

Health Insurance Exchange

2019 Quality Rating System Measure Technical Specifications

September 2018

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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 2019.

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 the Policy Clarification Support (PCS) system available at <http://pcs.ncqa.org>
 - Pharmacy Quality Alliance (PQA) for the *Proportion of Days Covered* measure: <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 2019 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 2019 requirements. The document specifically details the following:

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

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

Background

In accordance with the requirements specified in the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2019*, QHP issuers and Multi-State Plan (MSP) issuers² 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.³ 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.⁴ 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 A Multi-State Plan, certified by and under contract with the U.S. Office of Personnel Management (OPM), is recognized as a QHP per 45 CFR § 155.1010. Therefore, when describing requirements for "QHP issuers" within this document, it is assumed the same requirements apply to issuers offering MSPs, unless otherwise noted by OPM in guidance issued to MSP issuers.

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

⁴ 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 2019.

The measure set includes a subset of NCQA's HEDIS measures and one PQA measure. The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems⁵ (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 2019](#).

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. 2019 QRS Measures

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

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

⁶ 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 ⁶
Proportion of Days Covered	PQA	0541
Use of Imaging Studies for Low Back Pain	NCQA	Not Endorsed
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
<i>QRS Survey Measures</i>		
Access to Care	AHRQ, CMS	Not Endorsed
Access to Information	AHRQ, CMS	Not Endorsed
Care Coordination	AHRQ, CMS	Not Endorsed
Flu Vaccinations for Adults Ages 18-64	NCQA	0039
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS ⁷	Not Endorsed
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

⁷ 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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2019 HEDIS[®] General Guidelines for the QRS Measure Technical Specifications

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Calculated measure results based on HEDIS specifications may not be termed a “HEDIS rate” until it is audited and designated reportable by an NCQA-Certified Auditor. Such results should be referred to as an “Unaudited HEDIS Rate.” Henceforth in this publication and in any other NCQA publication, “HEDIS rate” refers to and assumes results audited by an NCQA-Certified HEDIS Auditor.

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

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Overview

HEDIS 2019

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, health care providers and policy makers, oversees the evolution of the measurement set. Multiple Measurement Advisory Panels (MAP) provide clinical and technical knowledge required to develop the measures. Additional HEDIS Expert Panels and the Technical Measurement Advisory Panel (TMAP) provide invaluable assistance by identifying methodological issues and providing feedback on new and existing measures.

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

Deleted indicator *Comprehensive Diabetes Care: Hemoglobin A1c Testing.*

Revised measures For specific revisions, refer to each measure’s *Summary of Changes*.

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 Exchange 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 2019* 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, 2018, with the release of the *2019 HEDIS for QRS Technical Update*:

- **HEDIS for QRS Technical Update** will be posted to the NCQA website (www.ncqa.org).
- **HEDIS for QRS Value Set Directory (10/1/2018 Release)** will be posted to the NCQA Download Center (<http://store.ncqa.org/index.php/catalog/product/view/id/3319/s/2019-quality-rating-system-qrs-hedis-value-set-directory/>).

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

- **Value Set Directory. HEDIS for QRS Value Set Directory (9/1/2018 Release)** will be posted to the NCQA Download Center and will be updated on October 1, 2018.
- The final **Medication List Directory (NDC codes)** and **HCC Risk Adjustment Tables** will be posted to the NCQA website (www.ncqa.org) by November 1, 2018.

If You Have Questions About the Specifications

Policy Clarification Support

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

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS for QRS uses and specifications, and are posted to the NCQA 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 the PCS system (<http://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 2019 HEDIS for QRS General Guidelines for the *2019 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Exchange and participating in the CMS Quality Rating System (QRS).^{1,2}

SUMMARY OF CHANGES TO HEDIS FOR QRS 2019

- Updated deadlines in the HEDIS Audit Timeline in *General Guideline 6*.
- Clarified requirements in *General Guideline 17*.
- Updated *General Guideline 23* to require that all services must have evidence of accountability by the practitioner.
- Renamed *General Guideline 27: Measures That Use Medication Lists*.
- Added a *Note* to *General Guideline 29* to indicate that BP readings collected using remote monitoring devices are not considered member-collected for HEDIS reporting.
- Revised *General Guideline 31*.
- Revised *General Guideline 34*.
- Added *General Guideline 35: ED and Observation Visits that Result in an Inpatient Stay*, which contains new instructions for identifying ED or observation visits that result in an inpatient stay.
- Clarified *General Guideline 37* (formerly *General Guideline 36*).
- Revised *General Guideline 40* (formerly *General Guideline 39*).

2019 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 Marketplace SM) 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 2019 that had more than 500 enrollees as of July 1, 2018 and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., 2019). Reporting units that are decertified or discontinued before June 15, 2019 are exempt from QRS reporting requirements.

All enrollees in QHPs offered on the Exchange and that provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *2019 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

¹The 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.

²A 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 (HIOS) 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>

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 managed care plan that covers network providers and in-network services, except in an emergency.

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

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

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

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

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

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

3. Minimum Enrollment Threshold

Organizations are required to submit data for each product offered through an Exchange in 2019 that had more than 500 enrollees as of July 1, 2018, and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., 2019).

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).

5. Multi-State Plan (MSP) Members

Multi-State Plan (MSP)³ members should be included in the corresponding organization's Exchange reporting units (not separated).

The NCQA HEDIS Compliance Audit™

The HEDIS Compliance Audit is required for all HEDIS for QRS measures in 2019, 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. No measure rate resulting from calculations based on the HEDIS specifications can be called a HEDIS rate until it is audited and approved by an NCQA-Certified HEDIS Auditor.

6. 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 for bids and selects a firm to conduct the HEDIS audit.

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

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

HEDIS Roadmap. Each organization must complete the HEDIS Record of Administration, Data Management and Processes (Roadmap). The Roadmap contains detailed questions about all audit standards and describes the operational and organizational structure of the organization. Auditors use the HEDIS Roadmap to review information about an organization's systems for collecting and processing data 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 Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, released in October.

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

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization contracts with an NCQA Licensed Organization. <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.	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 3
Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor.	December 3
Auditor completes source code review for noncertified hybrid measures, systematic sampling, CAHPS and 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
Measure certification deadline. NCQA will post final certification reports no later than February 19.	February 15
Organization submits all remaining core set measures' source code for auditor review (for noncertified measures).	By February 21
Auditor completes source code review for all remaining core set measures and organization addresses all corrective actions.	By March 1
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 1
Auditor finalizes approval of <i>all</i> supplemental data. PSV for nonstandard supplemental data must not occur prior to March 1, unless the organization finished all supplemental data processes, collection and entry. <i>There are NO exceptions!</i>	March 29
Organization submits preliminary rates to the auditor for review. Because preliminary rates must be produced through certified measure logic or approved source code, we encourage preliminary rates to be submitted to the auditors through IDSS.	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 3
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 9
Auditor picks a measure from each measure group and all exclusions, selects 16 records from each for MRRV review, and informs the organization of the selections.	By May 13

General Guidelines for Data Collection

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization sends selected records to the auditor for validation.	By May 15
Auditor begins sharing the MRRV results, including MRRV corrective actions, with the organization.	May 16–31
Organization completes all corrective actions and follow-up requests.	By May 31
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 3
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 9.	June 17
Organization submits the auditor-locked Exchange IDSS submission, with attestation, to NCQA.	June 17
Licensed Organization submits Exchange Final Audit Reports to NCQA.	July 15

7. Reporting

Audit results. HEDIS Compliance Audits result in audited rates or calculations at the measure and indicator level, and indicate if the measures can be publicly reported. All measures 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
<i>R</i>	<i>Reportable.</i> A reportable rate was submitted for the measure.
<i>NA</i>	<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>
<i>NB</i>	<i>Benefit Not Offered.</i> The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
<i>NR</i>	<i>Not Reported.</i> The organization chose not to report the measure.
<i>BR</i>	<i>Biased Rate.</i> The calculated rate was materially biased.

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

In Which Reports Do Exchange Members Remain?

8. 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.

9. 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.

10. 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 or claims/encounter data ([Hospice Value Set](#)).

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

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). 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 2019 HEDIS for QRS, all organizations reporting audited data to NCQA through the IDSS must submit data to NCQA on or before June 17, 2019.

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 17 deadline. For HEDIS for QRS reporting, organizations are required to "plan-lock" audited HEDIS for QRS data no later than **June 3, 2019**.

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 *2019 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 for supplemental data requirements.

22. Supplemental Data

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

For administrative-only measures, medical record data are considered supplemental data.

Supplemental data may help determine:

- Numerators (that are labeled as *numerators* in the specification).
- Observed Events in the Risk Adjusted Utilization measures.
- Optional exclusions.
- Eligible-population required exclusions not related to timing of the denominator event or diagnosis. For example:
 - *Medication Management for People With Asthma*. Organizations may use supplemental data for members who have any condition in step 3, *Required Exclusions* for the event/diagnosis.

Supplemental data may not be used for:

- *Denominator events*. Organizations may not create and use records to identify denominator events, other than for optional exclusions and appropriate required exclusions.
- *Clinical conditions that change*. Organizations may not create and use records, on an ongoing basis, for exclusions for clinical conditions that change.
- *Correcting bills or identifying valid data errors*. Organizations *may not* use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed. For example:

- Organizations may not exclude a member from the *Use of Imaging Studies for Low Back Pain* measure if the medical record shows that a diagnosis of back pain did not occur in the time frame required by the measure but was billed by a provider for ongoing therapy.
- *Risk adjustment.* Organizations may not use supplemental data sources when applying the risk adjustment methodology to the *Plan All-Cause Readmissions* measure.
- Measures where the specification specifically indicates supplemental data cannot be used.

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

Supplemental Data Definitions

Standard supplemental data. 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.

Examples of electronic files that may be used as standard supplemental data:

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

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

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

Examples of nonstandard supplemental data:

- EHR modules (e.g., uncertified eMeasure modules).
- Provider portals (i.e., electronic systems providers use to enter information about services rendered).
- Health Information registries.
- Provider abstraction forms.
- Records from services rendered or information collected during home visits.

- Member reported services.
 - Refer to *General Guideline 30* for requirements for member-reported services abstracted during medical record review.

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

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

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

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

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

Note: The lists of examples for standard and nonstandard supplemental data are not exhaustive. The final classification of all supplemental data sources is determined by the auditor.

Required Data Elements

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

Nonstandard supplemental data. Nonstandard supplemental data files must have all data elements required to meet criteria specified by the measure specifications, including payment status when applicable. If the measure has a hybrid specification, the supplemental data file must contain all data elements required by the hybrid specification.

- *Electronic sources (i.e., portal, uncertified eMeasure module).* Data collected or reported from the practitioner who renders the clinical service must have evidence of accountability by the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/NPI data in each session or header record).
- *Provider-abstracted forms.* Provider forms may not be simple “yes or no” responses as evidence of member compliance. Provider forms must have all necessary data elements required by the measure and are signed by the rendering practitioner, attesting to the accuracy of the information.
- *Records from services rendered or information collected during home visits.* Data collected or reported by practitioners who render the clinical service during home visits must have evidence of accountability by the practitioner and at a minimum include date, name and signature on each in-home form. NPI or TIN, along with date, would also be acceptable.
- *Member-reported services.* Proof-of-service documents required for member-reported services must include all data elements required by the measure (i.e., date and place of service, procedure,

prescription, test result or finding, practitioner type). If the measure has a hybrid specification, the proof-of-service documents must contain all data elements required by the hybrid specification.

All supplemental data. All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to *General Guideline 25* for date specificity requirements).

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

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

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

Supplemental Data Timeline and Systematic Sample Requirements

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

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

For hybrid measures, after the sample is pulled, organizations must follow the policies for collecting information for the systematic sample described in *General Guideline 23*. Supplemental data collection may not be targeted only at members selected for the systematic sample.

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

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

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

For additional information about audit requirements for supplemental data, refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, released each 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 have evidence of accountability by the practitioner and at a minimum include date, name and signature). NPI or TIN, along with date, would also be acceptable. 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 tests, 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 a denominator of 411.
- The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation.

24. Measures That Require Results From the Most Recent Test

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

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

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

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

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

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 prior to 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 pharmacy claims data. 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., ADHD Medications List). Medication lists used for HEDIS for QRS reporting are included in the Medication List Directory. A medication list includes the National Drug Code (NDC) that may be used for reporting and the generic name, the brand name (if applicable), the strength/dose and the route for each code. In addition, NDC codes not included the medication list may be used (consistently, across all measures) if the generic name (or brand name), strength/dose and route matches a medication included in the medication list. NDC mapping must be auditor approved.

The HEDIS 2019 Medication List Directory will be posted to the NCQA website on November 1, 2018.

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 Lab Panel Value Set, the Obstetric Panel Value Set, 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 Value Sets⁴

HEDIS value sets include codes from the following coding systems:

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).
- CVX—Vaccines Administered.

⁴ Updates to the International Classification of Diseases diagnosis and procedure codes are released annually in October by the American Hospital Association. Because HEDIS specifications are frozen with the release of the Technical Update, there is not enough time to review the appropriateness of ICD-10 codes; therefore, they are not included in HEDIS value sets and may not be used for HEDIS reporting. This policy ensures consistency in reporting across organizations and reduces burden by minimizing updates to the technical specifications after the freeze date. The codes will be considered for the following HEDIS season.

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- Medicare Severity Diagnosis-Related Group (MS-DRG).
- Healthcare Common Procedure Coding System (HCPCS) Level II.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).⁴
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).⁴
- International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).⁴
- Logical Observation Identifiers Names and Codes (LOINC).
- 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 included in the measure. 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.

Synchronous telehealth is commonly billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier. CMS and the American Medical Association have identified the CPT and HCPCS codes for professional services that can be billed with a telehealth modifier.

If telehealth is appropriate *and* if a value set includes codes that can be billed with a telehealth modifier, the specification will state the value set is eligible for use “with or without a telehealth modifier.” This is an indication that the appropriateness of telehealth was assessed and that the inclusion of telehealth is intentional for this measure. If telehealth is not appropriate the specification will contain instructions to exclude telehealth.

Measures that are silent about the inclusion or exclusion of telehealth are in the process of being reviewed and telehealth recommendations will be included in HEDIS 2020 Public Comment. There is no requirement to exclude services billed with a telehealth modifier from these measures.

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.

Unless otherwise stated 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.

Note: All measures that previously referenced “same claim” have been updated.

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

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

When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the 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 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.

37. CPT 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. 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.*

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39. 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.
- *SNOMED CT*. If a value set includes SNOMED CT codes, then the organization must only use the codes included in the value set. For value sets that do not include SNOMED CT codes, the organization may only map SNOMED CT codes that are included in the HEDIS Adjustments VSD.
- *RxNorm*. The organization may only map RxNorm codes that are included in the HEDIS Adjustments VSD.

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.

40. 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, 2016, is deleted from the specifications in HEDIS QRS 2019 after the two-year look-back period (2017, 2018) plus one additional year (2016) 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 HEDIS Compliance Audit.

SUMMARY OF CHANGES TO HEDIS FOR QRS 2019

- Removed the calculating the 95 percent confidence interval and finite population correction sections.
- Revised Table 1 to indicate that if reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for the *Prenatal and Postpartum Care* measure, the lowest rate of the two indicators must be used.
- Revised Table 1 to indicate the removal of the following indicator in the *Comprehensive Diabetes Care* measure: HbA1c Testing.

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 2019 for the 2018 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 2019.</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.

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.

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 at <http://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

2019 HEDIS for QRS Measures	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2018 Sample Size ⁵
Adult BMI Assessment	411	Y
Cervical Cancer Screening	411	Y
Childhood Immunization Status	411	Y ⁶
Colorectal Cancer Screening	411	Y
Comprehensive Diabetes Care	411	Y ⁸
Controlling High Blood Pressure	411	Y
Immunizations for Adolescents	411	Y
Prenatal and Postpartum Care	411	Y ⁷
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

⁵ 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.

⁶ 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.

⁷ If reducing the sample size based on the product line-specific current measurement year's administrative rate or the prior year's reported rate, the lowest of the two rates for *Timeliness of Prenatal Care, Postpartum Care* must be used for the *Prenatal and Postpartum Care* measure.

⁸ 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:
66%	371	89%	172
67%	366	90%	159
68%	360	91%	147
69%	354	92%	134
70%	348	93%	120
71%	342	94%	106
72%	335	≥95%	100

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

Systematic Sampling Methodology

NCQA implemented a systematic sampling scheme for the Hybrid Method. Proper 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 eligible member (EM) population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable).

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

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

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

Step 3 Determine the 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, etc., 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 2019 HEDIS for QRS (2018 measurement year), sort the list of EMs from A to Z. For 2020 HEDIS for QRS (2019 measurement year), sort the list from Z to A.

Note: Sort order applies to all components. For 2019 HEDIS for QRS, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).

Step 6 Calculate $N = EM / (MRSS + \text{all oversample records})$. 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 2018, 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 2018.

Step 8 Select the sample, choosing every i^{th} member using the formula: $i^{\text{th}} \text{ member} = START + [(i-1) \times (EM / MRSS + \text{all oversample records})]$
 (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 the PCS system at <http://my.ncqa.org>.

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

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

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

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 the PCS system at <http://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 $411 < 436$, skip to step 6.

Step 5 *Skip this step.*

Step 6 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.*

Complex Probability Sampling

Organization responsibility

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

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

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

Substituting Medical Records

Acceptable circumstances for substitution:

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).*
- *Annual Monitoring for Patients on Persistent Medications (MPM).*
- *Antidepressant Medication Management (AMM).*
- *Appropriate Testing for Children With Pharyngitis (CWP).*
- *Appropriate Treatment for Children With Upper Respiratory Infection (URI).*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB).*
- *Breast Cancer Screening (BCS).*
- *Cervical Cancer Screening (CCS).*
- *Childhood Immunization Status (CIS).*
- *Chlamydia Screening in Women (CHL).*
- *Colorectal Cancer Screening (COL).*
- *Comprehensive Diabetes Care (CDC).*
- *Controlling High Blood Pressure (CBP).*
- *Flu Vaccinations for Adults Ages 18–64 (FVA).*
- *Follow-Up After Hospitalization for Mental Illness (FUH).*
- *Follow-Up Care for Children Prescribed ADHD Medication (ADD).*
- *Immunizations for Adolescents (IMA).*
- *Medication Management for People With Asthma (MMA).*
- *Use of Imaging Studies for Low Back Pain (LBP).*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).*
- *Well-Child Visits in the First 15 Months of Life (W15).*
- *Well-Child Visit in the Third, Fourth, Fifth and Sixth Years of Life (W34).*

Description

Which services count? Unless otherwise specified in a particular measure, report all services for the Effectiveness of Care measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center; or services for which payment was denied because they were not properly authorized.

The organization must include all paid, suspended, pending and denied claims, and is ultimately responsible for the quality of care it provides to members.

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

Note: Denied claims are not included when identifying numerator events, but must be used to determine the eligible population for the following measures:

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

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

2019 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. **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).
- Nonacute inpatient encounters (Nonacute Inpatient Value Set).
- Acute inpatient encounters (Acute Inpatient Value Set).
- ED visits (ED Value Set).

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

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

Step 2

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

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

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

Step 3

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

For each 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.

Guidelines for Risk Adjusted Utilization Measures

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

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

Step 4

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

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

Example

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

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

Example: Table HCC—Rank

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

Step 5

Identify combination HCCs listed in Table HCC—Comb.

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

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

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

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

Example

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

Example: Table HCC—Combo

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

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2019 HEDIS for QRS
Measure Technical Specifications
(Alphabetical Order)

Adult BMI Assessment (ABA)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 10: 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	For members 20 years of age or older on the date of service, BMI (<u>BMI Value Set</u>) during the measurement year or the year prior to the measurement year.

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

Exclusions (optional)

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	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.

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.

For BMI percentile, either of the following meets criteria:

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

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%).

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 original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Annual Dental Visit (ADV)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 10: 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 2019 HEDIS FOR QRS

- Restructured the codes and value sets for identifying the required exclusions (step 2). Refer to the Value Set Directory for a detailed summary of changes.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 10: 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.

Antidepressant Medication Management

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 (Antidepressant Medications List) during the Intake Period.

**Step 2:
Required
exclusion** 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:

- An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set). To identify acute and nonacute inpatient stays:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Outpatient POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization/Intensive Outpatient Value Set with Major Depression Value Set.
- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set with Major Depression Value Set.
- Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set with Major Depression Value Set.
- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Telehealth POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with any diagnosis of major depression (Major Depression Value Set).

- An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with ED POS Value Set with Major Depression Value Set, with or without a telehealth modifier (Telehealth Modifier 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

Antidepressant Medication Management

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

Annual Monitoring for Patients on Persistent Medications (MPM)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

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

Eligible Population

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

Product line	Exchange.
Ages	18 years and older 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.
Benefits	Medical and pharmacy.
Event/ diagnosis	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to Additional Eligible Population Criteria for each rate.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year.

Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

Administrative Specification

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

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

Additional eligible population criteria Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year (ACE Inhibitor/ARB Medications List).

ACE Inhibitor/ARB Medications

Description	• Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan	• Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

Note: Members may switch therapy with any medication on the (ACE Inhibitor/ARB Medications List) during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

Numerator

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

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) **and** a serum creatinine test (Serum Creatinine Value Set) on the same date of service or on different dates of service.

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Diuretic Medications List), during the measurement year.

Note: Members may switch therapy with any medication on the (Diuretic Medications List) during the measurement year and have the days supply for those medications count toward the total 180 treatment days.

Diuretic Medications

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

Numerator

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

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) *and* a serum creatinine test (Serum Creatinine Value Set) on the same date of service or on different dates of service.

Exclusion (optional)

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

Data Elements for Reporting

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

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

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>For each of the 2 rates and total</i>
Number of optional exclusions	<i>For each of the 2 rates and total</i>
Numerator events by administrative data	<i>For each of the 2 rates and total</i>
Numerator events by supplemental data	<i>For each of the 2 rates and total</i>
Reported rate	<i>For each of the 2 rates and total</i>

Appropriate Testing for Children With Pharyngitis (CWP)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to *General Guideline 35* for new instructions.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Definitions

- 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 when the member had an outpatient or ED visit during the Intake Period with only diagnoses of pharyngitis.
- Exclude episode dates when the member had any diagnoses other those listed in the Pharyngitis Value Set on the same date of service.
- IESD** Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:
- Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date.
 - A 30-day Negative Medication History prior to the Episode Date.
 - The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date.
- Negative Medication History** To qualify for Negative Medication History, the following criteria must be met:
- 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.

Eligible Population

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

Product line	Exchange.
Ages	Children 3 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
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	Episode Date.
Benefits	Medical and pharmacy.
Event/ diagnosis	Outpatient or ED visit with only diagnoses of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period. Follow the steps below to identify the eligible population.
Step 1	Identify all members who had an outpatient visit (<u>Outpatient Value Set</u>), an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) during the intake period, with only diagnoses of pharyngitis (<u>Pharyngitis Value Set</u>). Do not include episode dates when the member had any diagnoses other than those listed in the <u>Pharyngitis Value Set</u> on the same date of service, in any setting. Do not include ED visits or observation visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).
Step 2	Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient or ED visits with only diagnoses of pharyngitis.
Step 3	Determine if antibiotics (<u>CWP Antibiotic Medications List</u>) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to three days after. Exclude Episode Dates if the member did not receive antibiotics on or up to three 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
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
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	• Cefibuten • Cefditoren • Ceftriaxone

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 where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total).

Step 6 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

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

Data Elements for Reporting

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

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

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to General Guideline 35 for new instructions.
- Added a note to indicate that supplemental data may not be used for this measure.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Calculation

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

Definitions

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 when the member had an outpatient or ED visit during the Intake Period with only a diagnosis of URI. Exclude episode dates when the member had any diagnoses other than those listed in the [URI Value Set](#).

IESD Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria:

- A 30-day Negative Medication History prior to the Episode Date.
- A Negative Competing Diagnosis on or 3 days after the Episode Date.
- The member was continuously enrolled 30 days prior to the Episode Date through 3 days after the Episode Date.

Negative Medication History To qualify for Negative Medication History, the following criteria must be met:

- 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 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 10: Members in Hospice.

Product line	Exchange.
Ages	Children 3 months as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year.
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	Episode Date.
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 (<u>Outpatient Value Set</u>), an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) during the Intake Period, with only diagnoses of URI (<u>URI Value Set</u>). Exclude episode dates when the member had any diagnoses other than those listed in the <u>URI Value Set</u> on the same date of service, in any setting. Exclude ED visits or observation visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits with only a URI diagnosis. Step 3 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (<u>CWP Antibiotic Medications List</u>) was filled 30 days prior to the Episode Date or was active on the Episode Date. Step 4 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis: <ul style="list-style-type: none">• <u>Pharyngitis Value Set</u>.• <u>Competing Diagnosis Value Set</u>. Step 5 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total). Step 6 Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication from the (CWP Antibiotic Medications List) on or three days after the IESD.

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
Miscellaneous antibiotics	• Erythromycin-sulfisoxazole	
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium
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 Children With Upper Respiratory Infection

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

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

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Incorporated telehealth into the measure specification.
- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to General Guideline 35 for new instructions.
- Added a note to indicate that supplemental data may not be used for this measure.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Calculation

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

Definitions

Intake Period	January 1–December 24 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.
IESD	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria: <ul style="list-style-type: none">• A 30-day Negative Medication History prior to the Episode Date.• A 12-month Negative Comorbid Condition History prior to and including the Episode Date.• A Negative Competing Diagnosis during the 38-day period from 30 days prior to the Episode Date through 7 days after the Episode Date.• The member was continuously enrolled 1 year prior to the Episode Date through 7 days after the Episode Date.
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 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

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

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 A period of 30 days prior to the Episode Date through 7 days after the Episode Date (38 total days), when the member had no claims/encounters with any competing diagnosis.

Eligible Population

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

Product line Exchange.

Ages Adults 18 years as of January 1 of the year prior to the measurement year to 64 years as of December 31 of the measurement year.

Continuous enrollment One year prior to the Episode Date through seven days after the Episode Date (373 total days).

Allowable gap No more than one gap of 45 days is permitted during the 365 days (1 year) prior to the Episode Date.

No gaps in enrollment are allowed on the IESD through 7 days after the IESD.

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) with or without a telehealth modifier (Telehealth Modifier Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessment 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 (Acute Bronchitis Value Set).

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

Step 2

Determine all acute bronchitis Episode Dates. For each member identified in step 1, determine all outpatient, observation or ED visits with a diagnosis of acute bronchitis.

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 during the period 30 days prior to the Episode Date through 7 days after the Episode Date (38 total days) the member had a claim/encounter with any competing diagnosis. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis Value Set.
 - Competing Diagnosis Value Set.
- Step 6** Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days (1 year) prior to the Episode Date through 7 days after the Episode Date (373 total days).
- Step 7** Select the IESD. This measure examines the earliest eligible episode per member.

Administrative Specification

- Denominator** The eligible population.
- Numerator** Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the IESD.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

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 	<ul style="list-style-type: none"> • Ticarcillin-clavulanate
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 • Erythromycin-sulfisoxazole • 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"> • Norfloxacin • 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
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"> • Ceftibuten • 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 in Adults With Acute Bronchitis

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Added exclusions for members with advanced illness and frailty.
- Added methods to identify bilateral mastectomy for the optional exclusion.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Eligible Population

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

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	Exclude members who meet any of the following criteria: <ul style="list-style-type: none">• Members 66 years of age and older as of December 31 of the measurement year with frailty (<u>Frailty Value Set</u>) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:<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>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) 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.– At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>).– A dispensed dementia medication (<u>Dementia Medications List</u>).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	<ul style="list-style-type: none"> <li style="margin-right: 10px;">• Donepezil <li style="margin-right: 10px;">• Galantamine • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • 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).
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) **without** a modifier with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- A unilateral mastectomy (Unilateral Mastectomy Value Set) **without** a modifier **and** a left mastectomy (refer to table below and use only mastectomy/modifier value sets; do not use absence of the left breast value set) with service dates 14 days or more apart).
- A unilateral mastectomy (Unilateral Mastectomy Value Set) **without** a modifier **and** a right mastectomy (refer to table below and use only mastectomy/modifier value sets; do not use absence of the right breast value set) with service dates 14 days or more apart).
- Any combination of codes that indicate a mastectomy on **both** the left **and** right side on the same or different dates of service.

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
<ul style="list-style-type: none"> • Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same visit) 	<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 visit)
<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 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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

Eligible Population

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

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, as identified in steps 1 and 2 below.
Step 1	Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Value Set</u>) during the measurement year or the two years prior to the measurement year.

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

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

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

Exclusion (optional)

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

Hybrid Specification

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

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

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

Medical record

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

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

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

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

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

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

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

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

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

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

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

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

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 original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Revised the MMR and VZV numerators in the Administrative Specification to indicate that vaccinations administered on or between the child’s first and second birthdays meet numerator criteria.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); vaccines by their second birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

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

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	For MMR, hepatitis B, and VZV, count any of the following: <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.

For DTaP, IPV, HiB 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.

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

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

MMR Any of the following on or between the child's first and second birthdays meet criteria:

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

Note: General Guideline 26 (i.e., the 14-day rule) does not apply to MMR.

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

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

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

VZV Either of the following on or between the child's first and second birthdays meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service between the child's first and second birthdays.

- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set).
- Pneumococcal conjugate** At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Combination rate** Children who received four DTaP; three IPV; one MMR; three HiB; three hepatitis B; one VZV; and four pneumococcal conjugate vaccinations on or before the child's second birthday.

Combination Vaccinations for Childhood Immunization Status

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

Exclusion (optional)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the member's second birthday meet optional exclusion criteria:

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

Hybrid Specification

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

Childhood Immunization Status

For DTaP, HiB, IPV, and pneumococcal conjugate count *only*:

- Evidence of the antigen or combination vaccine.

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

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

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

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

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

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

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

Exclusion (optional)

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)		<i>Each of the 8 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 8 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 8 rates</i>
Administrative rate on MRSS		<i>Each of the 8 rates</i>
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	<i>Each of the 8 rates</i>	<i>Each of the 8 rates</i>
Numerator events by medical records		<i>Each of the 8 rates</i>
Numerator events by supplemental data	<i>Each of the 8 rates</i>	<i>Each of the 8 rates</i>
Reported rate	<i>Each of the 8 rates</i>	<i>Each of the 8 rates</i>

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Eligible Population

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

Product line	Exchange.
Ages	Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate: <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 • 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"> • Nonxyol 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

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 2019 HEDIS FOR QRS

- Added exclusions for those with advanced illness and frailty.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

Eligible Population

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

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> <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 (<u>Frailty Value Set</u>) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria: <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>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) 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. – At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). – A dispensed dementia medication (<u>Dementia Medications List</u>).

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. Any of the following meet criteria:

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

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 “medical history” section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

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

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

Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (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.

Colorectal Cancer Screening

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 original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Incorporated telehealth into the measure specifications.
- Removed the HbA1c Testing indicator.
- Added exclusions for members with advanced illness and frailty.
- Added methods to identify bilateral eye enucleation.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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

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 a telehealth visit, a telephone visit or an online assessment. Identify 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. Use the code combinations below to identify telephone visits and online assessments:

- A telephone visit (Telephone Visits Value Set) with any diagnosis of diabetes (Diabetes Value Set).
- An online assessment (Online Assessments Value Set) with any diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

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

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	<ul style="list-style-type: none"> • Dulaglutide • Exenatide 	<ul style="list-style-type: none"> • Liraglutide 	<ul style="list-style-type: none"> • Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	<ul style="list-style-type: none"> • Canagliflozin 	<ul style="list-style-type: none"> • Dapagliflozin 	<ul style="list-style-type: none"> • Empagliflozin
Sulfonylureas	<ul style="list-style-type: none"> • Chlorpropamide • Glimepiride 	<ul style="list-style-type: none"> • Glipizide • Glyburide 	<ul style="list-style-type: none"> • Tolazamide • Tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> • Pioglitazone 	<ul style="list-style-type: none"> • Rosiglitazone 	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	<ul style="list-style-type: none"> • Alogliptin • Linagliptin 	<ul style="list-style-type: none"> • 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:

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty ([Frailty Value Set](#)) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:
 - At least two outpatient visits ([Outpatient Value Set](#)), observation visits ([Observation Value Set](#)), ED visits ([ED Value Set](#)) or nonacute inpatient encounters ([Nonacute Inpatient Value Set](#)) on different dates of service, with an advanced illness diagnosis ([Advanced Illness Value Set](#)). Visit type need not be the same for the two visits.
 - At least one acute inpatient encounter ([Acute Inpatient Value Set](#)) with an advanced illness diagnosis ([Advanced Illness Value Set](#)).
 - A dispensed dementia medication ([Dementia Medications List](#)).

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	<ul style="list-style-type: none"> • Donepezil 	<ul style="list-style-type: none"> • Galantamine 	<ul style="list-style-type: none"> • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • Memantine 		

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Control <8% Use codes in the [HbA1c Tests Value Set](#) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT 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 ⁸
<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 anytime 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).

⁸ The CPT Category II code (3045F) in this value set indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization must use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%. Because providers assign the Category II code after reviewing test results, the date of service for the Category II code may not match the date of service for the HbA1c test found in other sources; if dates differ, use the date of service when the test was performed. The date of service for the Category II code and the test result must follow the requirements outlined in *General Guideline 24* (i.e., the dates of service for the code and the test result must be no more than seven days apart).

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- 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 Value Set) **without** (Telehealth Modifier Value Set; Telehealth POS Value Set).
- Evidence of kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor/ARB Medications List).

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

ACE Inhibitor/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

Description	Prescription		
Antihypertensive combinations	<ul style="list-style-type: none"> • Aliskiren-valsartan • 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 • Eprosartan-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>
<i>HbA1c Control <8%</i>	<p>The <i>most recent</i> HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.</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. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.</p>

Eye Exam

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation anytime 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.

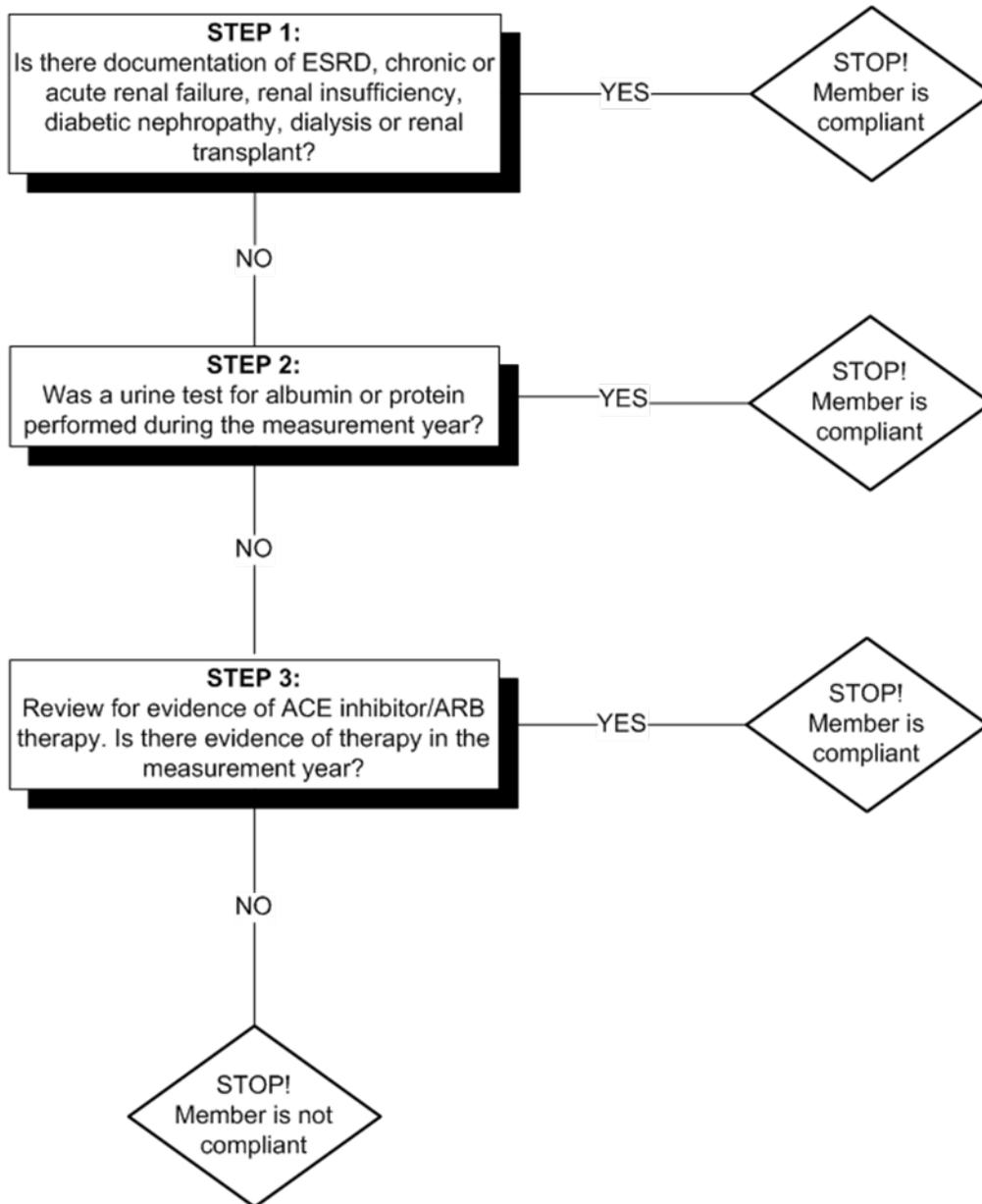
Exclusions (optional)

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 original sample 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 2019 HEDIS FOR QRS

- Removed requirement to identify and use different thresholds for members 60-85 without a diagnosis of diabetes.
- Revised the definition of representative BP to indicate that the BP reading must occur on or after the second diagnosis of hypertension.
- Revised the event/diagnosis criteria to include 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.
- Removed the diabetes flag identification from the event/diagnosis criteria.
- Incorporated telehealth into the measure specifications.
- Added exclusions for members with advanced illness and frailty.
- Added administrative method for reporting.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.
- Removed the requirement to confirm the hypertension diagnosis.
- Updated the *Notes* to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.
- Revised the Data Elements for Reporting table.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 10: 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	<p>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. Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> • Outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with or without a telehealth modifier (<u>Telehealth Modifier Value Set</u>), with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • A telephone visit (<u>Telephone Visits Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • An online assessment (<u>Online Assessments Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>).

Exclusions

- Exclude members who meet any of the following criteria:
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) during the measurement year.
 - Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty (Frailty Value Set) and advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years), meet criteria:
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - A dispensed dementia medication (Dementia Medications List).

Controlling High Blood Pressure

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator Use automated data to identify the most recent BP reading 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.

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/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/Equal To 90 Value Set</u>	Diastolic not compliant

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Because *Controlling High Blood Pressure* has been significantly revised, sample size reduction is not allowed.

Identifying the medical record 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.

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Use the following guidance to find the appropriate medical record to review.

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

Medical record

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension occurred.

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.

Include BP readings from remote monitoring devices that are digitally stored and transmitted to the provider. 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)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population 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.

Note

- All eligible BP readings in the appropriate medical record should be considered (regardless of practitioner type) when identifying the most recent reading.
- 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 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).
 - 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 original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Flu Vaccinations for Adults Ages 18–64 (FVA)

SUMMARY OF CHANGES TO 2019 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 website (<http://qhpcahps.cms.gov/>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the HEDIS for QRS measures. The QHP Enrollee Survey response data are submitted to CMS through the QHP Enrollee Survey website.

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, 1953, and July 1, 2000)
2 = Ineligible (the member was born before July 2, 1953, or after July 1, 2000)

The *Flu Vaccinations for Adults Ages 18–64* Eligibility Flag identifies the population eligible for the *Flu Vaccinations for Adults Ages 18–64* measure. Results are calculated using responses from respondents with a flag of “1 = Eligible.” The use of an eligibility flag protects member confidentiality (using the date of birth could result in a breach of confidentiality).

Questions Included in the Measure

Table FVA: Flu Vaccinations for Adults Ages 18–64

QHP Enrollee Survey	Question	Response Choices
Q60	Have you had either a flu shot or flu spray in the nose since July 1, YYYY?*	Yes No Don't know

*YYYY = the measurement year (2018 for the survey fielded in 2019).

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 2019 HEDIS FOR QRS

- Added the following age stratifications and total rate: 6–17, 18–64, 65 years and older.
- Revised the denominator to include members with a principal diagnosis of intentional self-harm.
- Clarified and reordered the instructions for acute and nonacute readmissions and direct transfers.
- Renamed “Exclusions” to “Nonacute readmission or direct transfer” in the Eligible Population.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.
- Removed the use of a mental health diagnosis as a proxy for a visit with a mental health practitioner (all numerator events require a mental health practitioner).
- Revised the Data Elements for Reporting table to reflect the addition of the age stratifications and total rate.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Exchange 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 10: Members in Hospice.

Product line	Exchange.
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: <ul style="list-style-type: none">• 6–17 years.• 18–64 years.• 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.
Benefit	Medical and mental health (inpatient and outpatient).

Event/ diagnosis An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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.

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 of mental illness 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, 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, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit (BH Outpatient Value Set **with** a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier 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, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) **with** a mental health practitioner.
- A community mental health center visit (Visit Setting Unspecified Value Set **with** Community Mental Health Center POS Value Set **with** a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier 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.
- A telehealth visit: Visit Setting Unspecified Value Set **with** Telehealth POS Value Set **with** a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) **with** a mental health practitioner.
- Transitional care management services (Transitional Care Management Services Value Set), **with** a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier 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).*
- *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>

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Clarified in the continuous enrollment of Rate 2 that members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 300 days following the IPSD (10 months).
New Episode	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Eligible Population: Rate 1—Initiation Phase

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

Product line	Exchange.
Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.

Event/ diagnosis Follow the steps below to identify the eligible population for the Initiation Phase.

- Step 1** Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List) during the 12-month Intake Period.

ADHD Medications

Description	Prescription
CNS stimulants	<ul style="list-style-type: none"> <li style="width: 33%;">• Amphetamine-dextroamphetamine <li style="width: 33%;">• Dextroamphetamine <li style="width: 33%;">• Methylphenidate <li style="width: 33%;">• Dexmethylphenidate <li style="width: 33%;">• Lisdexamfetamine <li style="width: 33%;">• Methamphetamine
Alpha-2 receptor agonists	<ul style="list-style-type: none"> <li style="width: 50%;">• Clonidine <li style="width: 50%;">• Guanfacine
Miscellaneous ADHD medications	<ul style="list-style-type: none"> • Atomoxetine

Step 2 Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4 Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Administrative Specification: Rate 1—Initiation Phase

Denominator	The Rate 1 eligible population.
Numerator	<p>An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSP. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:</p> <ul style="list-style-type: none">• An outpatient visit (<u>Visit Setting Unspecified Value Set with Outpatient POS Value Set</u>).• An outpatient visit (<u>BH Outpatient Value Set</u>).• An observation visit (<u>Observation Value Set</u>).• A health and behavior assessment/intervention (<u>Health and Behavior Assessment/Intervention Value Set</u>).• An intensive outpatient encounter or partial hospitalization (<u>Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set</u>).• An intensive outpatient encounter or partial hospitalization (<u>Partial Hospitalization/Intensive Outpatient Value Set</u>).• A community mental health center visit (<u>Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set</u>). <p>Note:</p> <ul style="list-style-type: none">• Do not count a visit on the IPSP as the Initiation Phase visit.• 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>).

Eligible Population: Rate 2—C&M Phase

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

Product line	Exchange.
Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Continuous enrollment	<p>Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSP and 300 days (10 months) after the IPSP.</p> <p>Members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1.</p>
Allowable gap	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSP.
Anchor date	None.
Benefits	Medical and pharmacy.

Event/ diagnosis	<p>Follow the steps below to identify the eligible population for the C&M Phase.</p> <p>Step 1 Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase.</p> <p>Step 2 Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSP and 300 days (10 months) after the IPSP.</p> <p>Step 3 Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSP. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)</p> <p>Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).</p> <p>Step 4 Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSP. Any of the following meet criteria:</p> <ul style="list-style-type: none"> • An acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>). • An acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a principal diagnosis of chemical dependency (<u>Chemical Dependency Value Set</u>).
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Administrative Specification: Rate 2—C&M Phase

Denominator	The Rate 2 eligible population.
Numerator	<p>Identify all members who meet the following criteria:</p> <ul style="list-style-type: none"> • Numerator compliant for Rate 1—Initiation Phase, and • At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSP. <p>Only one of the two visits (during days 31–300) may be a telephone visit (<u>Telephone Visits Value Set</u>) or a telehealth visit.</p> <p>Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (<u>Telehealth Modifier Value Set</u>) or the presence of a telehealth POS code (<u>Telehealth POS Value Set</u>) on the claim.</p> <p>Any of the following code combinations identify follow-up visits:</p> <ul style="list-style-type: none"> • An outpatient visit (<u>Visit Setting Unspecified Value Set</u> with <u>Outpatient POS Value Set</u>). • An outpatient visit (<u>BH Outpatient Value Set</u>). • An observation visit (<u>Observation Visit Value Set</u>).

Follow-Up Care for Children Prescribed ADHD Medication

- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set *with* Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set *with* Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set *with* Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).

Exclusions (*optional*)

Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

Note

- *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 1 for the definition of prescribing practitioner.*
- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).*

Data Elements for Reporting

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

Table ADD-4: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication

Element	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	<i>Each of the 2 rates</i>
Number of optional exclusions	<i>Each of the 2 rates</i>
Numerator events by administrative data	<i>Each of the 2 rates</i>
Numerator events by supplemental data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>

Immunizations for Adolescents (IMA)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Updated meningococcal vaccine references.
- Added optional exclusions for the Tdap vaccine.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 two combination rates.

Eligible Population

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

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 (<u>Meningococcal Vaccine Administered Value Set</u>), 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 Vaccine Administered Value Set</u>), with a date of service on or between the member’s 10th and 13th birthdays.

HPV

- At least two HPV vaccines (HPV Vaccine Administered Value Set), with different dates of service on or between the member’s 9th and 13th birthdays.
 - There must be at least 146 days between the first and second dose of the HPV vaccine. 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.

OR

- At least three HPV vaccines (HPV Vaccine Administered Value Set), 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 rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Any of the following meet optional exclusion criteria:

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member’s 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Tdap

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set) anytime 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 combinations. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerators

For meningococcal, Tdap and HPV, count *only* the evidence of the antigen or combination vaccine.

Administrative

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

Immunizations for Adolescents

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 the “meningococcal vaccine” was 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 Adolescent Immunization Status

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 5 rates</i>
Current year's administrative rate (before exclusions)		<i>Each of the 5 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 5 rates</i>
Administrative rate on MRSS		<i>Each of the 5 rates</i>
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Numerator events by medical records		<i>Each of the 5 rates</i>
Numerator events by supplemental data	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>
Reported rate	<i>Each of the 5 rates</i>	<i>Each of the 5 rates</i>

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

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to General Guideline 35 for new instructions.
- Replaced MAT references with references to “medication treatment.”
- Added the Observation Value Set to the measure to account for the removal of observation codes from the IET Stand Alone Visits Value Set. Codes remain unchanged.
- Clarified the Engagement of AOD Treatment numerator.
- Clarified in the *Notes* that members in the “other drug abuse or dependence” cohort do not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment and that methadone is not included in the medication lists for the measure.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

Definitions

Intake Period	January 1–November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index Episode	The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. <i>For ED visits that result in an inpatient stay, the inpatient discharge is the Index Episode.</i>
IESD	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. <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> <i>For an inpatient stay, the IESD is the date of discharge.</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).

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.

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Identify the admission and discharge dates for the stay.

Eligible Population

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

Product line

Exchange.

Ages

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

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

AOD diagnosis cohorts	Report the following diagnosis cohorts for each age stratification and the total rate: <ul style="list-style-type: none">• 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>, with or without a telehealth modifier (<u>Telehealth Modifier 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>, 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> 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>, with or without a telehealth modifier (<u>Telehealth Modifier 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>. <p>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>.</p>

- An acute or nonacute inpatient discharge **with** 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 discharges:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits 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.
- 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 (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence 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 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 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:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - 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, with or without a telehealth modifier (Telehealth Modifier 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 with or without a telehealth modifier (Telehealth Modifier 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 with or without a telehealth modifier (Telehealth Modifier 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 (Medication Treatment for Alcohol Abuse or Dependence 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 (Medication Treatment for Opioid Abuse or Dependence 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; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence 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 (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence 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.

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.

Engagement visits

Any of the following meet criteria for an **engagement visit**:

- An acute or nonacute inpatient admission 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. To identify acute or nonacute inpatient admissions:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - 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, with or without a telehealth modifier (Telehealth Modifier 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 **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, with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set **with** IET POS Group 2 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, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone 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.
- An online assessment (Online Assessments 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.

Engagement medication treatment events

Either of the following meets criteria for an **engagement medication treatment event**:

- If the IESD diagnosis was a *diagnosis of alcohol abuse or dependence* (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence 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 Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a *diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications).

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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.

Medication Treatment for Alcohol Abuse or Dependence Medications

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

Medication Treatment for Opioid Abuse or Dependence Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet and 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 2019 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 website (<http://qhpcahps.cms.gov/>) for more information about the QHP Enrollee Survey, including a crosswalk of survey questions associated with the HEDIS for QRS measures. The QHP Enrollee Survey response data are submitted to CMS through the QHP Enrollee Survey website.

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
Q61	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all → If Not at all, Go to Question 65 Don't know → If Don't know, Go to Question 65
Q62	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q63	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q64	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

Rolling averages are calculated using the formula below.

$$\text{Rate} = (\text{Year 1 Numerator} + \text{Year 2 Numerator}) / (\text{Year 1 Denominator} + \text{Year 2 Denominator})$$

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 *must* be as follows to be included in the denominator:

Q61 = “Every day” or “Some days.”

Q62 = “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 Q62.

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 *must* be as follows to be included in the denominator:

Q61 = “Every day” or “Some days.”

Q63 = “Never” or “Sometimes” or “Usually” or “Always.”

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 Q63.

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:
Q61 = “Every day” or “Some days.”
Q64 = “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 Q64.

Medication Management for People With Asthma (MMA)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Incorporated telehealth into the measure specifications.
- Removed “Mast cell stabilizers” from the [Asthma Controller Medications List](#).
- Revised step 4 of the numerator calculation to indicate that the ratio should be rounded to the nearest whole number using the .5 rule.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 Drug ID to determine if the prescriptions are the same or different.</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).• <i>Two prescriptions</i> for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).

- *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. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the NDC list to determine if the medications are the same or different.

Injection 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.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Calculating number of days covered for the numerator

If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication. For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller.

Subtract any days supply that extends beyond December 31 of the measurement year.

Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.

Eligible Population

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

Product line	Exchange.
Ages	Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate: <ul style="list-style-type: none">• 5–11 years.• 12–18 years.• 19–50 years.• 51–64 years.• Total. The total is the sum of the age stratifications.
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 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. <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 four outpatient visits (<u>Outpatient Value Set</u>) or observation visits (<u>Observation Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) and at least two asthma medication dispensing events for any controller medication (<u>Asthma Controller Medications List</u>) or reliever medication (<u>Asthma Reliever Medications List</u>). Visit type need not be the same for the four visits. Only three of the four visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (<u>Telehealth Modifier Value Set</u>) or the presence of a telehealth POS code (<u>Telehealth POS Value Set</u>) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments:<ul style="list-style-type: none">– A telephone visit (<u>Telephone Visits Value Set</u>) with any diagnosis of asthma (<u>Asthma Value Set</u>).– An online assessment (<u>Online Assessments Value Set</u>) with any diagnosis of asthma (<u>Asthma Value Set</u>).

- At least four asthma medication dispensing events for any controller medication (Asthma Controller Medications List) or reliever medication (Asthma Reliever Medications List).

Asthma Controller Medications

Description	Prescriptions	
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline
Antibody inhibitors	• Omalizumab	
Anti-interleukin-5	• Mepolizumab	• Reslizumab
Inhaled steroid combinations	• Budesonide-formoterol • Fluticasone-salmeterol	• Fluticasone-vilanterol • Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide • Ciclesonide	• Flunisolide • Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast • Zileuton
Methylxanthines	• Dyphylline	• Theophylline

Asthma Reliever Medications

Description	Prescriptions		
Short-acting, inhaled beta-2 agonists	• Albuterol	• Levalbuterol	• Pirbuterol

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/Vapors Value Set.
 - Cystic Fibrosis Value Set.
 - Acute Respiratory Failure Value Set.
- Members who had no asthma controller medications (Asthma Controller Medications List) dispensed during the measurement year.

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.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication ([Asthma Controller Medications List](#)) 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 ([Asthma Controller Medications List](#)) during the treatment period. To ensure that a days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Round (using the .5 rule) to 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 2019 HEDIS FOR QRS

- Revised the Planned Hospital Stay definition.
- Increased the denominator minimum from 30 to 150.
- Removed former step 5 in the denominator and added language about planned admissions to step 3 in the numerator.
- Revised steps 6 and 7 in Risk Adjustment Weighting.
- Renamed “Expected Readmission Rate” to “Estimated Readmission Risk” in step 8.
- Renamed “Total Variance” to “Variance.”
- Revised the Data Elements for Reporting tables.
- Added shading to the Data Elements for Reporting tables to indicate how data are reported.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 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 stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
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 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.

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 2
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Note: The risk adjustment tables will be released on November 1, 2018, and posted to www.ncqa.org.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 10: 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** An acute inpatient discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year.

Follow the steps below to identify acute inpatient stays.

Administrative Specification

Denominator The eligible population.

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

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.

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

- Step 2** **Acute-to-acute direct transfers:** Keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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

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: Required exclusions** 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 an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.

- Step 5** Calculate continuous enrollment.
- Step 6** Assign each acute inpatient stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

- Surgeries** Determine if the member underwent surgery during the inpatient 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 acute-to-acute direct transfers, use the direct transfer's primary discharge diagnosis.
- Exclude diagnoses that cannot be mapped to Table PCR-DischCC.
- Comorbidities** Refer to *Utilization Risk Adjustment Determination* in the *Guidelines for Risk Adjusted Utilization Measures*.

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender.

Note: The final weights table will be released on November 1, 2018. HEDIS for QRS uses the Commercial Risk Weights for risk adjustment.

- Step 1** For each IHS with a surgery, link the surgery weight.
- Use Table PCR-Comm-OtherWeights.
- Step 2** For each IHS with a discharge CC Category, link the primary discharge weights.
- Use Table PCR-Comm-DischCC-Weight.
- Step 3** For each IHS with a comorbidity HCC Category, link the weights.
- Use Table PCR-Comm-ComorbHCC-Weight.
- Step 4** Link the age and gender weights for each IHS.
- Use Table PCR-Comm-OtherWeights.
- Step 5** Identify the base risk weight.
- Use Table PCR-Comm-OtherWeights to determine the base risk weight.
- Step 6** Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight) 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

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (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.

Variance = Estimated Readmission Risk x (1 – 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.

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-10 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Estimated Readmission Risk	Variance
								Category	Weight	Category	Weight			
1250	1	-2.6087	67	Female	-0.0103	-0.2753	T44992S	58	0.2990	18	0.1961	-2.1783	0.1017	0.0914
										55	0.2209			
4010	1	-2.4722	50	Male	0	NA	J439	111	0.4221	NA	NA	-2.0501	0.1140	0.1010
4010	2	-2.4722	50	Male	0	NA	B180	29	0.6090	87	0.141	-1.7222	0.1516	0.1286

*Each Member ID field with a value represents a unique IHS.

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

- Step 1** Identify all acute inpatient stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the admission date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

- Step 2** **Acute-to-acute direct transfers:** Keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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

- Step 3** Exclude acute inpatient hospital admissions with any of the following 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 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 an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.

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

Reporting: Denominator

Count the number of IHS 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 with a readmission within 30 days of discharge for each age group and enter these values into the reporting table 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.

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 Readmission calculated by IDSS.

Note

- Supplemental data may not be used for this measure.

Plan All-Cause Readmissions

Table PCR-A-4: Plan All-Cause Readmissions Rates by Age and Risk Adjustment

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Deleted prenatal visits with internal organization codes for LMP/EDD and obstetrical history/risk assessment counseling from Decision Rule 3 of the Administrative specification. Internal organization codes are supplemental data and are in the scope of the hybrid specification.
- Clarified that documentation in the medical record of gestational age with either prenatal risk assessment and counseling/education or complete obstetrical history meets criteria for the Timeliness of Prenatal Care numerator.
- Clarified in the *Notes* that nonancillary services must be delivered by the required provider type.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Eligible Population

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

Product line	Exchange.
Ages	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/ diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting. <i>Multiple births.</i> Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

- Step 1** Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
- Step 2** Exclude non-live births (Non-live Births Value Set).
- Step 3** Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 56 days after delivery, with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Include only visits that occur while the member was enrolled.

Follow the steps below to identify the numerator.

Step 1 Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.

For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.

Step 2 Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester.

For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.

Step 3 Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).

For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.

For women whose last enrollment started less than 219 days before delivery, proceed to step 5.

Step 4 Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled

During the First Trimester and find a visit on or between the last enrollment start date and 176 days before delivery.

- Step 5** Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit on the enrollment start date or within 42 days after enrollment.

Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester

- Decision Rule 1** Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:
- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
 - A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- Decision Rule 2** A prenatal visit (Prenatal Visits Value Set) with an OB/GYN or other prenatal care practitioner and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service):
- An obstetric panel (Obstetric Panel Value Set).
 - An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set).
 - A pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) for the prenatal visit (codes must be from the same visit).
 - All of the following on the same date of service or on different dates of service:
 - Toxoplasma (Toxoplasma Antibody Value Set).
 - Rubella (Rubella Antibody Value Set).
 - Cytomegalovirus (Cytomegalovirus Antibody Value Set).
 - Herpes simplex (Herpes Simplex Antibody Value Set).
 - A rubella antibody test (Rubella Antibody Value Set) **and** an ABO test (ABO Value Set) on the same date of service or on different dates of service.
 - A rubella antibody test (Rubella Antibody Value Set) **and** an Rh test (Rh Value Set) on the same date of service or on different dates of service.
 - A rubella antibody test (Rubella Antibody Value Set) **and** an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service.
- Decision Rule 3** A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) (codes must be from the same visit) where the practitioner type is a PCP and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service):
- An obstetric panel (Obstetric Panel Value Set).
 - An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set).
 - All of the following on the same date of service or on different dates of service:
 - Toxoplasma (Toxoplasma Antibody Value Set).
 - Rubella (Rubella Antibody Value Set).

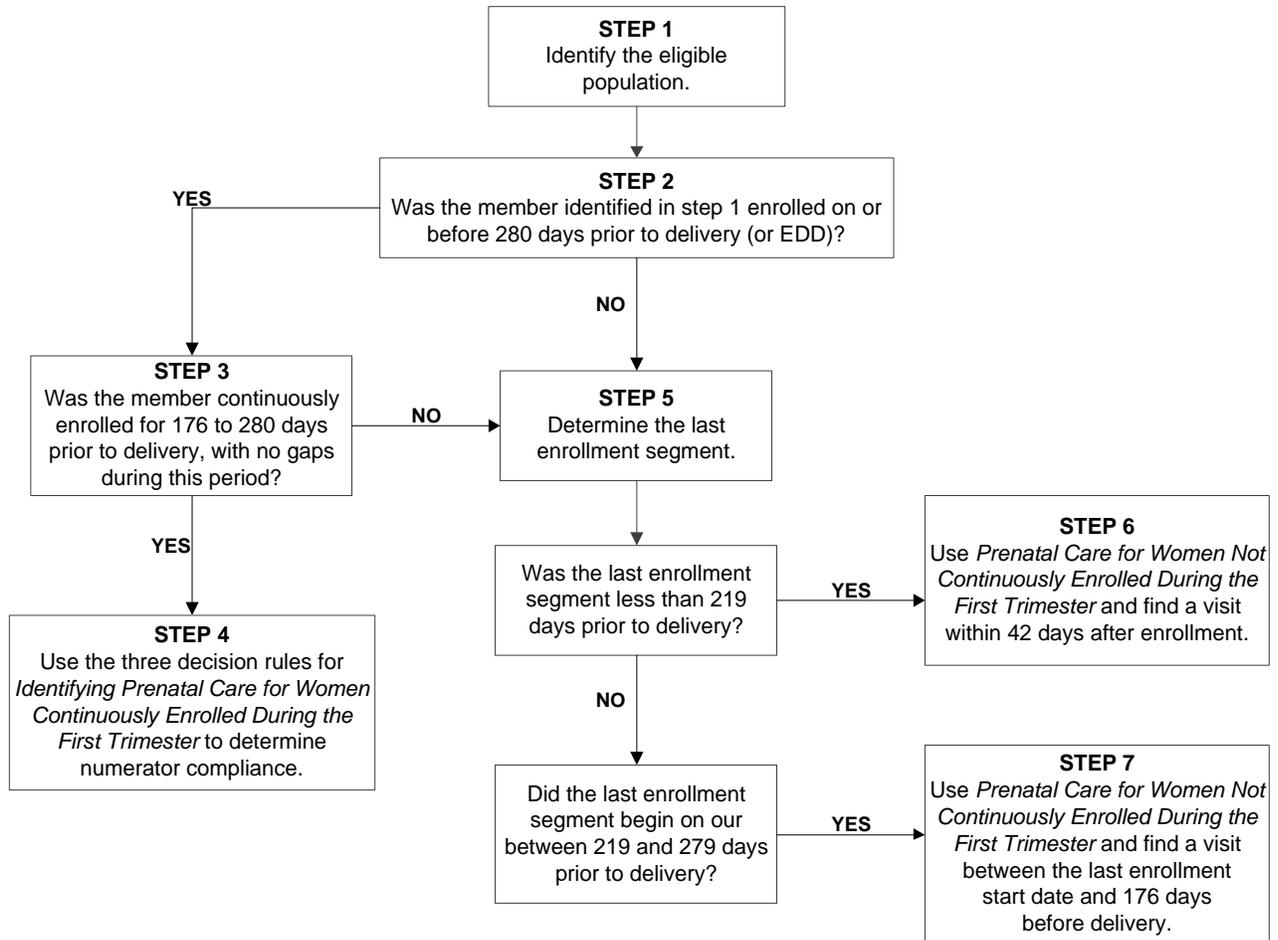
Prenatal and Postpartum Care

- Cytomegalovirus (Cytomegalovirus Antibody Value Set).
- Herpes simplex (Herpes Simplex Antibody Value Set).
- A rubella antibody test (Rubella Antibody Value Set) and an ABO test (ABO Value Set) on the same date of service or on different dates of service.
- A rubella antibody test (Rubella Antibody Value Set) and an Rh test (Rh Value Set) on the same date of service or on different dates of service.
- A rubella antibody test (Rubella Antibody Value Set) and an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service.

Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester

Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set) **and** an ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set) on the same date of service or on different dates of service.
- A prenatal visit (Prenatal Visits Value Set) **with** a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).



Postpartum Care

A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:

- A postpartum visit ([Postpartum Visits Value Set](#)).
- Cervical cytology ([Cervical Cytology Value Set](#)).
- A bundled service ([Postpartum Bundled Services Value Set](#)) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Note: *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.*

Hybrid Specification

Denominator

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

Numerator

Timeliness of Prenatal Care

A prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled.

Administrative

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

Medical record

Prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, **or** pelvic exam with obstetric observations, **or** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
 - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), **or**
 - TORCH antibody panel alone, **or**
 - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
 - 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.

Note: For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a diagnosis of pregnancy.

Postpartum Care A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

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

Medical record Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
 - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.

Note

- For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
 - For women whose last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
 - For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be 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 November 6 of the year prior to the measurement year and November 5 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.
- The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- A Pap test 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.

Prenatal and Postpartum Care

- The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. 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 practitioners.

Data Elements for Reporting

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

Table PPC-4: Data Elements for Prenatal and Postpartum Care

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Eligible population	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>For each of the 2 rates</i>
Current year's administrative rate (before exclusions)		<i>For each of the 2 rates</i>
Minimum required sample size (MRSS)		<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 2019 HEDIS FOR QRS

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to General Guideline 35 for new instructions.
- Clarified in step 4 required exclusions that for multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription.
- Added a note to indicate that supplemental data can be used for only required exclusions for this measure.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

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 10: 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 Identify all members in the specified age range who had any of the following during the Intake Period:

- Outpatient visit (Outpatient Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) or an ED visit (ED Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
 - Do not include observation visits or ED visits that result in an inpatient stay (Inpatient Stay Value Set).
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visit (Physical Therapy Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telephone visit (Telephone Visits Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Online assessment (Online Assessments Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

Step 2 Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

Step 4: Required exclusions Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- *Cancer.* Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:
 - Malignant Neoplasms Value Set.
 - Other Neoplasms Value Set.
 - History of Malignant Neoplasm Value Set.
 - Other Malignant Neoplasm of Skin Value Set.
- *Recent trauma.* Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Intravenous drug abuse.* IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Neurologic impairment.* Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *HIV.* HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.

- *Spinal infection.* Spinal infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant.* Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids.* 90 consecutive days of corticosteroid treatment any time during the 12 months (1 year) prior to and including the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (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	✓
Numerator events by supplemental data	✓
Reported rate	✓

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

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Clarified in the *Notes* that services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators.
- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

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

- BMI percentile documentation.
 - Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.
- Counseling for nutrition.
- Counseling for physical activity.

Definitions

BMI percentile The percentile ranking based on the CDC’s BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among others of the same gender and age.

Eligible Population

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

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.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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

Administrative Specification

Denominator The eligible population.

Numerators

BMI Percentile	BMI percentile (<u>BMI Percentile Value Set</u>) during the measurement year.
Counseling for Nutrition	Counseling for nutrition (<u>Nutrition Counseling Value Set</u>) during the measurement year.
Counseling for Physical Activity	Counseling for physical activity (<u>Physical Activity Counseling Value Set</u>) 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 or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.

For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:

 - Notation that a member with chronic knee pain is able to run without limping.
 - Notation that a member has exercise-induced asthma.
 - Notation that a member with diarrhea is following the BRAT diet.
 - Notation that a member has decreased appetite as a result of an acute or chronic condition.
- 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.
- 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 original sample records excluded because of valid data errors		<i>Each of the 3 rates</i>
Number of administrative data records excluded		<i>Each of the 3 rates</i>
Number of medical records excluded		<i>Each of the 3 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 3 rates</i>
Records added from the oversample list		<i>Each of the 3 rates</i>
Denominator		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by administrative data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by medical records		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by supplemental data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Reported rate	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>

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

SUMMARY OF CHANGES TO 2019 HEDIS FOR QRS

- Clarified that children who turn 15 months old during the measurement year are included in the measure.
- Clarified in the numerator to not count visits that occur after the member's 15-month birthday.
- Removed "Lower 95% confidence interval" and "Upper 95% confidence interval" data elements from the Data Elements for Reporting tables.

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.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 10: 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	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. The well-child visits must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

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	✓
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 2019 HEDIS FOR QRS

- Removed “Lower 95% confidence interval” and “Upper 95% confidence interval” data elements from the Data Elements for Reporting tables.

Description

The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Eligible Population

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

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	At least one well-child visit (<u>Well-Care Value Set</u>) with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

- 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	✓

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Appendix 1: Practitioner Types

APPENDIX 1 PRACTITIONER TYPES

clinical pharmacist

A pharmacist with extensive education in the biomedical, pharmaceutical, socio-behavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications.

Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.

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 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.

Appendix 1—Practitioner Types

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 2019 HEDIS for QRS, the measurement year is 2018.
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.
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. This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.
Current year's administrative rate (before exclusions)		✓		This is a calculated field in IDSS. Numerator events by administrative data in eligible population ÷ eligible population.
Minimum required sample size (MRSS)		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines.
Oversampling rate		✓		The percentage of additional records used only to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA.

Element	Admin	Hybrid	Research	Meaning
Number of oversample records		✓		This is a calculated field in IDSS. MRSS * oversample rate. Oversample records should be used only to replace cases taken out of the MRSS because of valid data errors, false positives, etc., otherwise, these records should not be reported in the final denominator.
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.
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. NCOA will use this element for research and analysis. The element will not be used for calculating the measure.
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error.
Denominator		✓		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.

Appendix 2—Data Element Definitions

Element	Admin	Hybrid	Research	Meaning
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: (Numerator events by administrative data + numerator events by supplemental data + numerator events by medical record data) ÷ 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 original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by supplemental data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓

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Appendix 3

Draft HEDIS 2020 Specifications

Plan All-Cause Readmissions 2020 Version (PCR2020)

These specifications should not be used for 2019 HEDIS for QRS reporting. This is the proposed version of the measure for HEDIS 2020. Additional changes may be included when released for reporting.

SUMMARY OF CHANGES TO HEDIS 2020

- Added definitions of “outlier,” “nonoutlier” and “plan population.”
- Added observation stays to inpatient admissions.
- Revised direct transfers to include observation discharges.
- Added steps to remove hospitalizations for outlier members and report a count of outlier members.
- Removed the base weight variable from the risk adjustment weighting.
- Added instructions and data element tables to report plan population and outlier rate.
- Added instructions and data element tables to report the rate among index stays discharged or transferred to skilled nursing care.

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. Exclude stays that meet the exclusion criteria in the denominator section.
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 inpatient or observation 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 <i>numerator</i> .
Plan population	Members who meet all of the following criteria: <ul style="list-style-type: none"> • 18 and older as of January 1 of the measurement year. • Enrolled on January 1 of the measurement year. • Continuously enrolled for at least 365 days at any point between January 1 of the year prior to the measurement year and December 1 of the measurement year with no more than one gap in enrollment of up to 45 days during the 365-day period.
Outlier	Members with three or more index hospital stays during the measurement year.
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 2
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-Comm-OtherWeights	Commercial surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Note: The risk adjustment tables will be released on November 1, 2018, and posted to www.ncqa.org.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 10: 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 discharge or observation stay 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 members who had one or more discharges on or between January 1 and December 1 of the measurement year.</p> <p>Follow the steps below to identify acute inpatient stays.</p>

Administrative Specification

Denominator	The eligible population.
Step 1	<p>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:</p> <ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).3. Identify the discharge date for the stay. <p>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.</p> <p>The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).</p>
Step 2	<p><i>Direct transfers:</i> For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition below.</p> <p>A direct transfer is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less. For example:</p> <ul style="list-style-type: none">• 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.

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: Required exclusions 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 stay.
- 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-A-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 surgeries, discharge condition, comorbidity, age and gender.

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 the *Utilization Risk Adjustment Determination* in the *Guidelines for Risk Adjusted Utilization Measures*.

Risk Adjustment Weighting

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

Note: The final weights table will be released on November 1, 2018. HEDIS for QRS uses the Commercial Risk Weights for risk adjustment.

- Step 1** For each IHS with a surgery, link the surgery weight.
Use Table PCR-Comm-OtherWeights.
- Step 2** For each IHS with a discharge CC Category, link the primary discharge weights.
Use Table PCR-Comm-DischCC-Weight.
- Step 3** For each IHS with a comorbidity HCC Category, link the weights.
Use Table PCR-Comm-ComorbHCC-Weight.
- Step 4** Link the age and gender weights for each IHS.
Use Table PCR-Comm-OtherWeights.
- Step 5** Identify the base risk weight.
Use Table PCR-Comm-OtherWeights to determine the base risk weight.
- Step 6** Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight) 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.

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-10 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Estimated Readmission Risk	Variance
								Category	Weight	Category	Weight			
1250	1	-2.6087	67	Female	-0.0103	-0.2753	T44992S	58	0.2990	18	0.1961	-2.1783	0.1017	0.0914
										55	0.2209			
4010	1	-2.4722	50	Male	0	NA	J439	111	0.4221	NA	NA	-2.0501	0.1140	0.1010
4010	2	-2.4722	50	Male	0	NA	B180	29	0.6090	87	0.141	-1.7222	0.1516	0.1286

*Each Member ID field with a value represents a unique IHS.

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

- Step 1** Identify all acute inpatient stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:
1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the admission date for the stay.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

Step 2 **Acute-to-acute direct transfers:** Keep the original admission date as the Index Admission Date, but use the direct transfer’s discharge date as the Index Discharge Date.

A **direct transfer** is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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

Step 3 Exclude acute inpatient hospital admissions with any of the following 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 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 an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.

Step 4 Remove hospital stays for outlier members.

Step 5 For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Number of Nonoutliers

The number of members in the plan population minus the number of outliers for each age and gender group and the overall total calculated by IDSS.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, multiplied by 1,000, for each age and gender group and the overall total. 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 Readmission calculated by IDSS.

Note

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

Table PCR-A-4: Plan Population and Outlier Rate

Age	Sex	Members in Plan Population	Outlier Members	Nonoutlier Members	Outlier Rate
18-44	Male				
	Female				
	Total				
45-54	Male				
	Female				
	Total				
55-64	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

Table PCR-B-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							
<i>Total*</i>							

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 medication-use measures in areas such as medication safety, medication adherence and appropriateness. PQA workgroups (comprised of individuals appointed by member organizations) identify measurement needs within the high-priority areas identified through the National Priorities Partnership, and aligns its activities with the National Quality Strategy.

PQA 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 the measure concepts to provide an initial assessment of the key properties of performance measures (i.e., importance, scientific acceptability, feasibility and usability). The measure concepts that are rated highly on these key properties will undergo testing and possibly further technical specification as draft measures. Step 4: The draft measures are provided to PQA member organizations for their comments prior to preparing technical specifications (including National Drug Code [NDC] lists) for pilot testing. PQA staff use member comments and 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 feasibility and reliability of the draft measures.
-

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* Measure Data Collection

Refer to NCQA’s “General Guidelines for Data Collection” in Section 3.1 for details that will inform appropriate data collection for the *Proportion of Days Covered* measure. All general guidelines apply, with the exception of the following items specified below.

PQA Specific Guidelines for National Drug Codes Inclusion

PQA compiles the NDC lists for the *Proportion of Days Covered* measure using three databases: First Databank, MediSpan, and the Food and Drug Administration’s NDC Structured Product Labeling Data Elements (NSDE) file. NDCs are included in the file if:

- There is no obsolete date noted by the three sources; *or*
- The obsolete date in any of the three databases is within the measurement year; *or*
- The obsolete date is within six months prior to the beginning of the measurement year.

PQA Posting of the National Drug Code Lists

The NDC lists for *Proportion of Days Covered* measure will be available by request from PQA. Please refer to the PQA website in order to obtain the NDC lists at <https://www.pqaalliance.org/QRS>.

The final list of NDCs for 2019 will be available on November 1, 2018. That list will include current NDCs from January 1, 2017 through September 30, 2018 and NDCs with obsolete dates of July 1, 2016 or after.

Required Data Elements for the *Proportion of Days Covered* Measure

Organizations must provide the following data elements for the *Proportion of Days Covered* measure.

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

Proportion of Days Covered (PDC): 3 Rates

Description

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

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

Index Prescription Start Date (IPSD)	The earliest date of service for a target medication between January 1 and October 2 of the measurement year.
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year, or until death or disenrollment. The treatment period must be at least 91 days long.
Proportion of Days Covered (PDC)	The number of days that a patient is covered by prescription claims for the same medication or another in its therapeutic category, divided by the number of days in the treatment period.
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).
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
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><i>Treatment Period:</i> The IPSD through the end of the measurement year or until death or disenrollment from the health plan. The treatment period must be at least 91 days long.</p> <p>Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year.</p> <p><i>Note:</i> Do not include members who dis-enroll and re-enroll more than one day later at any time during the measurement year after the treatment period.</p>
Allowable Gap	No gaps in enrollment during the continuous enrollment period.
Benefit	Pharmacy.

Administrative Specification

Report each of the rates separately. Patients may be counted in the denominator for multiple rates if they have been dispensed the relevant medications; though for each rate, the proportion of days covered should only be counted once per patient.

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

Additional Eligible Population Criteria	Patients 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>Sacubitril/valsartan: Patients with one or more prescription claims for sacubitril/valsartan during the treatment period (see Table PDC-RASA-B Exclusion: Sacubitril/Valsartan).</p> <p>ESRD: Any patient with an end-stage renal disease (ESRD) diagnosis at any time during the measurement year:</p>

- See PQA ICD Value Set, ESRD Exclusion
- 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.

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

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

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

Measure Calculation

- Step 1** Determine the patient’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 patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*
- Step 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.
- Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single 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. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, PDC-RASA tab.

3.2 PQA Measure Specifications

Rate 2: Diabetes All Class (PDC-DR)

Additional Eligible Population Criteria Patients 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.

Denominator The eligible population.

Denominator Exclusion Insulin: Patients with one or more prescription claims for insulin during the treatment period (see Table PDC-DR-H: Insulin Exclusion).

ESRD: Any patient with an end-stage renal disease (ESRD) diagnosis at any time during the measurement year:

- See PQA ICD Value Set, ESRD Exclusion
- 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.

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

Medication Tables

Table PDC-DR-A: Biguanides

Biguanide Medications and Combinations

- metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, 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

- | | | |
|---|-----------------------------|---------------|
| • chlorpropamide | • glipizide (+/- metformin) | • tolazamide |
| • glimepiride (+/- pioglitazone, rosiglitazone) | • glyburide (+/- metformin) | • 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

- | | |
|---|---------------------------------|
| • pioglitazone (+/- alogliptin, glimepiride, metformin) | • rosiglitazone (+/- metformin) |
|---|---------------------------------|

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-DR-D: DPP-4 Inhibitors

DPP-4 Medications and Combinations

- | | | |
|--|--|--|
| • alogliptin (+/- metformin, pioglitazone) | • saxagliptin (+/- metformin, dapagliflozin) | • sitagliptin (+/- metformin, simvastatin) |
| • linagliptin (+/- empagliflozin, metformin) | | |

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-DR-E: Incretin Mimetics

DPP-4 Medications and Combinations

- | | | |
|---------------|---------------|----------------|
| • albiglutide | • exenatide | • lixisenatide |
| • dulaglutide | • liraglutide | • semaglutide |

Table PDC-DR-F: Meglitinides

Meglitinides and Combinations		
• nateglinide	• 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		
• canagliflozin (+/- metformin)	• dapagliflozin (+/- metformin, saxagliptin)	• empagliflozin (+/- metformin, linagliptin)

NOTE: Active ingredients are limited to oral formulations only.

Table PDC-H: Insulin Exclusion

Insulins		
• insulin aspart (+/-insulin aspart protamine)	• insulin glargine (+/- lixisenatide)	• insulin lispro (+/- insulin lispro protamine)
• insulin degludec (+/- liraglutide)	• insulin glulisine	• insulin regular (including inhalation powder)
• insulin detemir	• insulin isophane (+/- regular insulin)	

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

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

Measure Calculation

- Step 1** Determine the patient’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 patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*
- Step 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.
- Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single 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. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, PDC-DR tab.

Rate 3: Statins (PDC-STA)

Additional Eligible Population Criteria Patients 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.

3.2 PQA Measure Specifications

Denominator Exclusion

ESRD: Any patient with an end-stage renal disease (ESRD) diagnosis at any time during the measurement year:

- See PQA ICD Value Set, ESRD Exclusion
- 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.

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

Table PDC-STA-A: Statins

Statin Medications		
• atorvastatin (+/- amlodipine, ezetimibe)	• pitavastatin	• rosuvastatin
• fluvastatin	• pravastatin	• simvastatin (+/-ezetimibe, niacin, sitagliptin)
• lovastatin (+/- niacin)		

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

Numerator

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

Measure Calculation

- Step 1** Determine the patient’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 patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*
- Step 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.
- Step 4** Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

*Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single 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. Please refer to the definition for *Calculating number of days covered for the numerator* and the NDC specifications, PDC-STA tab.

4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures⁸ that will be collected as part of the 2019 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 2019 QHP Enrollee Survey item(s), please see [QRS and QHP Enrollee Survey: Technical Guidance for 2019](#).

Additional details related to the 2019 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 2019 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?⁹
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 2019 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?

⁸ 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.

⁹ For 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 2019 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, 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 2019 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?
 5. In the last 6 months, how often were the forms from your health plan easy to fill out?
 6. 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 2019 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 2019 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 2019 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 2019 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?
-