually in October by the American Hospital Association. Because HEDIS specifications are frozen with the release of the Technical Update, there is not enough time to review the appropriateness of ICD-10 codes; therefore, they are not included in HEDIS value sets and may not be used for HEDIS reporting. This policy ensures consistency in reporting across organizations and reduces burden by minimizing updates to the technical specifications after the freeze date. The codes will be considered for the following HEDIS season.

- On a UB-04 claim form, the principal diagnosis is listed in Form Locator 67, *Principal Diagnosis Code*, and secondary diagnoses are listed in Form Locators 67A–Q, *Other Diagnosis Codes*. Do not include data in Form Locators 69, *Admitting Diagnosis Code* and 70a–c, *Patient’s Reason for Visit* in HEDIS for QRS reporting.
- On a CMS1500 claim form, the primary diagnosis is listed in Item Number 21, line 1, and secondary diagnoses are listed in Item Number 21, lines 2–4.

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### 37. CPT<sup>6</sup> Code Modifiers

**CPT modifiers** are two- or five-digit extensions that, when added to CPT codes, provide additional information about a service or procedure. Follow the guidelines below if procedure codes have modifiers (**xxxxx** denotes the five-digit CPT code).

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

Unless otherwise specified, if a CPT code specified in HEDIS for QRS appears in the organization’s database with any modifier other than those specified above, the code may be counted in the HEDIS for QRS measure.

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### 38. Uniform Bill Code Specificity

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

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

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

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### 39. Mapping Proprietary or Other Codes

For all HEDIS for QRS measures, if the specified coding systems are not used, organizations must “map” the codes they use to the codes specified in QRS HEDIS. Organizations may map proprietary codes, Level III and state-specific Level II HCPCS codes and NDC codes; it may not map standard codes or deleted codes to the codes used in the measures. When mapping codes, it is important to match the clinical specificity required for QRS HEDIS. NDC code mapping must be linked to the generic name, strength/ dose and route indicated in the HEDIS for QRS NDC lists posted on the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)).

For audit purposes, the organization documents the method used to map codes. At a minimum, documentation includes a crosswalk containing the relevant codes, descriptions and clinical information.

The organization documents the process for implementing codes. For Level III and state-specific Level II HCPCS mapping, the organization provides instructions for using state-specific codes. Auditors may request additional information.

## **40. Retiring Codes**

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NCQA annually tracks billing, diagnostic and procedure codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS for QRS measures. Obsolete codes are deleted from the HEDIS for QRS specifications one year after the look-back period is exhausted. For example, since the *Adult BMI Assessment* measure counts a BMI in the measurement year or the year prior to the measurement year, BMI codes, for this measure, have a two-year look-back period. A code that is designated obsolete effective January 1, 2015, is deleted from the specifications in HEDIS QRS 2018 after the two-year look-back period (2016, 2017) plus one additional year (2015) is exhausted.

Obsolete NDC codes are phased out of the specifications three years after the look-back period, to allow pharmacies and organizations to use their inventory and change their systems. NCQA encourages organizations to update their information systems and to ensure that complete, accurate and consistent coding is used for all encounters and claims so that HEDIS specifications can be followed. This will help the industry move toward a uniform system of performance measurement.

## **41. Table Names**

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Measure specifications contain two types of tables: one to present specification requirements and one used by organizations to submit data. Tables use a standardized naming system. Table names begin with a measure's three-character abbreviation; for example, *Comprehensive Diabetes Care* tables begin with "CDC."

**Specification tables.** Tables that are part of the specifications (i.e., medication tables) begin with the measure abbreviation and end with a hyphen (-) and a capital letter to distinguish them in the measure's specifications.

# **Guidelines for Calculations and Sampling**

## Guidelines for Calculations and Sampling

This section contains guidelines for calculating rates based on the Administrative and Hybrid Methods, as well as specifications for sampling when using the Hybrid Method. Organizations that use the Hybrid Method must follow the systematic sampling methodology described in this section or receive written authorization from NCQA for an alternative sort or sampling method; written authorization from NCQA is required annually. Proper use and implementation of these methods is assessed as part of NCQA's HEDIS Compliance Audit.

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### SUMMARY OF CHANGES TO HEDIS FOR QRS 2017

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- Deleted the *Human Papillomavirus Vaccine for Female Adolescents* measure from the membership-dependent denominators in the *Guidelines for the Hybrid Method*.
- Deleted the *Human Papillomavirus Vaccine for Female Adolescents* measure from Table 1: Sample Size Information for Hybrid Measures.
- Revised Table 1 to indicate that prior year rates may not be used to reduce the sample for the *Immunizations for Adolescents* measure.

### How to Use the Administrative Method

- Step 1** Identify the eligible population and remove all required exclusions. All required exclusions must be removed from the final eligible population.
- Step 2** Search administrative systems to identify numerator events for all members in the eligible population.
- Step 3** If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured.  
**Note:** *This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.*
- Step 4** Exclude from the eligible population, members from step 3 for whom administrative system data identified an exclusion to the service or procedure being measured.
- Step 5** Calculate the rate.

### Guidelines for the Hybrid Method

A subset of the HEDIS for QRS measures specify Hybrid Method data collection. Organizations must apply the hybrid methodology and sample at the product level.

Measures that can be collected using the Hybrid Method are listed in Table 1. Each hybrid measure can be classified into one of the following categories:

- Membership-dependent denominator. Defined by membership data only (e.g., women between 24 and 64 years of age for *Cervical Cancer Screening*), **or**
- Claims-dependent denominator. Defined by membership and claims data (e.g., members who were diagnosed with hypertension for *Controlling High Blood Pressure*).

**Drawing the sample prior to the reporting year**

Organizations are strongly encouraged to draw samples no earlier than January 2017 for the 2016 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.

Organizations must adhere to the following guidelines if samples are drawn prior to January 2017.

If the sample is drawn on or between December 1 and December 31 of the measurement year, organizations must perform the following tasks.

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
  - For example, for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday).
  - Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

**Drawing the sample between December 1–31**

If the sample is drawn on or between December 1 and December 31 of the measurement year, organizations must perform the following tasks.

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
  - For example, for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday).
  - Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

**Membership-dependent denominators**

The eligible population for the following measures are determined through membership data. Do not draw the sample prior to December 1 of the measurement year.

- *Childhood Immunization Status.*
- *Immunizations for Adolescents.*

- *Cervical Cancer Screening.*
- *Colorectal Cancer Screening.*

An organization that draws its sample on or between December 1 and December 31 of the measurement year must perform the following tasks.

Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.

On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.

For example, for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday).

Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

### **Claim-dependent denominators**

The eligible population for the following measures is determined through membership data and claims data. Organizations may draw the sample for these measures as early as December 1 of the measurement year. If an organization draws the sample on or between December 1 and December 31 of the measurement year, it must perform the tasks included in the “Membership-dependent denominators” section above (i.e., oversample as necessary and verify that members remain eligible on or after December 31 of the measurement year).

- *Adult BMI Assessment.*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.*
- *Controlling High Blood Pressure.*
- *Comprehensive Diabetes Care.*
- *Prenatal and Postpartum Care.*

### **Determining the required sample size**

Using the Hybrid Method to collect and report a measure requires a sample to be drawn from the eligible population. The organization may use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization's rate improves; for example, the organization calculates a 77 percent administrative rate for the Marketplace product line for a new measure and decides to implement the Hybrid Method.

Instead of using a sample size of 411, the organization reduces the sample size for this measure for its Marketplace product line by using the 77 percent administrative rate and Table 2. According to Table 2, the minimum required sample size is 296.



**Population definition**

In some cases, the size of the eligible population for a measure may be smaller than the required sample size. In this case, the organization must use its entire eligible population and report the data with a 95 percent confidence interval.

*Why use a 95 percent confidence interval when the entire eligible population is included?* When these data are used to make decisions, an inference is made about expected future performance on a group of potential members. The confidence interval provides an indication of the variability in the data. In either case, the user is interested in the “process of care,” which goes beyond an organization’s performance in a single year for a static product line. It is therefore appropriate to consider the organization’s entire eligible population for a measure as a sample from the universe of “all years” or “all populations.”

**Finite population correction**

Because HEDIS for QRS views organization enrollment as a sample from a larger potential population (see above), and the use of the finite population correction (FPC) decreases the power to detect differences between organizations, it is *not appropriate* to use the FPC for public reporting of QRS measures.

**Organization responsibility for chart review**

An organization that uses the Hybrid Method for a measure should attempt to pursue charts for all noncompliant members in the systematic sample, to preserve the integrity of the sample and its representative rate.

After the systematic sample is generated and chart pursuit has started, the sample may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternative sampling method, and the organization must submit a request for approval to the PCS site that includes the reason for not completing chart review, and the auditor’s approval showing that the members to be removed are distributed systematically across the larger sample and the hybrid results from the reduced sample are reportable.

**Calculating the 95 percent confidence interval**

The formula for calculating the 95 percent confidence interval around an organization’s HEDIS for QRS rate is:

$$lower = p - 1.96 \sqrt{\frac{p(1-p)}{n}} - \frac{1}{2n}$$

$$upper = p + 1.96 \sqrt{\frac{p(1-p)}{n}} + \frac{1}{2n}$$

where  $p$  = the organization’s rate and  $n$  = the sample size.

For example, suppose the organization has a sample size of 96 eligible members for its *Adult BMI Assessment* rate. Of these, 50 had a BMI documented during the measurement year or the year prior to the measurement year. The calculation would proceed as follows:

$$p = \frac{50}{96} = 52\%$$

$$lower = .52 - 1.96 \sqrt{\frac{.52(1-.52)}{96}} - \frac{1}{192} = 41.5\%$$

$$upper = .52 + 1.96 \sqrt{\frac{.52(1-.52)}{96}} + \frac{1}{192} = 62.5\%$$

Thus, the user can be 95 percent certain that the organization's true adult BMI rate is between 41.5 percent and 62.5 percent.

**Note**

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- For rates near 0 percent, the lower limit may be negative. If this occurs, replace the lower limit with 0 percent. For rates near 100 percent, the upper limit may exceed 100 percent. If this occurs, replace the upper limit with 100 percent. The IDSS automatically calculates these percentages.
- There are more complex confidence interval calculations with better properties at extreme values. This formula is provided because it performs adequately over a wide range of percentages and is simple to compute.

**Statistical assumptions for sample size**

Sample size is calculated assuming a two-tailed test of significance between two proportions ( $\alpha = .05$ , 80 percent power, two-tailed test of significance). A normal approximation to the binomial with a continuity correction was employed in the sample size calculation. The worst-case assumption of a 50 percent expected value was assumed.

The detectable difference for most measures is 10 percentage points. This was chosen because it is a big enough difference to be actionable, it is not a burden for data collection and it is not so small as to be "swamped" by nonsampling error.

**Table 1: Sample Size Information for Hybrid Measures**

2017 HEDIS for QRS Measures	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2016 Sample Size <sup>8</sup>
Adult BMI Assessment	411	Y
Cervical Cancer Screening	411	Y
Childhood Immunization Status	411	Y <sup>9</sup>
Colorectal Cancer Screening	411	Y
Comprehensive Diabetes Care	411	Y <sup>9</sup>
Controlling High Blood Pressure	411	Y
Immunizations for Adolescents	411	N <sup>10</sup>
Prenatal and Postpartum Care	411	Y <sup>11</sup>
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	Y <sup>9</sup>

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<sup>8</sup> Refer to *Table 2: Sample Sizes When Data Are Available on the Product Line Being Measured* in this section to determine the minimum required sample size.

<sup>9</sup> If reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for this measure, the lowest rate from all the indicators must be used.

<sup>10</sup> The sample for the *Immunizations for Adolescents* measure may be reduced using only the current year's administrative rate. The lowest rate from all indicators must be used.

<sup>11</sup> If reducing the sample size based on the product line-specific current measurement year's administrative rate or the prior year's reported rate, the lowest of the two rates for *Timeliness of Prenatal Care*, *Postpartum Care* must be used for the *Prenatal and Postpartum Care* measure.

Table 2: Sample Sizes When Data Are Available on the Products Being Measured

If the Current Year's Administrative Rate Is...	...the Sample Size Is:	If the Current Year's Administrative Rate Is...	...the Sample Size Is:
≤50%	411	73%	328
51%	411	74%	321
52%	410	75%	313
53%	410	76%	305
54%	409	77%	296
55%	407	78%	288
56%	405	79%	279
57%	403	80%	270
58%	401	81%	260
59%	398	82%	250
60%	395	83%	240
61%	392	84%	229
62%	388	85%	219
63%	384	86%	207
64%	380	87%	196
65%	376	88%	184
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	≥95%	100

**Note:** Truncate the decimal portion of the rate to obtain a whole number.

## Systematic Sampling Methodology

NCQA implemented a systematic sampling scheme for the Hybrid Method. Proper utilization and implementation of this method ensures ongoing integrity of HEDIS for QRS data and supports increasing requests for audited data. Complete the following steps for each hybrid measure.

**Step 1** Determine the eligible member (EM) population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable).

**Step 2** Determine the minimum required sample size (MRSS) from Table 1 or Table 2. This number becomes the denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to *Determining the required sample size* for instructions.) If the EM is ≤MRSS, proceed to step 4.

**Note:** The MRSS may only be the appropriate value from Table 1 or Table 2.

To use a larger MRSS, an organization must provide written rationale to NCQA through the PCS system (<http://my.ncqa.org>).

**Step 3** Determine the final sample size (FSS). The FSS includes the MRSS (from step 2) plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the MRSS is met; keep substitution criteria in mind.

Written approval from NCQA must be obtained to use an oversampling rate larger than 20 percent. Refer to *Oversample requests to NCQA* for details.

The FSS is calculated by the following formula:  $FSS = MRSS + (MRSS \times \text{oversampling rate})$  (round up to the next whole number), where MRSS = the minimum required sample size (step 2).

For example, if the MRSS is 411 and a 10 percent oversample is needed,  
 $FSS = 411 + (411 \times 0.10) = 453$ .

**Step 4** If  $EM > FSS$ , go to step 5. If  $EM \leq MRSS$ , all eligible members are included in the sample. If  $MRSS < EM \leq FSS$ , proceed to step 8.

**Step 5** Sort the list of EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable).

Sort EMs from A to Z in even measurement years and from Z to A in odd measurement years. For example, for 2017 HEDIS for QRS (2016 measurement year), sort the list of EMs from A to Z. For 2018 HEDIS for QRS (2017 measurement year), sort the list from Z to A.

**Note:** Sort order applies to all components. For 2017 HEDIS for QRS, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).

**Step 6** Calculate  $N = EM/FSS$ . Round down to a whole number.

Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation:  $N = EM/FSS$ , where EM = the eligible member population (step 1) and FSS = the final sample size (step 3).

**Step 7** Calculate  $START = (RAND \times N)$ . Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.

In October 2016, NCQA will release a Random Number (RAND) table that lists a value between 0 and 1 for each measure where the Hybrid Method is applicable. Refer to this table to determine the RAND to be used when determining START. The RAND for each measure is used to calculate the starting point from which to draw the final sample.

Calculate the number from which to start drawing the final sample as follows:  $START = (RAND \times N)$  (round per the .5 rule to the nearest whole number greater than 0), where RAND = the random number for each respective measure identified from the HEDIS for QRS *Technical Update*, released in October 2016.

**Step 8** Select the sample, choosing every  $i^{th}$  member using the formula:  $i^{th} \text{ member} = START + [(i-1) \times (EM/FSS)]$

(round  $[(i-1) \times (EM/FSS)]$  per the .5 rule to the nearest whole number greater than 0).

For  $i = 2, 3, 4, \dots, FSS$  where EM = the eligible member population (step 1). FSS = the final sample size (step 3).

Starting with the member corresponding to the number START, choose every  $i^{th}$  member until the MRSS is met. This becomes the primary list of sampled members.

Continue choosing every  $i^{th}$  member until the FSS is met. This set of members becomes the auxiliary list of sampled members (i.e., the oversample).

Stop when the FSS is achieved or use all members in the primary and auxiliary list.

**Note:** From step 4, if  $MRSS < EM \leq FSS$ , sort the EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). Choose the first MRSS EMs as the primary sample and the remaining EMs as the auxiliary sample.

If the oversample was calculated correctly, the majority of members in the auxiliary list are ultimately used to replace exclusions. All exclusions must be documented because they may be subject to audit.

**Oversample requests to NCQA**

Any oversampling rate larger than 20 percent must be approved by NCQA annually. Organizations submit a formal request with the rationale to NCQA through the PCS system at <http://my.ncqa.org>.

NCQA provides written notification of approval or disapproval within seven business days. The organization must maintain the documentation for the HEDIS Compliance Audit.

**Oversampling methodology**

For hybrid measures, the starting sample size must be higher than the designated sample size because medical records must be substituted if a member is ineligible for the measure; for example, if a member was incorrectly identified as a diabetic through administrative data or meets exclusion criteria for the measure.

To adjust for this, divide the sample size by the percentage of charts expected to be inappropriate for review. Suppose 10 percent of charts are expected to be inappropriate for the measure.

FSS (rounded *up* to the next whole number) =  $411 + (411 \times 0.10) = 452.1$  (rounded *up* to 453).

The recommended methodology for substitution is:

- Replace the member's chart with that of the first member in the auxiliary list.
- Continue replacing each ineligible member with the next consecutive member of the auxiliary list.

If the initial oversample was underestimated and all auxiliary members have been exhausted without satisfying the MRSS, the organization must contact NCQA through the Policy Clarification Support (PCS) system to determine next steps. The PCS system can be accessed on the NCQA Web site at <http://my.ncqa.org>.

Some organizations may calculate rates on their sample and oversample combined. They will have no substitutions because the oversample is included in the denominator. An organization that uses this type of reporting must include the entire oversample, regardless of its numerator compliance.

Organizations that report measures using the oversample and the sample must do so consistently across all measures.

**Note:** Many factors must be considered when determining the initial sample size and oversampling percentage—such as previous years' data, frequency of exclusions and claims lag.

**Example 1**

The eligible population for the Marketplace product line for *Adult BMI Assessment* is 9,000. Reduce the minimum required sample size using the current year's administrative Marketplace rate, which was 77 percent. Based on experience, estimate a 5 percent oversample rate. Follow the systematic sampling scheme.

**Step 1** EM = 9,000.

**Step 2** From Table 2, the MRSS is 296.

**Step 3** FSS =  $296 + (296 \times .05) = 310.8$  (the next whole number *above* is 311, so FSS = 311).

**Step 4** Because  $9,000 > 311$ , go to step 5.

**Step 5** Sort the list alphabetically and in this order: last name, first name, date of birth.

**Step 6**  $N = 9,000/311 = 28$ .

**Step 7** For this example, assume that  $RAND = 0.66$ , so  $START = 0.66 \times 28 = 18.48$ .

Rounding using the .5 rule,  $START = 18$ . The 18th sorted member is chosen *first*.

The 2nd member chosen is the  $18 + [(2-1) \times (9,000/311)] = 18 + 29 = 47$ th sorted member, after rounding the term  $[(2-1) \times (9,000/311)]$  to 29, using the .5 rule.

The 3rd member chosen is the  $18 + [(3-1) \times (9,000/311)] = 18 + 58 = 76$ th sorted member.

The 296th member (the last one in the primary list) is the  $18 + [(296-1) \times (9,000/311)] = 18 + 8,537 = 8,555$ th sorted member.

The last member in the auxiliary sample is the  $18 + [(311-1) \times (9,000/311)] = 18 + 8,971 = 8,989$ th sorted member.

### Example 2

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The eligible member population for *Colorectal Cancer Screening* is 389. This measure was not collected last year, nor will the administrative rate from this year be used to reduce the sample size. Follow the systematic sampling scheme.

**Step 1**  $EM = 389$ .

**Step 2** From Table 1, the MRSS is 411. Since  $389 < 411$ , skip to step 4.

**Step 3** Skip this step.

**Step 4** Include all 389 members in your primary list.

### Example 3

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The eligible member population for *Childhood Immunization Status* is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10 percent of the members from the primary sample will have to be excluded. Follow the systematic sampling scheme.

**Step 1**  $EM = 436$ .

**Step 2** From Table 1, the MRSS is 411.

**Step 3**  $FSS = 411 + (411 \times .10) = 452.1$  (the next whole number *above* is 453, so  $FSS = 453$ ).

**Step 4** Because  $411 < 436$ , skip to step 6.

**Step 5** Skip this step.

**Step 7** Sort the list and choose the first 411 as the primary list. The remaining 25 members become the auxiliary list.

## Complex Probability Sampling

### Organization responsibility

Properly applied, other techniques (e.g., stratified sampling, cluster sampling and other complex probability approaches) can improve precision and increase sampling efficiency. To use a probability sampling approach different from the one specified, submit a written rationale and documentation of the approach to NCQA through the PCS system (<http://my.ncqa.org>). The organization must demonstrate that the sampling approach is auditable and does not introduce bias against specific members. A committee of statisticians and health policy experts staffed by NCQA reviews the approach. Written notification of NCQA approval or disapproval is provided within 10 business days.

If complex sampling methods are used, report the estimated rate, in addition to any information required to perform a valid test of significance between that rate and another organization's rate.

Report the sample size (if different from the HEDIS for QRS recommendation) and document the method used in the calculation (including software used, if applicable). Consult a statistician before implementing a complex sampling methodology.

## **Substituting Medical Records**

### **Acceptable circumstances for substitution:**

#### **1. Errors in sampling data**

Organizations must specify the number of substituted records. Members who are noncompliant because they refused the service or because the organization cannot access their chart may not be substituted. Unless otherwise noted in the specifications for a particular measure, members or events may not be dropped from the sample or substituted, except under the three circumstances described below.

Chart review reveals that a member or event does not meet the eligibility criteria for inclusion in the sample. Data errors can be caused by incorrect member or clinical information. Examples of valid data errors:

- A member selected for the *Childhood Immunization Status* sample is found to be 22 years old.
- A member in the *Comprehensive Diabetes Care* sample has a diagnosis in the chart showing that a prescription for oral hypoglycemics was not related to diabetes.
- A member in the sample for any measure has a notation entered by the deadline established for the measure, explaining the reason for the erroneous inclusion and stating the member does not have the condition.

The medical record must have evidence that a member does not meet the criteria for the measure. A chart that does not contain a notation that substantiates or refutes the diagnosis is not evidence that the member does not have the condition being measured.

#### **2. Optional exclusion to treatment being measured**

A member has a valid, optional exclusion to the treatment being measured. For example, a diagnosis of colorectal cancer or total colectomy is a valid, optional exclusion in the denominator for the *Colorectal Cancer Screening* measure.

Valid, optional exclusions are included in the measure specifications. If members meet optional exclusion criteria, exclude only members for whom administrative data or medical record data do not show that the service or procedure was rendered within the appropriate period specified. The organization must verify that the exclusion occurred by the deadline established for the measure.

All exclusions must be available for auditor review.

#### **3. Employee/dependent was selected for the sample**

An employee of the organization or the vendor, or the employee's dependent, was selected for the sample, and the medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*.

### Hybrid Method: Three Approaches

There are three approaches to conducting the Hybrid Method; they differ only in the timing for identifying individuals in the denominator who have a valid, optional exclusion. The first two approaches allow organizations to first select the sample and then search for valid, optional exclusions. The third allows organizations to search for valid, optional exclusions on the entire eligible population prior to selecting the sample. Organizations may use any of the three approaches.

**Approach 1** Remove members that meet the optional exclusion criteria after the sample is drawn by searching the administrative systems prior to beginning medical record review. Substitute excluded members with members from the oversample population.

**Approach 2** Remove members that meet the optional exclusion criteria during or after the medical record review. Substitute excluded members with members from the oversample population.

**Approach 3** Remove members that meet the optional exclusion criteria from the eligible population by searching administrative systems prior to selecting the sample.

### References

Deming, W.E. On the interpretation of censuses as samples. 1941. *Journal of the American Statistical Association*. 36: 45–9.

Fleiss, L. *Statistical Methods for Rates and Proportions*. 2nd Ed. (New York: John Wiley & Sons, Inc.): 38–42.



# **Guidelines for HEDIS Effectiveness of Care Measures**

## Guidelines for HEDIS Effectiveness of Care Measures

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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These guidelines apply to the following measures:

- *Adult BMI Assessment (ABA).*
- *Annual Monitoring for Patients on Persistent Medications (MPM).*
- *Antidepressant Medication Management (AMM).*
- *Appropriate Testing for Children With Pharyngitis (CWP).*
- *Appropriate Treatment for Children With Upper Respiratory Infection (URI).*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB).*
- *Breast Cancer Screening (BCS).*
- *Cervical Cancer Screening (CCS).*
- *Childhood Immunization Status (CIS).*
- *Chlamydia Screening in Women (CHL).*
- *Colorectal Cancer Screening (COL).*
- *Comprehensive Diabetes Care (CDC).*
- *Controlling High Blood Pressure (CBP).*
- *Follow-Up After Hospitalization for Mental Illness (FUH).*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD).*
- *Immunizations for Adolescents (IMA).*
- *Medication Management for People With Asthma (MMA).*
- *Use of Imaging Studies for Low Back Pain (LBP).*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).*
- *Well-Child Visits in the First 15 Months of Life (W15).*
- *Well-Child Visit in the Third, Fourth, Fifth and Sixth Years of Life (W34).*

### Description

**Which services count?**

Unless otherwise specified in a particular measure, report all services for the Effectiveness of Care measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center; or services for which payment was denied because they were not properly authorized. The organization must include all paid, suspended, pending and denied claims, and is ultimately responsible for the quality of care it provides to members.

Organizations can choose whether to include reversed claims when reporting services. If an organization includes reversals, it must include these claims in all measures and avoid double counting services (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim).

**Note:** Denied claims are not included when identifying numerator events for the following measures:

- *Appropriate Treatment for Children With Upper Respiratory Infection.*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis.*
- *Use of Imaging Studies for Low Back Pain.*

**Optional exclusions**

Some measures in the Effectiveness of Care domain allow the organization to exclude members from the denominator who are identified as having a certain procedure or comorbidity (e.g., exclude women who have had a bilateral mastectomy from the *Breast Cancer Screening* measure).

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

The organization verifies that the exclusion occurred by the time specified in the measure. For hybrid measures, members from the oversample are used to replace members who met the exclusion criteria and were excluded from the sample. Refer to the *Guidelines for Calculations and Sampling* for more information on how to identify exclusions and substitute medical records.

**Measure format**

There are 10 possible sections in each measure specification in this domain:

1. Summary of Changes.
2. Description
3. Calculation
4. Definitions.
5. Eligible Population.
6. Administrative Specification.
7. Hybrid Specification.
8. Exclusion (optional).
9. Notes.
10. Data Elements for Reporting.

**Eligible population criteria**

**Eligible population** includes all members who meet the following seven criteria:

1. **Product line** Marketplace applicable to the measure.
2. **Age** group and gender requirements.
3. **Continuous enrollment** criteria for the measure.
4. **Allowable gap** in benefits during the continuous enrollment period. There are different allowable gap criteria for the Medicaid product line.
5. **Anchor date** specifies the required enrollment date for the eligible population (e.g., children must be enrolled in the organization on their second birthday for inclusion in the *Childhood Immunization Status* measure).
6. **Benefit** a member must have during the continuous enrollment period to be included in the eligible population (e.g., members must have both medical and pharmacy benefits for inclusion in the *Antidepressant Medication Management* measure).
7. **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population.

**Administrative  
Specification**

The **Administrative Specification** outlines the collection and calculation of a measure using only administrative data, and describes the eligible population, the numerator requirements and any optional exclusion allowed for the measure.

**Hybrid  
Specification**

The **Hybrid Specification** includes sampling requirements for the denominator population, medical record documentation requirements for the numerator and any optional exclusion allowed for the measure.

# **Guidelines for HEDIS Access/Availability of Care Measures**

## Guidelines for HEDIS Access/Availability of Care Measures

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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These guidelines apply to the following measures:

- *Annual Dental Visit (ADV).*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET).*
- *Prenatal and Postpartum Care (PPC).*

### Continuous Enrollment

For some Access/Availability of Care measures, the eligible population includes individuals who were continuously enrolled for a specific period (e.g., during the measurement year). For these measures, follow the guidelines on continuous enrollment described in the *General Guidelines*.

### Which Services Count

Report all services for Access/Availability of Care measures, whether or not the organization paid for them (e.g., report services paid for by a third party such as a community center, or services for which payment was denied because they were not properly authorized). Include all paid, suspended, pending and denied claims. Organizations are ultimately responsible for the quality of care they provide to members and for ensuring that certain services have been provided, even if another community practitioner provides the services.

To count services in the medical record, documentation in the medical record must indicate the date when the procedure was performed and the result or finding (when applicable).

### Hybrid Methodology

Organizations that use the Hybrid Method for measures that include a hybrid specification must follow the guidelines pertaining to that method and substitution of medical records in the *Guidelines for Calculations and Sampling*.

# **Guidelines for HEDIS Relative Resource Use Measure**

## Guidelines for HEDIS Relative Resource Use Measure

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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These guidelines apply to the following measure:

- *Relative Resource Use for People With Diabetes (RDI)*—Inpatient Facility Index.

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### SUMMARY OF CHANGES TO HEDIS QRS 2017

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- Added HIV Type 2 Value Set to the required exclusions.
- Clarified when denied claims are used to categorize services in step 7 of *Calculating Total Standard Cost and Frequency: Inpatient Facility*.

### Description

#### Relative Resource Use measures

Relative Resource Use (RRU) measures are a standardized way to measure relative resource use. When evaluated with the corresponding quality of care measures, they provide more information about the efficiency or value of an organization's services. RRU measures have the following features:

- They focus on high-cost conditions that have corresponding HEDIS for QRS Effectiveness of Care measures.
- They differentiate between unit price and utilization variation.
- They rely on a transparent risk-adjustment method similar to a proprietary risk-adjustment system.

### Definitions

#### *Inpatient Facility Index*

Organizations must collect and report to NCQA the data necessary to calculate the Diabetes Inpatient Facility Index. The index represents the percent above or below an organization's inpatient use is compared to the average observed/expected ratios for all organizations.

#### *Age and gender*

Stratify members by age and gender. When calculating HCC-RRU risk categories, total cost, service frequency and member months, use the age on the last day of the treatment period to identify the appropriate grouping.

#### *Required exclusions*

Exclude members with the following dominant medical conditions from RDI measures:

- Active cancer.
- HIV/AIDS.
- Organ transplant (other than kidney).

Refer to the *Exclusions (required)* section in the *Guidelines for Relative Resource Use Measures* for more details.

#### *Treatment period*

The period for counting service cost and frequency. The treatment period is the measurement year for all measures.



**Standard price**

The unit price per service that represents standardized, allowed payment levels for provider services, including payer liability and member cost sharing. Unit prices represent data derived from a single source, using a single approach for classifying and pricing services. Pricing algorithms represent average service pricing levels for organizations for the most recent period.

RRU measures use NCQA's standardized prices. The organization does not report prices based on its contracts and fee schedules; it applies a standard price to each service, multiplies it by the number of units of service and reports the resulting standard cost. Consistent standard prices protect the organization's proprietary fee schedules and contracts and support measure comparison across organizations without requiring adjustment for levels of service payment.

Download the SPT for each service category, the Major Surgery Table, the LOS Group Table and the Cost Cap table from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)).

- SPT-INP-ADSC.
- Maj-Surg Table.
- SPT-CAP Amount.
- LOS Group.

The SPTs contain the service codes used for the total standard cost estimation and their respective standard unit price. Not all pharmacy or CPT<sup>®</sup> codes are included in these tables; codes included represent a significant portion of expected utilization for the eligible populations.

**Standard cost**

The standard price multiplied by the quantity of the service. A member's services are aggregated by service categories, and then standard costs are aggregated across services and members to compute the overall cost of care.

Standard cost is reported for the following category:

- Inpatient Facility.

**Service frequency**

Service frequency is reported for the following categories:

- Acute Medicine: Discharges, Days.
- Acute Surgery: Discharges, Days.
- Nonacute Inpatient: Discharges, Days.

NCQA calculates:

- Total Inpatient Facility: Discharges, Days, ALOS.
- Total Acute Inpatient: Discharges, Days, ALOS:
- Total Acute Medicine: ALOS.
- Total Acute Surgery: ALOS.
- Total Nonacute Inpatient: ALOS.

**Note:** NCQA's SPTs will be posted to the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)) by November 1, 2016.

**Inpatient facility standard price**

Standard prices for inpatient facility services are assigned to each stay and based on the standard per diem price. Standard prices include room, board and ancillary services. Organizations use the length of stay and diagnosis codes to assign the appropriate standard price. Refer to *Calculating Total Standard Cost and Frequency: Inpatient Facility*.

### ***Risk adjustment***

Observed amounts represent the organization's services and costs for the eligible population during the treatment period.

NCQA calculates expected amounts based on national norms (i.e., based on data submitted to NCQA) after risk adjustment for the organization's mix of conditions and members.

A method that adjusts each measure's results based on hierarchical condition categories (HCC) risk adjustment approach. This approach combines diagnosis codes into a reduced code set of condition risk categories. Then, where relevant, condition risk categories and category combinations are mapped to disease groups called Hierarchical Condition Categories (HCC).

The approach further groups patients based on age, gender and condition to determine each patient's risk weight. Risk weight scores are then assigned to one of 13 risk groups.

Download the risk adjustment tables from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)).

- Table CC—Comorbid.
- Table HCC—Rank.
- Table RRU—Weight.

### ***Risk-adjusted (expected) peer amount***

For each risk group, NCQA compares the organization's results with a risk-adjusted peer amount. Peer amounts represent what is expected from an organization that has the same mix of members as other organizations with similar ages and genders.

## Overview

RRU measures report the organization's total resource use, including cost and service frequency for each eligible member, during each measure's treatment period. For RRU measures, the treatment period is the

12-month measurement year and resource use is calculated for all services, whether or not they relate to the chronic condition.

## Measurement and Calculation Process

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- Step 1** Identify members for the major clinical condition and determine the age and gender category for each member. The medical services for these members are identified for the treatment period.
- Step 2** Calculate total standard costs for the Inpatient Facility category using NCQA-provided SPTs. Refer to the SPTs posted on the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)) for standard prices.
- Step 3** Report service frequency and standard costs for the eligible population by member cohort.
- Step 4** NCQA uses the stratified data submitted by all organizations to calculate each organization's expected RRU amounts.

## Guidelines

1. **Reporting the RRU measures.** Organizations *must* report the related quality EOC measure when reporting RRU measures, specifically: RDI and CDC.

Additional information on quality indicator requirements for RRU reporting is available in the How NCQA Calculates a Quality Index for RRU document available at [www.ncqa.org/rru](http://www.ncqa.org/rru).

2. **Reporting members who switch products and product lines.** Assign members to the product and product line in which they are enrolled on the last day of the treatment period, as specified in each measure's eligible population criteria.
3. **Categorizing members by services.** To identify the eligible population and further categorize services (e.g., if an eligible member had major surgery during an inpatient stay), include all services, whether or not the organization paid for them or expects to pay for them (i.e., include denied claims).

**Counting services.** For cost and frequency reporting, report all services the organization paid for or expects to pay for (i.e., claims incurred but not paid yet). *Do not include* any denied service or day. If a member is enrolled retroactively, count all services for which the organization paid or expects to pay. The organization may have:

- Covered the full amount.
- Paid only a portion of the amount (e.g., 80 percent).
- Paid nothing because the member covered the entire amount to meet a deductible.
- Paid nothing because the service was covered as part of a PMPM payment.
- Denied the service.

Count the service if:

- The organization paid the full amount **or** a portion of the amount (e.g., 80 percent).
- The member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The service was covered under a PMPM payment.

Do not count the service if:

- The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The claim for the service was rejected because it was missing information or was invalid for another reason.

4. **Calculating member months.** Count all eligible members with the relevant benefit during the treatment period. Using the following steps, calculate member months after all optional and required exclusions are applied.

**Step 1** For chronic condition measures, determine member months using a prespecified day (e.g., the 15th or the last day of the month), which is determined by the organization's administrative processes. The day selected must be consistent from month to month and year to year. For example, if the organization tallies membership on the 15th of the month and Ms. X is enrolled in the organization on January 15, Ms. X contributes one member month in January.

*Retroactive enrollment.* Organizations may count any month in which members were enrolled retrospectively and the organization received a retroactive capitation payment.

**Step 2** Use the member's age on the last day of the treatment period to determine the age group where member months are counted. For example, for *Relative Resource Use for People With Diabetes*, if Ms. X turns 18 on December 31 and is enrolled for the entire treatment period, she contributes 12 member months to the 18–44 age category.

**Step 3** Attribute all member months to the product line in which the member is enrolled on the last day of the treatment period.

**5. Reporting inpatient services.**

*Services for pricing and frequency.* Identify inpatient stays that occurred during the treatment period, even if the inpatient admission was prior to the treatment period or the inpatient discharge was after the end of the treatment period. Refer to the inpatient stay cost calculation instructions.

When reporting frequency of inpatient services, include all priced stays in the frequency counts.

**6. Mapping proprietary or other codes.** Organizations and providers that use proprietary codes, Level II or state-specific Level III HCPCS codes must map them to industry standard codes. Organizations cannot count codes that are not included in the NCQA SPTs.

**7. Counting multiple billings for the same date of service.**

*Services for pricing:* Count *all* services billed for inpatient facility pricing.

*Services for frequency:* For inpatient discharges, count discharges, not the frequency of procedure codes billed. For example, if a surgeon submits a bill for professional charges for one inpatient stay, and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, count only one inpatient discharge.

**8. Counting transfers.** Follow the *Guidelines for Risk Adjusted Utilization Measures*.

**Mental health and chemical dependency transfers.** Follow the *Guidelines for Risk Adjusted Utilization Measures*.

**9. Calculating inpatient services length of stay.** Use the formula below to report length of stay (LOS).

*LOS.* All paid days from admission up to discharge. Do not count the last day of the stay unless the admission and discharge date are the same. For inpatient stays that start before the treatment period and end during the treatment period, or that start during the treatment period and end after the treatment period, count all paid days during the inpatient stay, even if they occur outside of the treatment period.

$$\text{LOS} = \text{discharge date} - \text{admit date} - \text{denied days}$$

**Note:** When an inpatient revenue code (i.e., UB Revenue code or equivalent) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, the discharge date minus admission date equals 1 day, not 0 days.

*LOS per diem multiplier.* If the inpatient stay falls completely within the treatment period, use the total number of paid days as the per diem multiplier. If the inpatient stay does not fall completely inside the treatment period, or the organization did not pay for all days or expect to pay for all days, count only the days within the treatment period (including the last day in the treatment period) that the organization paid for or expected to pay for, to compute the per diem multiplier.

## RRU Risk Adjustment

For the resource use measures, the following steps assign each member to a risk group. The steps are implemented after the eligible population is identified, Tables used to classify the eligible population by risk adjustment approach will be released with the SPTs on November 1, 2016.

### Step 1 Identify the qualified service diagnosis.

Use the following value sets and identify all diagnoses for encounters during the treatment period based on the date of service for outpatient or ED services or on the discharge date for inpatient stays.

- Outpatient (Outpatient Value Set).
- Observation (Observation Value Set).
- Acute inpatient (Acute Inpatient Value Set).
- Nonacute inpatient (Nonacute Inpatient Value Set).
- ED (ED Value Set).
- Surgery and procedure services. Services with a CPT<sup>6</sup> Procedure code in Table HCC—Surg.

Use all diagnosis codes for all services that meet the criteria listed above to complete the steps below.

### Step 2 Assign each diagnosis code to one CC category (CC) using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to step 6.

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

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

For a member's CC list, match the CC code to the CC code in the table, and assign:

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

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

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

### Step 4 Select only the highest-ranked HCC in each ranking group using the *Rank* column (1 is the highest possible rank).

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

**Note:** Refer to the *Utilization Risk Adjustment Determination* section in the *Guidelines for Risk Adjusted Utilization Measures for a Comorbid CC calculation example*.

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

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

Compare each member's list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.

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

If there are overlapping combinations use both sets of combinations.

Based on the combinations, a member can have none, one or more of these added HCCs.

**Note:** Refer to the *Utilization Risk Adjustment Determination* section in the *Guidelines for Risk Adjusted Utilization Measures for a Comorbid CC calculation example*.

**Step 6** Identify demographic HCCs for RRU.

Categorize members by age and gender using the age ranges described in Table RRU—Age/Gender—HCC. Assign a demographic HCC based on gender and the member's age on the last day of the treatment period.

At the end of step 6, each member will have a final list of HCCs that includes at least one demographic HCC and none, one or more HCCs based on steps 1–5.

**Step 7** Calculate the weight for all the HCCs on each member's list using Table RRU—Weight. Each HCC for RRU carries a predefined risk weight.

**Step 8** Sum each member's risk weights based on the final list of HCCs. A member's risk score is the sum of the risk weights for all HCCs on that member's list. Sum the weights based on the member's HCC lists. Round the final risk score to four decimal places.

**Step 9** Use the table below to assign the member to a risk group based on risk score.

For example, a member with a total HCC risk score of 1.2300 is assigned to Risk Group 5. Report all member months and cost information for this member in this risk group, within the appropriate age and gender stratifications.

Risk Group	Lower Score	Upper Score	Risk Group	Lower Score	Upper Score
1	0.0000	0.2499	8	2.0000	2.4999
2	0.2500	0.4999	9	2.5000	2.9999
3	0.5000	0.7499	10	3.0000	3.9999
4	0.7500	0.9999	11	4.0000	4.9999
5	1.0000	1.2499	12	5.0000	5.9999
6	1.2500	1.4999	13	6.0000	6.9999 over
7	1.5000	1.9999			

**Exclusions (required)**

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Exclude members with one or more of the following dominant conditions during the measurement year.

- Active cancer. Members who had any diagnosis of cancer (Malignant Neoplasms Value Set; Other Neoplasms Value Set) with treatment (Cancer Treatment Value Set) during the measurement year.
- Organ transplant (other than kidney). Organ transplant (other than kidney) (Organ Transplant Other Than Kidney Value Set) during the measurement year.
- HIV/AIDS. Members who met any of the following criteria during the measurement year:
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with an HIV diagnosis (HIV Disease Value Set; HIV Type 2 Value Set). Visit types need not be the same for the two visits.
  - At least one acute inpatient encounter (Acute Inpatient Value Set) with an HIV diagnosis (HIV Disease Value Set; HIV Type 2 Value Set).
  - At least one ED visit (ED Value Set) with an HIV diagnosis (HIV Disease Value Set; HIV Type 2 Value Set).

**Steps for Calculating Service Categories**

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**Calculating Service Frequency**

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**Step 1** Identify eligible members for each major clinical condition and assign them a risk group.

**Step 2** Identify all inpatient services rendered during the treatment period.

**Step 3** Match the services to the codes provided in the specifications then group them into the following utilization categories:

- Acute Medicine: Discharges, Days.
- Acute Surgery: Discharges, Days.
- Nonacute: Discharges, Days.

**Step 4** Count the unique services rendered during the treatment period in each utilization category, for each risk group. Refer to *Guideline 7—Counting multiple billings for the same date of service*.

**Step 5** Aggregate and report service frequencies by age, gender and risk group.

**Calculating Standard Cost**

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Apply the SPTs using the following steps. Refer to the measure specification for additional instructions.

**Step 1** Identify eligible members and assign them a risk group.

**Step 2** Identify all services rendered during the treatment period for the following category:

- Inpatient Facility (services provided by a facility during an inpatient stay).

**Step 3** Multiply the standard price by the units of service to compute a standard cost for the service.

**Step 4** Sum each member's total standard cost for the Inpatient Facility service category.

**Step 5** Report the total standard cost by age, gender and risk group.

**Step 6** If a member's standard cost exceeds the cap amount, report the total standard cost, including only the cap amount from Table SPT-CAP. Do not exclude members who exceed the cap.

More specific steps required for the Inpatient Facility category are described below.

### **Calculating Total Standard Cost and Frequency: Inpatient Facility**

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**Step 1** Identify all inpatient stays that occurred during the treatment period. Include stays that started before the treatment period or ended after the close of the treatment period. Create a unique record describing the member's inpatient stay.

**Step 2** Determine the LOS for frequency reporting. Compute the LOS in days, using paid for or expected-to-be-paid-for days only. Include all paid days in the calculation, whether or not they fall inside the treatment period. Use this LOS when reporting the frequency counts for each inpatient stay.

**Step 3** Determine the LOS category for standard cost reporting. Assign the appropriate LOS group using Table C.

**Table C: Length of Stay Group**

LOS (Days)	LOS GRP
1	A
2	B
3–4	C
5–6	D
7–8	E
9–15	F
≥16	G

**Step 4** Determine the LOS per diem multiplier. If the inpatient stay falls within the treatment period, use the total days the organization paid for or expects to pay for as the per diem multiplier. If the inpatient stay does not fall inside the treatment period, or if the organization did not pay for all days or does not expect to pay for all days, count *only* the days within the treatment period (including the last day of the treatment period) that are paid for or expected to be paid for, as the per diem multiplier.

**Step 5** Determine if the inpatient stay is acute or nonacute. Nonacute stays include nursing home, skilled nursing facility, rehabilitation, hospice, hospital transitional care, swing bed and respite; all other inpatient stays are acute.

Report acute and nonacute stays separately when reporting frequency of inpatient stays.

**Note:** SPT-INP tables assign the acute field a value of "1" if the discharge was from an acute inpatient stay and a value of "0" if the discharge is from a nonacute stay.

**Step 6** Assign an *Aggregate Diagnostic Service Category (ADSC)* for the inpatient stay using the principal discharge diagnosis. To assign ADSC, download the ADSC Table from the NCQA Web site ([www.ncqa.org](http://www.ncqa.org)) and match the principal diagnosis code from the discharge claim to an ADSC. If the principal diagnosis code is invalid or missing, or cannot be determined, map the inpatient stay to the ADSC Table's *MISA* category.

**Step 7** Determine if the member underwent major surgery during the inpatient stay. Identify major surgeries by using the list of codes from the Maj-Surg Table. Flag members if one procedure code, paid or denied, in the Maj-Surg Table is present from any provider during the stay.

If the inpatient stay is acute and has a major surgery, include it in the *Acute Surgery* category for frequency reporting. If the stay is acute but does not have a major surgery, include it in the *Acute*



Medicine category. Nonacute stays are not categorized as surgical or nonsurgical for frequency reporting.

**Note:** SPT-INP-ADSC assigns the field MAJSURG a value of “1” to indicate the standard price when a major surgery is identified and a value of “0” if no major surgery is identified during the member’s inpatient stay.

**Step 8** Match each ADSC, LOS group, major surgery flag and acute or nonacute assignment for the stay to the NCQA-provided SPT to obtain the assigned standard price. Multiply the per diem multiplier by the per diem standard price to compute the total standard cost for the stay.

For frequency reporting, report the stay in the appropriate category based on the acute or nonacute assignment and surgery or medicine assignment.

**Example:** A member with an inpatient stay that started on December 25 of the measurement year and ended on January 4 of the year after the measurement year, has a primary discharge diagnosis from the ADSC category Cardiovascular—A and these characteristics:

- LOS of 10 paid days (LOS GRP = F).
- Acute inpatient stay.
- No major surgery event during the stay.
- Per diem multiplier of 7 days (December 25–31).

Use the per diem multiplier with the original LOS GRP derived. Using *Sample Table: SPT-INP-ADSC*, the member’s total inpatient standard cost is  $7 \times \$1,825 = \$12,775$  and is counted in the Acute Medicine Inpatient category for frequency reporting.

**Example:** A member with an inpatient stay that started on June 15 and ended on June 19 of the measurement year, has a primary discharge diagnosis from the ADSC category Cardiovascular—A with these characteristics:

- LOS of 4 paid days (LOS GRP = E).
- Acute inpatient stay.
- Major surgery event during the stay.
- Per diem multiplier of 4 days.

Using *Sample Table: SPT-INP-ADSC*, the member’s total inpatient standard cost of  $4 \times \$4,000 = \$16,000$  and is counted in the Acute Surgery Inpatient category for frequency counting.

**Sample Table: SPT-INP-ADSC—Inpatient Facility Services**

ADSC	MAJSURG	ACUTE	LOS GRP	Per Diem Std Unit Price (\$)
Cardiovascular—A	0	1	A	6,400.00
Cardiovascular—A	0	1	B	3,400.00
Cardiovascular—A	0	1	C	3,100.00
Cardiovascular—A	0	1	D	2,950.00
Cardiovascular—A	0	1	E	1,850.00
Cardiovascular—A	0	1	F	1,825.00
Cardiovascular—A	0	1	G	1,775.00
Cardiovascular—A	1	1	A	7,700.00
Cardiovascular—A	1	1	B	5,500.00
Cardiovascular—A	1	1	C	4,900.00
Cardiovascular—A	1	1	D	4,450.00
Cardiovascular—A	1	1	E	4,000.00
Cardiovascular—A	1	1	F	3,700.00
Cardiovascular—A	1	1	G	3,400.00

**Note:** Standard prices are examples only and may not be the prices assigned to Cardiovascular—A.

## Relative Resource Use Results

Using the data submitted by all organizations, NCQA estimates the observed and expected RRU amounts for each clinical condition for each organization. Results can be assessed at an overall basis, across all members and major clinical conditions, by service category or for a member cohort within a condition.

NCQA uses the following approach and formulas to compute the expected standard cost and utilization frequency metrics for each submission.

- C** Organization standard costs.
- i** Indexes eligible members.
- s** Indexes service categories.
- m** Indexes member cohorts.
- o** Indexes reporting organizations.

Standard costs are reported by service category across all eligible members in a member cohort. Member cohorts are defined by HCC-RRU risk group, age and gender grouping. Following the assignment of standard price to services provided to eligible members, the organization sums standard costs across eligible members for each member cohort to compute total costs for a service category (for Organization O):  $C_{s,m,o} = \sum_i C_{i,s,m,o}$

In addition to standard costs, organizations report total member months (Totmm):  $Totmm_{m,o} = \sum_i Totmm_{i,m,o}$

NCQA collects this information for all organizations. Data are pooled across organizations in a “peer group” and used to compute normative benchmarks that can be used to estimate expected standard costs for each organization. Peer benchmarks are created at the per member per month (PMPM) level; standard cost benchmarks (BenchC) are created for each member cohort and service category. For example, for standard costs, NCQA first aggregates costs across organizations in a peer group:  $BenchC_{s,m} = \sum_o C_{s,m,o}$

Total member months are also summed.  $BenchTotmm_m = \sum_o Totmm_{m,o}$

**Note:** These calculations use only the values for *p* included in the peer benchmark group.

For nonpharmacy service categories, the benchmark PMPM for a peer group is:

$$BenchC_{pmpm_{s,m}} = BenchC_{s,m} / BenchTotmm_m$$

To compute expected amounts for standard costs, values are computed as follows.

$$\text{For nonpharmacy services: } E(C_{s,m,o}) = BenchC_{pmpm_{s,m}} * Totmm_{m,o}$$

At this point, expected and actual values can be compared and an RRU ratio calculated for each combination of service category and member cohort. The expected amount can also be aggregated and an RRU ratio calculated at any level. An overall ratio across all HCC-RRU risk categories and member cohorts would be (for organization *p*):  $RRU_o = \sum_s \sum_m C_{s,m} / \sum_s \sum_m E(C_{s,m})$ .

After calculating RRU findings, NCQA provides organizations with their relative resource observed-to-expected ratio at the service category and major clinical condition level.

- A score of 1.00 indicates that the observed amounts for standard costs or utilization are equal to the expected amounts.
- A score >1.00 indicates that the observed amounts for standard costs or utilization are greater than the expected amounts.
- A score <1.00 indicates that the observed amounts for standard costs or utilization are lower than the expected amounts.

For example, an organization whose O/E calculation is 1.10 for inpatient services in its *Relative Resource Use for People With Diabetes* measure has a total standard cost for inpatient services for RDI that is 10 percent higher than the expected total inpatient services cost.

### **Data Elements for Reporting**

NCQA defines a set of building blocks (data elements) and requires the use of XML. The measure specification includes a reporting table containing these building blocks: metric specification name, risk groups, age groups and gender options associated with the measure.

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# **Guidelines for Risk Adjusted Utilization**

## Guidelines for Risk Adjusted Utilization Measures

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### 2017 HEDIS FOR QRS SPECIFIC GUIDANCE

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These guidelines apply to the following measure:

- *Plan All-Cause Readmissions (PCR).*

#### Specific Instructions for Utilization Tables

- 1. Which services count?** Include all services, whether or not the organization paid for them or expects to pay for them (i.e., include denied claims) when applying risk adjustment in the Risk Adjusted Utilization measure (i.e., PCR). *Do not include* denied services (i.e., only include paid services and services expected to be paid) when identifying all other events (e.g., the IHS in the PCR measure).

The organization may have:

- Covered the full amount.
- Paid only a portion of the amount (e.g., 80 percent).
- Paid nothing because the member covered the entire amount to meet a deductible.
- Paid nothing because the service was covered as part of a PMPM payment.
- Denied the service.

Count the service as paid or expected to be paid if:

- The organization paid the full amount **or** a portion of the amount (e.g., 80 percent).
- The member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The service was covered under a PMPM payment.

Count the service as denied if:

- The organization denied the service for any reason, unless the member paid for the service as part of the benefit offering (e.g., to meet a deductible), **or**
- The claim for the service was rejected because it was missing information or was invalid for another reason.

- 2. Risk adjustment.** Organizations may not use supplemental data sources when applying the risk adjustment methodology.

Organizations may not use Risk Assessment Protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.

- 3. Counting transfers.** Unless otherwise specified in the measure, treat transfers *between* institutions as separate admissions. Base transfer reports *within* an institution on the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.

Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lesser level of care or from a lesser level of care to intensive care.

- 4. Mental health and chemical dependency transfers.** Unless otherwise specified in the measure, count as a separate admission a transfer within the same institution but to a different level of care (e.g., a transfer between inpatient and residential care). Each level must appropriately include discharges and length of stay (count inpatient days under inpatient; count residential days under residential).

### Utilization Risk Adjustment Determination

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

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

Use the date of service for outpatient, observation and ED visits. Use the discharge date for inpatient encounters.

For PCR, exclude the primary discharge diagnosis on the IHS.

**Step 2** Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Comorbid. If the code appears more than once in Table CC—Comorbid, it is assigned to multiple CCs.

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

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

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

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

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

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

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

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

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

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

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

**Example: Table HCC—Rank**

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

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

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

Compare each stay's list of unique HCCs to those in the *HCC* column in Table HCC—Comb and assign any additional HCC conditions.

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

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a member can have none, one or more of these added HCCs.

**Example** For a stay with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This *does not* replace HCC-17 and HCC-85.

**Example: Table HCC—Combo**

Combination: Diabetes and CHF			
Comorbid HCC	Comorbid HCC	Comorbid HCC	Combination HCC
HCC-17	HCC-85	NA	HCC-901
HCC-18	HCC-85	NA	HCC-901
HCC-19	HCC-85	NA	HCC-901



# **2017 HEDIS for QRS**

## **Measure Technical Specifications**

*(Alphabetical Order)*

## Adult BMI Assessment (ABA)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- No changes to this measure.

#### Description

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

#### Definitions

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Members who had an outpatient visit ( <u>Outpatient Value Set</u> ) during the measurement year or the year prior to the measurement year.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	For members 20 years of age or older on the date of service, BMI ( <u>BMI Value Set</u> ) during the measurement year or the year prior to the measurement year.

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

### Exclusions (optional)

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

### Hybrid Specification

<b>Denominator</b>	A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
<b>Numerator</b>	BMI during the measurement year or the year prior to the measurement year as documented through either administrative data or medical record review.
<b>Administrative</b>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
<b>Medical record</b>	<p>For members 20 years and older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI value must be from the same data source.</p> <p>For members younger than 20 years on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The height, weight and BMI percentile must be from the same data source.</p> <p>For BMI percentile, either of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• BMI percentile documented as a value (e.g., 85th percentile).</li> <li>• BMI percentile plotted on an age-growth chart.</li> </ul> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of &gt;99% or &lt;1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).</p>

### Exclusions (optional)

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year or the year prior to the measurement year.

### Note

The following notations or examples of documentation are considered "negative findings" and do not count as numerator compliant.

- No BMI or BMI percentile documented in medical record or plotted on age-growth chart.
- Notation of weight only.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table ABA-4: Data Elements for Adult BMI Assessment**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

## Annual Dental Visit (ADV)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

### HEDIS FOR QRS SPECIFIC GUIDANCE

HEDIS for QRS measures do not define benefits at the service or metal level (e.g., the QHP are required to offer a dental benefit but enrollees may choose not to purchase that service), the enrollee is not included in the applicable measures requiring this benefit, however the organization is accountable for reporting the measure.

#### Description

The percentage of members 2–20 years of age who had at least one dental visit during the measurement year.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	2–20 years as of December 31 of the measurement year. Report six age stratifications and a total rate. <ul style="list-style-type: none"> <li>• 2–3 years.</li> <li>• 4–6 years.</li> <li>• 7–10 years.</li> <li>• 11–14 years.</li> <li>• 15–18 years.</li> <li>• 19–20 years.</li> <li>• Total.</li> </ul> <p>The total is the sum of the age stratifications.</p>
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Dental.
<b>Event/diagnosis</b>	None.

**Note:** Visits for many 1-year-olds will be counted because the specification includes children whose second birthday occurs during the measurement year.

**Administrative Specification**

**Denominator**            The eligible population.

**Numerator**            One or more dental visits (Dental Visits Value Set) with a dental practitioner during the measurement year.

**Note:** Refer to Appendix 1 for the definition of dental practitioner.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table ADV-4: Data Elements for Annual Dental Visit**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>
Lower 95% confidence interval	<i>For each age stratification and total</i>
Upper 95% confidence interval	<i>For each age stratification and total</i>

## Antidepressant Medication Management (AMM)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Revised the required exclusion instructions for inpatient stays to search for admissions or discharges that occur during the 121-day period.
- Clarified the number of gap days allowed for each numerator.

### Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

### Definitions

<b>Intake Period</b>	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
<b>IPSD</b>	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
<b>Negative Medication History</b>	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
<b>Treatment days</b>	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18 years and older as of April 30 of the measurement year.
<b>Continuous enrollment</b>	105 days prior to the IPSD through 231 days after the IPSD.
<b>Allowable gap</b>	One gap in enrollment of up to 45 days.
<b>Anchor date</b>	IPSD.
<b>Benefits</b>	Medical and pharmacy.

- Event/diagnosis** Follow the steps below to identify the eligible population, which is used for both rates.
- Step 1** Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.
- Step 2: Required exclusion** Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:
- An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
    - AMM Stand Alone Visits Value Set **with** Major Depression Value Set.
    - AMM Visits Value Set **with** AMM POS Value Set **and** Major Depression Value Set.
  - An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
  - An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- Step 3** Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.
- Step 4** Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

### Administrative Specification

**Denominator** The eligible population.

**Numerators**

**Effective Acute Phase Treatment** At least 84 days (12 weeks) of treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.



**Table AMM-C: Antidepressant Medications**

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

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

**Effective  
Continuation  
Phase Treatment**

At least 180 days (6 months) of treatment with antidepressant medication (Table AMM-C) beginning on the IPSP through 231 days after the IPSP (232 total days).

This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

**Note**

- Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table AMM-4: Data Elements for Antidepressant Medication Management**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>
Lower 95% confidence interval	<i>Each of the 2 rates</i>
Upper 95% confidence interval	<i>Each of the 2 rates</i>

## Annual Monitoring for Patients on Persistent Medications (MPM)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

#### Description

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

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to Additional Eligible Population Criteria for each rate.  Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year.  <b>Note:</b> Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

## Administrative Specification

For each product line, report each of the three rates separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

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

<b>Additional eligible population criteria</b>	Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table CDC-L to identify ACE inhibitors and ARBs.  <b>Note:</b> Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).
<b>Numerator</b>	At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria: <ul style="list-style-type: none"><li>• A lab panel test (<u>Lab Panel Value Set</u>).</li><li>• A serum potassium test (<u>Serum Potassium Value Set</u>) <b>and</b> a serum creatinine test (<u>Serum Creatinine Value Set</u>).</li></ul> <b>Note:</b> The tests do not need to occur on the same service date, only within the measurement year.

### Rate 2: Annual Monitoring for Members on Digoxin

<b>Additional eligible population criteria</b>	Members who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.
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**Table MPM-B: Drugs to Identify Members on Digoxin**

Description	Prescription
Inotropic agents	Digoxin

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

<b>Numerator</b>	At least one serum potassium, at least one serum creatinine, <b>and</b> at least one serum digoxin therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria: <ul style="list-style-type: none"><li>• A lab panel test (<u>Lab Panel Value Set</u>) <b>and</b> a serum digoxin test (<u>Digoxin Level Value Set</u>).</li><li>• A serum potassium test (<u>Serum Potassium Value Set</u>) <b>and</b> a serum creatinine test (<u>Serum Creatinine Value Set</u>) <b>and</b> a serum digoxin test (<u>Digoxin Level Value Set</u>).</li></ul> <b>Note:</b> The tests do not need to occur on the same service date, only within the measurement year.
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**Rate 3: Annual Monitoring for Members on Diuretics****Additional eligible population criteria**

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

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

**Table MPM-C: Drugs to Identify Members on Diuretics**

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

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

**Numerator**

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

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

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

**Exclusion (optional)**

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

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table MPM-4: Data Elements for Annual Monitoring for Patients on Persistent Medications**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each of the 3 rates and total</i>
Number of optional exclusions	<i>For each of the 3 rates and total</i>
Numerator events by administrative data	<i>For each of the 3 rates and total</i>
Numerator events by supplemental data	<i>For each of the 3 rates and total</i>
Reported rate	<i>For each of the 3 rates and total</i>
Lower 95% confidence interval	<i>For each of the 3 rates and total</i>
Upper 95% confidence interval	<i>For each of the 3 rates and total</i>

## Appropriate Testing for Children With Pharyngitis (CWP)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Added instructions to identify ED visits and observation visits that result in an inpatient stay.

#### Description

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

#### Definitions

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

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

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	Children 3 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
<b>Continuous enrollment</b>	30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	Episode Date.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population.

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

Exclude claims/encounters with more than one diagnosis and ED visits or observation visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

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

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



**Table CWP-C: Antibiotic Medications**

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

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

- Step 4** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.
- Step 5** Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total).
- Step 6** Select the IESD. This measure examines the earliest eligible episode per member.

### Administrative Specification

**Denominator** The eligible population.

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

### Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CWP-4: Data Elements for Appropriate Testing for Children With Pharyngitis**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Appropriate Treatment for Children With Upper Respiratory Infection (URI)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Added instructions to identify ED visits and observation visits that result in an inpatient stay.
- Added a requirement to not include denied claims in the numerator.

### Description

The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

### Calculation

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

### Definitions

<b>Intake Period</b>	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.
<b>Episode Date</b>	The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of URI. Exclude claims/encounters with more than one diagnosis.
<b>IESD</b>	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria: <ul style="list-style-type: none"> <li>• A 30-day Negative Medication History prior to the Episode Date.</li> <li>• A Negative Competing Diagnosis on or 3 days after the Episode Date.</li> <li>• The member was continuously enrolled 30 days prior to the Episode Date through 3 days after the Episode Date.</li> </ul>
<b>Negative Medication History</b>	<p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>• A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li> <li>• No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.</li> </ul> <p>A prescription is considered active if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.</p>
<b>Negative Competing Diagnosis</b>	The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis.

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	Children 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
<b>Continuous enrollment</b>	30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	Episode Date.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Follow the steps below to identify the eligible population:  <b>Step 1</b> Identify all members who had an outpatient visit ( <u>Outpatient Value Set</u> ), an observation visit ( <u>Observation Value Set</u> ) or an ED visit ( <u>ED Value Set</u> ) during the Intake Period, with only a diagnosis of URI ( <u>URI Value Set</u> ).  Exclude claims/encounters with more than one diagnosis code and ED visits or observation visits that result in an inpatient stay ( <u>Inpatient Stay Value Set</u> ). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.  <b>Step 2</b> Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits with only a URI diagnosis.  <b>Step 3</b> Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the Episode Date or was active on the Episode Date.  <b>Step 4</b> Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis: <ul style="list-style-type: none"><li>• <u>Pharyngitis Value Set</u>.</li><li>• <u>Competing Diagnosis Value Set</u>.</li></ul> <b>Step 5</b> Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total).  <b>Step 6</b> Select the IESD. This measure examines the earliest eligible episode per member.

### **Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	Dispensed prescription for antibiotic medication (Table CWP-C) on or three days after the IESD.
	Do not include denied claims.

### **Note**

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

### **Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table URI-4: Data Elements for Appropriate Treatment for Children With Upper Respiratory Infection**

Element	Administrative

## Aspirin Use and Discussion (ASP)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- No changes to this measure.

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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- This measure is collected based on enrollee responses to a subset of the QHP Enrollee Survey questions.

Organizations should refer to the CMS Web site (<http://qhpcahps.cms.gov/>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the HEDIS for QRS measures. The QHP Enrollee Survey response data are submitted to CMS through the QHP Enrollee Survey Web site.

### Description

The following components of this measure assess different facets of managing aspirin use for the primary prevention of cardiovascular disease.

<b>Aspirin Use</b>	<p>A rolling average represents the percentage of members who are currently taking aspirin. A single rate is reported, for which the denominator includes:</p> <ul style="list-style-type: none"><li>• Women 56–79 years of age with at least two risk factors for cardiovascular disease.</li><li>• Men 46–65 years of age with at least one risk factor for cardiovascular disease.</li><li>• Men 66–79 years of age, regardless of risk factors.</li></ul>
<b>Discussing Aspirin Risks and Benefits</b>	<p>A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported, for which the denominator includes:</p> <ul style="list-style-type: none"><li>• Women 56–79 years of age.</li><li>• Men 46–79 years of age.</li></ul>

### Definitions

<b>Cardiovascular disease risk factor</b>	<p>Cardiovascular disease risk factors include:</p> <ul style="list-style-type: none"><li>• Current smoker or tobacco user.</li><li>• High cholesterol.</li><li>• High blood pressure.</li><li>• Parent or sibling who had a heart attack before 60 years of age.</li></ul>
<b>Cardiovascular disease</b>	<p>Because the measure assesses aspirin use for the primary prevention of cardiovascular disease, members with cardiovascular disease are excluded. This includes members with a history of:</p> <ul style="list-style-type: none"><li>• Heart attack.</li><li>• Angina or coronary heart disease.</li><li>• Stroke.</li><li>• Diabetes or high blood sugar.</li></ul>

**Eligible Population**

<b>Product line</b>	Marketplace.
<b>Ages</b>	Men 46–79 and women 56–79 as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The last six months of the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 31 days during the measurement year.
<b>Current enrollment</b>	Currently enrolled at the time the survey is completed.

**Protocol and Survey Instrument**

Collected annually by CMS as part of the QHP Enrollee Survey using a rolling average methodology.

**Gender-Dependent Age Band Eligibility Flags**

The issuer calculates the member's age as of December 31 of the measurement year for each member in the QHP Enrollee Survey sample frame data file.

Data Element	Value Labels
Member age as of December 31 of the measurement year	Numeric, 2-digit variable; Valid values are 18–80. For members age 80 years and older, code "80." For example, a member who is 89 years of age as of December 31 of the measurement year will be coded "80."

Prior to results calculation, the member gender and member age as of December 31 of the measurement year is used to assign a Gender-Dependent Age Band Eligibility Flag, as follows.

Gender-Dependent Age Band Eligibility Flags
1 = Female age 55 or younger as of December 31 of the measurement year
2 = Female age 56–79 as of December 31 of the measurement year
3 = Female age 80 or older as of December 31 of the measurement year
4 = Male age 45 or younger as of December 31 of the measurement year
5 = Male age 46–65 as of December 31 of the measurement year
6 = Male age 66–79 as of December 31 of the measurement year
7 = Male age 80 or older as of December 31 of the measurement year

The Gender-Dependent Age Band Eligibility Flag identifies members eligible for the *Aspirin Use and Discussion* measure rates. The use of an eligibility flag protects member confidentiality (using the date of birth could result in a breach of confidentiality).

## Questions Included in the Measure

Table ASP: Aspirin Use and Discussion

QHP Enrollee Survey	Question	Response Choices
Q61	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all Don't know
Q65	Do you take aspirin daily or every other day?	Yes No Don't know
Q66	Do you have a health problem or take medication that makes taking aspirin unsafe for you?	Yes No Don't know
Q67	Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?	Yes No
Q68	Are you aware that you have any of the following conditions? Mark one or more.	High cholesterol High blood pressure Parent or sibling with heart attack before the age of 60
Q69	Has a doctor ever told you that you have any of the following conditions? Mark one or more.	A heart attack Angina or coronary heart disease A stroke Any kind of diabetes or high blood sugar

## Calculation of Aspirin Use and Discussion

Rolling averages are calculated using the formula below:

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator).

### Aspirin Use

#### Denominator

The number of members who responded to the survey and indicated that they did not have a health problem or take medication that makes taking aspirin unsafe, did not have an exclusion and who are:

- Women 56–79 with at least two risk factors for cardiovascular disease.
- Men 46–65 with at least one risk factor for cardiovascular disease.
- Men 66–79.

#### Eligible gender-dependent age bands

Only members with Gender-Dependent Age Band Eligibility Flags of 2, 5 and 6 are included in the denominator.

- Members with a **Gender-Dependent Age Band Eligibility Flag = 2** must have at least two cardiovascular disease risk factors.
- Members with a **Gender-Dependent Age Band Eligibility Flag = 5** must have at least one cardiovascular disease risk factor.
- Members with a **Gender-Dependent Age Band Eligibility Flag = 6** are included, regardless of the number of cardiovascular disease risk factors.



<b>Summing cardiovascular disease risk factors</b>	<p>Each response choice below indicates a cardiovascular disease risk factor. Sum the responses by member to calculate the total number of risk factors for that member.</p> <p>Q61 = "Every day" or "Some days."</p> <p>Q68 = "High cholesterol."</p> <p>Q68 = "High blood pressure."</p> <p>Q68 = "Parent or sibling with heart attack before the age of 60."</p>
<b>Exclusions</b>	<p>Any response to Q69 indicates a cardiovascular disease exclusion. Exclude any member who selected <i>any</i> response choice for Q69: "A heart attack" or "Angina or coronary heart disease" or "A stroke" or "Any kind of diabetes or high blood sugar."</p>
<b>Aspirin use questions</b>	<p>Response choices must be as follows to be included in the denominator:</p> <p>Q65 = "Yes" or "No."</p> <p>Q66 = "No."</p>
<b>Numerator</b>	<p>The number of members in the denominator who indicated that they currently take aspirin daily or every other day.</p> <p>Member response choice must be as follows to be included in the numerator:</p> <p>Q65 = "Yes."</p>

## Discussing Aspirin Risks and Benefits

<b>Denominator</b>	The number of respondents who are women 56–79 and men 46–79 years of age.
<b>Eligible gender-dependent age bands</b>	Only members with Gender-Dependent Age Band Eligibility Flags of 2, 5 and 6 are included in the denominator.
<b>Exclusions</b>	<p>Any response to Q69 indicates a cardiovascular disease exclusion. Exclude any member who selected <i>any</i> response choice for Q69: "A heart attack" or "Angina or coronary heart disease" or "A stroke" or "Any kind of diabetes or high blood sugar."</p>
<b>Aspirin discussion question</b>	<p>Response choices must be as follows to be included in the denominator:</p> <p>Q67 = "Yes" or "No."</p>
<b>Numerator</b>	<p>The number of members in the denominator who indicated that their doctor or other provider discussed the risks and benefits of aspirin use to prevent heart attack or stroke.</p> <p>Member response choice must be as follows to be included in the numerator:</p> <p>Q67 = "Yes."</p>

## Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

### Description

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

### Calculation

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

### Definitions

<b>Intake Period</b>	January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.
<b>Episode Date</b>	The date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.
<b>IESD</b>	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria: <ul style="list-style-type: none"><li>• A 30-day Negative Medication History prior to the Episode Date.</li><li>• A 12-month Negative Comorbid Condition History prior to and including the Episode Date.</li><li>• A Negative Competing Diagnosis during the 38-day period from 30 days prior to the Episode Date through 7 days after the Episode Date.</li><li>• The member was continuously enrolled 1 year prior to the Episode Date through 7 days after the Episode Date.</li></ul>
<b>Negative Medication History</b>	<p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none"><li>• A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.</li><li>• No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.</li></ul>

A prescription is considered active if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date

and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

<b>Negative Comorbid Condition History</b>	A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
<b>Negative Competing Diagnosis</b>	A period of 30 days prior to the Episode Date through 7 days after the Episode Date (38 total days), when the member had no claims/encounters with any competing diagnosis.

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	Adults 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	One year prior to the Episode Date through seven days after the Episode Date (373 total days).
<b>Allowable gap</b>	No more than one gap of 45 days is permitted during the 365 days (1 year) prior to the Episode Date.  No gaps in enrollment are allowed on the IESD through 7 days after the IESD.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/diagnosis</b>	Follow the steps below to identify the eligible population:  <div> <b>Step 1</b> Identify all members who had an outpatient visit (<u>Outpatient Value Set</u>), an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) during the Intake Period, with a diagnosis of acute bronchitis (<u>Acute Bronchitis Value Set</u>).   Do not include ED visits or observation visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). An ED visit or observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less. </div> <b>Step 2</b> Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits with a diagnosis of acute bronchitis.  <b>Step 3</b> Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition: <ul style="list-style-type: none"> <li>• <u>HIV Value Set</u>.</li> <li>• <u>HIV Type 2 Value Set</u>.</li> <li>• <u>Malignant Neoplasms Value Set</u>.</li> <li>• <u>Emphysema Value Set</u>.</li> </ul>

- COPD Value Set.
- Cystic Fibrosis Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

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

**Step 5** Test for Negative Competing Diagnosis. Exclude Episode Dates where during the period 30 days prior to the Episode Date through 7 days after the Episode Date (38 total days) the member had a claim/encounter with any competing diagnosis. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

**Step 6** Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days (1 year) prior to the Episode Date through 7 days after the Episode Date (373 total days).

**Step 7** Select the IESD. This measure examines the earliest eligible episode per member.

#### **Administrative Specification**

**Denominator** The eligible population.

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

Do not include denied claims.

**Table AAB-D: Antibiotic Medications**

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

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

**Note**

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

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table AAB-4: Data Elements for Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Breast Cancer Screening (BCS)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

#### Description

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	Women 52–74 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	October 1 two years prior to the measurement year through December 31 of the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

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

#### Exclusion (*optional*)

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

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a bilateral modifier (Bilateral Modifier Value Set).

## Breast Cancer Screening

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

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
<ul style="list-style-type: none"><li>• Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same date of service)</li></ul>	<ul style="list-style-type: none"><li>• Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same date of service)</li></ul>
<ul style="list-style-type: none"><li>• Absence of the left breast (<u>Absence of Left Breast Value Set</u>)</li></ul>	<ul style="list-style-type: none"><li>• Absence of the right breast (<u>Absence of Right Breast Value Set</u>)</li></ul>
<ul style="list-style-type: none"><li>• Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>)</li></ul>	<ul style="list-style-type: none"><li>• Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)</li></ul>

### Note

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

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table BCS-4: Data Elements for Breast Cancer Screening**

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of optional exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓



## Cervical Cancer Screening (CCS)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Clarified that reflex testing does not meet criteria in step 2 of the hybrid specification.

#### Description

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

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace
<b>Ages</b>	Women 24–64 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.
<b>Step 1</b>	Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology ( <u>Cervical Cytology Value Set</u> ) during the measurement year or the two years prior to the measurement year.

**Step 2** From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set) with service dates four or less days apart during the measurement year or the four years prior to the measurement year **and** who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year.

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

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

### Exclusion (optional)

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

### Hybrid Specification

**Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

**Numerator** The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

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

#### Medical record

**Step 1** Identify the number of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

**Note:** Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

**Step 2** From the women who did not meet step 1 criteria, identify the number of women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year **and** who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
- The results or findings.

Include only cytology and HPV “co-testing”; in co-testing, both cytology and HPV tests are performed (i.e., the samples are collected and both tests are ordered, regardless of the cytology result) on the same date of service. Do not include reflex testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet criteria for the measure.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

**Note:** Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

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

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**Exclusion (optional)**

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Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through December 31 of the measurement year. Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

- Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy”.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CCS-4: Data Elements for Cervical Cancer Screening**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

## Childhood Immunization Status (CIS)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

### HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only combination 3 and related antigens.

#### 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 haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Age</b>	Children who turn 2 years of age during the measurement year.
<b>Continuous enrollment</b>	12 months prior to the child's second birthday.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
<b>Anchor date</b>	Enrolled on the child's second birthday.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerators</b>	<p>For MMR, hepatitis B, and VZV, count any of the following:</p> <ul style="list-style-type: none"> <li>• Evidence of the antigen or combination vaccine, <b>or</b></li> <li>• Documented history of the illness, <b>or</b></li> <li>• A seropositive test result for each antigen.</li> </ul> <p>For DTaP, IPV, HiB and pneumococcal conjugate, count <i>only</i>:</p> <ul style="list-style-type: none"> <li>• Evidence of the antigen or combination vaccine.</li> </ul>

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

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

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

**MMR** Any of the following on or before the child's second birthday meet criteria:

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

**Note:** General Guideline 27 (i.e., the 14-day rule) does not apply to MMR.

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

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

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

**Combination rate** Children who received four DTaP; three IPV; one MMR; three HiB; three hepatitis B; one VZV; and four pneumococcal conjugate vaccinations on or before the child's second birthday.

**Combination Vaccinations for Childhood Immunization Status**

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV
Combination 3	✓	✓	✓	✓	✓	✓	✓

**Exclusion (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 member's second birthday meet optional exclusion criteria:

- Any particular vaccine**
  - Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).
- DTaP**
  - Encephalopathy (Encephalopathy Due To Vaccination Value Set) **with** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).
- MMR, and VZV**
  - Immunodeficiency (Disorders of the Immune System Value Set).
  - HIV (HIV Value Set; HIV Type 2 Value Set).
  - Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
  - Anaphylactic reaction to neomycin.
- IPV**
  - Anaphylactic reaction to streptomycin, polymyxin B or neomycin.
- Hepatitis B**
  - Anaphylactic reaction to common baker's yeast.

**Hybrid Specification**

- Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
- Numerators**
  - For MMR, hepatitis B, and VZV, count any of the following:
    - Evidence of the antigen or combination vaccine.
    - Documented history of the illness.
    - A seropositive test result.
  - For DTaP, HiB, IPV, and pneumococcal conjugate 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.

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

**Medical record** For immunization evidence obtained from the medical record, count members 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 member's second birthday.

Notes in the medical record indicating that the member 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 "member 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.

### Exclusion (optional)

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Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred by the member's second birthday.

### Note

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- *This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.*



## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CIS-4: Data Elements for Childhood Immunization Status**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		Each of the 8 rates
Current year's administrative rate (before exclusions)		Each of the 8 rates
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		Each of the 8 rates
Administrative rate on FSS		Each of the 8 rates
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	Each of the 8 rates	Each of the 8 rates
Numerator events by medical records		Each of the 8 rates
Numerator events by supplemental data	Each of the 8 rates	Each of the 8 rates
Reported rate	Each of the 8 rates	Each of the 8 rates
Lower 95% confidence interval	Each of the 8 rates	Each of the 8 rates
Upper 95% confidence interval	Each of the 8 rates	Each of the 8 rates

## Chlamydia Screening in Women (CHL)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

#### Description

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	<p>Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:</p> <ul style="list-style-type: none"> <li>• 16–20 years.</li> <li>• 21–24 years.</li> <li>• Total.</li> </ul> <p>The total is the sum of the age stratifications.</p>
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	<p><i>Sexually active.</i> Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.</p> <p><i>Claim/encounter data.</i> Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:</p> <ul style="list-style-type: none"> <li>• <u>Pregnancy Value Set.</u></li> <li>• <u>Sexual Activity Value Set.</u></li> <li>• <u>Pregnancy Tests Value Set.</u></li> </ul> <p><i>Pharmacy data.</i> Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).</p>

**Table CHL-A: Prescriptions to Identify Contraceptives**

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

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

### Administrative Specification

**Denominator** The eligible population.

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

### Exclusion (optional)

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

- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year **and** a prescription for isotretinoin (Table CHL-E) on the date of the pregnancy test or the 6 days after the pregnancy test.
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year **and** an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test.

**Table CHL-E: Medications to Identify Exclusions**

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

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

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CHL-4: Data Elements for Chlamydia Screening**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Number of optional exclusions	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>
Lower 95% confidence interval	<i>For each age stratification and total</i>
Upper 95% confidence interval	<i>For each age stratification and total</i>

## Colorectal Cancer Screening (COL)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Clarified when pathology reports may be used for the numerator.

#### Description

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	51–75 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	One or more screenings for colorectal cancer. Any of the following meet criteria: <ul style="list-style-type: none"> <li>• Fecal occult blood test (<a href="#">FOBT Value Set</a>) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.</li> <li>• Flexible sigmoidoscopy (<a href="#">Flexible Sigmoidoscopy Value Set</a>) during the measurement year or the four years prior to the measurement year.</li> <li>• Colonoscopy (<a href="#">Colonoscopy Value Set</a>) during the measurement year or the nine years prior to the measurement year.</li> </ul>

#### Exclusion (optional)

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

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

**Hybrid Specification**

**Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

**Numerator** One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:

- FOBT during the measurement year.
- 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.

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

**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).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

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 member 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 member 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 member 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 member 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 member meets the screening criteria for inclusion in the numerator.*
  - *If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.*
  - *If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.*

*Do not count* digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

### **Exclusion (optional)**

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Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table COL-4: Data Elements for Colorectal Cancer Screening**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓



## Comprehensive Diabetes Care (CDC)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Added an administrative method and new value set to identify negative eye exams in the year prior to the measurement year.
- Added glycohemoglobin, glycated hemoglobin and glycosylated hemoglobin as acceptable HbA1c tests.
- Clarified documentation requirements for a negative eye exam.
- Replaced “Each of the 4 rates” with a “✓” for the “Measurement year” row in Table CDC-4.

### HEDIS FOR QRS-SPECIFIC GUIDANCE

- Organizations report only the following indicators: HbA1c Testing, HbA1c Control <8, Eye Exam (Retinal) Performed and Medical Attention for Nephropathy.

### Description

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

- Hemoglobin A1c (HbA1c) testing.
- HbA1c control (<8.0%).
- Eye exam (retinal) performed.
- Medical attention for nephropathy.

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18–75 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	<p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p>

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

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

**Table CDC-A: Prescriptions to Identify Members With Diabetes**

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

**Note:** Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to [www.ncqa.org](http://www.ncqa.org) by November 1, 2016.

## Administrative Specification

**Denominator** The eligible population.

**Numerators**

**HbA1c Testing** An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

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

Organizations that use CPT<sup>6</sup> Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Compliant
<u>HbA1c Level 7.0–9.0 Value Set</u>	Not compliant <sup>12</sup>
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Not compliant

**Eye Exam** Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

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

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set). All codes must be on the same claim.

<sup>12</sup>The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed. The date of service for the Category II code and the test result must follow the requirements outlined in *General Guideline 25* (i.e., the dates of service for the code and the test result must be no more than seven days apart).

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

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

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

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

**Table CDC-L: ACE Inhibitors/ARBs**

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

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

## Exclusions (optional)

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

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same.

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

## Hybrid Specification

<b>Denominator</b>	<p>A systematic sample drawn from the eligible population for each product line.</p> <p>The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size. Refer to the <i>Guidelines for Calculations and Sampling</i> for more information on reducing sample size.</p>
<b>Numerators</b>	
<b><i>HbA1c Testing</i></b>	An HbA1c test performed during the measurement year as identified by administrative data or medical record review.
<b><u>Administrative</u></b>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
<b><u>Medical record</u></b>	<p>At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:</p> <ul style="list-style-type: none"> <li>• A1c.</li> <li>• HbA1c.</li> <li>• Hemoglobin A1c.</li> <li>• Glycohemoglobin A1c.</li> <li>• HgbA1c.</li> <li>• Glycohemoglobin.</li> <li>• Glycated hemoglobin.</li> <li>• Glycosylated hemoglobin.</li> </ul>
<b><i>HbA1c Control &lt;8%</i></b>	The <i>most recent</i> HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.
<b><u>Administrative</u></b>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
<b><u>Medical record</u></b>	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 member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

**Eye Exam** Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

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

**Medical record** At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria). Documentation does not specifically have to state “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates “diabetes without complications” does not meet criteria.

***Medical Attention for Nephropathy*** A nephropathy screening test during the measurement year *or* evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

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

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

**Medical record** Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  - 24-hour urine for albumin or protein.
  - Timed urine for albumin or protein.
  - Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
  - Urine for albumin/creatinine ratio.
  - 24-hour urine for total protein.
  - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

### **Exclusions (optional)**

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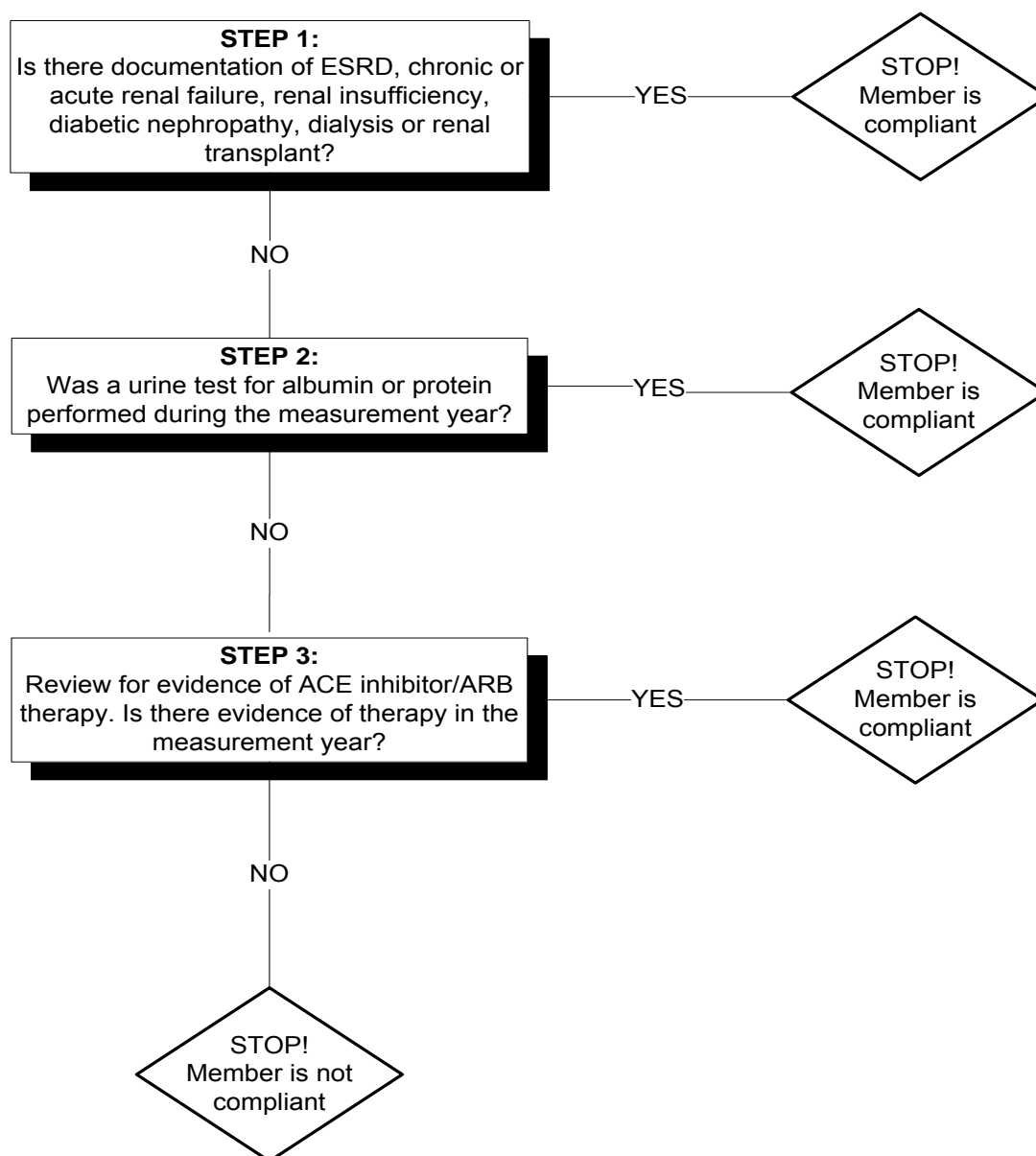
Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, **and** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

### **Note**

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- *Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*

## Monitoring for Diabetic Nephropathy





## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CDC-4: Data Elements for Comprehensive Diabetes Care**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Eligible population	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Number of numerator events by administrative data in eligible population (before optional exclusions)		<i>Each of the 4 rates</i>
Current year's administrative rate (before optional exclusions)		<i>Each of the 4 rates</i>
Minimum required sample size (MRSS) or other sample size		<i>Each of the 4 rates</i>
Oversampling rate		<i>Each of the 4 rates</i>
Final sample size (FSS)		<i>Each of the 4 rates</i>
Number of numerator events by administrative data in FSS		<i>Each of the 4 rates</i>
Administrative rate on FSS		<i>Each of the 4 rates</i>
Number of original sample records excluded because of valid data errors		<i>Each of the 4 rates</i>
Number of optional administrative data records excluded		<i>Each of the 4 rates</i>
Number of optional medical records excluded		<i>Each of the 4 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 4 rates</i>
Records added from the oversample list		<i>Each of the 4 rates</i>
Denominator		<i>Each of the 4 rates</i>
Numerator events by administrative data	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Numerator events by medical records		<i>Each of the 4 rates</i>
Numerator events by supplemental data	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Reported rate	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Lower 95% confidence interval	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>
Upper 95% confidence interval	<i>Each of the 4 rates</i>	<i>Each of the 4 rates</i>

## Controlling High Blood Pressure (CBP)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- Added a *Note* clarifying the intent when confirming the diagnosis of hypertension.
- Revised Table CBP-4 to include the medical record data elements only.

#### Description

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

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

**Note:** Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.

#### Definitions

<b>Adequate control</b>	Adequate control is defined as meeting any of the following criteria: <ul style="list-style-type: none"><li>• Members 18–59 years of age whose BP was &lt;140/90 mm Hg.</li><li>• Members 60–85 years of age with a diagnosis of diabetes whose BP was &lt;140/90 mm Hg.</li><li>• Members 60–85 years of age without a diagnosis of diabetes whose BP was &lt;150/90 mm Hg.</li></ul>
<b>Representative BP</b>	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18–85 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.

<b>Event/diagnosis</b>	<p>Members are identified as hypertensive if there is at least one outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with a diagnosis of hypertension (<u>Essential Hypertension Value Set</u>) during the first six months of the measurement year.</p> <p><b>Note:</b> In order to increase the specificity of the eligible population, only CPT<sup>6</sup> codes are used to identify outpatient visits.</p>
<b>Diabetes Flag for Numerator Assessment</b>	<p>After the Eligible Population is identified, assign each member either a <b>diabetic</b> or <b>not diabetic</b> flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for members with diabetes is different than the threshold for members without diabetes).</p> <p><b>Step 1</b> Assign a flag of <b>diabetic</b> to members identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> <li>• At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits.</li> <li>• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>).</li> </ul> <p><i>Pharmacy data.</i> Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).</p> <p><b>Step 2</b> From the members identified in step 1, assign a flag of <b>not diabetic</b> to members who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or year prior to the measurement year <b>and</b> who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year.</p> <p><b>Note:</b> Members classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are reclassified as <b>not diabetic</b> in this step.</p> <p><b>Step 3</b> Assign a flag of <b>not diabetic</b> to members who were not assigned a flag in step 1 or step 2.</p>

## Hybrid Specification

**Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record anytime during the member's history on or before June 30 of the measurement year:

- Hypertension.
- HTN.
- High BP (HBP).
- Elevated BP (↑BP).
- Borderline HTN.
- Intermittent HTN.
- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis that is not part of the office visit note; see the **Note** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

If the diagnosis of hypertension cannot be confirmed, the member is excluded and replaced by the next member from the oversample.

**Identifying the medical record** Use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

Use the following steps to find the appropriate medical record to review.

**Step 1** Identify the member's PCP.

If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.

If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.

If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

**Step 2** Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.

If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member's hypertension after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with a diagnosis of hypertension (Essential Hypertension Value Set) came from the specialist, the organization may use this chart for the most recent BP reading. If the member did not have any visit with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis.

**Numerator**

The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

To determine if the member's BP is adequately controlled, the representative BP must be identified.

**Administrative**

None.

**Medical record**

Follow the steps below to determine the representative BP.

**Step 1** Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

**Step 2** Determine numerator compliance based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged with a diagnosis of diabetes and whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year who were flagged as not having a diagnosis of diabetes and whose BP was <150/90 mm Hg.

The member is not compliant if the BP reading does not meet the specified threshold or is missing, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

**Step 3** A single rate is reported for all three groups. Sum the numerator events from step 2 to obtain the rate.

### Exclusions (optional)

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- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the admission date for the stay.

### Note

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- *When confirming the diagnosis of hypertension, the intent is to identify the date when the provider became aware of the hypertension diagnosis and documented the diagnosis of hypertension in the medical record (versus the time the patient acquired hypertension).*
- *Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note, it would be considered a dated problem list and the date of the visit must be used.*
- *Organizations generally require an oversample of 10–15 percent to meet the MRSS for confirmed cases of hypertension.*
- *Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the member during numerator assessment. The only exception is if the member is flagged as a diabetic but medical record evidence contains information that classifies the member as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis, as described in Substituting Medical records in the Guidelines for Calculations and Sampling. In this case, the diabetes flag may be changed to **not diabetic**, but the member may not be removed from the sample.*

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table CBP-4: Data Elements for Controlling High Blood Pressure**

Element	Hybrid
Measurement year	✓
Data collection methodology (Hybrid)	✓
Eligible population	✓
Minimum required sample size (MRSS) or other sample size	✓
Oversampling rate	✓
Final sample size (FSS)	✓
Number of original sample records excluded because of valid data errors	✓
Number of records excluded because of false-positive diagnoses	✓
Number of administrative data records excluded	✓
Number of medical record data records excluded	✓
Number of employee/dependent medical records excluded	✓
Records added from the oversample list	✓
Denominator	✓
Numerator events by medical records	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

**Note:** Because this is a hybrid only measure and medical record review is required, only the medical record data elements are included in the data reporting table and IDSS.

## Flu Vaccinations for Adults Ages 18–64 (FVA)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

### HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure is collected based on enrollee responses to a subset of the QHP Enrollee Survey questions.

Organizations should refer to the CMS Web site (<http://qhpcahps.cms.gov/>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the HEDIS for QRS measures. The QHP Enrollee Survey response data are submitted to CMS through the QHP Enrollee Survey Web site.

### Description

The percentage of members 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the QHP Enrollee Survey was completed.

### Eligible Population

<b>Product line</b>	Marketplace.
<b>Ages</b>	18–64 years as of July 1 of the measurement year.
<b>Continuous enrollment</b>	The last six months of the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 31 days during the measurement year.
<b>Current enrollment</b>	Currently enrolled at the time the survey is completed.

### Protocol and Survey Instrument

Collected annually by CMS as part of the QHP Enrollee Survey.

### Flu Vaccinations for Adults Ages 18–64 Eligibility Flag

The issuer assigns a *Flu Vaccinations for Adults Ages 18–64* Eligibility Flag for each member in the QHP Enrollee Survey sample frame data file.

Flu Vaccinations for Adults Ages 18–64 Eligibility Flag
1 = Eligible (the member was born on or between July 2, 1951, and July 1, 1998)
2 = Ineligible (the member was born before July 2, 1951, or after July 1, 1998)

The *Flu Vaccinations for Adults Ages 18–64* Eligibility Flag identifies the population eligible for the *Flu Vaccinations for Adults Ages 18–64* measure. Results are calculated using responses from respondents with a flag of “1 = Eligible.” The use of an eligibility flag protects member confidentiality (using the date of birth could result in a breach of confidentiality).



**Questions Included in the Measure**

**Table FVA: Flu Vaccinations for Adults Ages 18–64**

QHP Enrollee Survey	Question	Response Choices
Q60	Have you had either a flu shot or flu spray in the nose since July 1, YYYY?*	Yes No Don't know

\*YYYY = the measurement year (2016 for the survey fielded in 2017).

**Calculation of Flu Vaccinations for Adults Ages 18–64**

**Denominator**      The number of members with a Flu Vaccinations for Adults Ages 18–64 Eligibility Flag of “Eligible” who responded “Yes” or “No” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

**Numerator**      The number of members in the denominator who responded “Yes” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

## Follow-Up After Hospitalization for Mental Illness (FUH)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- Removed language instructing organizations to use only facility claims to identify discharges and diagnoses for denominator events. This is now addressed in *General Guideline 34*.
- Added value sets to identify direct transfers.

**Note:** For this measure, organizations are not required to differentiate between readmissions and direct transfers; therefore, the definition of direct transfer is not required.

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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- Marketplace organizations report only the 7-Day Follow-Up indicator.

#### Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within 7 days of discharge.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to *General Guideline 10: Members in Hospice*.

<b>Product line</b>	Marketplace.
<b>Ages</b>	6 years and older as of the date of discharge.
<b>Continuous enrollment</b>	Date of discharge through 30 days after discharge.
<b>Allowable gap</b>	No gaps in enrollment.
<b>Anchor date</b>	None.
<b>Benefit</b>	Medical and mental health (inpatient and outpatient).
<b>Event/diagnosis</b>	<p>An acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness (<u>Mental Illness Value Set</u>) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"><li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li><li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li><li>3. Identify the discharge date for the stay. Use only facility claims to identify denominator events (including readmissions or direct transfers). Do not use professional claims.</li></ol> <p>The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>

**Acute readmission or direct transfer** If the discharge is followed by readmission or direct transfer to an *acute inpatient care setting* for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

To identify readmissions and direct transfers to an acute inpatient care setting:

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

**Exclusions** Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions and direct transfers to an acute inpatient care setting:

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

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

## Administrative Specification

**Denominator** The eligible population.

**Numerator**

**7-Day Follow-Up** A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

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).

## Follow-Up After Hospitalization for Mental Illness

- 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 member was discharged with a principal diagnosis of mental illness.

**Transitional care management** is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

### Note

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 7 days after discharge).
- Refer to Appendix 1 for the definition of mental health practitioner.

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table FUH-4: Data Elements for Follow-Up After Hospitalization for Mental Illness**

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Follow-Up Care for Children Prescribed ADHD Medication (ADD)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

#### Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. *Continuation and Maintenance (C&M) Phase*. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

#### Definitions

<b>Intake Period</b>	The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
<b>Negative Medication History</b>	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
<b>IPSD</b>	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
<b>Initiation Phase</b>	The 30 days following the IPSD.
<b>C&amp;M Phase</b>	The 300 days following the IPSD (10 months).
<b>New Episode</b>	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
<b>Continuous Medication Treatment</b>	The number of medication treatment days during the 10-month follow-up period must be $\geq 210$ days (i.e., 300 treatment days – 90 gap days).
<b>Treatment days (covered days)</b>	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

**Eligible Population: Rate 1—Initiation Phase**

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace
<b>Ages</b>	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.
<b>Continuous enrollment</b>	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
<b>Allowable gap</b>	None.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	Follow the steps below to identify the eligible population for the Initiation Phase.

- Step 1** Identify all children in the specified age range who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.

**Table ADD-A: ADHD Medications**

Description	Prescription		
CNS stimulants	<ul style="list-style-type: none"> <li>Amphetamine-dextroamphetamine</li> <li>Dexamethylphenidate</li> </ul>	<ul style="list-style-type: none"> <li>Dextroamphetamine</li> <li>Lisdexamfetamine</li> </ul>	<ul style="list-style-type: none"> <li>Methylphenidate</li> <li>Methamphetamine</li> </ul>
Alpha-2 receptor agonists	<ul style="list-style-type: none"> <li>Clonidine</li> </ul>	<ul style="list-style-type: none"> <li>Guanfacine</li> </ul>	
Miscellaneous ADHD medications	<ul style="list-style-type: none"> <li>Atomoxetine</li> </ul>		

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

- Step 2** Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.
- Step 3** Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.
- Step 4** Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:
- An acute inpatient encounter ([Acute Inpatient Value Set](#)) with a principal mental health diagnosis ([Mental Health Diagnosis Value Set](#)).
  - An acute inpatient encounter ([Acute Inpatient Value Set](#)) with a principal diagnosis of chemical dependency ([Chemical Dependency Value Set](#)).

### Administrative Specification: Rate 1—Initiation Phase

<b>Denominator</b>	The Rate 1 eligible population.
<b>Numerator</b>	<p>An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSP. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:</p> <ul style="list-style-type: none"> <li>• <u>ADD Stand Alone Visits Value Set.</u></li> <li>• <u>ADD Visits Group 1 Value Set</u> <b>with</b> <u>ADD POS Group 1 Value Set.</u></li> <li>• <u>ADD Visits Group 2 Value Set</u> <b>with</b> <u>ADD POS Group 2 Value Set.</u></li> </ul> <p><b>Note:</b> Do not count a visit on the IPSP as the Initiation Phase visit.</p>

### Eligible Population: Rate 2—C&M Phase

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.
<b>Continuous enrollment</b>	<p>Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSP and 300 days (10 months) after the IPSP.</p> <p>Members who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1.</p>
<b>Allowable gap</b>	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSP.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and pharmacy.
<b>Event/ diagnosis</b>	<p>Follow the steps below to identify the eligible population for the C&amp;M Phase.</p> <p><b>Step 1</b> Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase.</p> <p><b>Step 2</b> Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSP and 300 days (10 months) after the IPSP.</p> <p><b>Step 3</b> Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSP. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&amp;M Phase [9 months].)</p> <p>Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p>

Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

**Step 4** Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSP. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set).

#### **Administrative Specification: Rate 2—C&M Phase**

**Denominator** The Rate 2 eligible population.

**Numerator** Identify all members who meet the following criteria:

- Numerator compliant for Rate 1—Initiation Phase, **and**
- At least two follow-up visits with any practitioner, from 31–300 days (9 months) after the IPSP.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

- ADD Stand Alone Visits Value Set.
- ADD Visits Group 1 Value Set **with** ADD POS Group 1 Value Set.
- ADD Visits Group 2 Value Set **with** ADD POS Group 2 Value Set.
- Telephone Visits Value Set.

#### **Exclusions (optional)**

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Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

#### **Note**

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- *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 1 for the definition of prescribing practitioner.*
- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSP).*



## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table ADD-4: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>Each of the 2 rates</i>
Number of optional exclusions	<i>Each of the 2 rates</i>
Numerator events by administrative data	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>
Lower 95% confidence interval	<i>Each of the 2 rates</i>
Upper 95% confidence interval	<i>Each of the 2 rates</i>

## Immunizations for Adolescents (IMA)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

#### Description

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

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Age</b>	Adolescents who turn 13 years of age during the measurement year.
<b>Continuous enrollment</b>	12 months prior to the member's 13th birthday.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday.
<b>Anchor date</b>	Enrolled on the member's 13th birthday.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerators</b>	For meningococcal conjugate, Tdap and HPV count <i>only</i> evidence of the antigen or combination vaccine.
<b>Meningococcal</b>	At least one meningococcal conjugate vaccine ( <u>Meningococcal Vaccine Administered Value Set</u> ), with a date of service on or between the member's 11th and 13th birthdays.
<b>Tdap</b>	At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine ( <u>Tdap Vaccine Administered Value Set</u> ), with a date of service on or between the member's 10th and 13th birthdays.
<b>HPV</b>	At least three HPV vaccines ( <u>HPV Vaccine Administered Value Set</u> ), with different dates of service on or between the member's 9th and 13th birthdays.

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

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

### Exclusion (optional)

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

Either of the following meet optional exclusion criteria:

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

### Hybrid Specification

<b>Denominator</b>	A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate for the lowest rate. For information on reducing the sample size, refer to the <i>Guidelines for Calculations and Sampling</i> .
<b>Numerators</b>	For meningococcal conjugate, Tdap and HPV, count <i>only</i> the evidence of the antigen or combination vaccine.
<b>Administrative</b>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
<b>Medical record</b>	<p>For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:</p> <ul style="list-style-type: none"> <li>• A note indicating the name of the specific antigen and the date of the immunization.</li> <li>• A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.</li> </ul> <p>For meningococcal conjugate, <i>do not count</i> meningococcal polysaccharide or meningococcal recombinant (serogroup B) (MenB) vaccines. Generic documentation that the "meningococcal vaccine" was administered meets criteria.</p> <p>Immunizations documented using a generic header or "Tdap/Td" can be counted as evidence of Tdap. The burden on organizations to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.</p>

### Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member's 13th birthday.

**Note**

- To align with Advisory Committee On Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal conjugate vaccine (serogroups A, C, W and Y) is included in the measure.
- This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table IMA-4: Data Elements for Adolescent Immunization Status**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		Each of the 5 rates
Current year's administrative rate (before exclusions)		Each of the 5 rates
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		Each of the 5 rates
Administrative rate on FSS		Each of the 5 rates
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	Each of the 5 rates	Each of the 5 rates
Numerator events by medical records		Each of the 5 rates
Numerator events by supplemental data	Each of the 5 rates	Each of the 5 rates
Reported rate	Each of the 5 rates	Each of the 5 rates
Lower 95% confidence interval	Each of the 5 rates	Each of the 5 rates
Upper 95% confidence interval	Each of the 5 rates	Each of the 5 rates

## Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Added instructions to identify direct transfers.
- Added instructions to identify ED visits that result in an inpatient stay.
- Clarified that an AOD diagnosis is not required for direct transfers when identifying the IESD.

### Description

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

- *Initiation of AOD Treatment.* 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.
- *Engagement of AOD Treatment.* 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.

### Definitions

<b>Intake Period</b>	January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
<b>Index Episode</b>	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit during the Intake Period with a diagnosis of AOD. <i>For ED visits that result in an inpatient stay, the inpatient discharge is the Index Episode.</i>
<b>IESD</b>	Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD. <i>For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.</i> <i>For an inpatient stay, the IESD is the date of discharge.</i> <i>For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.</i> <i>For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer).</i>
<b>Negative Diagnosis History</b>	A period of 60 days (2 months) before the IESD when the member had no claims/encounters with a diagnosis of AOD dependence. <i>For an inpatient stay, use the admission date to determine the Negative Diagnosis History.</i> <i>For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.</i>

An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.

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

**Direct transfer**

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

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

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

**Product line** Marketplace

**Ages** 13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate.

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

**Continuous enrollment** 60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).

**Allowable gap** None.

**Anchor date** None.

**Benefit** Medical and chemical dependency (inpatient and outpatient).

**Note:** Members with detoxification-only chemical dependency benefits do not meet these criteria.

**Event/diagnosis** New episode of AOD during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

**Step 1** Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria:
  - 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.
- A detoxification visit (Detoxification Value Set).
- An ED visit (ED Value Set) with a diagnosis of AOD (AOD Dependence Value Set).
- An acute or nonacute inpatient discharge with either a diagnosis of AOD (AOD Dependence Value Set) or an AOD procedure code (AOD Procedures Value Set). To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.

*For members with more than one episode of AOD, use the first episode.*

*For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.*

Select the IESD.

**Step 2** Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (AOD Dependence Value Set) during the 60 days (2 months) before the IESD.

*For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.*

*For an ED visit that results in an inpatient stay, use the ED date of service to determine the 60-day Negative Diagnosis History period. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.*

**Step 3** Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 44 days after the IESD, with no gaps.

## Administrative Specification

**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 member is compliant.*

*If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member 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 acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- 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.

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.

Exclude the member from the denominator for both indicators (*Initiation of AOD Treatment and Engagement of AOD Treatment*) if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

**Engagement of AOD Treatment**

Identify all members who meet the following criteria:

- Numerator compliant for the *Initiation of AOD Treatment* numerator **and**
- Two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). 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 acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute or nonacute inpatient admissions:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the admission date for the stay.
  - 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 members who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.*

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying engagement of AOD treatment.

The time frame for engagement, which includes the initiation event, is 30 total days.



**Note**

- Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table IET-4: Data Elements for Initiation and Engagement of AOD Dependence Treatment**

Element	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	<i>Each age stratification and total</i>
Numerator events by administrative data	<i>Each rate, for each age stratification and total</i>
Reported rate	<i>Each rate, for each age stratification and total</i>
Lower 95% confidence interval	<i>Each rate, for each age stratification and total</i>
Upper 95% confidence interval	<i>Each rate, for each age stratification and total</i>

## Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- No changes to this measure.

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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- Measure collection is based on enrollee responses to a subset of the QHP Enrollee Survey questions.

Organizations should refer to the CMS Web site (<http://qhpcahps.cms.gov/>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the HEDIS for QRS measures. The QHP Enrollee Survey response data are submitted to CMS through the QHP Enrollee Survey Web site.

### Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

<b>Advising Smokers and Tobacco Users to Quit</b>	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
<b>Discussing Cessation Medications</b>	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
<b>Discussing Cessation Strategies</b>	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

### Eligible Population

<b>Product line</b>	Marketplace.
<b>Ages</b>	18 years and older as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The last six months of the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 31 days during the measurement year.
<b>Current enrollment</b>	Currently enrolled at the time the survey is completed.

### Protocol and Survey Instrument

Collected annually by CMS as part of the QHP Enrollee Survey using a rolling average methodology.

## Questions Included in the Measure

**Table MSC: Medical Assistance With Smoking and Tobacco Use Cessation**

	Question	Response Choices
Q61	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all → If Not at all, Go to Question 65 Don't know → If Don't know, Go to Question 65
Q62	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q63	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q64	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

## Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

Rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

### Advising Smokers and Tobacco Users to Quit

<b>Denominator</b>	The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices <i>must</i> be as follows to be included in the denominator: Q61 = "Every day" or "Some days." Q62 = "Never" or "Sometimes" or "Usually" or "Always."
<b>Numerator</b>	The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q62.

### Discussing Cessation Medications

<b>Denominator</b>	The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices <i>must</i> be as follows to be included in the denominator: Q61 = "Every day" or "Some days." Q63 = "Never" or "Sometimes" or "Usually" or "Always."
<b>Numerator</b>	The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering "Sometimes" or "Usually" or "Always" to Q63.

**Discussing Cessation Strategies**

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<b>Denominator</b>	The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices <i>must</i> be as follows to be included in the denominator: Q61 = “Every day” or “Some days.” Q64 = “Never” or “Sometimes” or “Usually” or “Always.”
<b>Numerator</b>	The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q64.

## Medication Management for People With Asthma (MMA)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

### HEDIS FOR QRS SPECIFIC GUIDANCE

- QHP organizations report only Medication Compliance 75% indicator.

### Description

The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. The following rate is reported:

- The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

### Definitions

<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
<b>Treatment period</b>	The period of time beginning on the IPSD through the last day of the measurement year.
<b>PDC</b>	Proportion of days covered. The number of days that a member is covered by at least one asthma controller medication, divided by the number of days in the treatment period.
<b>Oral medication dispensing event</b>	<p>One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (<math>100/30 = 3.33</math>, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is filled.</p> <p>Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.</p> <ul style="list-style-type: none"> <li>• <i>Two prescriptions</i> for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).</li> <li>• <i>Two prescriptions</i> for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).</li> <li>• <i>Two prescriptions</i> for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).</li> <li>• <i>Two prescriptions</i> for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).</li> </ul>

**Inhaler dispensing event**

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

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

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

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

**Injection dispensing event**

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

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

**Calculating number of days covered for the numerator**

If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication. For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller.

Subtract any days supply that extends beyond December 31 of the measurement year.

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

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

**Product line**

Marketplace.

**Ages**

5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate:

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

The total is the sum of the age stratifications.

<b>Continuous enrollment</b>	The measurement year and the year prior to the measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefits</b>	Medical. Pharmacy during the measurement year.
<b>Event/diagnosis</b>	Follow the steps below to identify the eligible population for the measure.
<b>Step 1</b>	<p>Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</p> <ul style="list-style-type: none"> <li>• At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>).</li> <li>• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>).</li> <li>• At least four outpatient visits (<u>Outpatient Value Set</u>) or observation visits (<u>Observation Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) <b>and</b> at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits.</li> <li>• At least four asthma medication dispensing events (Table MMA-A).</li> </ul>

**Table MMA-A: Asthma Medications**

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

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

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

- Step 3:** Exclude members who met any of the following criteria:
- Required exclusions**
- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
    - Emphysema Value Set.
    - Other Emphysema Value Set.
    - COPD Value Set.
    - Obstructive Chronic Bronchitis Value Set.
    - Chronic Respiratory Conditions Due to Fumes/Vapors Value Set.
    - Cystic Fibrosis Value Set.
    - Acute Respiratory Failure Value Set.
  - Members who had no asthma controller medications (Table MMA-B) dispensed during the measurement year.

**Table MMA-B: Asthma Controller Medications**

Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline

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

## Administrative Specification

**Denominator** The eligible population.

### Numerator

**Medication Compliance 75%** The number of members who achieved a PDC of at least 75% for their asthma controller medications (Table MMA-B) during the measurement year.

Follow the steps below to identify numerator compliance.

- Step 1** Identify the IPSP. The IPSP is the earliest dispensing event for any asthma controller medication (Table MMA-B) during the measurement year.
- Step 2** To determine the treatment period, calculate the number of days beginning on the IPSP through the end of the measurement year.
- Step 3** Count the days covered by at least one prescription for an asthma controller medication (Table MMA-B) during the treatment period. To ensure that a days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.



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

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

**Medication Compliance 75%** Sum the number of members whose PDC is  $\geq 75\%$  for their treatment period.

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table MMA-4: Data Elements for Medication Management for People With Asthma**

Data Elements	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Number of required exclusions	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>
Lower 95% confidence interval	<i>For each age stratification and total</i>
Upper 95% confidence interval	<i>For each age stratification and total</i>

## Plan All-Cause Readmissions (PCR)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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- HEDIS for QRS uses the commercial risk weights for risk adjustment.

#### Description

For members 18-64 years of age, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

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

#### Definitions

<b>IHS</b>	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
<b>Index Admission Date</b>	The IHS admission date.
<b>Index Discharge Date</b>	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
<b>Index Readmission Stay</b>	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
<b>Index Readmission Date</b>	The admission date associated with the Index Readmission Stay.
<b>Planned Hospital Stay</b>	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the <i>Eligible Population</i> .
<b>Classification Period</b>	365 days prior to and including an Index Discharge Date.

**Risk Adjustment Tables**

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

**Note:** The risk adjustment tables will be released on November 1, 2016, and posted to [www.ncqa.org](http://www.ncqa.org).

**Eligible Population**

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18-64 as of the Index Discharge Date.
<b>Continuous enrollment</b>	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
<b>Allowable gap</b>	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.
<b>Anchor date</b>	Index Discharge Date.
<b>Benefit</b>	Medical.
<b>Event/ diagnosis</b>	<p>An acute inpatient discharge on or between January 1 and December 1 of the measurement year.</p> <p>The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year.</p> <p>Follow the steps below to identify acute inpatient stays.</p>

**Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Step 1</b>	<p>Identify all acute inpatient discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<a href="#">Inpatient Stay Value Set</a>).</li> <li>2. Exclude nonacute inpatient stays (<a href="#">Nonacute Inpatient Stay Value Set</a>).</li> <li>3. Identify the discharge date for the stay.</li> </ol>

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.

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

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

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

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

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

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

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

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

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

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

**Step 5:** For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays: identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year:  
**Required  
exclusions**

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

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

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

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

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

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

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

**Step 6** Calculate continuous enrollment.

**Step 7** Assign each acute inpatient stay to an age category. Refer to Table PCR-A-4.

## Risk Adjustment Determination

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

<b>Surgeries</b>	Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.
<b>Discharge Condition</b>	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute direct transfers, use the direct transfer's primary discharge diagnosis.  Exclude diagnoses that cannot be mapped to Table PCR-DischCC.
<b>Comorbidities</b>	Refer to <i>Utilization Risk Adjustment Determination</i> in the <i>Guidelines for Risk Adjusted Utilization Measures</i> .

## **Risk Adjustment Weighting**

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

**Note:** The final weights table will be released on November 1, 2016. HEDIS for QRS uses the Commercial Risk Weights for risk adjustment.

**Step 1** For each IHS with a surgery, link the surgery weight.

Use Table PCR-Comm-OtherWeights.

**Step 2** For each IHS with a discharge CC Category, link the primary discharge weights.

Use Table PCR-Comm-DischCC-Weight.

**Step 3** For each IHS with a comorbidity HCC Category, link the weights.

Use Table PCR-Comm-ComorbHCC-Weight.

**Step 4** Link the age and gender weights for each IHS.

Use Table PCR-Comm-OtherWeights.

**Step 5** Identify the base risk weight.

Use Table PCR-Comm-OtherWeights to determine the base risk weight.

**Step 6** Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).

**Step 7** Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.

Adjusted probability of readmission =

$$\frac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$$

**OR**

Adjusted probability of readmission = [exp (sum of weights for IHS )] / [ 1 + exp (sum of weights for IHS) ]

**Note:** “Exp” refers to the exponential or antilog function.

**Step 8** Use the formula below and the adjusted probability of readmission calculated in step 7 to calculate the variance for each IHS.

Variance = Adjusted probability of readmission x (1 – Adjusted probability of readmission)

*Example:* If the adjusted probability of readmission is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

**Note:** The variance is calculated at the IHS level. Organizations must sum the variances for each age/gender and total category when populating the Total Variance cells in the reporting tables.

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-9 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Adjusted Probability	Variance
								Category	Weight	Category	Weight			
1250	1	-1.08883	57	Female	0.1000	-0.2800	250.4	15	0.0700	20	0.1400	-0.8600	0.2976	0.2090
										25	0.2000			
4010	1	-1.08883	50.00	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.2811	0.2021
4010	2	-1.08883	50.00	Male	0.1200	NA	298.00	77	0.0600	5	0.0100	-0.5700	0.3615	0.2308
										47	0.3300			

\*Each Member ID field with a value represents a unique IHS.

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

**Step 1** Identify all acute inpatient stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:

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

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

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

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

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

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

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

**Step 3** Exclude acute inpatient hospital admissions with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

**Step 4** For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

### **Reporting: Denominator**

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Count the number of IHS for each age and enter these values into the reporting table.

### **Reporting: Risk Adjustment**

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**Step 1** Calculate the average adjusted probability for each IHS for each age and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable age group to calculate the average (which is reported to NCQA). For the total age category, the probability of readmission for all hospital stays in the age categories must be averaged together; organizations cannot take the average of the average adjusted probabilities reported for each age.



**Step 2** Round to four decimal places using the .5 rule and enter these values into the reporting table.

**Note:** *Do not take the average of the cells in the reporting table.*

**Example** For the “18–44” age category:

- Identify all IHS by 18–44 year-old males and calculate the average adjusted probability.
- Identify all IHS by 18–44 year-old females and calculate the average adjusted probability.
- Identify all IHS by all 18–44 year-olds and calculate the average adjusted probability.

Repeat for each subsequent group.

**Step 3** Calculate the total (sum) variance for each age and the overall total.

**Step 4** Round to four decimal places using the .5 rule and enter these values into the reporting table.

## Plan All-Cause Readmissions

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### Reporting: Numerator

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Count the number of IHS with a readmission within 30 days for each age and enter these values into the reporting table.

**Table PCR-A-4: Plan All-Cause Readmissions Rates by Age and Risk Adjustment**

Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Numerator)	Observed Readmissions (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmissions/Average Adjusted Probability)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18-44	_____	_____	_____	_____	_____			
45-54	_____	_____	_____	_____	_____			
55-64	_____	_____	_____	_____	_____			
<i>Total</i>	_____	_____	_____	_____	_____	_____	_____	_____

## Prenatal and Postpartum Care (PPC)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Clarified that the prenatal visit for the *Timeliness of Prenatal Care* numerator can occur on the date of enrollment.
- Clarified in the *Note* that the EDD must be on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
- Added a *Note* explaining that the organization may use EDD to identify the first trimester for the *Timeliness of Prenatal Care* rate and use the date of delivery for the *Postpartum Care* rate.
- Replaced “Each of the 2 rates” with a “✓” for the “Measurement year” row in Table PPC-4.

### Description

The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	None specified.
<b>Continuous enrollment</b>	43 days prior to delivery through 56 days after delivery.
<b>Allowable gap</b>	No allowable gap during the continuous enrollment period.
<b>Anchor date</b>	Date of delivery.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	<p>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting.</p> <p><i>Multiple births.</i> Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.</p>

Follow the steps below to identify the eligible population, which is the denominator for both rates.

- Step 1** Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
- Step 2** Exclude non-live births (Non-live Births Value Set).
- Step 3** Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 56 days after delivery, with no gaps.

### **Administrative Specification**

**Denominator** The eligible population.

**Numerator**

**Timeliness of Prenatal Care** A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

*Include only visits that occur while the member was enrolled.*

Follow the steps below to identify the numerator.

- Step 1** Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.

For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.

- Step 2** Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester*.

For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.

- Step 3** Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).

*For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.*

*For women whose last enrollment started less than 219 days before delivery, proceed to step 5.*

- Step 4** Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit on or between the last enrollment start date and 176 days before delivery.

- Step 5** Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* and find a visit on the enrollment start date or within 42 days after enrollment.

### Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester

<b>Decision Rule 1</b>	<p>Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:</p> <ul style="list-style-type: none"> <li>• A bundled service (<u>Prenatal Bundled Services Value Set</u>) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).</li> <li>• A visit for prenatal care (<u>Stand Alone Prenatal Visits Value Set</u>).</li> </ul>
<b>Decision Rule 2</b>	<p>Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN or other prenatal care practitioner, meet criteria:</p> <ul style="list-style-type: none"> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with an obstetric panel (<u>Obstetric Panel Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with an ultrasound (echocardiography) of the pregnant uterus (<u>Prenatal Ultrasound Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with a pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with all of the following: <ul style="list-style-type: none"> <li>– Toxoplasma (<u>Toxoplasma Antibody Value Set</u>).</li> <li>– Rubella (<u>Rubella Antibody Value Set</u>).</li> <li>– Cytomegalovirus (<u>Cytomegalovirus Antibody Value Set</u>).</li> <li>– Herpes simplex (<u>Herpes Simplex Antibody Value Set</u>).</li> </ul> </li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with rubella (<u>Rubella Antibody Value Set</u>) and ABO (<u>ABO Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with rubella (<u>Rubella Antibody Value Set</u>) and Rh (<u>Rh Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with rubella (<u>Rubella Antibody Value Set</u>) and ABO/Rh (<u>ABO and Rh Value Set</u>).</li> </ul>
<b>Decision Rule 3</b>	<p>Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:</p> <ul style="list-style-type: none"> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with a pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>) and an obstetric panel (<u>Obstetric Panel Value Set</u>).</li> <li>• A prenatal visit (<u>Prenatal Visits Value Set</u>) with a pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>) and an ultrasound (echocardiography) of the pregnant uterus (<u>Prenatal Ultrasound Value Set</u>).</li> </ul>

- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following:
  - Toxoplasma (Toxoplasma Antibody Value Set).
  - Rubella (Rubella Antibody Value Set).
  - Cytomegalovirus (Cytomegalovirus Antibody Value Set).
  - Herpes simplex (Herpes Simplex Antibody Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with an obstetrical history.
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with risk assessment and counseling/education.

**Note:** For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits Value Set) **and** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.

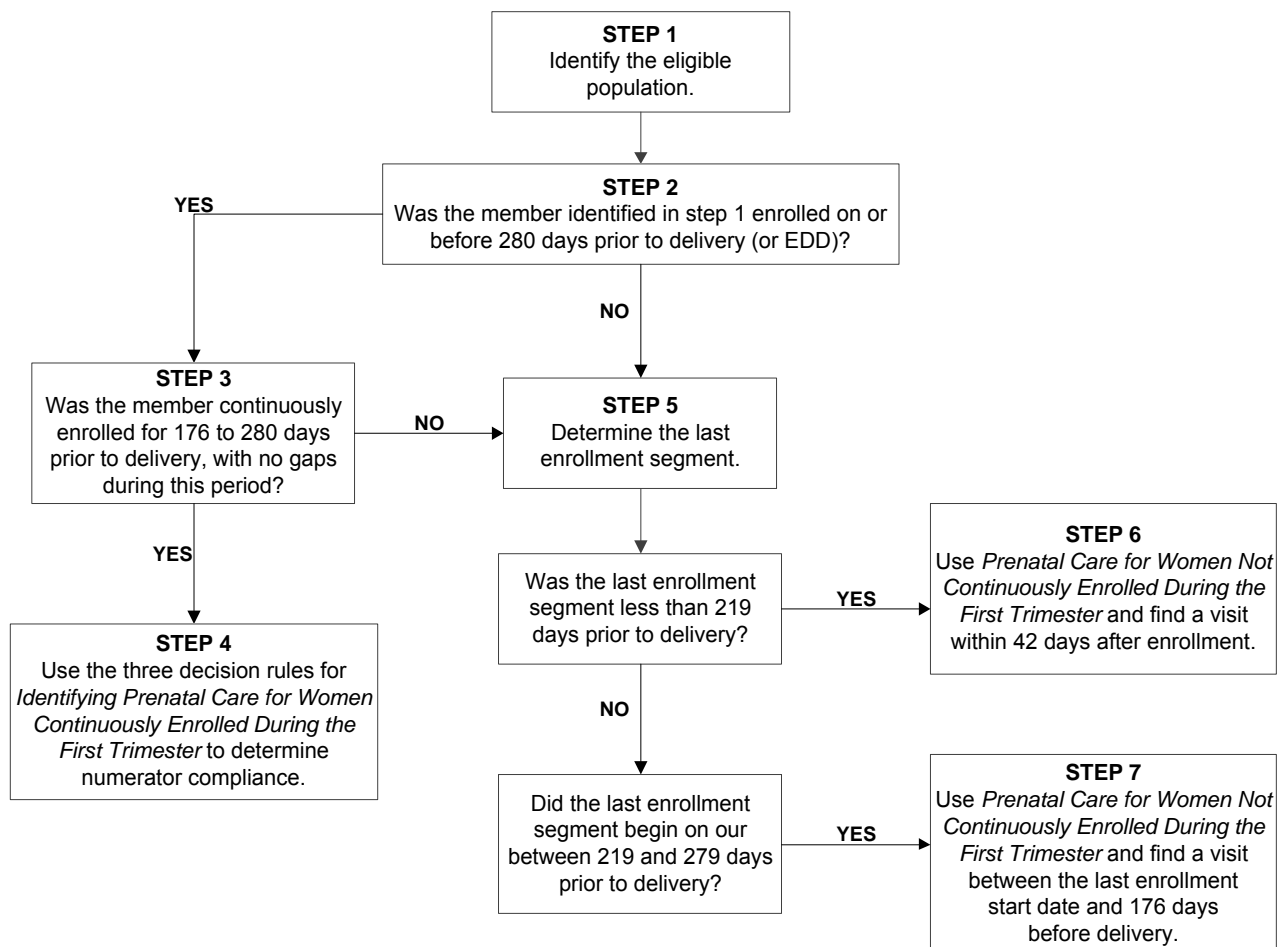
### **Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester**

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Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

**Note:** For criteria that require a prenatal visit code (Prenatal Visits Value Set) and a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.



- Postpartum Care** A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:
- A postpartum visit ([Postpartum Visits Value Set](#)).
  - Cervical cytology ([Cervical Cytology Value Set](#)).
  - A bundled service ([Postpartum Bundled Services Value Set](#)) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

**Note:** The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.

### Hybrid Specification

**Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate for the two indicators or the prior year's audited, product line-specific rate for the two indicators. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

**Numerator**

***Timeliness of Prenatal Care*** A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled.

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

**Medical record** Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
  - TORCH antibody panel alone, **or**
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
  - Echography of a pregnant uterus.
- Documentation of LMP or EDD in conjunction with *either* of the following.
  - Prenatal risk assessment and counseling/education.
  - Complete obstetrical history.

**Note:** For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a



*gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a diagnosis of pregnancy.*

**Postpartum Care** A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

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

**Medical record** Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.

#### **Note**

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- *For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.*
- *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
  - *For women whose last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.*
- *The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between November 6 of the year prior to the measurement year and November 5 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.*

## Prenatal and Postpartum Care

- The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.
- Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal practitioners.

### Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table PPC-4: Data Elements for Prenatal and Postpartum Care**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Eligible population	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>For each of the 2 rates</i>
Current year's administrative rate (before exclusions)		<i>For each of the 2 rates</i>
Minimum required sample size (MRSS) or other sample size		<i>For each of the 2 rates</i>
Oversampling rate		<i>For each of the 2 rates</i>
Final sample size (FSS)		<i>For each of the 2 rates</i>
Number of numerator events by administrative data in FSS		<i>For each of the 2 rates</i>
Administrative rate on FSS		<i>For each of the 2 rates</i>
Number of original sample records excluded because of valid data errors		<i>For each of the 2 rates</i>
Number of employee/dependent medical records excluded		<i>For each of the 2 rates</i>
Records added from the oversample list		<i>For each of the 2 rates</i>
Denominator		<i>For each of the 2 rates</i>
Numerator events by administrative data	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Numerator events by medical records		<i>For each of the 2 rates</i>
Reported rate	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Lower 95% confidence interval	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Upper 95% confidence interval	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>

## Relative Resource Use for People With Diabetes (RDI)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- No changes to this measure.

### HEDIS FOR QRS SPECIFIC GUIDANCE

- Organizations report only the data elements necessary to calculate the Inpatient Facility Index.

#### Description

The relative resource use by members with diabetes during the measurement year.

#### Eligible Population

**Note:** Organizations must report the quality measure (CDC) when reporting RDI. Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18–75 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the measurement year.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	<p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. Organizations must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> <li>• At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>), on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits.</li> <li>• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a diagnosis of diabetes (<u>Diabetes Value Set</u>).</li> </ul>

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

### Exclusions (optional)

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Identify members 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 had a diagnosis of gestational diabetes or steroid-induced diabetes ([Diabetes Exclusions Value Set](#)), in any setting, during the measurement year or the year prior to the measurement year.

**Note:** If the optional exclusions are applied for the CDC measure, they must be applied for the RDI measure. If the optional exclusions are not applied for the CDC measure, they may not be applied to the RDI measure. Because RDI is administrative only, do not exclude members from this measure based on exclusions found during chart review for the CDC measure. Members must be included in RDI even if they are excluded during chart review for CDC.

### Exclusions (required)

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Refer to Required Exclusions in the Guidelines for Relative Resource Use.

## Categorization of Eligible Population

**Major clinical condition** Diabetes.

**Risk group** Refer to *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use*.

## Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA's Web site by November 1, 2016).

**Apply standard price** SPTs categorize services as Inpatient Facility.

Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to NCQA's SPTs.

**Calculate total cost** Sum the total standard cost for each eligible member. Within each service category, if a member's standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA Cost Cap Amounts table (released with the SPTs).

Sum and report the total standard cost for the eligible population in each service category by member cohort.

## Service Frequency Calculations

**Total frequency of service**

Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. An organization reports each eligible member's services rendered during the treatment period for the following utilization categories:

- *Acute Medicine*: Discharges, Days.
- *Acute Surgery*: Discharges, Days.
- *Nonacute*: Discharges, Days.

**Inpatient Facility**

This category measures the number of acute and nonacute inpatient facility discharges and days regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.

Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days.

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table RDI-A-4: Data Elements for Relative Resource Use for People With Diabetes**

Metadata ID	Metadata Specification Name
EligiblePopulation	Eligible Population
Exclusions	Exclusions

**Table RDI-B-4: Data Elements for Relative Resource Use for People With Diabetes**

Gender	Age	Risk Group	Type	Metric Specification Name
Male	18-44	1	Cost	Inpatient Facility
Female	45-54	2	Count	Inpatient Facility: Acute Inpatient: Medical Days
	55-64	3	Count	Inpatient Facility: Acute Inpatient: Medical Discharges
	65-75	4	Count	Inpatient Facility: Acute Inpatient: Surgery Days
		5	Count	Inpatient Facility: Acute Inpatient: Surgery Discharges
		6	Count	Inpatient Facility: Nonacute: Days
		7	Count	Inpatient Facility: Nonacute: Discharges
		8	Mem	Member Months Medical
		9		
		10		
		11		
		12		
		13		

**Table RDI-C-4: Data Elements for Relative Resource Use for People With Diabetes**

Data Element
Exclusions
Inpatient Facility PMPM
Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY
Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY
Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY
Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY
Inpatient Facility: Nonacute Days per 1,000 MY
Inpatient Facility: Nonacute Discharges per 1,000 MY
Inpatient Facility Acute Medical ALOS
Inpatient Facility Acute Surgery ALOS
Inpatient Facility Nonacute ALOS
Total Inpatient Facility Acute ALOS
Total Inpatient Facility ALOS

**Note:** This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.

## Use of Imaging Studies for Low Back Pain (LBP)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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

### Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

### Calculation

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

### Definitions

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

## Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	180 days (6 months) prior to the IESD through 28 days after the IESD.
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Anchor date</b>	IESD.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Follow the steps below to identify the eligible population.

- Step 1** Identify all members in the specified age range who had any of the following during the Intake Period:
- Outpatient visit (Outpatient Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Observation visit (Observation Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include observation visits that result in an inpatient stay (Inpatient Stay Value Set). An observation visit results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.
  - ED visit (ED Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set). Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.
  - Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Physical Therapy visit (Physical Therapy Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Telehealth visit (Telehealth Value Set), with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Step 2** Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.
- Step 3** Test for Negative Diagnosis History. Exclude members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.



**Step 4:** Exclude any member who had a diagnosis for which imaging is clinically appropriate.  
**Required** Any of the following meet criteria:  
**exclusions**

- **Cancer.** Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:
  - Malignant Neoplasms Value Set.
  - Other Neoplasms Value Set.
  - History of Malignant Neoplasm Value Set.
- **Recent trauma.** Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- **Intravenous drug abuse.** IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **Neurologic impairment.** Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **HIV.** HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.
- **Spinal infection.** Spinal Infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **Major organ transplant.** Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- **Prolonged use of corticosteroids.** 90 consecutive days of corticosteroid treatment any time during the 12 months (1 year) prior to and including the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Table LBP-A). For overlapping prescriptions assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

No gaps are allowed.

**Table LBP-A: Corticosteroid Medications**

Description	Prescription
Corticosteroid	<ul style="list-style-type: none"> <li>• Hydrocortisone</li> <li>• Cortisone</li> <li>• Prednisone</li> <li>• Prednisolone</li> <li>• Methylprednisolone</li> <li>• Triamcinolone</li> <li>• Dexamethasone</li> <li>• Betamethasone</li> </ul>

**Step 5** Calculate and continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

### Administrative Specification

**Denominator** The eligible population.

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

Do not include denied claims.

### Note

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

### Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table LBP-4: Data Elements for Use of Imaging Studies for Low Back Pain**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

- Included examples of services specific to the assessment or treatment of an acute or chronic condition that do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.
- Replaced “Each of the 3 rates” with “✓” for the “Measurement year” row in Table WCC-4.

### Description

The percentage of members 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.
  - Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- Counseling for nutrition.
- Counseling for physical activity.

### Definitions

**BMI percentile** The percentile ranking based on the CDC’s BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among others of the same gender and age.

### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators: <ul style="list-style-type: none"><li>• 3–11 years.</li><li>• 12–17 years.</li><li>• Total.</li></ul> The total is the sum of the age stratifications.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
<b>Anchor date</b>	December 31 of the measurement year.

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	Members who had an outpatient visit ( <u>Outpatient Value Set</u> ) with a PCP or an OB/GYN during the measurement year.

### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerators</b>	
<b><i>BMI Percentile</i></b>	BMI percentile ( <u>BMI Percentile Value Set</u> ) during the measurement year.
<b><i>Counseling for Nutrition</i></b>	Counseling for nutrition ( <u>Nutrition Counseling Value Set</u> ) during the measurement year.
<b><i>Counseling for Physical Activity</i></b>	Counseling for physical activity ( <u>Physical Activity Counseling Value Set</u> ) during the measurement year.

### Exclusions (optional)

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Members 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 members must do so for all rates.

### Hybrid Specification

<b>Denominator</b>	<p>A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.</p> <p>Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
<b>Numerators</b>	
<b><i>BMI Percentile</i></b>	BMI percentile during the measurement year as identified by administrative data or medical record review.
<b><u>Administrative</u></b>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
<b><u>Medical record</u></b>	<p>Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.</p> <p>Either of the following meets criteria for BMI percentile:</p> <ul style="list-style-type: none"><li>• BMI percentile documented as a value (e.g., 85th percentile).</li><li>• BMI percentile plotted on age-growth chart.</li></ul> <p>Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.</p>

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

***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.
- Member 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.

**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 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.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

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### **Exclusions (optional)**

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

**Note**

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- The following notations or examples of documentation do not count as numerator compliant:
  - **BMI**
    - No 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 of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.
    - 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; however services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators. For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - Notation that a member with chronic knee pain is able to run without limping.
  - Notation that a member has exercise-induced asthma.
  - Notation that a member with diarrhea is following the BRAT diet.
  - Notation that a member has decreased appetite as a result of an acute or chronic condition.
- Refer to Appendix 1 for the definition of PCP and OB/GYN practitioner.

## Data Elements for Reporting

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table WCC-4: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>
Eligible population	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 3 rates, for each age stratification and total</i>
Current year's administrative rate (before exclusions)		<i>Each of the 3 rates, for each age stratification and total</i>
Minimum required sample size (MRSS) or other sample size		<i>Each of the 3 rates</i>
Oversampling rate		<i>Each of the 3 rates</i>
Final sample size (FSS)		<i>Each of the 3 rates</i>
Number of numerator events by administrative data in FSS		<i>Each of the 3 rates, for each age stratification and total</i>
Administrative rate on FSS		<i>Each of the 3 rates, for each age stratification and total</i>
Number of original sample records excluded because of valid data errors		<i>Each of the 3 rates</i>
Number of administrative data records excluded		<i>Each of the 3 rates</i>
Number of medical records excluded		<i>Each of the 3 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 3 rates</i>
Records added from the oversample list		<i>Each of the 3 rates</i>
Denominator		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by administrative data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by medical records		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by supplemental data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Reported rate	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Lower 95% confidence interval	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Upper 95% confidence interval	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>

## Well-Child Visits in the First 15 Months of Life (W15)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS

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- No changes to this measure.

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### HEDIS FOR QRS SPECIFIC GUIDANCE

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- QHP organizations report only the *Six or more well-child visits* indicator.

#### Description

The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Age</b>	15 months old during the measurement year.
<b>Continuous enrollment</b>	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2015, turns 15 months old on April 9, 2016.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
<b>Anchor date</b>	Day the child turns 15 months old.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	<p>The number of members who received 6 or more well-child visits (<u>Well-Care Value Set</u>), on different dates of service, with a PCP during their first 15 months of life.</p> <p>The well-child visits must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.</p>



**Note**

- Refer to Appendix 1 for the definition of PCP.
- This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at [www.aap.org](http://www.aap.org) and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at [www.brightfutures.org](http://www.brightfutures.org) for more information about well-child visits.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table W15-4: Data Elements for Well-Child Visits in the First 15 Months of Life**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

## Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

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### SUMMARY OF CHANGES TO 2017 HEDIS FOR QRS 2016

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- No changes to this measure.

#### Description

The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

#### Eligible Population

**Note:** Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

<b>Product line</b>	Marketplace.
<b>Ages</b>	3–6 years as of December 31 of the measurement year.
<b>Continuous enrollment</b>	The measurement year.
<b>Allowable gap</b>	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
<b>Anchor date</b>	December 31 of the measurement year.
<b>Benefit</b>	Medical.
<b>Event/diagnosis</b>	None.

#### Administrative Specification

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	At least one well-child visit ( <u>Well-Care Value Set</u> ) with a PCP during the measurement year.  The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

#### Note

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- Refer to Appendix 1 for the definition of PCP.
  - This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits.
  - Refer to the American Academy of Pediatrics Guidelines for Health Supervision at [www.aap.org](http://www.aap.org) and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at [www.brightfutures.org](http://www.brightfutures.org) for more information about well-child visits.

**Data Elements for Reporting**

Organizations that submit HEDIS for QRS data to NCQA must provide the following data elements.

**Table W34-4: Data Elements for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

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# Appendix 1: Practitioner Types

## APPENDIX 1

### PRACTITIONER TYPES

**clinical  
pharmacist**

A pharmacist with extensive education in the biomedical, pharmaceutical, socio-behavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications.

Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.

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**dental practitioner**

A practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.

Certified and licensed dental hygienists are considered dental practitioners.

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**mental health  
practitioner**

A practitioner who provides mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.

- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

**OB/GYN and other prenatal care practitioner**

Includes:

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
- Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).

**PCP**

Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.

Licensed practical nurses and registered nurses are not considered PCPs.

**prescribing practitioner**

A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

**primary care physician**

Includes:

- General or family practice physicians.
- Geriatricians.
- General internal medicine physicians.
- General pediatricians.
- Obstetricians/gynecologists (OB/GYN).

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## **Appendix 2: Data Element Definitions**

## APPENDIX 2

### DATA ELEMENT DEFINITIONS

Element	Admin	Hybrid	Research	Meaning
Measurement year	✓	✓		Data year (i.e., year prior to reporting year). For 2017 HEDIS for QRS, the measurement year is 2016.
Data collection methodology (Administrative or Hybrid)	✓	✓		Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample.
Eligible population	✓	✓		<ul style="list-style-type: none"> <li>Members who meet all criteria for the population. This is the universe of members for each measure.</li> <li>For administrative measures, the eligible population is reported after evaluation for optional exclusion criteria and after required exclusions are applied.</li> <li>For hybrid measures, the eligible population of members is reported prior to optional exclusions and after required exclusions are applied (see <i>Guidelines for Calculations and Sampling</i> for the three approaches to conducting the Hybrid Method).</li> </ul>
Number of optional exclusions			✓	Number of members excluded from the eligible population because they did not meet the numerator criteria and did meet the optional exclusion criteria.
Number of required exclusions			✓	Number of members excluded from the eligible population because they did meet the required exclusion criteria.
Number of numerator events by administrative data in eligible population (before exclusions)		✓		The number of members in the eligible population who met the numerator criteria.
Current year's administrative rate (before exclusions)		✓		This is a calculated field in IDSS. Numerator events by administrative data in eligible population ÷ eligible population.
Minimum required sample size (MRSS) or other sample size		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines.
Oversampling rate		✓		The percentage of additional records needed to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA.
Final sample size (FSS)		✓		Minimum required sample size + oversample.
Number of numerator events by administrative data in FSS		✓		Number of members in the final sample size who meet numerator criteria through transactional data.
Administrative rate on FSS		✓		This is a calculated field in IDSS. Numerator events by administrative data in the FSS ÷ FSS.
Number of original sample records excluded because of valid data errors		✓		If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error.

Element	Admin	Hybrid	Research	Meaning
Number of administrative data records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using system or transactional data.
Number of records excluded because of false positive diagnoses*			✓	This is an optional data element in <i>Controlling High Blood Pressure</i> . NCQA will analyze the exclusion criteria. Organizations may choose to report their exclusions using this element, but this element will only be used for analysis and not for calculating the measure.
Number of medical records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using medical record data.
Number of employee/dependent medical records excluded		✓		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee.
Exclusions			✓	The number of required/optional exclusions. NCQA will use this element for research and analysis. The element will not be used for calculating the measure.
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error.
Denominator		✓		MRSS – exclusions + members added from the auxiliary list. This population is the denominator used to report the measure.
Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using transactional data.
Numerator events by supplemental data	✓	✓		The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
Numerator events by medical records		✓		The number of members in the denominator who met numerator criteria using medical record data.
Reported rate	✓	✓		This is a calculated field in IDSS. <i>Administrative Method:</i> Numerator events by administrative data/ eligible population <i>Hybrid Method:</i> Numerator events by administrative data + numerator events by medical records/denominator. <b>Note:</b> Numerator events are collected separately for administrative, medical record and supplemental data. For these measures, the reported rate calculation is the sum of all numerator events by administrative data, medical record data and supplemental data, divided by the eligible population for administrative measures, or by the denominator for hybrid measures (i.e., reported rate = numerator events by administrative data + numerator events by medical record data + numerator events by supplemental data / eligible population or denominator).
Lower 95% confidence interval	✓	✓		The organization is 95% sure that the reported rate falls between this lower rate and the upper confidence interval. This is a calculated field in IDSS.
Upper 95% confidence interval	✓	✓		The organization is 95% sure that the reported rate falls between this higher rate and the lower confidence interval. This is a calculated field in IDSS.

\*Data element is optional.

## Appendix 2—Data Element Definitions

**Standard Administrative Data Element Table**

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Number of optional exclusions	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

**Standard Hybrid Data Element Table**

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by supplemental data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

## **3. QRS Clinical Measure Specifications**

### **3.1 NCQA Measure Specifications**

### **3.2 PQA Measure Specifications**

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## 3.2 PQA Measure Specifications

### Overview

#### Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to improving health care quality and patient safety with a focus on the appropriate use of medications and development of strategies for measuring and reporting performance related to medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 150 member organizations. The mission of PQA is to improve the quality of medication management and use across healthcare settings with the goal of improving patients' health through a collaborative process to develop and implement performance measures and recognize examples of exceptional pharmacy quality.

#### PQA Measure Development Process

PQA develops medication-use measures in areas such as medication safety, medication adherence and appropriateness. PQA workgroups (comprised of individuals appointed by member organizations) identify measurement needs within the high-priority areas identified through the National Priorities Partnership, and aligns its activities with the National Quality Strategy.

PQA develops performance measures through a consensus-driven process to draft, test, refine and endorse measures of medication-use quality.

- Step 1: PQA workgroups comprised of experts in all phases of drug use and management identify measure concepts that may be appropriate for development into fully specified performance measures or indicators for organizational internal quality improvement. The workgroups focus on specific aspects of the medication-use system and/or specific therapeutic areas.
- Step 2: PQA workgroups recommend measure concepts to the PQA Quality Metrics Expert Panel (QMEP) for evaluation and refinement. The QMEP reviews the measure concepts to provide an initial assessment of the key properties of performance measures (i.e., feasibility, usability and scientific validity). The measure concepts that are rated highly on these key properties will undergo technical specification as draft measures.
- Step 3: The draft measures are provided to PQA member organizations for their comments prior to preparing technical specifications for pilot testing. PQA staff use member comments and workgroup and QMEP recommendations to formulate a testing plan for each draft measure.
- Step 4: PQA selects partners to test the draft measures. These partners are often PQA member health plans or academic institutions with expertise in quality and performance measure testing. The testing partner implements the draft technical specifications within their existing datasets and provides a report to PQA that details testing results and recommendations for modifications of the technical specifications.
- Step 5: The workgroup that developed the measure reviews the testing results and provides comment. The QMEP reviews the workgroup comments, testing results, recommendations and potential modifications and provides a final assessment of the feasibility and scientific validity of the draft performance measures.
- Step 6: Measures that are recommended by the QMEP for endorsement are posted on the PQA web site for member review, written comments are requested, and a conference call for member organizations is held to gather feedback and address any questions. This process allows members to discuss their views on the measures in advance of the voting period.

### 3.2 PQA Measure Specifications

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Step 7: PQA member organizations vote on endorsement of the Performance Measures and approval of Quality Improvement Indicators.

#### General Guidelines for the *Proportion of Days Covered* Measure Data Collection

Refer to NCQA's "General Guidelines for Data Collection" in Section 3.1 for details that will inform appropriate data collection for the *Proportion of Days Covered* measure. All general guidelines apply, with the exception of the following items specified below.

#### PQA Specific Guidelines for National Drug Codes Inclusion

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PQA compiles the NDC lists for the *Proportion of Days Covered* measure using three databases: First Databank, MediSpan, and the Food and Drug Administration's NDC Structured Product Labeling Data Elements (NSDE) file. NDCs are included in the file if:

- There is no obsolete date noted by the three sources; *or*
- The obsolete date in any of the three databases is within the measurement year; *or*
- The obsolete date is within six months prior to the beginning of the measurement year.

#### PQA Posting of the National Drug Code Lists

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The NDC lists for *Proportion of Days Covered* measure will be available by request from PQA. Please refer to the PQA website in order to obtain the NDC lists at <http://pqaalliance.org/measures/qrs.asp>.

- The final list of NDCs for 2016 will be available on November 2, 2016. That list will include current NDCs from January 1, 2015 through September 30, 2016 and NDCs with obsolete dates from July 1, 2014 through September 30, 2016.

#### Required Data Elements for the *Proportion of Days Covered* Measure

---

Organizations must provide the following data elements for the *Proportion of Days Covered* measure.

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each of the 3 rates</i>
Numerator events by administrative data	<i>For each of the 3 rates</i>
Reported rate	<i>For each of the 3 rates</i>
Lower 95% confidence interval	<i>For each of the 3 rates</i>
Upper 95% confidence interval	<i>For each of the 3 rates</i>



## Proportion of Days Covered (PDC): 3 Rates

### SUMMARY OF CHANGES

- The following addition was made to Rate 1: Renin Angiotensin System (RAS) Antagonists
  - Denominator Exclusion:**  
Patients with one or more prescription claims for the medication, sacubitril/valsartan. (Table PDC-B: Exclusion)
  - Table PDC-B: Exclusion was added**
- The following additions were made to Medication Tables in Rate 1: Renin Angiotensin System (RAS)
  - Table PDC-B: Renin Angiotensin System (RAS) Antagonists**  
Added to the subcategory ACE Inhibitor Combination Products
    - perindopril & amlodipine
- The following clarifying language was added to Rate 2: Diabetes medications
  - The prescriptions can be for the same or different medications, and can be from any of these seven tables.
- The following additions were made to Medication Tables in Rate 2: Diabetes Medications
  - Table PDC-D: Biguanide Medications**  
Added medication combinations to the subcategory Biguanide & SGLT2 Inhibitor Combinations
    - empagliflozin & metformin
  - Table PDC-H Insulins (Exclusion Table)**  
Added to the subcategory Human Insulins
    - insulin degludec

### Description

The percentage of patients 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement period.

Report a rate for each of the following:

- Renin Angiotensin System (RAS) Antagonists
- Diabetes All Class
- Statins

### Definitions

<b>IPSD</b>	Index prescription start date. The earliest prescription dispensing date for the target medication between January 1 and September 30 of the measurement year.
<b>Treatment period</b>	The period of time beginning on the IPSD through the last day of the measurement year, or until death or disenrollment. The treatment period must be at least 90 days long.
<b>PDC</b>	Proportion of days covered. The number of days that a patient is covered by prescription claims for the same medication or another in its therapeutic category, divided by the number of days in the treatment period.
<b>PDC threshold</b>	The level of PDC above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (80% for diabetes and cardiovascular drugs)

### 3.2 PQA Measure Specifications

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<b>Prescription Claims</b>	Only paid, non-reversed prescription claims are included in the data set to calculate the measure
<b>Calculating number of days covered for the numerator</b>	<p>If multiple prescriptions for different target medications (i.e. two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days supply.</p> <p>If multiple prescriptions for different target medications (i.e. two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days supply, count each day covered by a target medication only once within the treatment period. For example, if a prescription for simvastatin and a prescription for atorvastatin are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.</p> <p>If multiple prescriptions for the same target medication (i.e. one or more products with the same generic ingredient) are dispensed on the same day or different days where the days supply overlap, adjust the prescription start date to be the day after the previous fill has ended. For example, if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered.</p> <p>Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e. same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e. same generic ingredient) is common.</p> <p>Any days supply that extend beyond the end of the treatment period are not included when calculating the total number of days covered.</p> <p>The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.</p>

#### Eligible Population

<b>Ages</b>	18 years and older as of the last day of the treatment period.
<b>Continuous enrollment</b>	<p><i>Treatment period:</i> The IPSD through the end of the measurement year or until death or disenrollment from the health plan.</p> <p>Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.</p> <p><i>Note: Do not include members who disenroll and reenroll more than one day later at any time during the measurement year, after the treatment period.</i></p>
<b>Allowable gap</b>	No gaps in enrollment during the continuous enrollment period.
<b>Benefit</b>	Pharmacy.

#### Administrative Specification

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

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**Rate 1: Renin Angiotensin System (RAS) Antagonists**

<b>Additional eligible population criteria</b>	Patients who filled at least two prescriptions for a RAS Antagonist: ACEI/ARB/Direct Renin Inhibitor or ACEI/ARB/Direct Renin Inhibitor Combination (Table PDC-B: RAS Antagonists) on different dates of service during the treatment period.
<b>Denominator exclusion</b>	Patients with one or more prescription claims for the medication, sacubitril/valsartan. (Table PDC-B: Exclusion)

**Table PDC-B: Renin Angiotensin System (RAS) Antagonists**

Direct Renin Inhibitor Medications			
<ul style="list-style-type: none"> <li>aliskiren</li> </ul>			
ARB Medications			
<ul style="list-style-type: none"> <li>candesartan</li> <li>eprosartan</li> </ul>	<ul style="list-style-type: none"> <li>irbesartan</li> <li>losartan</li> </ul>	<ul style="list-style-type: none"> <li>olmesartan</li> <li>telmisartan</li> </ul>	<ul style="list-style-type: none"> <li>valsartan</li> <li>azilsartan</li> </ul>
ACE Inhibitor Medications			
<ul style="list-style-type: none"> <li>benazepril</li> <li>captopril</li> <li>enalapril</li> </ul>	<ul style="list-style-type: none"> <li>fosinopril</li> <li>lisinopril</li> <li>moexipril</li> </ul>	<ul style="list-style-type: none"> <li>perindopril</li> <li>quinapril</li> <li>ramipril</li> </ul>	<ul style="list-style-type: none"> <li>trandolapril</li> </ul>
ACE Inhibitor Combination Products			
<ul style="list-style-type: none"> <li>amlodipine &amp; benazepril</li> <li>benazepril &amp; HCTZ</li> <li>captopril &amp; HCTZ</li> </ul>	<ul style="list-style-type: none"> <li>enalapril &amp; HCTZ</li> <li>fosinopril &amp; HCTZ</li> <li>perindopril &amp; amlodipine</li> </ul>	<ul style="list-style-type: none"> <li>lisinopril &amp; HCTZ</li> <li>moexipril &amp; HCTZ</li> </ul>	<ul style="list-style-type: none"> <li>quinapril &amp; HCTZ</li> <li>trandolapril-verapamil HCL</li> </ul>
ARB Combination Products			
<ul style="list-style-type: none"> <li>candesartan &amp; HCTZ</li> <li>eprosartan &amp; HCTZ</li> <li>telmisartan &amp; amlodipine</li> </ul>	<ul style="list-style-type: none"> <li>irbesartan &amp; HCTZ</li> <li>losartan &amp; HCTZ</li> <li>amlodipine &amp; olmesartan</li> <li>azilsartan &amp; chlorthalidone</li> </ul>	<ul style="list-style-type: none"> <li>olmesartan &amp; HCTZ</li> <li>telmisartan &amp; HCTZ</li> <li>aliskiren &amp; valsartan</li> <li>olmesartan &amp; amlodipine &amp; HCTZ</li> </ul>	<ul style="list-style-type: none"> <li>valsartan &amp; HCTZ</li> <li>amlodipine &amp; valsartan</li> <li>amlodipine &amp; valsartan &amp; HCTZ</li> </ul>
Direct Renin Inhibitor Combination Products			
<ul style="list-style-type: none"> <li>aliskiren &amp; amlodipine</li> </ul>	<ul style="list-style-type: none"> <li>aliskiren &amp; amlodipine &amp; HCTZ</li> </ul>	<ul style="list-style-type: none"> <li>aliskiren &amp; HCTZ</li> </ul>	

Note: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

**Table PDC-B: Exclusion**

ARB/Neprilysin Inhibitor Combination Medication
<ul style="list-style-type: none"> <li>sacubitril/valsartan</li> </ul>

<b>Numerator</b>	The number of patients who met the PDC threshold during the measurement year. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.
<b>Step 1</b>	Determine the treatment period.
<b>Step 2</b>	Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, adjust the prescription start date to be the day after the previous fill has ended.*

### 3.2 PQA Measure Specifications

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

**Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

\*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and the NDC specifications, RASA tab.

#### Rate 2: Diabetes medications

**Additional eligible population criteria** Patients who filled at least two prescriptions for any of the diabetes medications listed in Tables PDC-D, PDC-E, PDC-F, PDC-G, PDC-J, PDC-K, or PDC-L on different dates of service during the treatment period. The prescriptions can be for the same or different medications, and can be from any of these seven tables.

**Required Exclusions** Patients who have one or more prescriptions for insulin in the treatment period (refer to Table PDC-H)

#### Table PDC-D: Biguanide Medications

Biguanides	
• metformin	
Biguanide & Sulfonylurea Combination Products	
• glipizide & metformin	• glyburide & metformin
Biguanide & Thiazolidinedione Combination Products	
• rosiglitazone & metformin	• pioglitazone & metformin
Biguanide & Meglitinide Combinations	
• repaglinide & metformin	
Biguanide & SGLT2 Inhibitor Combinations	
• dapagliflozin & metformin	• empagliflozin & metformin
• canagliflozin & metformin	
Biguanide & DPP-IV Inhibitor Combinations	
• sitagliptin & metformin IR & SR	• linagliptin & metformin
• saxagliptin & metformin SR	• alogliptin & metformin

Note: Active ingredients are limited to oral formulations only.  
Excludes nutritional supplement/dietary management combination products.

#### Table PDC-E: Sulfonylurea Medications

Sulfonylureas	
• chlorpropamide	• glyburide
• glimepiride	• tolazamide
• glipizide	• tolbutamide
Sulfonylurea & Biguanide Combination Products	
• glipizide & metformin	• glyburide & metformin
Sulfonylurea & Thiazolidinedione Combination Products	
• rosiglitazone & glimepiride	• pioglitazone & glimepiride

Note: Active ingredients are limited to oral formulations only (includes all salts and dosage forms).

**Table PDC-F: Thiazolidinedione Medications**

Thiazolidinediones	
• pioglitazone	• rosiglitazone
Thiazolidinedione & Biguanide Combination Products	
• rosiglitazone & metformin	• pioglitazone & metformin
Thiazolidinedione & Sulfonylurea Combination Products	
• rosiglitazone & glimepiride	• pioglitazone & glimepiride
Thiazolidinedione & DPP IV Inhibitor Combination Products	
alogliptin & pioglitazone	

Note: Active ingredients are limited to oral formulations only.

**Table PDC-G: DPP-IV Inhibitor Medications**

DPP-IV Inhibitors		
• sitagliptin	• saxagliptin	
• linagliptin	• alogliptin	
DPP-IV Inhibitor Combination Products		
• sitagliptin & metformin IR & SR	• sitagliptin & simvastatin	• alogliptin & metformin
• saxagliptin & metformin SR	• linagliptin & metformin	• alogliptin & pioglitazone
		• linagliptin & empagliflozin

Note: Active ingredients are limited to oral formulations only.

**Table PDC-J: Incretin Mimetic Agents**

Incretin Mimetic Agents	
• exenatide	• liraglutide
• albiglutide	• dulaglutide

**Table PDC-K: Meglitinides**

Meglitinides	
• nateglinide	• repaglinide
	• repaglinide & metformin

Note: Active ingredients are limited to oral formulations only

**Table PDC-L: Sodium glucose co-transporter2 (SGLT2) Inhibitors**

SGLT2 Inhibitors		
• canagliflozin	• dapagliflozin	• empagliflozin
SGLT2 Inhibitor Combination Products		
• canagliflozin & metformin	• dapagliflozin & metformin	• empagliflozin & linagliptin
		• empagliflozin & metformin

Note: Active ingredients are limited to oral formulations only

**Table PDC-H: Insulins (Exclusion Table)**

Human Insulins		
• insulin aspart	• insulin glulisine	• insulin lispro
• insulin aspart Protamine & Aspart	• insulin isophane & regular human insulin	• insulin lispro Protamine & Insulin lispro
• insulin detemir	• insulin isophane (human N)	• insulin regular (human R)
• insulin glargine	• insulin regular (human) inhalation powder	• insulin degludec

Note: The active ingredients are limited to injectable and inhalation formulations only.

### 3.2 PQA Measure Specifications

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

**Step 1** Determine the treatment period.

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

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

**Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

\*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, Diabetes tab.

#### Rate 3: Statins

**Additional eligible population criteria**

Patients who filled at least two prescriptions for a statin or statin combination (Table PDC-I: Statin Medications) on different dates of service during the treatment period.

**Table PDC-I: Statin Medications**

Statin Medications			
• lovastatin	• fluvastatin	• pravastatin	• simvastatin
• rosuvastatin	• atorvastatin	• pitavastatin	
Statin Combination Products			
• niacin & lovastatin	• niacin & simvastatin	• ezetimibe & simvastatin	
• atorvastatin & amlodipine	• sitagliptin & simvastatin	• ezetimibe & atorvastatin	

Note: The active ingredients are limited to oral formulations only.

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

**Step 1** Determine the treatment period.

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

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

**Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

\*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, Statins tab.

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## **4. QRS Survey Measure Specifications**

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## QRS Survey Measure Descriptions

### Overview

This section includes descriptions for the QRS survey measures<sup>8</sup> that will be collected as part of the QHP Enrollee Survey. The QHP Enrollee Survey is largely based on items from the CAHPS® Surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), please see <https://qhpcahps.cms.gov/qhp-enrollee-survey-quality-rating-system>.

Additional details related to the QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey website at <http://qhpcahps.cms.gov>.

### QRS Survey Measure Descriptions

#### ***Access to Care***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topics:

1. Got care for illness/injury as soon as needed
  2. Got non-urgent appointment as soon as needed
  3. Easy to get care after regular office hours
  4. How often it was easy to get necessary care, tests, or treatment
  5. Got appointment with specialists as soon as needed
- 

#### ***Access to Information***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey and provides information on the following:

1. Written materials or Internet provided information needed about how plan works
  2. Found out from health plan about cost for health care service or equipment
  3. Found out from health plan about cost for specific prescriptions
- 

#### ***Care Coordination***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topics:

1. Doctor seemed informed and up-to-date about care from other health providers
  2. Doctor had your medical records
  3. Doctor followed up about blood test, x-ray results
  4. Got blood test, x-ray results as soon as you needed them
  5. Doctor talked about prescription drugs you are taking
  6. Got help you needed from doctor's office to manage your care among different providers
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<sup>8</sup> The following QRS survey measures are HEDIS® measures and are addressed in NCQA's Measure Specifications: Aspirin Use and Discussion; Flu Vaccinations for Adults Ages 18-64; Medical Assistance with Smoking Cessation.

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### ***Cultural Competence***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topics:

1. How often got an interpreter
  2. Forms available in preferred language
  3. Forms available in preferred format, such as large print or braille
- 

### ***Plan Administration***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topics:

1. Customer service gave necessary information/help
  2. Customer service staff courteous and respectful
  3. Wait-time to talk to customer service took longer than expected
  4. Forms were easy to fill out
  5. Health plan explained purpose of forms
- 

### ***Rating of All Health Care***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topic:

1. Rating of all health care
- 

### ***Rating of Health Plan***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topic:

1. Rating of health plan
- 

### ***Rating of Personal Doctor***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topic:

1. Rating of personal doctor
- 

### ***Rating of Specialist***

This QRS survey measure is based on enrollee responses to the QHP Enrollee Survey on the following topic:

1. Rating of specialist
-