

Health Insurance Exchange

2020 Quality Rating System Measure Technical Specifications

September 2019

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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 2020.

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>
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)¹ 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 My.NCQA available at <https://my.ncqa.org>
 - Pharmacy Quality Alliance (PQA) for the PQA measures: <https://www.pqaalliance.org/QRS>
- For questions regarding QRS survey measures, the QHP Enrollee Survey, or QRS requirements, please contact the Marketplace Service Desk (MSD) via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Reference the “Marketplace Quality Initiative (MQI)-QRS”.

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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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 2020 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 2020 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 Pharmacy Quality Alliance (PQA) measures. 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 measures in the QRS measure set. For the PQA measures, 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 measures 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 2020*, QHP issuers that offered coverage through a Health Insurance Exchange (Exchange) 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.² CMS will calculate the quality performance ratings for QHPs offered through all Exchanges, regardless of the Exchange 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.³ 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.

² 45 CFR § 156.200(b)(5)(h); § 156.1120; and § 156.1125.

³ 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 2020.

The measure set includes a subset of NCQA's HEDIS measures and PQA measures. 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 Systems⁴ (CAHPS®) surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to [QRS and QHP Enrollee Survey: Technical Guidance for 2020](#).

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. 2020 QRS Measures

Measure Title	Measure Steward	National Quality Forum (NQF) ID ⁵
<i>QRS Clinical Measures</i>		
Adult BMI Assessment	NCQA	N/A
Annual Dental Visit	NCQA	1388
Antidepressant Medication Management	NCQA	0105
Appropriate Testing for Pharyngitis	NCQA	0002
Appropriate Treatment for Upper Respiratory Infection	NCQA	0069
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	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: 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
Immunizations for Adolescents (Combination 2)	NCQA	1407
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	0004
International Normalized Ratio Monitoring for Individuals on Warfarin	PQA	0555
Medication Management for People With Asthma (75% of Treatment Period)	NCQA	1799
Plan All-Cause Readmissions	NCQA	1768
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541

⁴ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. The surveys are available at <https://cahps.ahrq.gov>.

⁵ 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 ⁵
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
QRS Survey Measures		
Access to Care	AHRQ, CMS	0006
Access to Information	AHRQ, CMS	0007
Care Coordination	AHRQ, CMS	0006
Flu Vaccinations for Adults Ages 18-64	NCQA	0039
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS ⁶	0006
Rating of All Health Care	AHRQ	0006 ⁷
Rating of Health Plan	AHRQ	0006 ⁷
Rating of Personal Doctor	AHRQ	0006 ⁷
Rating of Specialist	AHRQ	0006 ⁷

⁶ 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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2020 HEDIS® General Guidelines for the QRS Measure Technical Specifications

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A calculated measure result (a “rate”) from a HEDIS measure that has been certified via NCQA’s Measure Certification ProgramSM, and is based on unadjusted HEDIS specifications, may not be called a “Health Plan HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, applicable measure rates produced by [Product] shall be designated or referred to as “Unaudited Health Plan HEDIS Rates.”

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Appendix 1: Practitioner Types**Appendix 2: Data Element Definitions**

Overview

HEDIS 2020

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets 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, Accountable Care Organizations and other organizations.

How HEDIS Is Developed

NCQA’s Committee on Performance Measurement (CPM), which includes representation from purchasers, consumers, health plans, clinicians 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.

What’s New in HEDIS for the Quality Rating System?

Retired measures	<i>Annual Monitoring for Patients on Persistent Medications (MPM)</i> <i>Follow-up Care for Children Prescribed ADHD Medication (ADD)</i>
Revised measures	For specific revisions, refer to each measure’s <i>Summary of Changes</i> .

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 (QHP) in the Exchanges 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 2020* is posted to the CMS Marketplace Quality Initiative (MQI) website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html>).

NCQA will freeze the specifications on October 1, 2019, with the release of the *2020 HEDIS for QRS Technical Update*:

- **HEDIS for QRS Technical Update** will be posted to the NCQA website (www.ncqa.org).
- The **HEDIS for QRS Value Set Directory** may be ordered through the NCQA Store (<http://store.ncqa.org/index.php/catalog/product/view/id/3643/s/2020-quality-rating-system-grs-hedis-value-set-directory/>). It will be released on 9/25/2019 and updated on 10/1/2019 to include the Technical Update. Once released, it may be retrieved from the My Downloads section in My.NCQA (<https://my.ncqa.org/Downloads>).

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 Medication List Directory (NDC codes) and HCC Risk Adjustment tables.

- The **Medication List Directory** is available for free order in the NCQA Store (<http://store.ncqa.org/index.php/catalog/product/view/id/3741/s/hedis-2020-ndc>). Once ordered, the Medication List Directory will be made available in the NCQA Download Center (<https://downloads.ncqa.org/customer/Login.aspx>) by November 1, 2019.

Referring to HEDIS Measures and Rates

HEDIS measures and resulting rates must always retain the HEDIS name. Specifically:

- Refer to all *unadjusted* HEDIS measures as **“HEDIS measures.”**
- Refer to all *adjusted* HEDIS measures as **“Adjusted HEDIS measures.”**

Unadjusted Certified Measure Rates: A calculated measure result (a “rate”) from a HEDIS measure that has been certified via NCQA’s Measure Certification ProgramSM, and is based on *unadjusted* HEDIS specifications, may not be called a “Health Plan HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **“Unaudited Health Plan HEDIS Rates.”**

Adjusted Certified Measure Rates: A calculated measure result (a “rate”) from a HEDIS measure that has been certified via NCQA’s Measure Certification Program, and is based on *adjusted* HEDIS specifications, may not be called an “Adjusted HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **“Adjusted, Unaudited HEDIS Rates.”**

Unadjusted Uncertified Measures: A calculated measure result (a “rate”) from a HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on *unadjusted* HEDIS specifications, may not be called a “Health Plan HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **“Uncertified, Unaudited Health Plan HEDIS Rates”** and *may only be used* for population health purposes within an affiliated health plan network (e.g. Accountable Care Organization) and internal, quality improvement purposes (e.g., trend analysis).

Adjusted Uncertified Measures: A calculated measure result (a “rate”) from a HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on *adjusted* HEDIS specifications, may not be called an “Adjusted HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **“Uncertified, Adjusted, Unaudited HEDIS Rates”** and *may only be used* for population health purposes within an affiliated health plan network (e.g. Accountable Care Organization) and internal, quality improvement purposes (e.g., trend analysis).

Organizations that need assistance in determining the correct naming convention for HEDIS measures/rates should contact NCQA through <https://my.ncqa.org>.

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 policy interpretation questions to NCQA staff: Policy Clarification Support (PCS) accessed through My.NCQA at <https://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 website (www.ncqa.org) 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: **844-440-0077** (not available from Mexico).
 - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Website:** <https://www.lighthouse-services.com/ncqa>.
- **Email:** 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. These should be reported to NCQA through PCS system via My.NCQA (<https://my.ncqa.org>). 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.

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General Guidelines for Data Collection

General Guidelines for Data Collection

These 2020 HEDIS for QRS General Guidelines for the 2020 Quality Rating System Measure Technical Specifications are unique to the issuers offering plans on the Exchanges and participating in the CMS Quality Rating System (QRS).^{1,2}

SUMMARY OF CHANGES TO HEDIS FOR QRS 2020

- Deleted General Guideline 5; renumbered subsequent guidelines.
- Updated deadlines in the HEDIS Audit Timeline in *General Guideline 5 (formerly General Guideline 6)*.
- Clarified in *General Guideline 9* (formerly General Guideline 10) that supplemental data may be used when excluding members in hospice.
- Added *General Guideline 10: Deceased Members*.
- Significantly revised *General Guideline 22*.
- Removed the requirement that standard and nonstandard supplemental data files must contain all data elements required by the hybrid specification.
- Clarified in *General Guideline 24* that it applies to most recent tests or measurements.
- Clarified in *General Guideline 24* that for lab results documented in a progress note, it is not appropriate to assume the date of the progress note was the date of the lab test.
- Revised *General Guideline 27*.
- Revised *General Guideline 33*.
- Revised *General Guideline 35*.
- Added *General Guideline 39: SNOMED Codes*; renumbered subsequent guidelines.

2020 HEDIS for QRS Data Collection

1. Exchange Product Line

QHP issuers (“organizations”) must collect HEDIS for QRS measure data separately for the Health Insurance Exchange (also known as MarketplaceSM) population. The HEDIS for QRS specifications are for reporting the Exchange product line only.

2. Reporting Units (Product)

Organizations must collect HEDIS for QRS measure data for each product (i.e., EPO, HMO, POS, PPO) offered through an Exchange in 2020 that had more than 500 enrollees as of July 1, 2019 and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., 2020). Reporting units that are decertified or discontinued before June 15, 2020 are exempt from QRS reporting requirements.

¹ 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 Exchange.

² A QHP issuer has a certification issued by or recognized by an Exchange to demonstrate that each health plan offered in the Exchange 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 an Exchange 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 an Exchange and that provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *2020 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 Exchange or non-QHPs. Non-QHPs are health plans that are offered outside of the Exchange 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 type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

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 an Exchange in 2020 that had more than 500 enrollees as of July 1, 2019, and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., 2020).

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

Include Small Business Health Options Program and individual Exchange members in the same Exchange reporting unit (do not separate).

The NCQA HEDIS Compliance Audit™

The HEDIS Compliance Audit is required for all HEDIS for QRS measures in 2020, including the sampling frame used to administer the QHP Enrollee Survey.

The HEDIS Compliance Audit runs concurrent with the data collection process. The audit allows comparability across organizations and ensures validity and integrity of reported HEDIS data.

5. Audit Preparation

Contract with an audit firm. The organization requests an application for a HEDIS for QRS Audit from an NCQA Licensed Organization (www.ncqa.org/hedis-quality-measurement/data-reporting-services/hedis-compliance-audit-program) 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 (LO) 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 LOs 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 used 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 2020 Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, released in October.

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization contracts with an NCQA Licensed Organization. <i>Contracting can occur after this date, but it could be difficult for organizations to meet all audit requirements if this doesn't occur by early October.</i>	October 1
Auditor selects a core set of noncertified measures for code review. <i>Note: This date can be adjusted by the auditor, as needed, as long as the December 3 date is met.</i>	By November 1
Organization submits source code for hybrid measures, systematic sampling and QHP enrollee survey sample frames to auditor for review (for noncertified measures).	By December 2
Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor.	December 2
Auditor completes source code review for noncertified hybrid measures, systematic sampling, QHP enrollee survey sample frames, and organization addresses all corrective actions.	By December 31
Onsite visits begin. Onsite visits are not to be held prior to the start of the reporting year.	After January 1
Organization submits the completed current year's Roadmap to the auditor. <i>The auditor must receive the Roadmap by January 31 or at least two weeks before the site visit, whichever is earlier.</i>	January 15–31
Auditor completes the survey sample frame validation. <i>This is only the date the sample frame must be approved. Approval in the Healthcare Organization Questionnaire (HOQ) must be done by the HOQ closing deadline.</i>	January 31
Organization submits all remaining core set measures' source code for auditor review (for noncertified measures).	By January 31
Measure certification deadline. NCQA will post final certification reports no later than February 19.	February 15
Auditor completes source code review for all remaining core set measures and organization addresses all corrective actions.	By March 2
Organization completes and stops all nonstandard supplemental data collection and entry. <i>There are NO exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates.</i>	March 2
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. <i>There are NO exceptions!</i>	March 31
Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year's specifications.</i>	By April 17
Onsite visits completed.	April 30
Preliminary rate review is completed by the auditor. <i>NCQA encourages preliminary rate review to take place earlier in the audit process.</i>	By May 1
Organization completes the medical record abstraction process for all measures and sends the final numerator-compliant counts for all measures and exclusions for MRRV. <i>There are NO exceptions! Failure to meet this deadline could result in inability to use medical record data to report rates.</i>	May 8
Auditor picks measures from each measure group and all exclusions, selects 16 records from each for MRRV review, and informs the organization of the selections; organization sends selected records to the auditor for validation; auditor shares the results and corrective actions with the organization. <i>It is up to the organization and auditor to determine the timing.</i>	May 8–29
Organization completes all audit corrective actions and follow-up requests.	By May 29

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization submits the plan-locked Exchange submission to auditor. <i>There are NO exceptions! Data must be final. The lock should be removed only to correct data at the auditor's request.</i>	June 1
Auditor reviews all IDSS warnings (including manual data entry and GUID validations), performs final rate review, ensures that the MRR numerator counts entered in IDSS match the lists submitted on May 8 and measure identifiers match vendor's final certification report.	June 15
Organization submits the auditor-locked Exchange IDSS submission, with attestation, to NCQA.	June 15
Licensed Organization submits Exchange Final Audit Reports to NCQA.	July 15

6. 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 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 to report a valid rate. <i>Note: Organizations report their data regardless of denominator size. The IDSS automatically assigns NA when the denominator is too small to report a valid rate.</i>
NB*	<i>No Benefit (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.

**Benefits are assessed at the global level, not the service level (refer to General Guideline 17: Required Benefits).*

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 Exchange Members Remain?

7. Eligible Population

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 Exchange 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.

8. The “Working Aged” and Retirees

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

9. Members in Hospice

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year regardless of when the services began. These members may be identified using various methods, which may include, but are not limited to, enrollment data, medical record, claims/encounter data ([Hospice Encounter Value Set](#); [Hospice Intervention Value Set](#)) or supplemental data for this required exclusion. If organizations use the Monthly Membership Detail Data File to identify these members, use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

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 sample and replaced by a member from the oversample. Documentation that a member is near the end of life (e.g., comfort care, DNR, DNI) or is in palliative care does not meet criteria for the hospice exclusion.

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

Note

- *Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say “supplemental data may not be used for the measure” (e.g., PCR).*

10. Deceased Members

Members who die during the measurement year may be excluded. These members may be identified using various methods, which include, but are not limited to enrollment data, medical record, claims/encounter data or supplemental data.

If an organization excludes these members then the organization 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 deceased 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 deceased members is subject to auditor review.

Note

- *Deceased members are not excluded from the measures in the Risk Adjusted Utilization subdomain.*
- *Supplemental data can be used for excluding deceased members for all applicable measures, including measures that say “supplemental data may not be used for the measure” (e.g., URI).*

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, Exchange]) 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 non-surviving 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 non-surviving 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 Exchange product line during the continuous enrollment period is reported in the Exchange HEDIS for QRS report.

The organization must use claims data from all products/product lines, even when there is a gap in 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 requirement (inpatient stays).

Required Enrollment Periods and Benefits

14. Continuous Enrollment

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

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

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

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 similarly if the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit). Organizations must assess benefits first at the organization level and then at the individual member level using continuous enrollment data.

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

If the organization does not offer the benefit, the plan does not report the measure and receives an NB (No Benefit) audit designation. No member assessment is necessary.

At the member level: Members who do not have a specified benefit are not counted in the measure.

Exhausted benefits (optional). *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.

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.

HEDIS for QRS Data Submission and Reporting to NCQA

19. Reporting Date

The previous calendar year is the standard measurement year for HEDIS for QRS. For 2020 HEDIS for QRS, all organizations reporting audited data to NCQA through the IDSS must submit data to NCQA on or before June 15, 2020.

Note: *Organizations must submit and “plan-lock” audited HEDIS for QRS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For 2020 HEDIS for QRS reporting, organizations are required to “plan-lock” audited HEDIS for QRS data no later than **June 1, 2020**.*

20. Required Data Elements

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

Data Collection Methods and Data Sources

21. Data Collection Methods

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 methods 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 *2020 Qualified Health Plan Enrollee Experience Survey Quality Assurance Guidelines and Technical Specifications*, which is available on the CMS QHP Enrollee Survey page of the MQI website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page.html>).

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 if 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 22: Supplemental Data for supplemental data requirements.

22. Supplemental Data

Supplemental data uses. Organizations may find information about services for their members in administrative data, medical records and other data sources. 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.
- Optional exclusions.
- Members in hospice and members who have died.
- Eligible-population required exclusions that are labeled as *Required Exclusions* in the specification. 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 and required exclusions.
- 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.
- Measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and for excluding deceased members.

Supplemental Data Definitions

The auditor determines the classification of all supplemental data, not the organization.

Standard supplemental data. Electronically generated 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.

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. These data are loaded as administrative data.*

Nonstandard supplemental data. Data used to capture missing service data not received through administrative sources (claims or encounters) or in the standard electronically generated files described above, whether collected by a plan, 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 and by whom, how they are validated and used for HEDIS for QRS reporting.

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

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.

Certified eCQM vendor data

Data from a certified eCQM vendor can be considered standard supplemental data if the vendor:

- Completed the current year's Supplemental Data Roadmap section. The Roadmap must explain how the data from the certified eCQM vendor gets to the reporting entity. If there is a hand-off between the vendor and another entity prior to reaching the health plan, this relationship must be explained and include:
 - The data flow process—how are data transferred?
 - What is done to the data by the intermediary entity?
- Completed NCQA's eCQM Certification by February 15 of the reporting year and provides the auditor a certification report that indicates the measures that were certified and the date they were certified.
- Produces QRDA1 files (this result is listed in the certification report).

Audit requirements. The auditor confirms that the data meet all the requirements above. If all the requirements are met, data from certified eCQM vendors are not required to undergo primary source verification, unless requested by the auditor. See Volume 5 for more details.

Continuity of Care Documents (CCDs)

CCDs are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a patient's care as a snapshot in time, but they are not a replacement for an EHR. These files are typically XML-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the accuracy of these (through PSV) to ensure that the data in the file match the EHR. This data source must meet both criteria:

- There is a completed, current year's Roadmap section.
- The Roadmap must include a description of how the CCD is created and by whom (e.g., produced by the provider in the office and sent to the plan or created by a vendor), the validation process and how the data are transmitted.

Audit requirements. The auditor confirms that the data meet all requirements. Primary source verification is required (e.g., go back to each unique EHR) to validate the CCDs accuracy. This level of validation is required for at least the first year, or the first submission by the EHR, but may continue in subsequent

years until the auditor is certain the data are accurate, reliable and have not changed.

Required Data Elements

Standard supplemental data. Organizations must have policies and procedures for using data files as standard supplemental data. Data files must have standard file layouts, standard data fields and industry standard codes, and must include all elements required by measure specifications, including payment status when applicable, and evidence that tests or services were performed and not merely ordered.

Nonstandard supplemental data. Nonstandard supplemental data must have all data elements required to meet criteria specified by the measure specifications, including:

- Payment status when applicable.
- Evidence that tests or services were performed, not just ordered.
- Evidence of provider accountability from the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name and signature on each in-home form. Documentation of the practitioner's NPI/TIN is not required; however, documentation of NPI/TIN with date, name and signature is preferred.
- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.

All data elements for a measure must be captured for member-reported services (i.e., date and place of service, procedure, prescription, test result or finding, practitioner type). See General Guideline 30: Member-Reported Services for more information about member-reported data.

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 25 for date specificity requirements).

When pharmacy data are classified as supplemental data, the following data elements must be present: the generic name (or brand name), strength/dose, route and date when the medication was dispensed to the member. Dispensed date is required; other dates (e.g., start date) cannot be used as a proxy. Data elements must map to a medication listed in the Medication Set Directory to be eligible for use. 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

Supplemental data may be collected during the measurement year and into the beginning of the reporting year. All supplemental data must follow the Audit Timeline requirements in *General Guideline 5: Audit Preparation*.

Identifying and Validating Supplemental Data

All supplemental data (standard and nonstandard) 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* 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.

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 October.

23. Obtaining Information for the Systematic Sample

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. Documentation in a medical record of a diagnosis or procedure code 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 results, are reviewed by the certified HEDIS Compliance Auditor.

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 meeting the MRSS is possible.
- 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.

24. Measures That Require Results From the Most Recent Test or Measurement

For measures that require the use of results from the most recent test or measurement (e.g., HbA1c test or BP reading), 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 or measurement was performed (that should be included when identifying the most recent test or measurement) 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 or measurement 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. For lab results documented in a progress note, it is not appropriate to assume the date of the progress note was the date of the lab test; the date of the lab test must be documented or there must be additional evidence that the lab results had the same date of service as the progress note.

25. Date Specificity

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, 2016.

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 2018, 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 on or before December 31 of the measurement year.

26. Collecting Data for Measures With Multiple Numerator Events

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 and dates are less than 14 days apart (or the organization cannot determine if the dates are at least 14 days apart), it must use only the medical record event. The 14-day threshold 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.

27. Measures That Use Medication Lists

Some measures require the use of clinical pharmacy data or pharmacy claims data to identify dispensed medications. The specifications reference medication lists that must be used for HEDIS for QRS reporting for each pharmacy-dependent measure in the specifications, medication list references are underlined (e.g., Antidepressant Medications List). Medication lists used for HEDIS for QRS reporting are included in the Medication List Directory. A medication list includes the National Drug Codes (NDC) and RxNorm codes that may be used for reporting along with the generic name, the brand name (if applicable), the strength/dose and the route for each code.

If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting then to avoid double counting, deduplicate and count an NDC code and an RxNorm code for the same drug on the same date of service as only one dispensing event.

The HEDIS 2020 Medication List Directory will be posted to the NCQA website on November 1, 2019.

28. 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. Use laboratory claims and data only for the Pregnancy Tests Value Set, the Sexual Activity Value Set (which do not contain LOINC codes) and value sets that contain LOINC codes.

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

Diagnosis codes on pharmacy claims may not be used.

29. 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.

Note: *BP readings collected using remote monitoring devices are not considered member-collected for HEDIS reporting.*

30. 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

31. Coding Systems Included in HEDIS Reporting

HEDIS measures include codes from the following coding systems:

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).
- CVX—Vaccines Administered.
- Healthcare Common Procedure Coding System (HCPCS) Level II.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).
- Logical Observation Identifiers Names and Codes (LOINC).
- National Uniform Claim Committee Health Care Provider Taxonomy.
- Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT)
- Uniform Bill (UB) revenue and Type of Bill (TOB).

32. Presentation of Codes in HEDIS for QRS Value Set

A value set is the complete set of codes used to identify the service or condition. 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). 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 (VSD).

33. Telehealth

HEDIS measures include synchronous telehealth (which requires real-time interactive audio and video telecommunications), telephone visits and online assessments, as appropriate. A measure specification will indicate when telephone visits or online assessments are eligible for use in reporting.

A measure specification that is silent about telehealth includes telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present).

A measure specification will indicate when telehealth is not eligible for use and should be excluded.

34. Using Claims to Identify Events in Conjunction With Diagnoses or other Events

Many measures' administrative specifications require that a visit code or procedure code be used in conjunction with a diagnosis code.

Except for inpatient stays (as described below) and unless noted otherwise in a measure specification, when a measure requires a code be in conjunction with another code the codes must be from the same visit. The organization develops a method for identifying claims from the same visit (e.g., the same outpatient visit, the same inpatient stay). The method is subject to review by the HEDIS auditor.

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Identifying acute or nonacute inpatient stays is a two-step process. The first step uses the Inpatient Stay Value Set to identify all acute and nonacute inpatient stays. The second step uses the Nonacute Inpatient Stay Value Set to identify stays that were nonacute. When identifying nonacute codes in step 2, the nonacute code must be on the same claim that was identified in step 1. In addition, any required diagnosis or procedure must be on the same claim.

35. Outpatient, ED and Observation Visits that Result in an Inpatient Stay

Select measures require the exclusion of outpatient, ED or observation visits that result in an inpatient stay.

When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the outpatient/ ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An outpatient, ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

36. Principal vs. Secondary Diagnosis

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.

Some measures require a specific principal diagnosis for eligibility; other measures allow any diagnosis (principal or secondary). For example, *Medication Management for People With Asthma* specifies that any diagnosis of an asthma is eligible. If a member's claim lists the principal diagnosis as "severe cough," but asthma is listed as a secondary diagnosis on the same claim form, the member is included in the *Medication Management for People With Asthma* measure.

The concept of "principal," "primary" and "secondary" diagnoses is unique to claims data. Supplemental data (such as EHR data) may not include this concept. Therefore, when using supplemental data to identify a "principal" or "primary" diagnosis, use any diagnosis.

37. Code Modifiers

Modifiers are two extensions that, when added to CPT or HCPCS codes, provide additional information about a service or procedure.

Exclude any CPT Category II code in conjunction with a 1P, 2P, 3P or 8P modifier code (CPT CAT II Modifier Value Set) from HEDIS for QRS reporting. These modifiers indicate the service *did not occur*. In the HEDIS for QRS Value Set Directory, CPT Category II codes are identified in the Code System column as "CPT-CAT-II."

Unless otherwise specified, if a CPT or HCPCS 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.

38. SNOMED Codes

When using SNOMED codes to identify "history of" procedures, the date of the procedure must be available (do not use *the date the provider documented the procedure* as the date of the procedure).

39. Uniform Bill Code Specificity

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

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 HEDIS for QRS Value Set Directory.*

40. Mapping Proprietary or Other Codes

Organizations may only map the following codes for use in HEDIS reporting:

- *State-specific codes.* The organization must provide the auditor with evidence that the codes are required by the state.
- *NDC codes.* An NDC code that is not in the HEDIS Medication List Directory (MLD) can only be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD.
- *RxNorm codes.* An RxNorm code that is not in the HEDIS Medication List Directory (MLD) can only be mapped if its generic name (or brand name), strength/dose and route match those of a code in the MLD.

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. Auditors may request additional information.

41. Retiring Codes

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, 2017, is deleted from the specifications in HEDIS QRS 2020 after the two-year look-back period (2018, 2019) plus one additional year (2017) is exhausted.

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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 a HEDIS Compliance Audit.

SUMMARY OF CHANGES TO HEDIS FOR QRS 2020

- Clarified in *Determining the Required Sample Size* that the sample size can be reduced even when the eligible member population is less than 411.
- Updated the Organization Responsibility for Chart Review to indicate that chart pursuit is up to the organization.
- Updated Table 1 to indicate that the prior year's audited rate may be used to reduce MY2019 sample size for the Controlling High Blood Pressure measure.
- Updated Table 1 to indicate that the prior year's audited rate may not be used to reduce MY2019 sample size for the Cervical Cancer Screening and Prenatal and Postpartum Care measures.
- Added Example 4 to the Systematic Sampling Methodology.

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	<p>Organizations are strongly encouraged to draw samples no earlier than January 2020 for the 2019 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.</p> <p>Organizations must adhere to the following guidelines if samples are drawn prior to January 2020.</p>
Membership-dependent denominators	<p>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.</p> <ul style="list-style-type: none"> • <i>Childhood Immunization Status.</i> • <i>Immunizations for Adolescents.</i> • <i>Cervical Cancer Screening.</i> • <i>Colorectal Cancer Screening.</i> <p>An organization that draws its sample on or between December 1 and December 31 of the measurement year must perform the following tasks.</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – For example, for the <i>Childhood Immunization Status</i> 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	<p>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).</p> <ul style="list-style-type: none"> • <i>Adult BMI Assessment.</i> • <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.</i> • <i>Controlling High Blood Pressure.</i> • <i>Comprehensive Diabetes Care.</i> • <i>Prenatal and Postpartum Care.</i>

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. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.

Use Table 2 if the prior year's rate is used to determine the current year's sample. 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 commercial 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 Exchange product line by using the 77 percent administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original eligible member (EM) population is less than 411.

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.

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. Chart pursuit is recommended but is determined by the organization.

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 PCS via My.NCQA (<https://my.ncqa.org>) 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.

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

2020 HEDIS for QRS Measures	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2019 Sample Size ³
Adult BMI Assessment	411	Y
Cervical Cancer Screening	411	N
Childhood Immunization Status	411	Y ⁴
Colorectal Cancer Screening	411	Y
Comprehensive Diabetes Care	411	Y ⁶
Controlling High Blood Pressure	411	Y
Immunizations for Adolescents	411	Y
Prenatal and Postpartum Care	411	N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	Y

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

³ Refer to Table 2: Sample Sizes When Data Are Available on the Products Being Measured in this section to determine the minimum required sample size.

⁴ If reducing the sample size based on the current year's administrative rate or the prior year's rate for this measure, the lowest rate from all the indicators must be used.

If the Current Year's Administrative Rate Is...	...the Sample Size Is:	If the Current Year's Administrative Rate Is...	...the Sample Size Is:
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 use and implementation of this method ensures ongoing integrity of collected data and supports increasing requests for audited data. Complete the following steps for each hybrid measure.

Step 1 Determine the 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 PCS via My.NCQA (<https://my.ncqa.org>).

Step 3 Determine the oversample. The oversample should be 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 oversample records should be used, and reported, only to replace cases taken out of the MRSS because of valid data errors, false positives and so on; otherwise, these records should not be reported on in the final denominator

Step 4 If $EM \leq MRSS$, all eligible members are included in the sample. If $EM > MRSS$ + all oversample records, go to step 5. If $MRSS < EM \leq MRSS$ + all oversample records, 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 2020 HEDIS for QRS (2019 measurement year), sort the list of EMs from Z to A. For 2021 HEDIS for QRS (2020 measurement year), sort the list from A to Z.

Note: Sort order applies to all components. For HEDIS 2020, sort all fields by descending order (i.e., last name descending, first name descending, date of birth descending, event descending).

Step 6 Calculate $N = EM / (MRSS + \text{all oversample records})$. 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: $N = EM / (MRSS + \text{all oversample records})$, where EM = the eligible member population (step 1) and MRSS = the minimum required sample size (step 2).

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 2019, 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 2019.

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

(rounding $[(i-1) \times EM / (MRSS + \text{all oversample records})]$ per the .5 rule to the nearest whole number greater than 0).

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

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 oversample is met. This set of members becomes the oversample. The oversample records should be used and reported only to replace cases taken out of the MRSS because of valid data errors, false positives, etc., otherwise, these records should not be reported on in the final denominator.

Note: From step 4, if $MRSS < EM \leq MRSS + \text{all oversample records}$, 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 oversample.

The oversample list is only 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 PCS via My.NCQA (<https://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.

To determine the oversample, multiply the MRSS by the oversample percent and round *up* to the nearest whole number $411 \times 0.10 = 41.1$ (rounded *up* to 42= oversample).

The recommended methodology for substitution is:

- Replace the member's chart with that of the first member in the oversample list.
- Continue replacing each ineligible member with the next consecutive member of the oversample list.
- If the initial oversample was underestimated and all oversample members have been exhausted without satisfying the MRSS, the organization must contact NCQA through PCS via My.NCQA (<https://my.ncqa.org>) to determine next steps.

Organizations must only use the oversample for substitution and must report all measures using their MRSS.

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 Exchange product line for *Adult BMI Assessment* is 9,000. Reduce the minimum required sample size using the current year's administrative Exchange 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 Oversample = $296 \times .05 = 14.8$ (the next whole number *above* is 15, so the oversample = 15).

Step 4 Because $9,000 > 296$ (MRSS) and 311 (296 + oversample) go to step 5.

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

Step 6 $N = 9,000/311$ (MRSS + oversample) = 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 oversample* is the $18 + [(311-1) \times (9,000/311)] = 18 + 8,971 = 8,989$ th sorted member.

**Remember, members in the oversample are used only to replace members excluded from the sample.*

Example 2

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

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 Oversample = $411 \times .10 = 41.1$ (the next whole number *above* is 42, so the oversample = 42).

Step 4 Because $411 < 436 \leq (411 + 42)$, skip to step 8.

Step 5 Skip this step.

Step 6 Skip this step.

Step 7 Skip this step.

Step 8 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the oversample list*.

**Remember, members in the oversample are used only to replace members excluded from the sample.*

Example 4

The eligible member population for *Cervical Cancer Screening* is 400. Reduce the minimum required sample size using the rate from the prior year's HEDIS submission, which was 62 percent. Based on experience, estimate a 5 percent oversample rate. Follow the systematic sampling scheme.

Step 1 EM = 400.

Step 2 From Table 2, the MRSS is 388.

Step 3 Oversample = $388 \times .05 = 19.4$ (the next whole number *above* is 20, so oversample = 20).

Step 4 Because $388 < 400 \leq (388 + 20)$, skip to step 8.

Step 5 Skip this step.

Step 6 Skip this step.

Step 7 Skip this step.

Step 8 Sort the list and choose the first 388 as the primary list. The remaining 12 members become the oversample list*.

*Remember, members in the oversample are used only to replace members excluded from the sample.

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 PCS via My.NCQA (<https://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:

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.

1. Errors in sampling data

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*. Employee and employee dependents are not excluded from administrative reporting and should not be removed before the sample is drawn.

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.

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Guidelines for HEDIS Effectiveness of Care Measures

Guidelines for HEDIS Effectiveness of Care Measures

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- *Adult BMI Assessment (ABA).*
- *Antidepressant Medication Management (AMM).*
- *Appropriate Testing for Pharyngitis (CWP).*
- *Appropriate Treatment for Upper Respiratory Infection (URI).*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (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).*
- *Flu Vaccinations for Adults Ages 18–64 (FVA).*
- *Follow-Up After Hospitalization for Mental Illness (FUH).*
- *Immunizations for Adolescents (IMA).*
- *Medical Assistance with Smoking and Tobacco Use Cessation (MSC)*
- *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, but must be used to determine the eligible population (if applicable) for the following measures:

- *Appropriate Treatment for Pharyngitis.*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis.*
- *Use of Imaging Studies for Low Back Pain.*

Organizations must include all claims (paid, suspended, pending and denied) for required exclusions in all the measures listed above.

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** (Exchange) 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

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- *Annual Dental Visit (ADV).*
- *Initiation and Engagement of Alcohol and Other Drug Abuse or 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 Risk Adjusted Utilization

Guidelines for Risk Adjusted Utilization Measures

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Added *General Guideline 5: Observation stays without discharge date*; renumbered subsequent guidelines.
- Added *General Guideline 6: Direct transfers*.
- Updated value sets in the Utilization Risk Adjustment Determination section.

2020 HEDIS FOR QRS SPECIFIC GUIDANCE

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).
5. **Observation stays without discharge date.** For observation stays (Observation Stay Value Set) that do not have a recorded discharge date, set the discharge date to the last date of service on the claim.
6. **Direct transfers.** A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example:
 - A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer.
 - A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer.
 - A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct stays.
 - A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer.

Direct transfers may occur from and between different facilities and/or different service levels. Refer to individual measure specification for detail.

7. **Data Element Tables.** Cells in the risk-adjusted data element tables are shaded according to how data are reported:
 - No shading: Data are reported by the organization.
 - Light gray shading: Data are calculated by IDSS.
 - Solid black shading: Data are not used or reported.

Example

Reported by the organization
Calculated by IDSS
Data not used

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](#)).
- ED visits ([ED Value Set](#)).
- Inpatient events:
 - Nonacute inpatient encounters ([Nonacute Inpatient Value Set](#)).
 - Acute inpatient encounters ([Acute Inpatient Value Set](#)).
 - Acute and nonacute inpatient discharges ([Inpatient Stay Value Set](#)).

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

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 encounter'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 an encounter 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 encounter'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 an encounter 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

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2020 HEDIS for QRS
Measure Technical Specifications
(Alphabetical Order)

Adult BMI Assessment (ABA)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- 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

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which 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 9: Members in Hospice.

Product line	Exchange.
Ages	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	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

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

Exclusions (optional)

Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to 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 <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
Numerator	BMI during the measurement year or the year prior to the measurement year as documented through either administrative data or medical record review.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	<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"> • BMI percentile documented as a value (e.g., 85th percentile). • BMI percentile plotted on an age-growth chart. <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 >99% or <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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical 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	✓	✓

Annual Dental Visit (ADV)

SUMMARY OF CHANGES TO 2020 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 organization is accountable for reporting the measure and must include all members who elect to purchase the dental benefit.

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 9: Members in Hospice.

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

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>

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Added value sets so that both professional and facility claims are used to identify the major depression diagnosis (step 2: Required exclusions).
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.

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

Intake Period	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.
IPSD	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.
Negative Medication History	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.
Treatment days	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 9: Members in Hospice*.

Product line	Exchange.
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days.
Anchor date	IPSD.
Benefits	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 (<u>Antidepressant Medications List</u>) during the Intake Period.
Step 2: Required exclusion	<p>Exclude members who did not have an encounter with a diagnosis of major depression 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:</p> <ul style="list-style-type: none">• An acute or nonacute inpatient stay with any diagnosis of major depression (<u>Major Depression Value Set</u>) on the discharge claim. To identify acute and nonacute inpatient stays:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.• An acute inpatient encounter with any diagnosis of major depression: <u>Acute Inpatient Value Set</u> with <u>Major Depression Value Set</u>.• A nonacute inpatient encounter with any diagnosis of major depression: <u>Nonacute Inpatient Value Set</u> with <u>Major Depression Value Set</u>.• An outpatient visit with any diagnosis of major depression: <u>Visit Setting Unspecified Value Set</u> with <u>Outpatient POS Value Set</u> with <u>Major Depression Value Set</u>.• An outpatient visit with any diagnosis of major depression: <u>BH Outpatient Value Set</u> with <u>Major Depression Value Set</u>.• An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: <u>Visit Setting Unspecified Value Set</u> with <u>Partial Hospitalization POS Value Set</u> with <u>Major Depression Value Set</u>.• An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: <u>Partial Hospitalization or Intensive Outpatient Value Set</u> with <u>Major Depression Value Set</u>.• A community mental health center visit with any diagnosis of major depression: <u>Visit Setting Unspecified Value Set</u> with <u>Community Mental Health Center POS Value Set</u> with <u>Major Depression Value Set</u>.• Electroconvulsive therapy with any diagnosis of major depression: <u>Electroconvulsive Therapy Value Set</u> with <u>Major Depression Value Set</u>.• Transcranial magnetic stimulation visit with any diagnosis of major depression: <u>Transcranial Magnetic Stimulation Value Set</u> with <u>Major Depression Value Set</u>.• A telehealth visit with any diagnosis of major depression: <u>Visit Setting Unspecified Value Set</u> with <u>Telehealth POS Value Set</u> with <u>Major Depression Value Set</u>.• An observation visit (<u>Observation Value Set</u>) with any diagnosis of major depression (<u>Major Depression Value Set</u>).• An ED visit (<u>ED Value Set</u>) with any diagnosis of major depression (<u>Major Depression Value Set</u>).

- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** ED POS Value Set **with** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) with any diagnosis of major depression (Major Depression Value Set).

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 (Antidepressant Medications List) 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.

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

**Effective
Continuation
Phase Treatment**

At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List) beginning on the IPSD through 231 days after the IPSD (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	Each of the 2 rates
Numerator events by supplemental data	Each of the 2 rates
Reported rate	Each of the 2 rates

Appropriate Testing for Pharyngitis (CWP)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Revised the measure name.
- Expanded the age range to members 3 years of age and older.
- Changed the measure from a member-based denominator to an episode-based denominator.
- Revised the Episode Date definition, removed the IESD definition and added the Negative Comorbid Condition History and Negative Competing Diagnosis definitions.
- Added age ranges, age stratifications and a total rate to the eligible population.
- Removed the anchor date requirements.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Removed the requirement to exclude episode dates where there was any diagnosis other than pharyngitis on the same date.
- Added telehealth visits to the event/diagnosis criteria.
- Added *Penicillin G Benzathine* to the “Natural penicillins” description in the [CWP Antibiotic Medications List](#).
- Added a comorbid condition exclusion to the event/diagnosis criteria.
- Added a competing diagnosis exclusion to the event/diagnosis criteria.
- Added instructions for deduplicating eligible episodes to the event/diagnosis criteria.
- Revised the Data Elements for Reporting table.

Description

The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient, telephone, online assessment, observation or ED visit during the Intake Period with a diagnosis of pharyngitis.
Negative Medication History	<p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none"> • A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date. <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>

Negative Comorbid Condition History	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.
Negative Competing Diagnosis	The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.		
Ages	<p>Members who were 3 years or older as of the Episode Date.</p> <p>Report three age stratifications and total rate:</p> <table><tr><td><ul style="list-style-type: none">• 3–17 years.• 18–64 years.</td><td><ul style="list-style-type: none">• 65 years and older.• Total.</td></tr></table> <p>The total is the sum of the age stratifications.</p>	<ul style="list-style-type: none">• 3–17 years.• 18–64 years.	<ul style="list-style-type: none">• 65 years and older.• Total.
<ul style="list-style-type: none">• 3–17 years.• 18–64 years.	<ul style="list-style-type: none">• 65 years and older.• Total.		
Continuous enrollment	30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).		
Allowable gap	No gaps in enrollment during the continuous enrollment period.		
Anchor date	None.		
Benefits	Medical and pharmacy.		
Event/ diagnosis	Follow the steps below to identify the eligible population.		
Step 1	<p>Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the intake period, with a diagnosis of pharyngitis (Pharyngitis Value Set).</p> <p>Do not include outpatient, ED or observation visits that result in an inpatient stay (Inpatient Stay Value Set).</p>		
Step 2	Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessment, observation or ED visits with a diagnosis of pharyngitis.		
Step 3	<p>Determine if antibiotics (CWP Antibiotic Medications List) 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.</p> <p>Exclude Episode Dates if the member did not receive antibiotics on or up to three days after the Episode Date.</p>		

CWP Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

Step 4 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:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasms of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

- Step 5** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (CWP Antibiotic Medications List) was filled 30 days prior to the Episode Date or was active on the Episode Date.
- Step 6** Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis (Competing Diagnosis Value Set) on or 3 days after the Episode Date.
- Step 7** 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 8** Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically including only one per 31-day period.

Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.

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 Episode Date through three days after the Episode Date.

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 Pharyngitis

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>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Appropriate Treatment for Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Revised the measure name.
- Expanded the age range to members 3 months of age and older.
- Changed the measure from a member-based denominator to an episode-based denominator.
- Revised the Episode Date definition, removed the IESD definition and added the Negative Comorbid Condition History definition.
- Added the Medicare product line.
- Added age ranges, age stratifications and a total rate to the eligible population.
- Removed the anchor date requirements.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Removed the requirement to exclude episode dates where there was any diagnosis other than upper respiratory infection on the same date.
- Added telehealth visits to the event/diagnosis criteria.
- Added Penicillin G Benzathine to the “Natural penicillins” description in the [CWP Antibiotic Medications List](#).
- Added a comorbid condition exclusion to the event/diagnosis criteria.
- Added instructions for deduplicating eligible episodes to the event/diagnosis criteria.
- Revised the Data Elements for Reporting table.

Description

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient, telephone, online assessments, observation or ED visit during the Intake Period with a diagnosis of URI.
Negative Medication History	To qualify for Negative Medication History, the following criteria must be met: <ul style="list-style-type: none"> • A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.

- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.

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

Negative Comorbid Condition History 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.

Negative Competing Diagnosis The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line Exchange.

Ages Members who were 3 months of age or older as of the Episode Date.

Report three age stratifications and total rate:

- | | |
|----------------------|-----------------------|
| • 3 months–17 years. | • 65 years and older. |
| • 18–64 years. | • Total. |

The total is the sum of the age stratifications.

Continuous enrollment 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date None.

Benefits Medical and pharmacy.

Event/ diagnosis Follow the steps below to identify the eligible population:

Step 1

Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessments Value Set) an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of URI (URI Value Set).

Exclude outpatient, ED or observation visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 2

Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessments, observation or ED visits with a URI diagnosis.

- Step 3** 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:
- HIV Value Set.
 - HIV Type 2 Value Set.
 - Malignant Neoplasms Value Set.
 - Other Malignant Neoplasm of Skin Value Set.
 - Emphysema Value Set.
 - COPD 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 (CWP Antibiotic Medications List) 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 the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis Value Set.
 - Competing Diagnosis Value Set.
- Step 6** 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 7** Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.*

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication from the CWP Antibiotic Medications List on or 3 days after the Episode Date.

CWP Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

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.
 - Supplemental data may not be used for this measure.

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 Upper Respiratory Infection

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	For each age stratification and total
Numerator events by administrative data	For each age stratification and total
Reported rate	For each age stratification and total.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Revised the measure name.
- Expanded the age range to members 3 months of age and older.
- Changed the measure from a member-based denominator to an episode-based denominator.
- Revised the Intake Period.
- Removed the IESD definition.
- Revised the Negative Competing Diagnosis time frame.
- Added the Medicare product line.
- Added age ranges, age stratifications and a total rate to the eligible population.
- Updated the continuous enrollment and allowable gap requirements.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Deleted Cystic Fibrosis Value Set from step 3 in the event/diagnosis criteria (codes for cystic fibrosis were moved to the Comorbid Conditions Value Set).
- Added instructions for deduplicating eligible episodes to the event/diagnosis criteria.
- Revised the Data Elements for Reporting table.

Description

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did *not* result in an antibiotic dispensing event).

Definitions

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient, telephone, online assessment, observation or ED visit during the Intake Period with a diagnosis of acute bronchitis/bronchiolitis.
Negative Medication History	<p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none">• A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.

- No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.

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

Negative Comorbid Condition History A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.

Negative Competing Diagnosis The Episode Date and 3 days following the Episode Date 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 9: Members in Hospice.

Product line Exchange.

Ages Members who were 3 months or older as of the Episode Date.

Report three age stratifications and a total rate:

- | | |
|----------------------|-----------------------|
| • 3 months–17 years. | • 65 years and older. |
| • 18–64 years. | • Total. |

The total is the sum of the age stratifications.

Continuous enrollment 30 days prior to the Episode Date through three days after the Episode Date (34 total days).

Allowable gap No gaps in enrollment during the continuous enrollment period.

Anchor date None.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).

Do not include outpatient, ED or observation visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 2 Determine all acute bronchitis/bronchiolitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessment, observation or ED visits with a diagnosis of acute bronchitis/bronchiolitis.

Step 3 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:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 3

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:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Cystic Fibrosis Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 4

Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) 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 the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6

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 total days).

Step 7

Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	<ul style="list-style-type: none"> Amikacin Gentamicin 	<ul style="list-style-type: none"> Streptomycin 	<ul style="list-style-type: none"> Tobramycin
Aminopenicillins	<ul style="list-style-type: none"> Amoxicillin 	<ul style="list-style-type: none"> Ampicillin 	
Beta-lactamase inhibitors	<ul style="list-style-type: none"> Amoxicillin-clavulanate Ampicillin-sulbactam 	<ul style="list-style-type: none"> Piperacillin-tazobactam 	
First-generation cephalosporins	<ul style="list-style-type: none"> Cefadroxil 	<ul style="list-style-type: none"> Cefazolin 	<ul style="list-style-type: none"> Cephalexin
Fourth-generation cephalosporins	<ul style="list-style-type: none"> Cefepime 		
Ketolides	<ul style="list-style-type: none"> Telithromycin 		
Lincomycin derivatives	<ul style="list-style-type: none"> Clindamycin 	<ul style="list-style-type: none"> Lincomycin 	
Macrolides	<ul style="list-style-type: none"> Azithromycin Clarithromycin Erythromycin 	<ul style="list-style-type: none"> Erythromycin ethylsuccinate Erythromycin lactobionate 	<ul style="list-style-type: none"> Erythromycin stearate
Miscellaneous antibiotics	<ul style="list-style-type: none"> Aztreonam Chloramphenicol Dalfopristin-quinupristin 	<ul style="list-style-type: none"> Daptomycin Linezolid 	<ul style="list-style-type: none"> Metronidazole Vancomycin
Natural penicillins	<ul style="list-style-type: none"> Penicillin G benzathine-procaine Penicillin G potassium 	<ul style="list-style-type: none"> Penicillin G procaine Penicillin G sodium 	<ul style="list-style-type: none"> Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	<ul style="list-style-type: none"> Dicloxacillin 	<ul style="list-style-type: none"> Nafcillin 	<ul style="list-style-type: none"> Oxacillin
Quinolones	<ul style="list-style-type: none"> Ciprofloxacin Gemifloxacin 	<ul style="list-style-type: none"> Levofloxacin Moxifloxacin 	<ul style="list-style-type: none"> Ofloxacin
Rifamycin derivatives	<ul style="list-style-type: none"> Rifampin 		
Second generation cephalosporin	<ul style="list-style-type: none"> Cefaclor Cefotetan 	<ul style="list-style-type: none"> Cefoxitin Cefprozil 	<ul style="list-style-type: none"> Cefuroxime
Sulfonamides	<ul style="list-style-type: none"> Sulfadiazine 	<ul style="list-style-type: none"> Sulfamethoxazole-trimethoprim 	
Tetracyclines	<ul style="list-style-type: none"> Doxycycline 	<ul style="list-style-type: none"> Minocycline 	<ul style="list-style-type: none"> Tetracycline

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

Description	Prescription		
Third generation cephalosporins	<ul style="list-style-type: none">• Cefdinir• Cefditoren• Cefixime	<ul style="list-style-type: none">• Cefotaxime• Cefpodoxime• Ceftazidime	<ul style="list-style-type: none">• Cefibuten• Ceftriaxone
Urinary anti-infectives	<ul style="list-style-type: none">• Fosfomycin• Nitrofurantoin• Nitrofurantoin macrocrystals	<ul style="list-style-type: none">• Nitrofurantoin macrocrystals-monohydrate• Trimethoprim	

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.*
- *Supplemental data may not be used for this measure.*

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 for Acute Bronchitis/Bronchiolitis

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	For each age stratification and total.
Numerator events by administrative data	For each age stratification and total.
Reported rate	For each age stratification and total.

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Updated value sets used to identify advanced illness.
- Deleted value set combinations for unilateral mastectomy where laterality (bilateral, left, right) is not specified.

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 9: Members in Hospice.

Product line	Exchange.
Ages	Women 52–74 years as of December 31 of the measurement year.
Continuous enrollment	October 1 two years prior to the measurement year through December 31 of the measurement year.
Allowable gap	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.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Exclusions	<p>Exclude members who meet any of the following criteria:</p> <p>Note: Supplemental and medical record data may not be used for these exclusions.</p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced

illness diagnosis ([Advanced Illness Value Set](#)). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

1. Identify all acute and nonacute inpatient stays ([Inpatient Stay Value Set](#)).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code ([Nonacute Inpatient Stay Value Set](#)) on the claim.
 3. Identify the discharge date for the stay.
- At least one acute inpatient encounter ([Acute Inpatient Value Set](#)) with an advanced illness diagnosis ([Advanced Illness Value Set](#)).
 - At least one acute inpatient discharge with an advanced illness diagnosis ([Advanced Illness Value Set](#)) on the discharge claim. To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays ([Inpatient Stay Value Set](#)).
 2. Exclude nonacute inpatient stays ([Nonacute Inpatient Stay Value Set](#)).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication ([Dementia Medications List](#)).

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		

Administrative Specification

Denominator The eligible population.

Numerator One or more mammograms ([Mammography Value Set](#)) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion (optional)

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

- Bilateral mastectomy ([Bilateral Mastectomy Value Set](#)).
- Unilateral mastectomy ([Unilateral Mastectomy Value Set](#)) with a bilateral modifier ([Bilateral Modifier Value Set](#)).
- Unilateral mastectomy found in clinical data ([Clinical Unilateral Mastectomy Value Set](#)) with a bilateral modifier ([Clinical Bilateral Modifier Value Set](#)). Note: the "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.
- History of bilateral mastectomy ([History of Bilateral Mastectomy Value Set](#)).
- Any combination of codes from the table below 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"> Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same procedure) 	<ul style="list-style-type: none"> Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same procedure)
<ul style="list-style-type: none"> Unilateral mastectomy found in clinical data (<u>Clinical Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Clinical Left Modifier Value Set</u>) (same procedure) 	<ul style="list-style-type: none"> Unilateral mastectomy found in clinical data (<u>Clinical Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Clinical Right Modifier Value Set</u>) (same procedure)
<ul style="list-style-type: none"> Absence of the left breast (<u>Absence of Left Breast Value Set</u>) 	<ul style="list-style-type: none"> Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
<ul style="list-style-type: none"> Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>) 	<ul style="list-style-type: none"> Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

Note

- This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance. Do not count MRIs, ultrasounds or biopsies towards the numerator; although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes they are performed as an adjunct to mammography and do not alone count toward the numerator.*

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

Element	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	✓

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Updated screening methods to include primary high-risk human papillomavirus testing.
- Modified value sets to make them compatible with digital measure formatting.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.

Description

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

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 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 9: Members in Hospice.

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

Administrative Specification

Denominator	The eligible population.
Numerator	The number of women who were screened for cervical cancer. Either of the following meet criteria:
Step 1	<ul style="list-style-type: none">• Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Lab Test Value Set</u>; <u>Cervical Cytology Result or Finding Value Set</u>) during the measurement year or the two years prior to the measurement year.

- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year **and** who were 30 years or older on the date of the test.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore additional methods to identify cotesting are not necessary.

Exclusion (optional)

Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual 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. Because Cervical Cancer Screening has been significantly revised, sample size reduction is not allowed.
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 <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	<p>Appropriate screenings are defined by any of the following:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> – Documentation in the medical record must include both of the following: <ul style="list-style-type: none"> ▪ 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. <p>Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.</p> <ul style="list-style-type: none"> • Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing 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 hrHPV test was performed.
Generic documentation of “HPV test” can be counted as evidence of hrHPV test.
 - The results or findings.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.

Exclusion (optional)

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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical 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	✓	✓

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Added live attenuated influenza vaccine (LAIV) as numerator compliant for the influenza rate.
- Reformatted/reorganized the MMR numerator (MMR numerator requirements were not changed).

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 9: Members in Hospice.

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

Administrative Specification

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

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

DTaP

At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure 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) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure 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 meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- At least one measles and rubella vaccination (Measles Rubella Immunization Value Set; Measles Rubella Vaccine Procedure Value Set) **and** one of the following:
 - At least one mumps vaccination (Mumps Immunization Value Set; Mumps Vaccine Procedure Value Set) on or between the child's first and second birthdays.
 - History of mumps illness (Mumps Value Set) any time on or before the child's second birthday.
- Any combination of codes from the table below that indicates evidence of all three antigens (on the same or different date of service).

Measles (any of the following)	Mumps (any of the following)	Rubella (any of the following)
<ul style="list-style-type: none"> • At least one measles vaccination (<u>Measles Immunization Value Set</u>; <u>Measles Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays. 	<ul style="list-style-type: none"> • At least one mumps vaccination (<u>Mumps Immunization Value Set</u>; <u>Mumps Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays. 	<ul style="list-style-type: none"> • At least one rubella vaccination (<u>Rubella Immunization Value Set</u>; <u>Rubella Vaccine Procedure Value Set</u>) administered on or between the child's first and second birthdays.
<ul style="list-style-type: none"> • History of measles (<u>Measles Value Set</u>) illness anytime on or before the child's second birthday. 	<ul style="list-style-type: none"> • History of mumps (<u>Mumps Value Set</u>) illness anytime on or before the child's second birthday. 	<ul style="list-style-type: none"> • History of rubella (<u>Rubella Value Set</u>) illness anytime on or before the child's second birthday.

Note: General Guideline 26: Collecting Data for Measures With Multiple Numerator Events(i.e., the 14-day rule) does not apply to MMR.

HiB

At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure 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 Immunization Value Set](#); [Hepatitis B Vaccine Procedure 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 meet criteria:

- At least one VZV vaccination ([Varicella Zoster \(VZV\) Immunization Value Set](#); [Varicella Zoster \(VZV\) Vaccine Procedure Value Set](#)), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness ([Varicella Zoster Value Set](#)) on or before the child's second birthday.

Pneumococcal conjugate

At least four pneumococcal conjugate vaccinations ([Pneumococcal Conjugate Immunization Value Set](#); [Pneumococcal Conjugate Vaccine Procedure 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.

Childhood Immunization Status

Immunizations documented using a generic header (e.g., polio vaccine) or “IPV/OPV” can be counted as evidence of IPV. The burden on organizations to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.

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

Exclusion (optional)

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

Note

- This measure follows the CDC and ACIP guidelines for immunizations.

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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		Each of the 8 rates
Administrative rate on MRSS		Each of the 8 rates
Number of medical 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

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO 2020 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 9: Members in Hospice.

Product line	Exchange.
Ages	<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"> • 16–20 years. • 21–24 years. • Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	<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"> • <u>Pregnancy Value Set.</u> • <u>Sexual Activity Value Set.</u> • <u>Pregnancy Tests Value Set.</u> <p><i>Pharmacy data.</i> Members who were dispensed prescription contraceptives during the measurement year (<u>Contraceptive Medications List</u>).</p>

Contraceptive Medications

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

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 (Retinoid Medications List) on the date of the pregnancy test or the six days after the pregnancy test.
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year **and** an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the 6 days after the pregnancy test.

Retinoid Medications

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

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 in Women

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>

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Updated value sets used to identify advanced illness.
- Updated the Hybrid specification to indicate that a result is not required if the documentation is clearly part of the member's medical history.

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 9: Members in Hospice.

Product line	Exchange.
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Exclusions	<p>Exclude members who meet any of the following criteria:</p> <p>Note: Supplemental and medical record data may not be used for these exclusions.</p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not

be the same for the two visits. To identify a nonacute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		

Administrative Specification

Denominator The eligible population.

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

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT DNA Lab Test Value Set; FIT DNA Test Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

Exclusion (optional)

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

- Colorectal cancer ([Colorectal Cancer Value Set](#)).
- Total colectomy ([Total Colectomy Value Set](#); [History of 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.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA during the measurement year or the two 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 member's "medical history"; 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 (FIT). 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.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT 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)

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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical 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	✓	✓

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Updated value sets to identify acute and nonacute inpatient events for the event/diagnosis.
- Updated value sets used to identify advanced illness.
- Updated value sets to identify IVD acute inpatient events.
- Updated value sets to identify thoracic aortic aneurysm inpatient events.
- Clarified the telehealth requirements.
- Removed the telehealth exclusion from ESRD.
- Reformatted the denominator of the Hybrid Specification.

HEDIS FOR QRS-SPECIFIC GUIDANCE

- Organizations report only the following indicators: 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:

- 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 9: Members in Hospice*.

Product line	Exchange.
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/diagnosis

There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) **without** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), online assessments (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) **without** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Only one of the two visits may be an outpatient telehealth visit, a telephone visit or an online assessment. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.

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 (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • 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.

Exclusions

Exclude members who meet any of the following criteria:

Note: Supplemental and medical record data may not be used for these exclusions.

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below) on different dates of

service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Control <8% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

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*
<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.
- Bilateral eye enucleation any time during the member's history through December 31 of 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).
- 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.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **with** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) **and** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **and** a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.

- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **and** a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

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 Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
- Evidence of nephrectomy (Nephrectomy Value Set) or 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 (ACE Inhibitor and ARB Medications List).

Note: A process flow diagram is included at the end of this specification to help implement this measure.

ACE Inhibitor and ARB Medications

Description	Prescription		
Angiotensin converting enzyme inhibitors	<ul style="list-style-type: none"> • Benazepril • Captopril • Enalapril • Fosinopril 	<ul style="list-style-type: none"> • Lisinopril • Moexipril • Perindopril 	<ul style="list-style-type: none"> • Quinapril • Ramipril • Trandolapril
Angiotensin II inhibitors	<ul style="list-style-type: none"> • Azilsartan • Candesartan • Eprosartan 	<ul style="list-style-type: none"> • Irbesartan • Losartan • Olmesartan 	<ul style="list-style-type: none"> • Telmisartan • Valsartan
Antihypertensive combinations	<ul style="list-style-type: none"> • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone 	<ul style="list-style-type: none"> • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril 	<ul style="list-style-type: none"> • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil

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

Denominator	<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>
HbA1c Control <8%	<p>The <i>most recent</i> HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.</p>
<u>Administrative</u>	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.</p>
<u>Medical record</u>	<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. 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.</p> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.</p>
Eye Exam	<p>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:</p> <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A <i>negative</i> retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year. • Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

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 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.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- 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).
 - Documentation does not have to state specifically “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 or monitoring 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 during the measurement year 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 the date 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 evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:
 - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.
 - Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
 - Documentation that the member took an ACE inhibitor/ARB during the measurement year.

Exclusions (optional)

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.

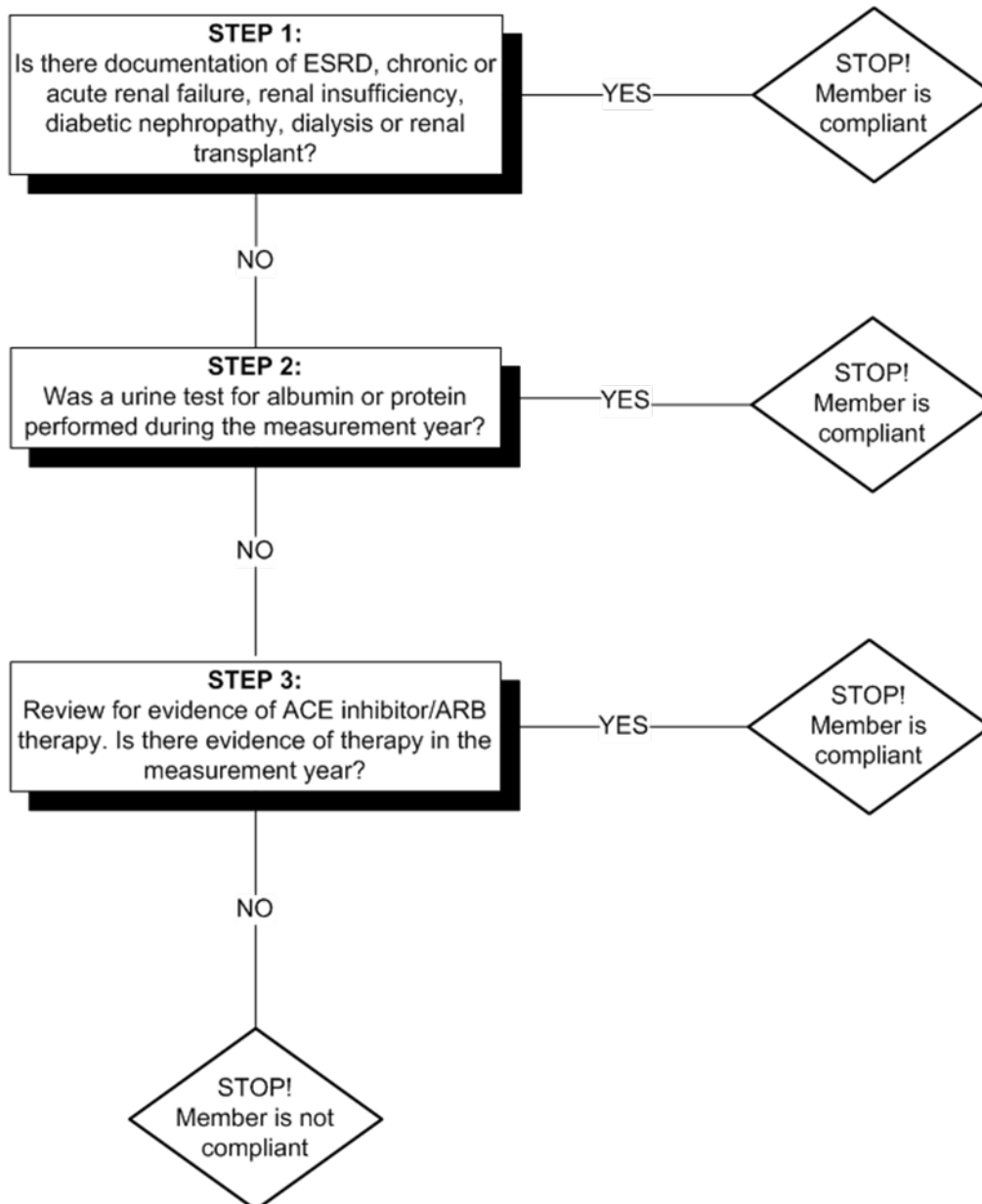
Note

- Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for 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.
- To facilitate HEDIS reporting the denominator for all rates must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).
- Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam

annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.

- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source.*

Monitoring for 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 3 rates</i>	<i>Each of the 3 rates</i>
Eligible population	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>
Number of numerator events by administrative data in eligible population (before optional exclusions)		<i>Each of the 3 rates</i>
Current year's administrative rate (before optional exclusions)		<i>Each of the 3 rates</i>
Minimum required sample size (MRSS)		<i>Each of the 3 rates</i>
Oversampling rate		<i>Each of the 3 rates</i>
Number of oversample records		<i>Each of the 3 rates</i>
Number of numerator events by administrative data in MRSS		<i>Each of the 3 rates</i>
Administrative rate on MRSS		<i>Each of the 3 rates</i>
Number of medical records excluded because of valid data errors		<i>Each of the 3 rates</i>
Number of optional administrative data records excluded		<i>Each of the 3 rates</i>
Number of optional 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</i>
Numerator events by administrative data	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>
Numerator events by medical records		<i>Each of the 3 rates</i>
Numerator events by supplemental data	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>
Reported rate	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Added value sets to identify outpatient telehealth visits for the event/diagnosis.
- Updated value sets used to identify advanced illness.
- Updated the Hybrid specification to indicate that sample size reduction is allowed.
- Clarified optional exclusion criteria apply to both the Administrative and Hybrid data collection methods.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second 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 9: Members in Hospice*.

Product line	Exchange.
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria:

- Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
- An online assessment (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).

Only one of the two visits may be a telephone visit, an online assessment or an outpatient telehealth visit. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.

Exclusions

Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
 - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet *both* of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		

Administrative Specification

Denominator The eligible population.

Numerator Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Without UBREV Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than or Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than or Equal To 90 Value Set</u>	Diastolic not compliant

Exclusions (optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female 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.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. The organization may reduce the sample size using 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.
Identifying the medical record	<p>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.</p> <p>Use the following guidance to find the appropriate medical record to review.</p> <ul style="list-style-type: none">• 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.
Numerator	The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member's BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a member's BP is adequately controlled, the representative BP must be identified.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
Medical record	<p>Identify the most recent BP reading noted during the measurement year.</p> <p>The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.</p>

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the member.

BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider.

Note: *Member-reported results to the provider from a remote monitoring device are not acceptable.*

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. 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.

The member is not compliant if the BP reading is $\geq 140/90$ mm Hg or is missing, or 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).

Exclusions (optional)

Refer to the *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, **or** evidence of ESRD, dialysis, nephrectomy or kidney transplant any time during the member's history through December 31 of the measurement year.

Note

- *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).*
- *An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.*
- *When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
 - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
 - *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.*
 - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*

Controlling High Blood Pressure

- A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.
- BP readings taken on the same day that the member receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive (this list is just for reference, and is not exhaustive):
 - Vaccinations.
 - Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).
 - TB test.
 - IUD insertion.
 - Eye exam with dilating agents.
 - Wart or mole removal.

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

	Admin	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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical 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	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Flu Vaccinations for Adults Ages 18–64 (FVA)

SUMMARY OF CHANGES TO 2020 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 MQI website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the QRS survey measures. The QHP Enrollee Survey response data are submitted to CMS.

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

Product line	Exchange.
Ages	18–64 years as of July 1 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 31 days during the continuous enrollment period.
Anchor date	December 31 of the measurement year.
Current enrollment	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, 1954, and July 1, 2001)
2 = Ineligible (the member was born before July 2, 1954, or after July 1, 2001)

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
Q45	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 (2019 for the survey fielded in 2020).

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)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Added the Mental Health Practitioner Value Set to make the measure compatible with digital measure formatting.
- Clarified that the diagnosis must be on the discharge claim when identifying the event/diagnosis and direct transfers.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Added a *Note* to address mapping providers to the codes in the Mental Health Practitioner Value Set.

HEDIS FOR QRS SPECIFIC GUIDANCE

- QHP 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 or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to *General Guideline 9: Members in Hospice*.

Product line	Exchange.		
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: <table> <tr> <td> <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. </td><td> <ul style="list-style-type: none"> • 65 years and older. • Total. </td></tr> </table>	<ul style="list-style-type: none"> • 6–17 years. • 18–64 years. 	<ul style="list-style-type: none"> • 65 years and older. • Total.
<ul style="list-style-type: none"> • 6–17 years. • 18–64 years. 	<ul style="list-style-type: none"> • 65 years and older. • Total. 		
Continuous enrollment	The total is the sum of the age stratifications. Date of discharge through 30 days after discharge.		
Allowable gap	No gaps in enrollment.		
Anchor date	None.		
Benefits	Medical and mental health (inpatient and outpatient).		
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (<u>Mental Illness Value Set</u> ; <u>Intentional Self-Harm Value Set</u>) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. 		

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.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 7 day follow-up period:

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.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 7-day follow-up period, regardless of the 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.

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. Do not include visits that occur on the date of discharge.

Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set **with** Outpatient POS Value Set **with** a mental health practitioner (Mental Health Practitioner Value Set).
- An outpatient visit (BH Outpatient Value Set **with** a mental health practitioner (Mental Health Practitioner Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set **with** Partial Hospitalization POS Value Set **with** a mental health practitioner (Mental Health Practitioner Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** a mental health practitioner (Mental Health Practitioner Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set **with** Community Mental Health Center POS Value Set **with** a mental health practitioner (Mental Health Practitioner Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) **with** a mental health practitioner (Mental Health Practitioner Value Set).
- A telehealth visit: Visit Setting Unspecified Value Set **with** Telehealth POS Value Set **with** a mental health practitioner (Mental Health Practitioner Value Set).
- An observation visit (Observation Value Set) **with** a mental health practitioner (Mental Health Practitioner Value Set).
- Transitional care management services (Transitional Care Management Services Value Set), **with** a mental health practitioner (Mental Health Practitioner Value Set).

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).
- If an organization does not use the codes in the Mental Health Practitioner Value Set, it must map providers to a code in the value set for reporting. Only providers who meet the definition of mental health practitioner (refer to Appendix 3) are eligible to be mapped. Mapping is subject to review by the HEDIS auditor.
- 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

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>The rate for each age stratification and total</i>
Numerator events by supplemental data	<i>The rate for each age stratification and total</i>
Reported rate	<i>The rate for each age stratification and total</i>

Immunizations for Adolescents (IMA)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Clarified in the Hybrid Specification that immunizations documented under a generic header of “meningococcal conjugate vaccine” or “meningococcal polysaccharide vaccine” meet criteria.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS does not report Combination 1 (Meningococcal, Tdap).

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th 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 9: Members in Hospice.

Product line	Exchange.
Age	Adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the member's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday.
Anchor date	Enrolled on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	For meningococcal, Tdap and HPV count <i>only</i> evidence of the antigen or combination vaccine.
Meningococcal serogroups A, C, W, Y	At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set ; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the member's 11th and 13th birthdays.

Tdap	At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (<u>Tdap Immunization Value Set</u> ; <u>Tdap Vaccine Procedure Value Set</u>), with a date of service on or between the member's 10th and 13th birthdays.
HPV	<ul style="list-style-type: none"> At least two HPV vaccines (<u>HPV Immunization Value Set</u>; <u>HPV Vaccine Procedure Value Set</u>), with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25. <p>OR</p> <ul style="list-style-type: none"> At least three HPV vaccines (<u>HPV Immunization Value Set</u>; <u>HPV Vaccine Procedure Value Set</u>), with different dates of service on or between the member's 9th and 13th birthdays.
Combination 2 (Meningococcal, Tdap, HPV)	Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Exclusion (optional)

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

Any of the following meet optional exclusion criteria:

Any particular vaccine	<ul style="list-style-type: none"> Anaphylactic reaction to the vaccine or its components (<u>Anaphylactic Reaction Due To Vaccination Value Set</u>) anytime on or before the member's 13th birthday. Anaphylactic reaction to the vaccine or its components (<u>Anaphylactic Reaction Due To Serum Value Set</u>), with a date of service prior to October 1, 2011.
Tdap	<ul style="list-style-type: none"> Encephalopathy (<u>Encephalopathy Due To Vaccination Value Set</u>) with a vaccine adverse-effect code (<u>Vaccine Causing Adverse Effect Value Set</u>) any time on or before the member's 13th birthday.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. Organizations may reduce the sample size using current year's administrative rate or prior year's audited, product-line specific rate for the lowest rate across all antigens and Combination 2. For information on reducing the sample size, refer to the <i>Guidelines for Calculations and Sampling</i> .
Numerators	For meningococcal, Tdap and HPV, count <i>only</i> the evidence of the antigen or combination vaccine.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.

Medical record

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either 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 the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal, *do not count* meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of “meningococcal” and generic documentation that “meningococcal vaccine,” “meningococcal conjugate vaccine” or “meningococcal polysaccharide vaccine” were administered meet criteria.

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.

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 vaccine (serogroups A, C, W and Y) is included in the measure.*
- *To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).*

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 Immunizations for Adolescents

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)		<i>Each of the 4 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 4 rates</i>
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		<i>Each of the 4 rates</i>
Administrative rate on MRSS		<i>Each of the 4 rates</i>
Number of medical 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	<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>

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Revised the Intake Period to end on November 13 of the measurement year.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Clarified that the diagnosis must be on the discharge claim when identifying acute and nonacute inpatient discharges.
- Renamed the medication lists.
- Added “Buprenorphine injections” to the Opioid Use Disorder Treatment Medications List.

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or 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, telehealth or medication treatment within 14 days of the diagnosis.
- *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

Definitions

Intake Period	January 1–November 13 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index Episode	<p>The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.</p> <p><i>For ED visits that result in an inpatient stay, the inpatient discharge is the Index Episode.</i></p>
IESD	<p>Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.</p> <p><i>For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.</i></p> <p><i>For an inpatient stay, the IESD is the date of discharge.</i></p> <p><i>For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).</i></p>

Negative Diagnosis History A period of 60 days (2 months) before the IESD when the member had no claims/ encounters with a diagnosis of AOD dependence.

For an inpatient stay, use the admission date to determine the Negative Diagnosis History.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. 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 9: Members in Hospice.

Product line Exchange.

Ages 13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate.

3. 13–17 years.
4. 18+ years.
5. Total.

The total is the sum of the age stratifications.

AOD diagnosis cohorts Report the following diagnosis cohorts for each age stratification and the total rate:

- Alcohol abuse or dependence.
- Opioid abuse or dependence.
- Other drug abuse or dependence.
- Total.

Continuous enrollment 60 days (2 months) prior to the IESD through 48 days after the IESD (109 total days).

Allowable gap	None.
Anchor date	None.
Benefit	Medical, pharmacy and chemical dependency (inpatient and outpatient). <i>Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.</i>
Event/diagnosis	New episode of AOD abuse or dependence 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: <ul style="list-style-type: none">• An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:<ul style="list-style-type: none">– <u>IET Stand Alone Visits Value Set</u> with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.– <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.– <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• A detoxification visit (<u>Detoxification Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• An ED visit (<u>ED Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• An observation visit (<u>Observation Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• An acute or nonacute inpatient discharge with one of the following on the discharge claim: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. To identify acute and nonacute inpatient discharges:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Identify the discharge date for the stay.• A telephone visit (<u>Telephone Visits Value Set</u>) with one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.

- An online assessment (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2

Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3

Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) 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 or observation visit that results in an inpatient stay, use the ED/observation date of service to determine the 60-day Negative Diagnosis History period.

Step 4

Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 48 days after the IESD (109 total days), with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment within 14 days of diagnosis.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and 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** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessment Value Set) **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or

medication treatment during a visit (AOD Medication Treatment Value Set).

- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Alcohol Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.

If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

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 November 27 of the measurement year.

Engagement of AOD Treatment

Step 1

Identify all members compliant for the Initiation of AOD Treatment numerator.

For members who initiated treatment via an inpatient admission, the 34-day period for the two engagement visits begins the day after discharge.

Step 2

Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 3

Identify the remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2).

These members are numerator compliant if they meet either of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

<i>Engagement visits</i>	<p>Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:</p> <ul style="list-style-type: none">• An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>. To identify acute or nonacute inpatient admissions:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Identify the admission date for the stay.• <u>IET Stand Alone Visits Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>., with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>).• <u>Observation Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>., with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>).• <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>., with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>).• A telephone visit (<u>Telephone Visits Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.• An online assessment (<u>Online Assessments Value Set</u>) with a diagnosis matching the IESD diagnosis cohort using one of the following: <u>Alcohol Abuse and Dependence Value Set</u>, <u>Opioid Abuse and Dependence Value Set</u>, <u>Other Drug Abuse and Dependence Value Set</u>.
<i>Engagement medication treatment events</i>	<p>Either of the following meets criteria for an engagement medication treatment event:</p> <ul style="list-style-type: none">• If the IESD diagnosis was a <i>diagnosis of alcohol abuse or dependence</i> (<u>Alcohol Abuse and Dependence Value Set</u>), one or more medication treatment dispensing events (<u>Alcohol Use Disorder Treatment Medications List</u>) or medication treatment during a visit (<u>AOD Medication Treatment Value Set</u>), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for <u>Alcohol Abuse and Dependence Treatment</u>.

- If the IESD diagnosis was a *diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

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.
- For members in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.

Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

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, diagnosis stratification and total</i>
Numerator events by administrative data	<i>Each rate, for each age stratification, diagnosis stratification and total</i>
Reported rate	<i>Each rate, for each age stratification, diagnosis stratification and total</i>

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- No changes to the measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Measure collection is based on enrollee responses to a subset of the QHP Enrollee Survey questions.

Organizations should refer to the [CMS MQI website](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html) (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the QRS survey measures. The QHP Enrollee Survey response data are submitted to CMS.

Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit	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.
Discussing Cessation Medications	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.
Discussing Cessation Strategies	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

Product line	Exchange.
Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 31 days during the measurement year.
Anchor date	December 31 of the measurement year.
Current enrollment	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
Q46	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 50 Don't know → If Don't know, Go to Question 50
Q47	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
Q48	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
Q49	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

Denominator	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: Q46 = “Every day” or “Some days.” Q47 = “Never” or “Sometimes” or “Usually” or “Always.”
Numerator	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 Q47.

Discussing Cessation Medications

Denominator	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: Q46 = “Every day” or “Some days.” Q48 = “Never” or “Sometimes” or “Usually” or “Always.”
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Numerator 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 Q48.

Discussing Cessation Strategies

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:
Q46 = “Every day” or “Some days.”
Q49 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator 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 Q49.

Medication Management for People With Asthma (MMA)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Updated value sets to identify acute inpatient events for the event/diagnosis.
- Modified medication lists to make them compatible with digital measure formatting.
- Clarified the telehealth requirements for identifying the event/diagnosis.
- Added Benralizumab to the “Anti-interleukin-5” description in the [Asthma Controller Medications List](#).
- Clarified in step 4 that the equation must be multiplied by 100 before rounding to the nearest whole number.

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

IPSD	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days that a member is covered by at least one asthma controller medication, divided by the number of days in the treatment period.
Oral medication dispensing event	<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 ($100/30 = 3.33$, 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 medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.</p> <ul style="list-style-type: none">• <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).

- *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaler dispensing event

When *identifying the eligible population*, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications 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 medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection or intravenous dispensing event

Each injection or intravenous infusion 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.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

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 medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	<p>Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate:</p> <ul style="list-style-type: none">• 5–11 years.• 12–18 years.• 19–50 years.• 51–64 years.• Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.
Event/diagnosis	Follow the steps below to identify the eligible population for the measure.
Step 1	<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">• At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>).• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>).• At least one acute inpatient discharge with a principal diagnosis of asthma (<u>Asthma Value Set</u>). To identify an acute inpatient discharge:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).3. Identify the discharge date for the stay.• At least four outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), telephone visits (<u>Telephone Visits Value Set</u>) or online assessments (<u>Online Assessments Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications. <p>Only three of the four visits may be an outpatient telehealth visit, a telephone visit or an online assessment. Identify outpatient telehealth</p>

visits by the presence of a telehealth modifier ([Telehealth Modifier Value Set](#)) or the presence of a telehealth POS code ([Telehealth POS Value Set](#)) associated with the outpatient visit.

- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications. (At least one ED visit ([ED Value Set](#)), with a principal diagnosis of asthma ([Asthma Value Set](#)).

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Subcutaneous
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Subcutaneous
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Subcutaneous
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Intravenous
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Step 2

A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma ([Asthma Value Set](#)), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Step 3: Required exclusions

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
 - [Emphysema Value Set](#).
 - [Other Emphysema Value Set](#).
 - [COPD Value Set](#).
 - [Obstructive Chronic Bronchitis Value Set](#).
 - [Chronic Respiratory Conditions Due to Fumes or Vapors Value Set](#).
 - [Cystic Fibrosis Value Set](#).
 - [Acute Respiratory Failure Value Set](#).
- Members who had no asthma controller medications dispensed during the measurement year. Use all the medication lists in the Asthma Controller Medications table above to identify asthma controller medications.

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 during the measurement year.

Follow the steps below to identify numerator compliance.

Use all the medication lists in the Asthma Controller Medications table above to identify asthma controller medications.

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication during the measurement year.

Step 2

To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for an asthma controller medication 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. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

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

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>

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Added definitions of “outlier,” “nonoutlier” and “plan population.”
- Added observation stays to inpatient admissions.
- Revised direct transfers to include observation discharges.
- Moved instructions for direct transfer to *Guideline 6* in the *Guidelines for Risk Adjusted Utilization Measures*.
- Added steps to remove hospitalizations for outlier members and report a count of outlier members.
- Added a step in the Risk Adjustment Weighting section for observation stay IHS.
- Removed the base weight variable from the Risk Adjustment Weighting.
- Removed Sample Table: PCR—Risk Adjustment Weighting in Risk Adjustment Weighting.
- Added a *Note* to step 4 in the numerator.
- Added instructions and data element tables to report plan population and outlier rate.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS uses the commercial risk weights for risk adjustment.

Description

For members 18–64 years of age, the number of acute inpatient and observation 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 Observed 30-Day Readmissions (numerator).
3. Count of Expected 30-Day Readmissions.

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute or observation inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.

Planned hospital Stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the numerator.
Plan population	<p>Members who meet all of the following criteria:</p> <ul style="list-style-type: none"> • 18 and older as of January 1 of the measurement year. • Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year. <p>Assign members to the product and product line at the start of this defined continuous enrollment period.</p>
Outlier	<p>Members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year.</p> <p>Assign members who transition between product lines during the measurement year to the product they were enrolled in on January 1 of the measurement year.</p>
Nonoutlier	Members in the plan population who are not considered outliers.
Classification Period	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 3
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 4
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5

Note: The risk adjustment tables will be released on November 1, 2019, and posted to www.ncqa.org.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	Ages 18–64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.

Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/ diagnosis	<p>An acute inpatient or observation stay 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 or observation stay discharges for nonoutlier 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 and observation stays.</p>

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation 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 stays.

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

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the Risk Adjusted Utilization Guidelines.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

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:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table PCR-4.

Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS among nonoutlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation Stay	Determine if the IHS at discharge was an observation stay (<u>Observation Stay Value Set</u>). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the member underwent surgery during the stay. Download the list of codes from the NCQA website (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.
Discharge Condition	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For direct transfers, use the primary discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table PCR-DischCC.
Comorbidities	Refer to <i>Utilization Risk Adjustment Determination</i> in the <i>Guidelines for Risk Adjusted Utilization Measures</i> .

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Note: The final weights table will be released on November 1, 2019. HEDIS for QRS uses the Commercial Risk Weights for risk adjustment.

- Step 1** For each IHS discharge that is an observation stay, link the observation stay IHS weight.

Use Table PCR-Comm-OtherWeights.
- Step 2** For each IHS with a surgery, link the surgery weight.

Use Table PCR-Comm-OtherWeights..

Step 3 For each IHS with a discharge CC Category, link the primary discharge weights.

Use Table PCR-Comm-DischCC-Weight

Step 4 For each IHS with a comorbidity HCC Category, link the weights.

Use Table PCR-Comm-ComorbHCC-Weight..

Step 5 Link the age and gender weights for each IHS.

Use Table PCR-Comm-OtherWeights.

Step 6 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS.

$$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$$

OR

$$\text{Estimated Readmission Risk} = [\exp (\text{sum of weights for IHS})] / [1 + \exp (\text{sum of weights for IHS})]$$

Note: “Exp” refers to the exponential or antilog function.

Step 7 Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

$$\text{Count of Expected Readmissions} = \sum (\text{Estimated Readmission Risk})$$

Step 8 Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

$$\text{Variance} = \text{Estimated Readmission Risk} \times (1 - \text{Estimated Readmission Risk})$$

Example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: This variance is calculated at the IHS level. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables.

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

Step 1 Identify all acute inpatient and observation 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) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 2 Direct transfers: For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the Risk Adjusted Utilization Guidelines.

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- Planned admissions using any of the following:
 - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter 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, Introduction of Autologous Pancreatic Cells 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 a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: Count each acute hospitalization only once toward the numerator, for the last denominator event.

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- Acute Inpatient Stay 1: May 1–10.
- Acute Inpatient Stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).
- Acute Inpatient Stay 3: May 30–June 5.

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only towards the last denominator event (Stay 2, May 15–25).

Reporting: Number of Members in Plan Population

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of members in the plan population for each age group and the overall total. Enter these values in reporting Tables PCR-4.

Reporting: Number of Outliers

- Step 1** Determine the member's age as of January 1 of the measurement year.
- Step 2** Report the count of outlier members for each age group and the overall total. Enter these values in reporting Tables PCR-4.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall totals calculated by IDSS.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group and enter these values into the reporting table under Count of Index Stays.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Count of Expected 30-Day Readmissions

- Step 1** Calculate the Count of Expected Readmissions among nonoutlier members for each age group and overall total.
- Step 2** Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting tables.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

Reporting: Variance

- Step 1** Calculate the total (sum) variance for each age group.
- Step 2** Round to four decimal places using the .5 rule and enter the variance into the reporting tables.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions divided by the Count of Expected 30-Day Readmissions calculated by IDSS.

Note

- Supplemental data may not be used for this measure.

Table PCR-4: Plan Population and Outlier Rate

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
18-64 Total			

Table PCR-A-4: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate	Count of Expected 30-Day Readmissions	Expected Readmission Rate	Variance	O/E Ratio
18-44							
45-54							
55-64							
18-64 Total							

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Revised the timing of the event/diagnosis criteria.
- Revised the *Timeliness of Prenatal Care* numerator to allow for visits that occur before the enrollment start date.
- Revised the timing of the *Postpartum Care* numerator.
- Added a *Definitions* section.
- Revised the *Continuous Enrollment* criteria.
- Added a *Note* to Step 1 of the event/diagnosis to clarify that the date of service or, for inpatient claims, the date of discharge is used if the date of delivery cannot be interpreted on the claim.
- Deleted the decision rules and standardized the prenatal care visit requirements in the *Timeliness of Prenatal Care* numerator.
- Clarified in the *Timeliness of Prenatal Care* and *Postpartum Care* numerators to not count visits that occur on the date of delivery.
- Updated the *Postpartum Care* numerator to exclude services provided in an acute inpatient setting.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.
- Added bullets to the Hybrid Specification of the *Postpartum Care* numerator to meet criteria.

Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 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 in the first trimester, on or before 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 7 and 84 days after delivery.

Definitions

First trimester	280–176 days prior to delivery (or EDD).
Enrollment segment	A period of continuous enrollment with no gaps in enrollment.
Last enrollment segment	The enrollment segment during the pregnancy with the start date that is closest to the delivery date.

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 9: Members in Hospice.

Product line	Exchange.
Ages	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 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 October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p>
Step 1	Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.
Step 2	Exclude non-live births (<u>Non-live Births Value Set</u>).
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 during the first trimester, on or before 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.
Step 1	<p>Identify women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).</p> <p>These women must have a prenatal visit during the first trimester.</p>

Step 2	<p>Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).</p> <p>These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.</p> <p>Do not count visits that occur on the date of delivery.</p>
Step 3	<p>Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:</p> <ul style="list-style-type: none">• 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).• A visit for prenatal care (<u>Stand Alone Prenatal Visits Value Set</u>).• A prenatal visit (<u>Prenatal Visits Value Set</u>) with a pregnancy-related diagnosis code (<u>Pregnancy Diagnosis Value Set</u>).
Postpartum Care	<p>A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:</p> <ul style="list-style-type: none">• A postpartum visit (<u>Postpartum Visits Value Set</u>).• Cervical cytology (<u>Cervical Cytology Lab Test Value Set</u>; <u>Cervical Cytology Result or Finding Value Set</u>).• A bundled service (<u>Postpartum Bundled Services Value Set</u>) 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). <p>Exclude services provided in an acute inpatient setting (<u>Acute Inpatient Value Set</u>; <u>Acute Inpatient POS Value Set</u>).</p> <p>Note: <i>The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.</i></p>

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for each product line. Because <i>Prenatal and Postpartum Care</i> has been significantly revised, sample size reduction is not allowed.
Numerator	
<i>Timeliness of Prenatal Care</i>	A prenatal visit in the first trimester, on or before 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. Do not count visits that occur on the date of delivery.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> 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 diagnosis of pregnancy.
- 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**
 - Ultrasound of a pregnant uterus.
- Documentation of LMP, EDD or gestational age in conjunction with *either* of the following.
 - Prenatal risk assessment and counseling/education.
 - Complete obstetrical history.

Postpartum Care

A postpartum visit on or between 7 and 84 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 or other prenatal care practitioner or PCP on or between 7 and 84 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. Do not include postpartum care provided in an acute inpatient setting.

- 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.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
 - Infant care or breastfeeding.

- Resumption of intercourse, birth spacing, or family planning.
- Sleep/fatigue.
- Resumption of physical activity and attainment of healthy weight.

Note

- *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 before, on or between 280 and 219 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 combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, 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 October 8 of the year prior to the measurement year and October 7 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 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 as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis, rather than assessing treatment for emergent events.*
- *Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal practitioner.*

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)		<i>For each of the 2 rates</i>
Oversampling rate		<i>For each of the 2 rates</i>
Number of oversample records		<i>For each of the 2 rates</i>
Number of numerator events by administrative data in MRSS		<i>For each of the 2 rates</i>
Administrative rate on MRSS		<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>

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Modified value sets to make them compatible with digital measure formatting.
- Removed “with or without a telehealth modifier” language; refer to *General Guideline 33*.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Clarified the timing of the prolonged use of corticosteroids exclusion in step 4 of the event/diagnosis criteria.

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

Intake Period	January 1–December 3 of the measurement year. The Intake Period is used to identify the first eligible encounter with a primary diagnosis of low back pain.
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
Negative Diagnosis History	A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to *General Guideline 9: Members in Hospice*.

Product line	Exchange.
Ages	18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year.
Continuous enrollment	180 days (6 months) prior to the IESD through 28 days after the IESD.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	IESD.
Benefit	Medical.

Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	<p>Identify all members in the specified age range who had any of the following during the Intake Period:</p> <ul style="list-style-type: none"> • Outpatient visit (<u>Outpatient Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>). • An observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>). <ul style="list-style-type: none"> – Do not include outpatient, ED or observation visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). • Osteopathic or chiropractic manipulative treatment (<u>Osteopathic and Chiropractic Manipulative Treatment Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>). • Physical therapy visit (<u>Physical Therapy Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>). • Telephone visit (<u>Telephone Visits Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>). • Online assessment (<u>Online Assessments Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).
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 (<u>Uncomplicated Low Back Pain Value Set</u>) during the 180 days (6 months) prior to the IESD.
Step 4: Required exclusions	<p>Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:</p> <ul style="list-style-type: none"> • <i>Cancer.</i> Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria: <ul style="list-style-type: none"> – <u>Malignant Neoplasms Value Set</u>. – <u>Other Neoplasms Value Set</u>. – <u>History of Malignant Neoplasm Value Set</u>. – <u>Other Malignant Neoplasm of Skin Value Set</u>. • <i>Recent trauma.</i> Trauma (<u>Trauma Value Set</u>) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD. • <i>Intravenous drug abuse.</i> IV drug abuse (<u>IV Drug Abuse Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD. • <i>Neurologic impairment.</i> Neurologic impairment (<u>Neurologic Impairment Value Set</u>) 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 366-day period that begins 365 days prior to the IESD and ends on the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day 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.

Corticosteroid Medications

Description	Prescription	
Corticosteroid	<ul style="list-style-type: none">• Hydrocortisone• Cortisone• Prednisone• Prednisolone	<ul style="list-style-type: none">• Methylprednisolone• Triamcinolone• Dexamethasone• Betamethasone

Step 5 Calculate and continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

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.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*

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	✓
Reported rate	✓

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Clarified in the *Notes* that referral to WIC may be used to meet criteria for the Counseling for Nutrition indicator.

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.
- Counseling for nutrition.
- Counseling for physical activity.

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

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 9: Members in Hospice.*

Product line Exchange.

Ages 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Members who had an outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

BMI Percentile BMI percentile (BMI Percentile Value Set) during the measurement year.

Counseling for Nutrition Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.

Counseling for Physical Activity Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Exclusions (optional)

Female 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

Denominator 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.

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 *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

BMI Percentile BMI percentile during the measurement year as identified by administrative data or medical record review.

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

Medical record 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.

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile).
- BMI percentile plotted on age-growth chart.

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

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.

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

- *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.
 - Documentation related to a member’s “appetite” does not meet criteria.
 - **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 of 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.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*
- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*
- *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>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)		<i>Each of the 3 rates</i>
Oversampling rate		<i>Each of the 3 rates</i>
Number of oversample records		<i>Each of the 3 rates</i>
Number of numerator events by administrative data in MRSS		<i>Each of the 3 rates, for each age stratification and total</i>
Administrative rate on MRSS		<i>Each of the 3 rates, for each age stratification and total</i>
Number of medical 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>

Well-Child Visits in the First 15 Months of Life (W15)

SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS

- Added instructions to not count services provided via telehealth when reporting this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- 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.

Note

- This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Age	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	Day the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	<p>The number of members who received 6 or more well-child visits (<u>Well-Care Value Set</u>) with a PCP, on different dates of service, on or before the child's 15-month birthday.</p> <p>Do not count visits billed with a telehealth modifier (<u>Telehealth Modifier Value Set</u>) or billed with a telehealth POS code (<u>Telehealth POS Value Set</u>). 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 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 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	✓

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)**SUMMARY OF CHANGES TO 2020 HEDIS FOR QRS**

- Added instructions to not count services provided via telehealth when reporting 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.

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	3–6 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	<p>At least one well-child visit (<u>Well-Care Value Set</u>) with a PCP during the measurement year.</p> <p>Do not count visits billed with a telehealth modifier (<u>Telehealth Modifier Value Set</u>) or billed with a telehealth POS code (<u>Telehealth POS Value Set</u>).</p> <p>The well-child visit 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 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 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	✓

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.

**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.

**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 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, nurse practitioners or physician assistants 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.

Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor.

- To be certified as an FQHC, an entity must meet any one of the following criteria:
 - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements.
 - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a “FQHC look-alike”) based on the recommendation of the Health Resources and Services Administration.
 - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990.
 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991.
- For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above):
 - Provide comprehensive services and have an ongoing quality assurance program.
 - Meet other health and safety requirements.
 - Not be concurrently approved as a Rural Health Clinic.

Only certified Rural Health Clinics (RHC) are considered PCPs. This must be reviewed and approved by an auditor.

To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.

**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).

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 2020 HEDIS for QRS, the measurement year is 2019.
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"> Members who meet all criteria for the population. This is the universe of members for each measure. For administrative measures, the eligible population is reported after evaluation for optional exclusion criteria and after required exclusions are applied. For hybrid measures, the eligible population of members is reported prior to optional exclusions and after required exclusions are applied (see Guidelines for Calculations and Sampling for the three approaches to conducting the Hybrid Method).
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 (labeled “required exclusions” in the specification).
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. <i>This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.</i>
Current year’s administrative rate (before exclusions)		✓		This is a calculated field in IDSS. Numerator events by administrative data in eligible population ÷ eligible population. <i>This rate may or may not include numerator events by supplemental data.</i>
Minimum required sample size (MRSS)		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines.

Element	Admin	Hybrid	Research	Meaning
Oversampling rate		✓		The percentage of additional records used only to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA. <i>The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the eligible population.</i>
Number of oversample records		✓		This is a calculated field in IDSS. MRSS * oversample rate. <i>Oversample records should be used only to replace cases taken out of the MRSS because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.</i>
Number of numerator events by administrative data in MRSS		✓		Number of members in the MRSS who meet numerator criteria through transactional data (which may include supplemental data).
Administrative rate on MRSS		✓		This is a calculated field in IDSS. Numerator events by administrative data in MRSS ÷ MRSS.
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.
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. <i>These members are only excluded from the MRSS, they are not removed from the eligible population.</i>
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. <i>Employees/dependents are only excluded from the MRSS, they are not removed from the eligible population.</i>
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.

Appendix 2—Data Element Definitions

Element	Admin	Hybrid	Research	Meaning
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error. <i>This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.</i>
Denominator		✓		This population is the denominator used to report the measure. MRSS – exclusions + members added from the oversample list.
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. Measures that collect numerator events by supplemental data: <i>Administrative:</i> (Numerator events by administrative data + numerator events by supplemental data) ÷ eligible population. <i>Hybrid:</i> (Numerator events by administrative data + numerator events by supplemental data + numerator events by medical records) ÷ denominator.

*Data element is optional.

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	✓

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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical 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	✓	✓

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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 optimizing health by advancing the quality of medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with 250 member organizations.

PQA Measure Development Process

PQA develops and serves as a steward for medication-use measures in areas such as medication safety, medication adherence and appropriateness. PQA uses a systematic, transparent, consensus-based process to draft, test, refine, and endorse measures of medication-use quality.

- Step 1: Measure concepts for development are prioritized by PQA staff based on input from PQA's Measure Advisement Group, Implementation Advisory Panel, and Patient & Caregiver Advisory Panel. Environmental scans are conducted to identify whether similar measures exist, ensuring harmonization and avoiding duplication. Selected concept ideas are considered to represent areas in which there are measurement and performance gaps to have the greatest chance of implementation in existing measure sets and performance systems, and to align with the National Quality Strategy.
- Step 2: PQA Measure Development Teams (MDTs) and Task Forces (TFs), comprised of experts in all phases of drug use and management, discuss and draft specifications for measure concepts that may be appropriate for development into fully specified performance measures (or quality improvement indicators). The MDTs/TFs focus on specific aspects of the medication-use system and/or specific therapeutic areas and benefit by having their development work reviewed by larger groups, Stakeholder Advisory Panels. They may also receive input from the Patient & Caregiver Advisory Panel, Implementation Advisory Panel, and Risk Adjustment Advisory Panel.
- Step 3: PQA MDTs/TFs recommend measure concepts to the PQA Quality Metrics Expert Panel (QMEP) for evaluation and refinement. The QMEP reviews and provides an initial assessment of the measure concept focusing on the criterion of importance (i.e., evidence supports that measurement can have a positive impact on healthcare quality). The QMEP votes to approve the measure concept to move forward for testing.
- Step 4: PQA staff prepare technical specifications (including National Drug Code [NDC] lists) for pilot testing and use MDT/TF and QMEP recommendations to formulate a testing plan for each draft measure.
- Step 5: 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 that also have access to the data sources needed to calculate the measure rates. 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 6: The QMEP reviews the testing results and recommendations and determines final criteria for the measure based on the findings. The QMEP provides a final assessment of the draft measures' feasibility and reliability and recommends whether measures should move forward for PQA endorsement consideration.

3.2 PQA Measure Specifications

Step 7: The Measure Validity Panel, an independent group of individuals not involved in the development or review of the measure concept or draft measure, determines through discussion and vote whether the performance measure score is an accurate reflection of quality and can distinguish good from poor performance (i.e., face validity).

Step 8: Performance measures that are recommended by the QMEP for endorsement consideration by the PQA membership are posted on the PQA web site for member review, written comments are requested, and a webinar 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.

Step 9: PQA member organizations vote on endorsement of performance measures and approval of quality improvement indicators.

General Guidelines for the *Proportion of Days Covered* and *International Normalized Ratio Monitoring for Individuals on Warfarin* 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 Posting of the Value Sets

The Value Sets for PQA measures will be available by request from PQA. Please refer to the PQA website in order to obtain the Value Sets, including the National Drug Code (NDC) lists, at <https://www.pqaalliance.org/QRS>.

The final Value Sets, including National Drug Code (NDC) lists, for 2020 will be available on November 1, 2019. The NDC lists will include current NDCs from January 1, 2018 through September 27, 2019 and NDCs with obsolete dates of July 1, 2017 or after.

Required Data Elements for PQA Measures

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

Description

The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent during the measurement period.

A higher rate indicates better performance.

Report a rate for each of the following:

- Renin Angiotensin System Antagonists (PDC-RASA)
- Diabetes All Class (PDC-DR)
- Statins (PDC-STA)

Definitions

Proportion of Days Covered (PDC)	The number of days that an individual 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.
PDC Threshold	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).
Index Prescription Start Date (IPSD)	The earliest date of service for a target medication during the measurement year. The IPSD should occur at least 91 days before the end of the enrollment period.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Treatment Period	The individual's treatment period begins on the IPSD through whichever comes first: the last day of the measurement year, death, or disenrollment. The treatment period must be at least 91 days long.
Calculating Number of Days Covered for the Numerator	<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>

3.2 PQA Measure Specifications

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.

Any days supply that extend beyond the end of the treatment period are not included when calculating the total number of days covered.

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.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	<p>The Treatment Period</p> <p>Exclude individuals who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1-day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year.</p>
Allowable Gap	No gaps in enrollment during the continuous enrollment period.
Benefit	Medical and Pharmacy.

Administrative Specification

Report each of the rates separately. Individuals 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 individual.

Rate 1: Renin Angiotensin System (RAS) Antagonists (PDC-RASA)

Additional Eligible Population Criteria	Individuals who filled at least two prescriptions for any RAS Antagonist: ACEI/ARB/Direct Renin Inhibitor or ACEI/ARB/Direct Renin Inhibitor Combination (see Table PDC-RASA-A: RAS Antagonists) on different dates of service during the treatment period. The prescriptions can be for the same or different medications.
Denominator	The eligible population.
Denominator Exclusion	<p>Any individuals with one or more of the following:</p> <ul style="list-style-type: none">• Hospice: Individuals in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.• ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.• Sacubitril/valsartan: A prescription claim for sacubitril/valsartan during the treatment period (see Table PDC-RASA-B Exclusion: Sacubitril/Valsartan).

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

Direct Renin Inhibitor Medications and Combinations		
<ul style="list-style-type: none"> aliskiren (+/- amlodipine, hydrochlorothiazide) 		
ARB Medications and Combinations		
<ul style="list-style-type: none"> azilsartan (+/- chlorthalidone) candesartan (+/- hydrochlorothiazide) eprosartan (+/- hydrochlorothiazide) 	<ul style="list-style-type: none"> irbesartan (+/- hydrochlorothiazide) losartan (+/- hydrochlorothiazide) olmesartan (+/- amlodipine, hydrochlorothiazide) 	<ul style="list-style-type: none"> telmisartan (+/- amlodipine, hydrochlorothiazide) valsartan (+/- amlodipine, hydrochlorothiazide, nebivolol)
ACE Inhibitor Medications and Combination Products		
<ul style="list-style-type: none"> benazepril (+/- amlodipine, hydrochlorothiazide) captopril (+/- hydrochlorothiazide) enalapril (+/- hydrochlorothiazide) fosinopril (+/- hydrochlorothiazide) 	<ul style="list-style-type: none"> lisinopril (+/- hydrochlorothiazide) moexipril (+/- hydrochlorothiazide) perindopril (+/- amlodipine) 	<ul style="list-style-type: none"> quinapril (+/- hydrochlorothiazide) ramipril trandolapril (+/- verapamil)

NOTE: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products.

Table PDC-RASA-B Exclusion: Sacubitril/Valsartan

ARB/Neprilysin Inhibitor Combination Medication
<ul style="list-style-type: none"> sacubitril/valsartan

Numerator

The number of individuals who met the PDC threshold during the measurement year. Follow the steps below for each individual to determine whether the individual meets the PDC threshold.

Measure Calculation

- Step 1** Determine the individual's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.
- Step 2** Within the treatment period, count the days the individual 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 individual.
- Step 4** Count the number of individuals who had a PDC of 80% or greater and then divide by the total number of eligible individuals.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

Rate 2: Diabetes All Class (PDC-DR)**Additional Eligible Population Criteria**

Individuals who filled at least two prescriptions for any of the diabetes medications listed in Medication Tables PDC-DR-A: Biguanides, PDC-DR-B: Sulfonylureas, PDC-DR-C: Thiazolidinediones, PDC-DR-D: DPP-4 Inhibitors, PDC-DR-E: Incretin Mimetics, PDC-DR-F: Meglitinides, or PDC-DR-G: SGLT2 Inhibitors on different dates of service in the treatment period. The prescriptions can be for the same or different medications, and can be from any of these seven tables.

3.2 PQA Measure Specifications

Denominator The eligible population.

Denominator Exclusion Any individual with one or more of the following:

- Hospice: Individuals in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.
- Insulin: Individuals with one or more prescription claims for insulin during the treatment period (see Table PDC-DR-H: Insulin Exclusion).

Medication Tables

Table PDC-DR-A: Biguanides

Biguanide Medications and Combinations
<ul style="list-style-type: none">• metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

Note: Active ingredients are limited to oral formulations only. Excludes nutritional supplement/dietary management combination products

Table PDC-DR-B: Sulfonylureas

Sulfonylurea Medications and Combinations		
<ul style="list-style-type: none">• chlorpropamide• glimepiride (+/- pioglitazone)	<ul style="list-style-type: none">• glipizide (+/- metformin)• glyburide (+/- metformin)	<ul style="list-style-type: none">• tolazamide• tolbutamide

NOTE: Active ingredients are limited to oral formulations only (includes all salts and dosage forms).

Table PDC-DR-C: Thiazolidinediones

Thiazolidinedione Medications and Combinations		
<ul style="list-style-type: none">• pioglitazone (+/- alogliptin, glimepiride, metformin)	<ul style="list-style-type: none">• rosiglitazone (+/- metformin)	

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-DR-D: DPP-4 Inhibitors

DPP-4 Medications and Combinations		
<ul style="list-style-type: none">• alogliptin (+/- metformin, pioglitazone)• linagliptin (+/- empagliflozin, metformin)	<ul style="list-style-type: none">• saxagliptin (+/- metformin, dapagliflozin)	<ul style="list-style-type: none">• sitagliptin (+/- metformin, ertugliflozin)

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-DR-E: Incretin Mimetics

Incretin Mimetics		
<ul style="list-style-type: none">• albiglutide• dulaglutide	<ul style="list-style-type: none">• exenatide• liraglutide	<ul style="list-style-type: none">• lixisenatide• semaglutide

Table PDC-DR-F: Meglitinides

Meglitinides and Combinations		
<ul style="list-style-type: none">• nateglinide	<ul style="list-style-type: none">• repaglinide (+/-metformin)	

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-DR-G: Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors

SGLT2 Inhibitors and Combinations		
<ul style="list-style-type: none">• canagliflozin (+/- metformin)• dapagliflozin (+/- metformin, saxagliptin)	<ul style="list-style-type: none">• empagliflozin (+/- metformin, linagliptin)	<ul style="list-style-type: none">• ertugliflozin (+/- sitagliptin, metformin)

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-H: Insulin Exclusion

Insulins		
<ul style="list-style-type: none"> insulin aspart (+/- insulin aspart protamine) insulin degludec (+/- liraglutide) insulin detemir 	<ul style="list-style-type: none"> insulin glargine (+/- lixisenatide) insulin glulisine insulin isophane (+/- regular insulin) 	<ul style="list-style-type: none"> insulin lispro (+/- insulin lispro protamine) insulin regular (including inhalation powder)

NOTE: The active ingredients are limited to inhaled and injectable formulations only.

Numerator The number of individuals who met the PDC threshold during the measurement year. Follow the steps below for each patient to determine whether the individual meets the PDC threshold.

Measure Calculation

- Step 1** Determine the individual's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.
- Step 2** Within the treatment period, count the days the individual 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 individual.
- Step 4** Count the number of individuals who had a PDC of 80% or greater and then divide by the total number of eligible individuals.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.

Rate 3: Statins (PDC-STA)

Additional Eligible Population Criteria Individuals who filled at least two prescriptions for any statin or statin combination product (Table PDC-STA-A: Statins) on different dates of service in the treatment period. The prescriptions can be for the same or different medications.

Denominator The eligible population.

Denominator Exclusion Any individual with one or more of the following:

- Hospice: Patients in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.

Table PDC-STA-A: Statins

Statin Medications		
<ul style="list-style-type: none"> atorvastatin (+/- amlodipine, ezetimibe) fluvastatin lovastatin (+/- niacin) 	<ul style="list-style-type: none"> pitavastatin pravastatin 	<ul style="list-style-type: none"> rosuvastatin simvastatin (+/- ezetimibe, niacin)

Note: The active ingredients are limited to oral formulations only.

3.2 PQA Measure Specifications

Numerator	The number of individuals who met the PDC threshold during the measurement year. Follow the steps below for each individual to determine whether the individual meets the PDC threshold.
Measure Calculation	<p>Step 1 Determine the individual's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.</p> <p>Step 2 Within the treatment period, count the days the individual 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.*</p> <p>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 individual.</p> <p>Step 4 Count the number of individuals who had a PDC of 80% or greater and then divide by the total number of eligible individuals.</p> <p>*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single drug or when there is an overlap of a combination product to another combination product where at least one of the target drugs is common.</p>

International Normalized Ratio Monitoring for Individuals on Warfarin (INR)

Description

The percentage of members 18 years of age and older who had at least one 56-day interval of warfarin therapy and who received at least one international normalized ratio (INR) monitoring test during each 56-day interval with active warfarin therapy.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for warfarin during the measurement year.
Treatment Period	<p>The period of time beginning on the IPSD and ending with the last prescription dispensing date for warfarin during the measurement year plus the days supply of the last warfarin dispensing event within the measurement year. If the days' supply extends past the measurement year, the treatment period ends on December 31 of the measurement year.</p> <p>Use the last warfarin dispensing event to determine the end of the treatment period even if another prescription is active after the end of the treatment period. For example, if the last dispensing event is on December 1 for 5 days supply and another dispensing event is on November 30 for 10 days supply, the end of the treatment period is December 5.</p> <p>If two warfarin dispensing events occur on the last prescription dispensing date during the measurement year, the dispensing event with the longest days supply is used to calculate the end of the treatment period.</p> <p>Gaps in warfarin dispensing events can occur during the treatment period.</p>

Eligible Population

Ages	18 years and older as of December 31 of the measurement year.
Continuous enrollment	The treatment period.
Allowable gap	No gaps in enrollment.
Benefit	Medical and pharmacy.
Event/diagnosis	Members who were dispensed warfarin during the measurement year and whose treatment period was at least 56 days.
Required exclusions	<p>Exclude members with either of the following:</p> <ul style="list-style-type: none"> Members whose IPSD or last dispensing event for warfarin during the measurement year were missing days' supply. <p>Members who are monitoring INR at home during the treatment period. See PQA INR Home Monitoring Value Set</p>

Administrative Specification

Denominator The eligible population.

Numerator Members who received at least one INR monitoring test during or was hospitalized during each 56-day interval with active warfarin therapy.

Use the steps below to determine the numerator.

Step 1 For the treatment period, determine the start and end dates for each full 56-day interval.

For example, if a member's treatment period starts on January 1 and ends on April 30, their treatment period is 120 days and they have 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 25 and ends on April 21.

Note: Days left over after the last interval are not included. Only full 56-day intervals are used for calculating the numerator.

Step 2 Members are identified for the numerator in two ways for each interval: by at least one INR monitoring test or a hospitalization of more than 48 hours. If hours are not available, stays of at least three days meet numerator criteria.

Members must have a test or hospitalization in each interval to meet numerator criteria.

See PQA INR Test Value Set

4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures⁷ that will be collected as part of the 2020 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 2020 QHP Enrollee Survey item(s), please see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html>.

Additional details related to the 2020 QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page.html/>

QRS Survey Measure Descriptions

Access to Care

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following:

1. In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed?⁸
2. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
3. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
4. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Access to Information

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey and provides information on the following:

1. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?
2. In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it?
3. In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

⁷ The following QRS survey measures are HEDIS® measures and are addressed in NCQA's Measure Specifications: Flu Vaccinations for Adults Ages 18-64 and Medical Assistance with Smoking Cessation.

⁸ Beginning with the 2019 QHP Enrollee Experience Survey, multiple screener questions were collapsed into the first question in the series. As a result, the *Access to Care* screening question was combined with the first question of that series. In previous years the "emergency room, doctor's office, or clinic" language was part of the screener question. This change does not impact scoring of the *Access to Care* measure for the QRS.

Care Coordination

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following:

1. When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care?
 2. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
 3. In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them?
 4. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?
 5. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
 6. In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?
-

Plan Administration

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following:

1. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
 2. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
 3. In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected?
 4. In the last 6 months, how often were the forms from your health plan easy to fill out?
 5. In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out?
-

Rating of All Health Care

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following topic:

1. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
-

Rating of Health Plan

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following topic:

1. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months?
-

Rating of Personal Doctor

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following topic:

1. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
-

Rating of Specialist

This QRS survey measure is based on enrollee responses to the 2020 QHP Enrollee Survey on the following topic:

1. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?
-