Quality Rating System
Measure Technical Specifications

September 2014

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 the 2015 beta test.

Website Links

- Centers for Medicare & Medicaid Services (CMS) Health Insurance Marketplace Quality Initiatives website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html

- CMS Qualified Health Plan (QHP) Enrollee Experience Survey (QHP Enrollee Survey) website: http://qhpcahps.cms.gov

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[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: http://pqaalliance.org/measures/qrs.asp

- For questions regarding the QRS survey measures and the QHP Enrollee Survey, please contact the Exchange Operations Support Center (XOSC) Help Desk and reference the "Marketplace Quality Initiative" or "MQI": CMS_FEPS@cms.hhs.gov or 1-855-CMS-1515 (1-855-267-1515)

- For all other questions related to the QRS requirements, please contact the XOSC Help Desk and reference the "Marketplace Quality Initiative" or "MQI"

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

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1. Introduction

Introduction

Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2015 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 2015 beta test 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. For the 2015 QRS, the 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 QRS survey measures 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 *2015 Beta Test of the Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2015,* QHP issuers and Multi-State Plan (MSP) issuers[2] are required to submit third-party validated QRS clinical measure data and QHP Enrollee Survey response data to CMS as a condition of certification and participation in the Health Insurance Marketplaces (Marketplaces).[3] Using the validated QRS clinical measure data and a subset of the QHP Enrollee Survey response data (QRS survey measures),[4] CMS will calculate quality ratings for each QHP offered through the Marketplaces. CMS will apply the QRS rating methodology to aggregate clinical measure data and survey response data to produce quality performance ratings on a 1- to 5- star rating scale. In 2015, CMS will calculate quality rating information (i.e., QHP QRS scores and ratings and QHP Enrollee Survey results) for each QHP issuer's product type (e.g., Health Maintenance Organization [HMO]) and apply these ratings to each product's respective QHPs.

[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); § 156.1120(a),(d); and § 156.1125(b),(e).

[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.

2015 will serve as the "beta test" for both the QRS and the QHP Enrollee Survey; therefore, QHP quality rating information is not required to be publicly displayed. Beginning in 2016, Marketplaces will be required to prominently display QHP quality rating and enrollee experience information on their websites to help consumers compare QHPs.[5] The quality rating information will reflect the quality of health care services including health outcomes, enrollee experience, and accessibility of care.

[5] 45 CFR § 155.1400 and § 155.1405.

2. QRS Measure Set

QRS Measure Set

CMS developed the 2015 QRS measure set based on stakeholder input received through public comment forums such as the "Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework, Measures, and Methodology" Federal Register Notice (FRN) (CMS-3288-NC).[6] CMS also refined the measure set based on recommendations from the National Quality Forum (NQF) Measures Application Partnership Health Insurance Exchange Task Force.

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 the 2015 beta test. The remaining measures in the QRS measure set require at least two years of data collection and will not be reportable until 2016 or 2017 (see Exhibit 2).

The measure set includes a subset of NCQA's HEDIS measures and one PQA measure. The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems[7] (CAHPS®) Surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the CMS Health Insurance Marketplace Quality Initiatives website.

QHP issuers are required to collect and submit data for every indicator associated with a measure, unless a specific indicator is shown in parentheses next to the measure in the exhibits below.

Exhibit 1. 2015 QRS Measures

Measure Title	Measure Steward	National Quality Forum (NQF) ID[8]
QRS Clinical Measures		
Annual Dental Visit	NCQA	1388
Annual Monitoring for Patients on Persistent Medications	NCQA	Not Endorsed[9]
Appropriate Testing for Children With Pharyngitis	NCQA	0002
Appropriate Treatment for Children With Upper Respiratory Infection	NCQA	0069
Cervical Cancer Screening	NCQA	0032
Chlamydia Screening in Women	NCQA	0033
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	0055
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA	0575
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	NCQA	0057
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	0062
Controlling High Blood Pressure	NCQA	0018
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)	NCQA	0576
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA	0004
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541
Relative Resource Use for People with Diabetes (Inpatient Facility Index)	NCQA	1557

[6] The public period was open from November 19, 2013 to January 21, 2014. The FRN is available at https://www.federalregister.gov/articles/2013/11/19/2013-27649/patient-protection-and-affordable-care-act-exchanges-and-qualified-health-plans-quality-rating

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

[8] Definitions of NQF-endorsed measures can be found here: http://www.qualityforum.org/Home.aspx

[9] Measure is not NQF-endorsed upon publication of this guidance, but it was submitted for endorsement in early 2014.

2. QRS Measure Set

Measure Title	Measure Steward	National Quality Forum (NQF) ID[8]
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA	1516
QRS Survey Measures		
Access to Care	AHRQ	0006[10]
Access to Information	AHRQ	0006[10]
Care Coordination	AHRQ	Not Endorsed
Cultural Competence	AHRQ	Not Endorsed
Flu Vaccinations for Adults Ages 18-64	NCQA	0039
Plan Administration	AHRQ, CMS[11]	0006[10]
Rating of All Health Care	AHRQ	0006[10]
Rating of Health Plan	AHRQ	0006[10]
Rating of Personal Doctor	AHRQ	0006[10]
Rating of Specialist	AHRQ	0006[10]

Exhibit 2. Additional QRS Measures for 2016 and 2017

Measure Title	Measure Steward	NQF ID
QRS Clinical Measures		
Adult BMI Assessment	NCQA	Not Endorsed
Antidepressant Medication Management	NCQA	0105
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	0058
Breast Cancer Screening	NCQA	Not Endorsed[12]
Childhood Immunization Status (Combination 3)	NCQA	0038
Colorectal Cancer Screening	NCQA	0034
Follow-Up Care for Children Prescribed ADHD Medication	NCQA	0108
Human Papillomavirus Vaccination for Female Adolescents	NCQA	1959
Immunizations for Adolescents (Combination 1)	NCQA	1407
Medication Management for People With Asthma (75% of Treatment Period)	NCQA	1799
Plan All-Cause Readmissions	NCQA	1768
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	NCQA	1392
QRS Survey Measures		
Aspirin Use and Discussion	NCQA	Not Endorsed
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	0027

[10] NQF ID #0006 reflects NQF endorsement for the CAHPS Health Plan 4.0 Survey. The QHP Enrollee Experience Survey and associated QRS survey measures largely align with items from the CAHPS Health Plan 5.0 Surveys, which have not yet been submitted for endorsement upon publication of this guidance. Further, the Plan Administration survey measure includes one survey item developed by CMS; this survey item is not included in the CAHPS Survey.
[11] Measure consists of CAHPS survey items and a survey item developed for purposes of the QHP Enrollee Survey.
[12] Measure is not NQF-endorsed upon publication of this guidance, but it was submitted for endorsement in early 2014. As currently specified, the Breast Cancer Screening measure requires three years of data to report and will therefore not be required until 2017.

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

General Guidelines for HEDIS® Measures Included in 2015 Quality Rating System (QRS)

NCQA Customer Support: 888-275-7585
NCQA Fax: 202-955-3599
NCQA Web Site: www.ncqa.org

NCQA Policy Clarification Support at: http://pcs.ncqa.org

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Overview

HEDIS 2015

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

How HEDIS Is Developed

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

Additional Resources

Technical specification updates	NCQA will freeze the specifications on October 1, 2014, with the release of the HEDIS 2015 QRS *Technical Update*: • *QRS HEDIS Technical Update memo,* which will be posted to the NCQA Web site (www.ncqa.org). • *QRS HEDIS Value Set Directory (10/1/2014 Release)*, which will be posted to the NCQA Store (http://store.ncqa.org/). Organizations are accountable for all changes included in the *Technical Update*, but are not required to use information posted after the freeze date, with the exception of NDC codes, Standard Pricing Tables (SPT) and HCC Risk Adjustment tables.
NDC codes	The final NDC codes will be posted to the NCQA Web site by November 3, 2014.
Relative Resource Use SPTs	The SPTs will be posted to the NCQA Web site by November 3, 2014.
HCC Risk Adjustment tables	The HCC Risk Adjustment tables will be posted to the NCQA Web site by November 3, 2014.

Specifications for 2016 and 2017 QRS HEDIS Measures

The 2015 QRS HEDIS materials include only a brief description of the 2016 and 2017 QRS measures. While measure descriptions are unlikely to change in the next few years, the measure specifications may change before it is time for organizations to report the measure data beginning in 2016. If an organization would like to review the current specifications for the 2016 and 2017 measures, please contact NCQA through the Policy Clarification Support (PCS) described below.

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 policy interpretation questions to NCQA staff: the Policy Clarification Support (PCS) system. The PCS system can be accessed on the NCQA Web site (http://pcs.ncqa.org).

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS uses and specifications, and are posted to the NCQA Web site (www.ncqa.org) on the 15th of each month.

General Guidelines for Data Collection

General Guidelines for Data Collection

These General Guidelines and Technical Specifications are unique to the HEDIS measures required for the CMS Quality Rating System (QRS) for Health Insurance Marketplace Qualified Health Plan (QHP) Issuers.[1][2] The contents are based on NCQA's HEDIS 2015 Volume 2: Technical Specifications. HHS requires all QHP issuers to collect and report a specific set of measure data to support the calculation of the QRS by CMS. In 2015, QHP issuers should submit these data, detailed in these materials, to CMS through the NCQA Interactive Data Submission System (IDSS).

2015 QRS HEDIS Data Collection

1. Marketplace Product Line

QHP Issuers ("organizations") must collect HEDIS measure data separately for the Marketplace population.

In the event that an organization offers an identical QHP through and outside of the Marketplace, the organization may include enrollees in the version of the QHP that is offered outside of the Marketplace only if it is certified as a QHP and has the same standard component ID (SCID) as the version offered through the Marketplace.

2. Data Collection Units (Products)

Organizations must collect 2015 QRS HEDIS measure data separately at the product level (i.e., EPO, HMO, POS, PPO). Additionally, sampling for the 2015 QRS measures that specify a hybrid method for data collection will occur at the product level. Combining product types into one data collection 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.

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

[2] A **QHP Issuer** has a certification issued by or recognized by a Marketplace to demonstrate that each health plan offered in the Marketplace is a QHP and meets the requirements described in 45 CFR 155.2. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a state geographic unit. A QHP Issuer must operate on a Marketplace for at least one year before it is required to collect QRS measure data.

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. Metal Levels

Organizations offer different categories of coverage within their product types, including bronze, silver, gold, platinum and catastrophic QHPs. Measure data will not be collected at the metal level for the 2015 QRS measure set.

4. Minimum Enrollment Threshold

For the 2015 beta test, CMS requires data submission for each QHP issuer's product types (e.g., HMO, PPO). For both the QRS and Enrollee Survey, QHPs are required to submit data for each product that has more than 500 enrollees as of July 1, 2014. For the QHP Enrollee Survey, a QHP issuer that is required to submit data must contract with a CMS-approved survey vendor to conduct the survey for those products. QHP issuers may not combine product types for purposes of collecting and submitting QRS and QHP Enrollee Survey data.

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

An organization's Small Business Health Options Program (SHOP) and individual benefit Marketplace members are included in the same Marketplace data collection unit (not separated).

6. Multi-State Plan (MSP) Members

Multi-State Program Plans (MSPP)[3] members should be included in the corresponding organization's Marketplace data collection units (not separated).

7. Model Type and Mixed-Model Type Organizations

Model type is the type of structure the organization uses to provide members with care (e.g., Staff, Group, IPA, Direct Contract, Mixed, Network).

Mixed-model organizations (e.g., an organization with an IPA and a group model) report data for all model types combined.

[3] The Multi-State Plan (MSP) Program, established under the Affordable Care Act, directs OPM to contract with private health insurers in each state to offer high-quality, affordable health insurance options called Multi-State Plans. MSP coverage is offered through the Marketplace.

The HEDIS Compliance Audit

The HEDIS Compliance Audit™ is required for all QRS measures, including the sampling frame used to administer the QHP Enrollee Survey. The HEDIS Audit runs concurrently with 2015 QRS measure set Data Collection. The audit allows comparability across organizations and ensures validity and integrity of 2015 QRS measure set data.

8. Audit Preparation

Contract with an audit firm

The organization requests an application for a 2015 QRS HEDIS Audit from an NCQA Licensed Organization (www.ncqa.org/audit.aspx), and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations (www.ncqa.org/audit.aspx) for bids and selects a firm to conduct the HEDIS audit.

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

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

HEDIS Roadmap

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

Medical record review validation

The medical record review validation (MRRV) process uses like-measure groupings for measure validation; includes hybrid measure exclusions; applies a different statistical test to the process; and defines MRR milestones clearly to ensure consistency across organizations. Refer to *HEDIS 2015: Volume 5, HEDIS Compliance Audit™: Standards, Policies and Procedures,* released in November.

HEDIS Audit Timeline Task	NCQA Deadline
Organization contracts with an NCQA Licensed Organization.	June 1–December 1
Organization submits the completed current year's Roadmap to the auditor.	January 16-30
Auditor completes the survey sample frame validation.	January 30
Auditor selects a core set of noncertified measures for code review.	February 13
Auditor receives software vendor's final certification report and measure identifiers, or organization submits completed source code for auditor review (for noncertified code).	March 2
Organization completes and stops all nonstandard and member-reported supplemental data collection and entry.	March 2
Auditor finalizes approval of *all* supplemental data. PSV for member-reported and nonstandard supplemental data must not occur prior to March 2 unless the organization finished all supplemental data processes, collection and entry.	March 31
Onsite visits completed.	April 30
Auditor selects measures for MRRV and informs the plan of the selections. Selections may be sent before May 1, *only* if the plan is finished with the MRR process.	May 1
Preliminary rate review and feedback completed.	May 4
Organization completes the medical record abstraction process for all measures; sends final numerator-compliant counts for all measures; sends exclusions and numerator-compliant lists for selected measures to the auditor for MRRV.	May 15
Auditor picks 16 records for each selected MRRV measure and exclusions for review and informs plan of the selections.	May 19
Organization sends selected records to the auditor for validation.	May 26
Auditor begins communicating MRRV results, including MRRV corrective actions, with the organization.	June 1
Organization completes all corrective actions and follow-up requests and submits the plan-locked submissions to auditor.	June 8
Auditor performs final rate review and ensures that the MRR numerator counts entered in the IDSS match the lists submitted on May 15.	June 15
Organization submits the auditor-locked Marketplace IDSS submission, with attestation, to NCQA.	June 15
Licensed Organization submits Marketplace Final Audit Reports to NCQA.	July 15

9. Reporting

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

For Performance Measures

Rate/Result	Comment
0–XXX	*A rate or numeric result*. The organization followed the specifications and produced a reportable rate or result for the measure.
NB	*Benefit Not Offered*. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reportable*. • The calculated rate was materially biased, ***or*** • The organization chose not to report the measure.

Note: *The QRS does not use the NA (Not Applicable) audit designation given that all QRS measures are required to be collected and reported.*

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 *Appendix 10: Bias Determination* in *Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*.

10. Marketing

Release of HEDIS Audit results must be in accordance with NCQA's *Guidelines for Advertising and Marketing,* posted on the NCQA Web site at www.ncqa.org*.* Organizations may release the entire Final Audit Report without prior authorization from NCQA, but must obtain written authorization from NCQA before releasing abridged, summarized or quoted information from the Final Audit Report.

Refer to CMS guidance materials for QRS specific marketing guidelines.

11. Measure Rotation

The QRS does not allow the use of measure rotation.

In Which Reports Do Marketplace Members Remain?

12. 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 Marketplace report.

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

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

13. The "Working Aged" and Retirees

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

Membership Changes

14. 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 18: Continuous Enrollment*, and all other guidelines affecting continuous enrollment (i.e., allow switching between products [HMO, POS, PPO, EPO] or product lines [Medicaid, commercial, Medicare, Marketplace]) consistently, across all measures.

15. 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. This guideline must be used consistently across all measures.

Measures without a continuous enrollment period

The surviving organization may include members from the nonsurviving entity in the eligible population, starting on the official date of the merger or acquisition. For example, if the merger or acquisition occurred on March 1 of the measurement year, the surviving organization excludes members acquired from the nonsurviving entity from the eligible population for January and February. This guideline must be used consistently across all measures.

16. Members Who Switch Product Lines

Measures with a continuous enrollment requirement

Assign members who enrolled in different product lines (commercial, Medicaid, Medicare, Marketplace) at different times during the measurement year to the product line they belonged to at the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the Marketplace product line during the continuous enrollment period is reported in the Marketplace report.

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

Measures without a continuous enrollment requirement

Assign members to a category based on the product line in which they were enrolled on the date of service (outpatient services) or date of discharge (inpatient services).

17. Members Who Switch Products or Metal Levels

Measures with a continuous enrollment requirement

QRS measure data are reported at the product level. Members who switch from the Marketplace HMO product to the Marketplace POS product (or vice versa) in the time specified for continuous enrollment for a measure are continuously enrolled and included in the product-specific 2015 QRS HEDIS report in which they were enrolled as of the end of the continuous enrollment period.

- *For HMO or POS 2015 QRS HEDIS reporting,* count enrollment in a PPO or EPO as a gap in continuous enrollment.
- *For EPO or PPO 2015 QRS HEDIS reporting,* count enrollment in an HMO or POS product as a gap in continuous enrollment.

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

Measures without a continuous enrollment requirement

Measure data are reported at the product type level. Members who switch between product types during the measurement year are reported in the product type where they were enrolled on the date of service (outpatient services) or on the date of discharge (inpatient services).

Required Enrollment Periods and Benefits

18. 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).

19. 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.

20. 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.

21. Required Benefits

HEDIS 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 measures do not define benefits at the service level.

…at the organization level

Organizations report HEDIS measures requiring a specific benefit provided to members directly or through a contractor. Organizations are not required to report HEDIS 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.

…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.

22. 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.

2015 QRS HEDIS Data Submission and Reporting to NCQA

23. QRS Reporting Date

The previous calendar year is the standard measurement year for 2015 QRS HEDIS data. For 2015 QRS HEDIS, Data Collection Units must submit data to NCQA on or before **June 15, 2015.**

Note: *Organizations must submit and "plan-lock" 2015 QRS HEDIS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For 2015 QRS HEDIS reporting, organizations are required to "plan-lock" 2015 QRS HEDIS data no later than June 8, 2015 to allow for a final submission on June 15.*

24. Required Data Elements

Organizations that submit 2015 QRS HEDIS data to NCQA must report the data elements identified in each measure specification. Data elements are standard for hybrid measures and administrative measures. Refer to *Appendix 2: Data Element Definitions.*

25. Small Numbers

All organizations must report all 2015 QRS HEDIS measures and associated data elements to NCQA regardless of the measure's denominator size.

Data Collection Methods and Data Sources

26. Data Collection Methods

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

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

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

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

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

Survey Method — Requires organizations to collect data through the QHP Enrollee Survey. The HEDIS materials include the specifications for clinical survey measures. Other survey measure specifications are included in *QHP Enrollee Survey Guidance and Technical Guidance, which is available on CMS' website at https://qhpcahps.cms.gov. .*

27. Supplemental Data

Supplemental data uses

To supplement claims data for calculating HEDIS measures, organizations may use sources other than claims and encounters to collect data about their members and about delivery of health services to their members. Validation and review of these data differ by the processes used to collect and report them.

All supplemental data are considered an administrative data source. *For the hybrid sample only,* all data entered into a chart review form or tool, regardless of the source, are considered medical record data.

Supplemental data may help determine:

- The numerator.
- Optional exclusions.
- Eligible-population required exclusions not related to timing of the denominator event or diagnosis. For example:
  - *Use of Imaging Studies for Low Back Pain*. Organizations may use supplemental data for members who have cancer, but *may not* use supplemental data for members whose recent trauma, IV drug abuse or neurological impairment must be assessed in relation to the low back pain event.

Supplemental data may not be used for:

- Denominator events. Organizations *may not* create and use records to identify denominator events, other than for optional exclusions and appropriate required exclusions. For example:
  - *Appropriate Testing for Children With Pharyngitis.* Organizations may not use supplemental data to find additional diagnoses for any claim that qualifies for the eligible population. Exclude "claims" with multiple diagnoses only.
- Chronic conditions. 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.

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

Supplemental Data Definitions

Standard supplemental data

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

Electronic files that may be used as standard supplemental data:

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

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.

Nonstandard supplemental data

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

Organizations must have clear policies and procedures that describe how the data are collected, validated and used for 2015 QRS HEDIS reporting.

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

Examples of nonstandard supplemental data:

- EHR modules (e.g., eMeasure modules).
- Provider portals (i.e., electronic systems providers use to enter information about services rendered).

- Health Information registries.
- Provider abstraction forms.

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.

Member-reported services

Acceptable *only* if accompanied by proof-of-service documents from the legal health record, whether reported to a disease- or case-management clinician, collected during targeted quality improvement programs or reported during any other data collection process.

Proof-of-service documents must be mailed, faxed or otherwise delivered by the member to the entity contacting the member for the information. Permitted proof-of-service documents include:

- Lab or radiology reports.
- Sections of the member's legal health record showing the service or assessment.
  - Documentation from the legal health record must be recorded, signed and dated by the rendering provider.

When original proof-of-service documents are not available, member-reported information is acceptable only if:

- The information is collected by the end of the measurement year, 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 is recorded, dated and maintained in the member's legal health record.
  - Obtain copies of the member's legal health record from the practitioner who recorded the information.
- The information meets the specific requirements of the measure.

All documents must meet the requirements for supplemental data and the measure to which they apply, and must be available for auditor review.

Organizations collecting member-reported information must have documents describing the policies and procedures for contacting members and for obtaining copies of legal health records.

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

Audit requirements. Member-reported services must be accompanied by proof-of-service documents for *every* record, and the audit requires primary source verification annually.

Required Data Elements

Standard supplemental data

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

Nonstandard supplemental data

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

Electronic sources (i.e., portal, eMeasure module). Data collected or reported from the practitioner who renders the clinical service must have evidence of accountability by the practitioner or practitioner group (i.e., signed contracts with accountability tied to passwords, e-signatures or TIN/PIN data in each session or header record).

Provider-abstracted forms. Provider forms may not be simple "yes or no" responses as evidence of member compliance. Provider forms must have all necessary data elements required by the measure and are signed by the rendering practitioner, attesting to the accuracy of the information.

Member-reported services

Proof-of-service documents required for member-reported services must include all data elements required by the measure (i.e., date and place of service, procedure, prescription, test result or finding, practitioner type). If the measure has a hybrid specification, the proof-of-service documents must contain all data elements required by the hybrid specification.

All supplemental data

All proof-of-service documents must show that services were rendered by the deadline established for the measure (refer to *General Guideline 42* 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.

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

Supplemental Data Timeline and Systematic Sample Requirements

Supplemental data may be collected during the measurement year and into the beginning of the reporting year, but data collection for nonstandard and member-reported files must be completed by the March deadline listed in the Audit Timeline in *General Guideline 8*.

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

For hybrid measures, after the sample is pulled, organizations must follow the policies for collecting information for the systematic sample described in *General Guideline 28*. Supplemental data collection may not be targeted only at members selected for the systematic sample.

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

Refer to the Audit Timeline in *General Guideline 8* for additional deadline requirements.

Identifying and Validating Supplemental Data

All supplemental data (standard, nonstandard and member-reported) must be identifiable. Because supplemental data can affect reporting and incentives, plans or vendors that use supplemental data for HEDIS 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 Roadmap Section 5, including all attachments.
- Impact of supplemental data source by measure (e.g., lists of numerator-positive hits from the supplemental data, by measure; year-to-year comparisons of percentage increases associated with supplemental data; proportion of numerator compliance from supplemental data.)
- Primary source verification where required or requested by the auditor.

Supplemental data that do not pass all audit validation steps by the deadline may not be used to calculate 2015 QRS HEDIS rates. Organizations may wait to load supplemental data until primary source verification is complete and the source is approved.

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

28. Obtaining Information for the Systematic Sample

Organizations (and their contractors) that use the Hybrid Method are responsible for determining compliance with 2015 QRS HEDIS measurement specifications.

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

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

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward 2015 QRS HEDIS compliance. Some EHRs record CPT codes when the practitioner enters a service order in the "order" screen. A CPT code found on the "order" list alone does not comply with the numerator criteria.

After the systematic sample is determined, supplemental data collection may not be used only for noncompliant members selected in the sample.

Processes used to determine the validity and integrity of abstracted data, including interrater reliability, quality control and rater-to-standard tests, are reviewed by the certified HEDIS Compliance Auditor.

Data refresh for the systematic sample

Because the 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.

29. 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). 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 2015 QRS HEDIS reporting. To be eligible for use, medical record documentation must include the collection date or the reported date.

30. Date Specificity

2015 QRS HEDIS 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, 2012. 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 2014, 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.

31. Indicators That Require the Same Data Collection Method

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

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

32. Measures That Use Pharmacy Data

Some measures require the use of pharmacy data. The specifications include medication tables that must be referenced in conjunction with the National Drug Code (NDC) lists posted to NCQA's Web site. The tables include a *Description* column that indicates the therapeutic category, and a *Prescription* column that includes all appropriate medications in their generic form. Organizations must use the NDC lists for each pharmacy-dependent measure. Final NDC lists for pharmacy-related measures will be posted to the NCQA Web site on November 3, 2014.

33. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

Many organizations find a high rate of false positives when they use laboratory data to identify members with a disease or condition. Diagnosis codes are frequently reported on laboratory tests in cases where the condition is being ruled out. Laboratory claims and data may only be used for the Lab Panel Value Set, the Obstetric Panel Value Set (which contain only CPT 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. Organizations determine how 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.

34. 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.

HEDIS Coding Conventions

35. Coding Systems Included in HEDIS

HEDIS includes codes from the following coding systems:

- CMS Place of Service (POS).
- Current Procedural Terminology (CPT).
- 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)**.
- Logical Observation Identifiers Names and Codes (LOINC).
- Uniform Bill (UB) revenue and Type of Bill (TOB).

***** *LOINC® is a registered trademark of the Regenstrief Institute.*

****** *Updates to the ICD-9-CM Diagnosis and Procedure codes are released annually on October 1 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-9 codes released on the same date; 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.*

36. Presentation of Codes in HEDIS 2015 Value Set

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

Value sets used for 2015 QRS HEDIS reporting are included in the QRS-HEDIS Value Set Directory.

37. Principal vs. Secondary Diagnosis

Principal and secondary diagnoses are mentioned throughout HEDIS. 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.

On a UB-04 claim form, the principal diagnosis is listed in Form Locator 67, *Principal Diagnosis Code,* and secondary diagnoses are listed in Form Locators 67A–Q, *Other Diagnosis Codes*. Do not include data in Form Locators 69, *Admitting Diagnosis Code* and 70a–c, *Patient's Reason for Visit* in HEDIS reporting.

On a CMS1500 claim form, the primary diagnosis is listed in Item Number 21, line 1, and secondary diagnoses are listed in Item Number 21, lines 2–4.

38. CPT Code Modifiers

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

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

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

39. Uniform Bill Code Specificity

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

The 2015 QRS HEDIS Value Set Directory does not currently include UB codes. They will be released in October 2014.

40. Mapping Proprietary or Other Codes

For all 2015 QRS HEDIS measures, if the specified coding systems are not used, organizations must "map" the codes they use to the codes specified in 2015 QRS HEDIS. Organizations may map proprietary codes, Level III and state-specific Level II HCPCS codes and NDC codes; it may not map standard codes or deleted codes to the codes used in the measures. When mapping codes, it is important to match the clinical specificity required for 2015 QRS HEDIS. NDC code mapping must be linked to the generic name, strength/dose and route indicated in the 2015 QRS HEDIS NDC lists posted on the NCQA Web site (www.ncqa.org).

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

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

41. Retiring Codes

NCQA annually tracks billing, diagnostic and procedure codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many 2015 QRS HEDIS measures. Obsolete codes are deleted from the 2015 QRS HEDIS specifications one year after the look-back period is exhausted.

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

42. Table Names

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

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

Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

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

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 QRS measures specify Hybrid Method data collection. For Marketplace, organizations must apply the hybrid methodology and sample at the Product level, not the metal level.

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

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

Drawing the sample prior to the reporting year

Organizations are strongly encouraged to draw samples no earlier than January 2015 for the 2014 measurement year. This increases the accuracy and completeness of the eligible population from which the sample is drawn.

Organizations must adhere to the following guidelines if samples are drawn prior to January 2015.

Membership-dependent denominators

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

- *Cervical Cancer Screening*.

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

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
  - Any ineligible member (i.e., does not meet one or more denominator criteria) must be excluded and replaced by an eligible member from the oversample group.

Claim-dependent denominators

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

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

Determining the required sample size

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

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

Population definition

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

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

Finite population correction

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

Organization responsibility for chart review

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

After the systematic sample is generated and chart pursuit has started, the sample may be reduced on rare occasions, such as after a natural disaster. Removing uninvestigated members from the sample in this situation is an alternative sampling method, and the organization must submit a request for approval to PCS at http://pcs.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.

Calculating the 95 percent confidence interval

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

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

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

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

For example, suppose the organization has a sample size of 96 eligible members for its *Cervical Cancer Screening* rate. Of these, 50 were screened for cervical cancer during the measurement year or the two years prior to the measurement year. The calculation would proceed as follows:

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

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

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

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

Note

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

Statistical assumptions for sample size

Sample size is calculated assuming a two-tailed test of significance between two proportions (α = .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

Measure	Marketplace Sample Size
Effectiveness of Care	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411
Cervical Cancer Screening	411
Controlling High Blood Pressure	411
Comprehensive Diabetes Care	411
Access/Availability of Care	
Prenatal and Postpartum Care	411
Utilization and Relative Resource Use	
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	411

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

Organizations may use a rate calculated from the current year's administrative rate to determine the sample size.

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

Note

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

Systematic Sampling Methodology

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

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

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

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

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

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

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

The FSS is calculated by the following formula:

$$FSS = MRSS + (MRSS \times \text{oversampling rate})$$

(round *up* to the next whole number), where MRSS = the minimum required sample size (step 2).

For example, if the MRSS is 411 and a 10 percent oversample is needed,

$$FSS = 411 + (411 \times 0.10) = 453.$$

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

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

Sort EMs from A to Z in even measurement years and from Z to A in odd measurement years. For example, for HEDIS 2015 (2014 measurement year), sort the list of EMs from A to Z. For HEDIS 2016 (2015 measurement year), sort the list from Z to A.

Note: *Sort order applies to all components. For HEDIS 2015, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).*

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

Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation:

$$N = EM/FSS$$

where EM = the eligible member population (step 1) and FSS = the final sample size (step 3).

Step 7 Calculate START = (RAND × 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 2014, 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 Volume 2 *Technical Update,* released in October 2014.

Step 8 Select the sample, choosing every i^{th} member using the formula:

$$i^{th} \text{ member} = START + [(i-1) \times (EM/FSS)]$$

(rounding [(i-1) x (EM/FSS)] per the .5 rule to the nearest whole number greater than 0).

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

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

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

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

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

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

Oversample requests to NCQA

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

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

Oversampling methodology

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

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

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

The recommended methodology for substitution is:

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

If the initial oversample was underestimated and all auxiliary members have been exhausted without satisfying the MRSS, the organization must contact NCQA through the PCS system (http://pcs.ncqa.org) to determine next steps.

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

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

Example 1

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

Step 1 EM = 9,000.

Step 2 From Table 2, the MRSS is 296.

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

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

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

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

Step 7 For this example, assume that RAND = 0.66, so START = 0.66 x 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) x (9,000/311)] = 18 + 29 = 47th sorted member, after rounding the term [(2-1) x (9,000/311)] to 29, using the .5 rule.
- The 3rd member chosen is the 18 + [(3-1) x (9,000/311)] = 18 + 58 = 76th sorted member.
- The 296th member (the last one in the primary list) is the 18 + [(296-1) x (9,000/311)] = 18 + 8,537 = 8,555th sorted member.
- The last member in the auxiliary sample is the 18 + [(311-1) x (9,000/311)] = 18 + 8,971 = 8,989th sorted member.

Example 2

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

Step 1 EM = 436.

Step 2 From Table 1, the MRSS is 411.

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

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

Step 5 *Skip this step.*

Step 6 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the auxiliary list.

Complex Probability Sampling

Organization responsibility

Properly applied, other techniques (e.g., stratified sampling, cluster sampling and other complex probability approaches) can improve precision and increase sampling efficiency. To use a probability sampling approach different from the one specified, submit a written rationale and documentation of the approach to NCQA through the PCS system (http://pcs.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 2015 QRS HEDIS 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 *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* 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 evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix is a valid, optional exclusion in the denominator for the *Cervical Cancer Screening* measure.

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

All exclusions must be available for auditor review.

3. Employee/ dependent was selected for the sample

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

Hybrid Method: Three Approaches

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

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

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

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

References

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

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

Guidelines for HEDIS Effectiveness of Care Measures

Guidelines for HEDIS Effectiveness of Care Measures

QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- *Annual Monitoring for Patients on Persistent Medications (MPM).*
- *Appropriate Testing for Children with Pharyngitis (CWP).*
- *Appropriate Treatment for Children With Upper Respiratory Infection (URI).*
- *Cervical Cancer Screening (CCS).*
- *Chlamydia Screening in Women (CHL).*
- *Comprehensive Diabetes Care (CDC)*
- *Controlling High Blood Pressure (CBP).*
- *Follow Up After Hospitalization for Mental Illness (FUH).*
- *Use of imaging Studies for Low Back Pain (LBP).*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).*
- *Well-Child Visit in the Third, Fourth, Fifth and Sixth Years of Life (W34).*

Description

Which services count?

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).

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

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

1. **Product line** (commercial, Medicaid, Medicare) 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 to be included in the eligible population
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 (i.e., the indicated treatment or procedure) 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

QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

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

Continuous Enrollment

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

Which Services Count

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

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

Hybrid Methodology

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

Guidelines for HEDIS Relative Resource Use Measure

Guidelines for HEDIS Relative Resource Use Measure

2015 QRS HEDIS SPECIFIC GUIDANCE

These guidelines apply to the following QRS HEDIS measure:

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

The RRU Standard Pricing Tables and HCC Risk Adjustment tables will be posted to the NCQA Web site (www.ncqa.org) by November 3, 2014.

Description

RRU measures

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

- They focus on high-cost conditions that have corresponding 2015 QRS HEDIS Effectiveness of Care measures.
- They differentiate between unit price and utilization variation.
- They rely on a transparent risk-adjustment method similar to a proprietary risk-adjustment system.

Definitions

Inpatient Facility Index

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

Age and gender

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

Required exclusions

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

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

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

Treatment period

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

Standard price

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

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

Download the SPT for each service category, the Major Surgery Table, the LOS Group Table and the cost cap table from www.ncqa.org:

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

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

Standard cost

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

Standard cost is reported for the following category:

- Inpatient Facility.

Service frequency

Service frequency is reported for the following categories:

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

NCQA calculates:

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

Note: *NCQA's SPTs will be posted to www.ncqa.org by November 3, 2014.*

Inpatient facility standard price

Standard prices for inpatient facility services are assigned to each stay and based on the standard per diem price. Standard prices include room, board and ancillary services. Organizations use the length of stay and ICD-9-CM Diagnosis codes to assign the appropriate standard price. Refer to *Calculating Total Standard Cost and Frequency: Inpatient Facility*.

Observed amount	Observed amounts represent the organization's services and costs for the eligible population during the treatment period.
Expected amount	NCQA calculates expected amounts based on regional or national norms (i.e., based on data submitted to NCQA) after risk adjustment for the organization's mix of conditions and members.
Risk adjustment	A method that adjusts each measure's results based on hierarchical condition categories (HCC) risk adjustment approach. This approach combines diagnosis codes into a reduced code set of condition risk categories. Then, where relevant, condition risk categories and category combinations are mapped to disease groups called Hierarchical Condition Categories (HCC). The approach further groups patients based on age, gender and condition to determine each patient's risk weight. Risk weight scores are then assigned to one of 13 risk groups. Download the risk adjustment tables from www.ncqa.org: • Table CC—Comorbid. • Table HCC—Rank. • Table RRU—Weight.
Risk-adjusted (expected) peer amount	For each risk group, NCQA compares the organization's results with a risk-adjusted peer amount. Peer amounts represent what is expected from an organization that has the same mix of members as other organizations with similar ages and genders.

Overview

RRU measures report the organization's total resource use, including cost and service frequency for each eligible member, during each measure's treatment period. For RRU measures, the treatment period is the 12-month measurement year and resource use is calculated for all services, whether or not they relate to the chronic condition.

Measurement and Calculation Process

Step 1 Identify members for the major clinical condition and determine the age and gender category for each member. The medical services for these members are identified for the treatment period.

Step 2 Calculate total standard costs for the Inpatient Facility category using NCQA-provided SPTs. Refer to the SPTs posted on the NCQA Web site (www.ncqa.org) for standard prices.

Step 3 Report service frequency and standard costs for the eligible population by member cohort.

Step 4 NCQA uses the stratified data submitted by all organizations to calculate each organization's expected RRU amounts.

Guidelines

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

Organizations that rotate a related quality EOC measure may report the corresponding RRU measure.

Additional information on quality indicator requirements for RRU reporting is available in the *How NCQA Calculates a Quality Index for RRU* document available at www.ncqa.org/rru.

2. **Reporting members who switch products and product lines.** Assign members to the product and product line in which they are enrolled on the last day of the treatment period, as specified in each measure's eligible population criteria.

3. **Categorizing members by services.** To identify or further categorize the eligible population (e.g., if an eligible member had major surgery during an inpatient stay), include all services, whether or not the organization paid for them or expects to pay for them (i.e., include denied claims).

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

The organization may have:

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

Count the service if:

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

Do not count the service if:

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

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

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

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

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

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

5. **Reporting inpatient services.**

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

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

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

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

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

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

8. **Counting transfers.** 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.

Mental health and chemical dependency transfers Count as 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 should appropriately include discharges and length of stay (inpatient days should be counted under inpatient and residential days should be counted under residential).

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

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

LOS = discharge date – admit date – denied days

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

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

HCC-RRU Risk Adjustment

For the resource use measures, the following steps assign each member to a risk group. The steps are implemented after the eligible population is identified, Tables used to classify the eligible population by risk adjustment approach will be released with the SPTs on November 3, 2014.

Step 1 Identify the qualified service diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/renal/diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.

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

Step 6 Identify demographic HCCs for RRU.

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

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

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

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

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

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

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

Exclusions *(required)*

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

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

Steps for Calculating Service Categories

Calculating Service Frequency

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

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

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

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

Step 4 Count the unique services rendered during the treatment period in each utilization category, for each risk group. Refer to *Guideline 8—Counting multiple billings for the same date of service.*

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

Calculating Standard Cost

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

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

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

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

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

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

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

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

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

Calculating Total Standard Cost and Frequency: Inpatient Facility

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

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

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

Table C: Length of Stay Group

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

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

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

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

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

Step 6 Assign an *Aggregate Diagnostic Service Category (ADSC)* for the inpatient stay using the principal discharge diagnosis. To assign ADSC, download the ADSC Table from the NCQA Web site (www.ncqa.org) and match the principal ICD-9-CM Diagnosis code from the discharge claim to an ADSC. If the principal ICD-9-CM Diagnosis code is invalid or missing, or cannot be determined, map the inpatient stay to the ADSC Table's *MISA* category.

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

If the inpatient stay is acute and has a major surgery, include it in the *Acute Surgery* category for frequency reporting. If the stay is acute but does not have a major surgery, include it in the *Acute Medicine* category. Nonacute stays are not categorized as surgical or nonsurgical for frequency reporting.

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

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

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

Example The treatment period is January 1–December 31 of the measurement year and a member had an inpatient stay that started on December 25 of the measurement year and ended on January 4, with a primary discharge diagnosis from the ADSC category Cardiovascular—A and these characteristics:

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

Use the per diem multiplier with the original LOS GRP derived. The member's total inpatient cost is 7 x $1,825 = $12,775.

Example An member with an inpatient admission has a primary discharge diagnosis from the ADSC category Cardiovascular—A with these characteristics:

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

The total inpatient standard cost of 4 x $4,000 = $16,000 is counted in the Acute Surgery Inpatient category for frequency counting.

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

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

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

Relative Resource Use Results

Using the data submitted by all organizations, NCQA estimates the observed and expected RRU amounts for each clinical condition for each organization. RRU index amounts are based on the ratio of observed to expected (O/E) amounts. Results can be assessed at an overall basis, across all members and major clinical conditions, by service category or for a member cohort within a condition.

NCQA uses the following approach and formulas to compute the RRU index for standard costs; similar logic is used for the selected utilization frequency measures.

C Organization standard costs.

i Indexes eligible members.

s Indexes service categories.

m Indexes member cohorts.

o Indexes reporting organizations. Standard costs are reported by service category across all eligible members in a member cohort. Member cohorts are defined by HCC-RRU risk group, age and gender grouping. Following the assignment of standard price to services provided to eligible members, the organization sums standard costs across eligible members for each member cohort to compute total costs for a service category (for Organization O).

$$C_{s,m,o} = \sum_i C_{i,s,m,o}$$

In addition to standard costs, organizations report total member months (Totmm)

$$Totmm_{m,o} = \sum_i Totmm_{i,m,o}$$

NCQA collects this information for all organizations. Data are pooled across organizations in a "peer group" and used to compute normative benchmarks that can be used to estimate expected standard costs for each organization. Peer benchmarks are created at the per member per month (PMPM) level; standard cost benchmarks (BenchC) are created for each member cohort and service category. For example, for standard costs, NCQA first aggregates costs across organizations in a peer group:

$$BenchC_{s,m} = \sum_o C_{s,m,o}$$

Total member months are also summed.

$$BenchTotmm_m = \sum_o Totmm_{m,o}$$

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

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

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

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

For nonpharmacy services:

$$E(C_{s,m,o}) = BenchCpmpm_{s,m} * Totmm_{m,o}$$

At this point, expected and actual values can be compared and an RRU index or ratio calculated for each combination of service category and member cohort. The expected amount can also be aggregated and an RRU ratio calculated at any level. An overall ratio across all HCC-RRU risk categories and member cohorts would be (for organization p):

$$RRU_o = \sum_s \sum_m C_{s,m} / \sum_s \sum_m E(C_{s,m}).$$

After calculating RRU findings, NCQA provides organizations with their relative resource index score at the service category and major clinical condition level.

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

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

Data Elements for Reporting

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

Measure Specifications for HEDIS® Measures Included in 2015 Quality Rating System

(alphabetical order)

Annual Dental Visit (ADV)

Description

The percentage of members 2–21 years of age who had at least one dental visit during the measurement year.

Eligible Population

Product line Medicaid, Marketplace (report each product line separately).

Ages 2–21 years as of December 31 of the measurement year. Report six age stratifications and a total rate.

- 2–3 years.
- 4–6 years.
- 7–10 years.
- 11–14 years.
- 15–18 years.
- 19–21 years.
- Total.

The total is the sum of the age stratifications.

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 (Dental Visits Value Set) with a dental practitioner during the measurement year.

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

Data Elements for Reporting

Organizations must provide the following data elements.

Table ADV-4: Data Elements for Annual Dental Visit

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

Annual Monitoring for Patients on Persistent Medications (MPM)

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare, Marketplace (report each product line separately).
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

Report each of the three rates separately and as a combined rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

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

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table CDC-L to identify ACE inhibitors and ARBs.

Note: *Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

Numerator

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

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

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

Rate 2: Annual Monitoring for Members on Digoxin

Additional eligible population criteria

Members who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.

Table MPM-B: Drugs to Identify Members on Digoxin

Description	Prescription
Inotropic agents	Digoxin

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Numerator

At least one serum potassium, at least one serum creatinine *and* at least one serum digoxin 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) ***and*** a serum digoxin test (Digoxin Level Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set) ***and*** a serum digoxin test (Digoxin Level Value Set).

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

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria

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

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

Table MPM-C: Drugs to Identify Members on Diuretics

Description	Prescription		
Antihypertensive combinations	• 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	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan	
Loop diuretics	• Bumetanide • Ethacrynic acid	• Furosemide • Torsemide	
Potassium-sparing diuretics	• Amiloride • Eplerenone	• Spironolactone • Triamterene	
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide	• Methyclothiazide • Metolazone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Numerator

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

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

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

Exclusion *(optional)*

Exclude members from each eligible population rate who had an inpatient (acute or nonacute) claim/ encounter during the measurement year.

Data Elements for Reporting

Organizations must provide the following data elements.

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

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

Appropriate Testing for Children With Pharyngitis (CWP)

Description

The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Definitions

Intake Period A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

Episode Date The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of pharyngitis.

Exclude claims/encounters with more than one diagnosis.

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

Product lines Commercial, Medicaid, Marketplace (report each product line separately).

Ages Children 2 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 (inclusive).

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 a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.

Follow the steps below to identify the eligible population.

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

Exclude claims/encounters with more than one diagnosis and ED visits that result in an inpatient admission.

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

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

Table CWP-C: Antibiotic Medications

Description	Prescription	
Aminopenicillins	• 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	• Sulfisoxazole
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

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

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

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 must provide the following data elements.

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

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

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

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 – (numerator/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 for any outpatient or ED visit during the Intake Period with only a diagnosis of URI. Exclude claims/encounters with more than one diagnosis.

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

Product lines Commercial, Medicaid, Marketplace (report each product line separately).

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 (inclusive).

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 a diagnosis of URI during the Intake Period.

Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with only a diagnosis of URI (URI Value Set).

Exclude claims/encounters with more than one diagnosis code and ED visits that result in an inpatient admission.

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters 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 (Table CWP-C) 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:

- (Pharyngitis Value Set).
- (Competing Diagnosis Value Set).

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.

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

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for antibiotic medication (Table CWP-C) on or three days after the IESD.

Data Elements for Reporting

Organizations must provide the following data elements.

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

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

Cervical Cancer Screening (CCS)

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Marketplace (report each product line separately).
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 (Cervical Cytology Value Set) 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 December 1 and December 5 of the measurement year.

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. Organizations may reduce the sample size using the current year's administrative 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.

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.

In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.

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.

Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

Data Elements for Reporting

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

Table CCS-1/2: Data Elements for Cervical Cancer Screening

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

Chlamydia Screening in Women (CHL)

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

Product lines

Commercial, Medicaid, Marketplace (report each product line separately).

Ages

Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 16–20 years.
- 21–24 years.
- Total.

The total is the sum of the age stratifications.

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

Sexually active. 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.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:

- (Pregnancy Value Set).
- (Sexual Activity Value Set).

Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A).

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	• Desogestrel-ethinyl estradiol • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate biphasic • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel • Ethinyl estradiol-norelgestromin	• Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindrone
Diaphragm	• Diaphragm	
Spermicide	• Nonxynol 9	

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

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 alone* ***and*** who meet either of the following:

- A pregnancy test (Pregnancy Tests Value Set) during the measurement year followed within seven days (inclusive) by a prescription for isotretinoin (Table CHL-E).
- A pregnancy test (Pregnancy Tests Value Set) during the measurement year followed within seven days (inclusive) by an x-ray (Diagnostic Radiology Value Set).

Table CHL-E: Medications to Identify Exclusions

Description	Prescription
Retinoid	• Isotretinoin

Note: *An NDC list for isotretinoin will be available on www.ncqa.org by November 3, 2014.*

Data Elements for Reporting

Organizations must provide the following data elements.

Table CHL-4: Data Elements for Chlamydia Screening

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

Comprehensive Diabetes Care (CDC)

QRS SPECIFIC GUIDANCE

- Marketplace organizations report only HbA1c Testing, HbA1c Control <8, Eye Exam and Medical Attention for Nephropathy indicators.

Description

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

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

Eligible Population

Product lines	Commercial, Medicaid, Medicare, Marketplace (report each product line separately).
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 two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).

Table CDC-A: Prescriptions to Identify Members With Diabetes

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose • Miglitol		
Amylin analogs	• Pramlinitide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin	• Glyburide-metformin • Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Exenatide	• Liraglutide	• Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. NCQA will post a complete list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Testing An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

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

Organizations that use CPT 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
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant*
HbA1c Level Greater Than 9.0 Value Set	Not compliant

*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.

Eye Exam An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

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

Any of the following meet criteria:

- Any code in the (Diabetic Retinal Screening Value Set) billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the (Diabetic Retinal Screening Value Set) billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the (Diabetic Retinal Screening With Eye Care Professional Value Set) billed by any provider type during the measurement year.
- Any code in the (Diabetic Retinal Screening With Eye Care Professional Value Set) billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the (Diabetic Retinal Screening Negative Value Set) billed by any provider type during the measurement year.

Medical Attention for Nephropathy A nephropathy screening 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 test (Nephropathy Screening Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Value Set).
- Evidence of kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- A positive urine macroalbumin test (Positive Urine Macroalbumin Tests Value Set).

- A urine macroalbumin test (Urine Macroalbumin Tests Value Set) where laboratory data indicates a positive result ("trace" urine macroalbumin test results are not considered numerator compliant).
- At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

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

Table CDC-L: ACE Inhibitors/ARBs

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

Note: *NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by November 3, 2014.*

Exclusions *(optional)*

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

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member's history through December 31 of the measurement year.
- 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.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line.

Organizations may reduce the sample size using the current year's lowest product line-specific administrative rate among all the reported CDC indicators. Refer to the *Guidelines for Calculations and Sampling* for more information on reducing sample size.

Numerators

HbA1c Testing An HbA1c test performed 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 At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c.
- Hemoglobin A1c.
- HgbA1c.
- HbA1c.
- Glycohemoglobin A1c.

HbA1c Control <8% The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by automated laboratory data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Eye Exam An eye screening 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.

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

Medical record At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria).

Medical Attention for Nephropathy

A nephropathy screening test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

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

Administrative

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

Medical record

Nephropathy screening test. At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result or finding. Any of the following meet the criteria for a urine microalbumin test:

- 24-hour urine for microalbumin.
- Timed urine for microalbumin.
- Spot urine for microalbumin.
- Urine for microalbumin/creatinine ratio.
- 24-hour urine for total protein.
- Random urine for protein/creatinine ratio.

Evidence of nephropathy. Any of the following meet the criteria for evidence of nephropathy:

- 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.
- A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date when the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test:
  - Positive urinalysis (random, spot or timed) for protein.
  - Positive urine (random, spot or timed) for protein.
  - Positive urine dipstick for protein.
  - Positive tablet reagent for urine protein.
  - Positive result for albuminuria.

  - Positive result for macroalbuminuria.
  - Positive result for proteinuria.
  - Positive result for gross proteinuria.

    Note: *"Trace" urine macroalbumin test results are not considered numerator compliant.*

- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

Exclusions *(optional)*

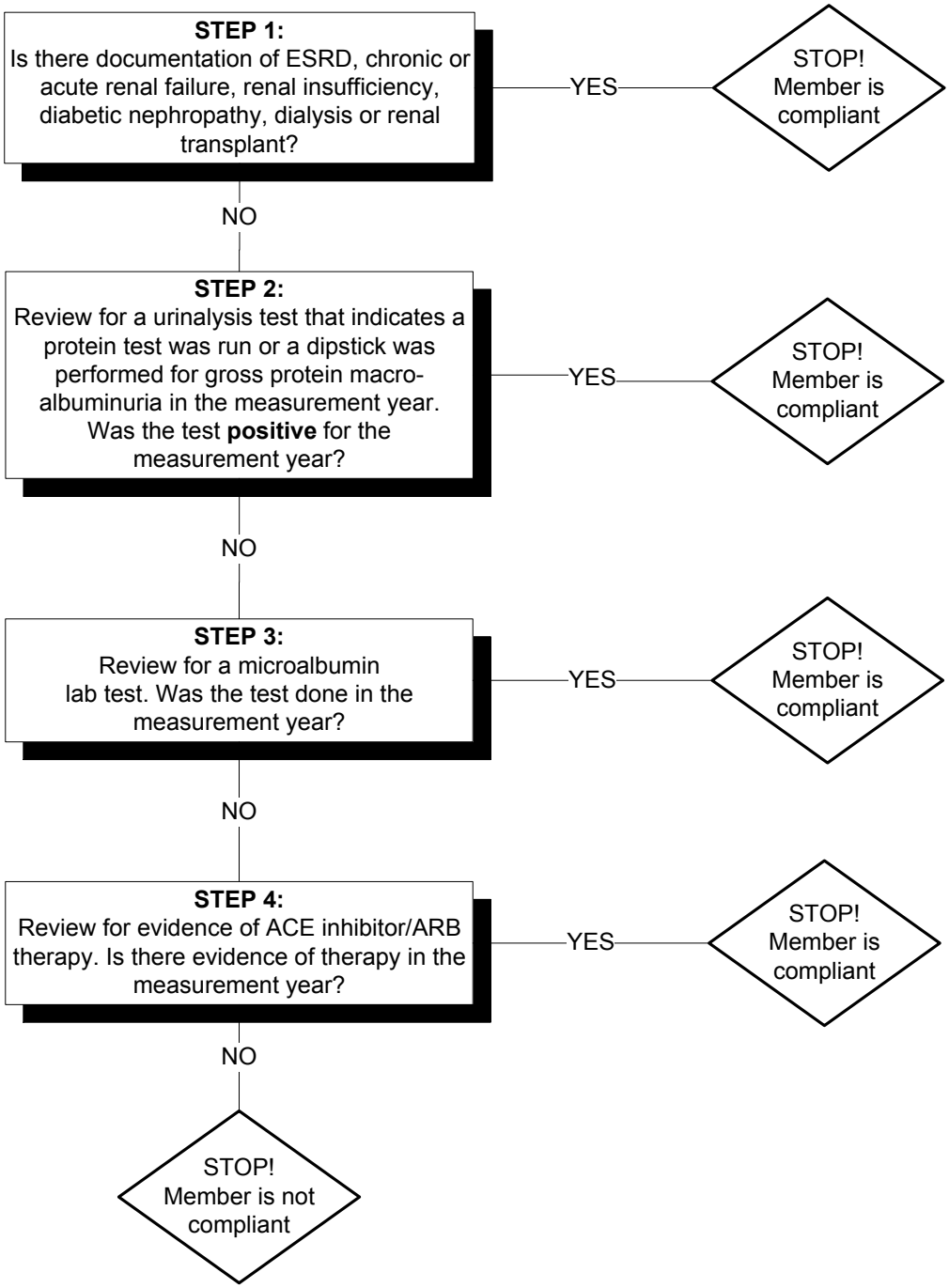
Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, and who meet either of the following criteria:

- A diagnosis of polycystic ovaries, in any setting, any time during the member's history through December 31 of the measurement year.
- 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 HbA1c testing and control rates must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*

Monitoring for Diabetic Nephropathy



Data Elements for Reporting

Organizations must provide the following data elements.

Table CDC-4: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	*Each of the 4 rates*	*Each of the 4 rates*
Data collection methodology (Administrative or Hybrid)	*Each of the 4 rates*	*Each of the 4 rates*
Eligible population	*Each of the 4 rates*	*Each of the 4 rates*
Number of numerator events by administrative data in eligible population (before optional exclusions)		*Each of the 4 rates*
Current year's administrative rate (before optional exclusions)		*Each of the 4 rates*
Minimum required sample size (MRSS) or other sample size		*Each of the 4 rates*
Oversampling rate		*Each of the 4 rates*
Final sample size (FSS)		*Each of the 4 rates*
Number of numerator events by administrative data in FSS		*Each of the 4 rates*
Administrative rate on FSS		*Each of the 4 rates*
Number of original sample records excluded because of valid data errors		*Each of the 4 rates*
Number of optional administrative data records excluded		*Each of the 4 rates*
Number of optional medical records excluded		*Each of the 4 rates*
Number of employee/dependent medical records excluded		*Each of the 4 rates*
Records added from the oversample list		*Each of the 4 rates*
Denominator		*Each of the 4 rates*
Numerator events by administrative data	*Each of the 4 rates*	*Each of the 4 rates*
Numerator events by medical records		*Each of the 4 rates*
Reported rate	*Each of the 4 rates*	*Each of the 4 rates*
Lower 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*
Upper 95% confidence interval	*Each of the 4 rates*	*Each of the 4 rates*

Controlling High Blood Pressure (CBP)

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Note: *Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*

Definitions

Adequate control Adequate control is defined as meeting any of the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Representative BP The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product lines Commercial, Medicaid, Medicare, Marketplace (report each product line separately).

Ages 18–85 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Members are identified as hypertensive if there is at least one outpatient visit (Outpatient CPT Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year.

Note: *In order to increase the specificity of the eligible population, only CPT codes are used to identify outpatient visits.*

Diabetes Flag for the Numerator

After the eligible population is identified, assign each member a flag to identify if the member does or does not have diabetes as identified by claims/encounter and pharmacy data (as described below). The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for members with diabetes is different than the threshold for members without diabetes).

Assign a flag of *diabetic* to members who were identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).

Assign a flag of *not diabetic* to members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the member's history through December 31 of the measurement year.
- 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.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record anytime during the member's history on or before June 30 of the measurement year:

- Hypertension
- HTN.
- High BP (HBP).
- Elevated BP (↑BP).
- Borderline HTN.
- Intermittent HTN.
- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see ***Note*** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

Identifying the medical record

Use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

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

Step 1 Identify the member's PCP.

If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.

If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.

If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Step 2 Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.

If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member's hypertension after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may use this chart for the most recent BP reading. If the member did not have any visit with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis.

Numerator The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

To determine if the member's BP is adequately controlled, the representative BP must be identified.

Administrative None.

Medical record Follow the steps below to determine representative BP.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Step 2 Determine numerator compliance based on the following criteria:

- Members 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

The member is not compliant if the BP reading does not meet the specified threshold or is missing, 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).

Step 3 A single rate is reported for all three groups. Sum the numerator events from Step 2 to obtain the rate.

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 all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year.

Note

- *Organizations may use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.*
- *Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.*

Data Elements for Reporting

Organizations must provide the following data elements.

Table CBP-4: Data Elements for Controlling High Blood Pressure

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

Flu Vaccinations for Adults Ages 18–64 (FVA)

QRS SPECIFIC GUIDANCE

- This measure is collected using the QHP Enrollee Survey. Marketplace organizations should refer to the http://qhpcahps.cms.gov for the complete QRS survey measure set, including the data collection protocols related to the QHP Enrollee Survey.

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	Commercial, Medicaid, Marketplace (report each product line separately).
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 45 days during the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Protocol and Survey Instrument

Collected annually 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, 1949, and July 1, 1996)
2 = Ineligible (the member was born before July 2, 1949, or after July 1, 1996)

The Flu Vaccinations for Adults Ages 18–64 Eligibility Flag identifies the population eligible for the *Flu Vaccinations for Adults Ages 18–64* measure. NCQA calculates the results 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
Q68	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 (2014 for the survey fielded in 2015).

Follow-Up After Hospitalization for Mental Illness (FUH)

QRS SPECIFIC GUIDANCE

- Marketplace organizations report the 7-Day indicator only.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge.

Eligible Population

Product lines	Commercial, Medicaid, Medicare, Marketplace (report each product line separately).
Ages	6 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	Discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. 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. Use only facility claims to identify denominator events (including readmissions or direct transfers). Do not use professional claims.
Acute facility readmission or direct transfer	If the discharge is followed by readmission or direct transfer to an *acute facility* for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.
Exclusions	Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Administrative Specification

Denominator The eligible population.

Numerators

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

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

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set ***and*** FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set ***and*** FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the member was discharged with a principal diagnosis of mental illness.

Note: *Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.*

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 7 days after discharge).*
- *Refer to Appendix 1 for the definition of mental health practitioner.*

Data Elements for Reporting

Organizations must provide the following data elements.

Table FUH-4: Data Elements for Follow-Up After Hospitalization for Mental Illness

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

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

Description

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

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

Definitions

Intake Period January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.

Index Episode The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit during the Intake Period with a diagnosis of AOD.

For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.

IESD Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.

For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.

For an inpatient (acute or nonacute) event, the IESD is the date of discharge.

For an ED visit that results in an inpatient event, the IESD is the date of the inpatient discharge.

For direct transfers, the IESD is the discharge date from the second admission.

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 event, use the admission date to determine the Negative Diagnosis History.

For ED visits that result in an inpatient event, use the ED date of service to determine the Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Eligible Population

Product lines Commercial, Medicaid, Medicare, Marketplace (report each product line separately).

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

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment 60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).

Allowable gap None.

Anchor date None.

Benefits Medical and chemical dependency (inpatient and outpatient).

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/ diagnosis New episode of AOD during the Intake Period.

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

Step 1 Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set ***with*** AOD Dependence Value Set.
  - IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** AOD Dependence Value Set.
  - IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** AOD Dependence Value Set.
- A detoxification visit (Detoxification Value Set).
- An ED visit (ED Value Set) with a diagnosis of AOD (AOD Dependence Value Set).
- An inpatient discharge with a diagnosis of AOD as identified by either of the following:
  - An inpatient discharge with a diagnosis of AOD (AOD Dependence Value Set).
  - An inpatient discharge with an AOD procedure code (AOD Procedures Value Set).

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

For members whose first episode was an ED visit that resulted in an inpatient event, use the inpatient discharge.

Select the IESD.

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (AOD Dependence Value Set) during the 60 days (2 months) before the IESD.

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

For an ED visit that results in an inpatient event, use the ED date of service to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 44 days after the IESD, with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

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

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

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

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

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

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.

Exclude the member from the denominator for both indicators *(Initiation of AOD Treatment and Engagement of AOD Treatment)* if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment

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

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

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

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

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying engagement of AOD treatment.

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 (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).*

Data Elements for Reporting

Organizations must provide the following data elements.

Table IET-4: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	*Each age stratification and total*
Numerator events by administrative data	*Each rate, for each age stratification and total*
Reported rate	*Each rate, for each age stratification and total*
Lower 95% confidence interval	*Each rate, for each age stratification and total*
Upper 95% confidence interval	*Each rate, for each age stratification and total*

Prenatal and Postpartum Care (PPC)

Description

The percentage of deliveries of live births 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 *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

Product lines Commercial, Medicaid, Marketplace (report each product line separately).

Age 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 a birthing center.

Multiple births. 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 between November 6 of the year prior to the measurement year and November 5 of the measurement year. Either of the following meets criteria:

- A delivery (Deliveries Value Set).
- A delivery on an infant claim (Deliveries Infant Record Value Set), where the organization can link infant and mother records.

Step 2 Exclude non-live births (Non-live Births Value Set).

Step 3 Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 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 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 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 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

Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN or other prenatal care practitioner, meet criteria:

- A prenatal visit (Prenatal Visits Value Set) with an obstetric panel (Obstetric Panel Value Set).
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).
- A prenatal visit (Prenatal Visits Value Set) with all of the following:
- Toxoplasma (Toxoplasma Antibody Value Set).
- Rubella (Rubella Antibody Value Set).
- Cytomegalovirus (Cytomegalovirus Antibody Value Set).
- Herpes simplex (Herpes Simplex Antibody Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).

Decision Rule 3

Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:

- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an obstetric panel (Obstetric Panel Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following:
- Toxoplasma (Toxoplasma Antibody Value Set).
- Rubella (Rubella Antibody Value Set).
- Cytomegalovirus (Cytomegalovirus Antibody Value Set).
- Herpes simplex (Herpes Simplex Antibody Value Set).

- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with an obstetrical history.
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with risk assessment and counseling/education.

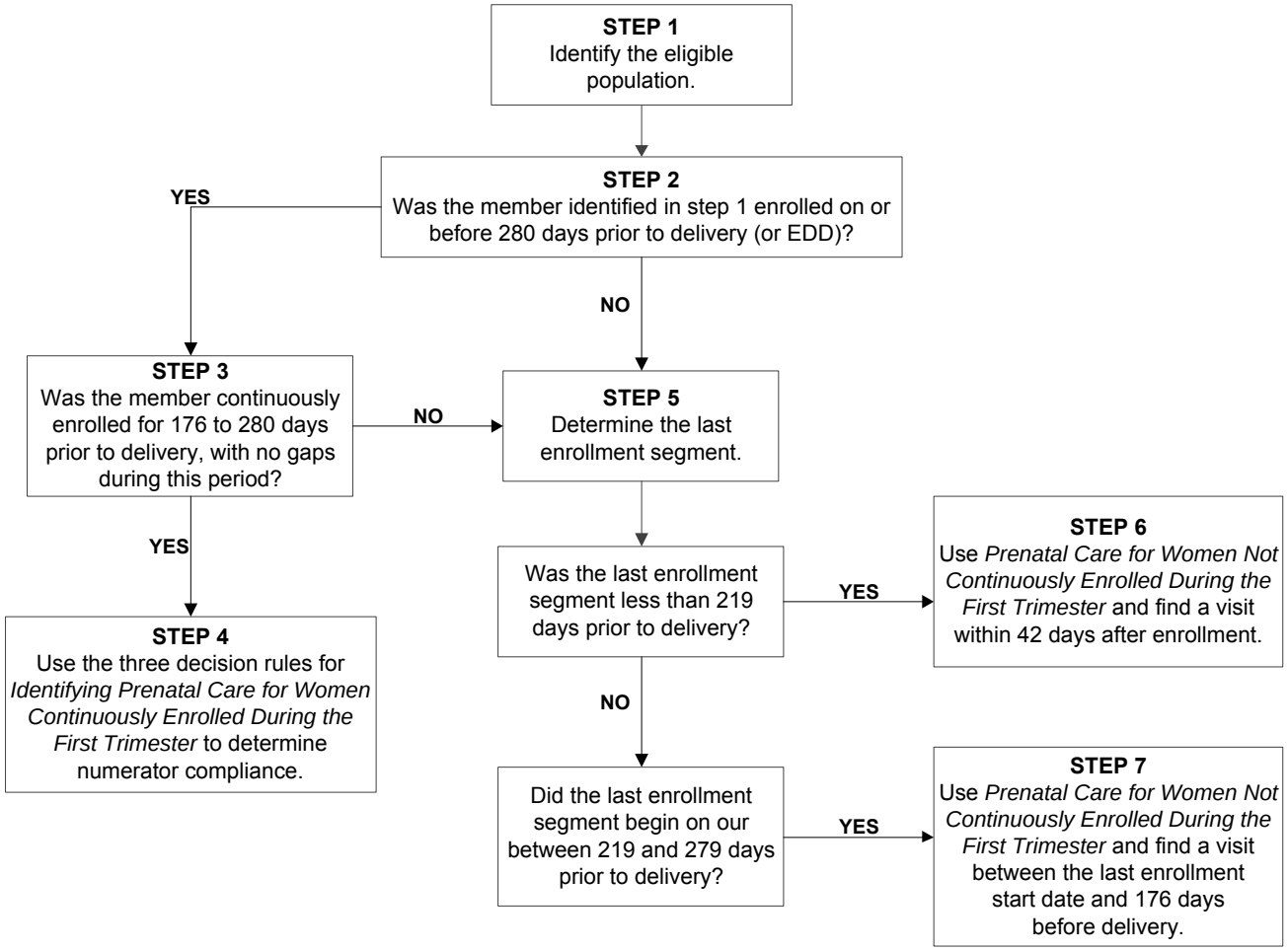
Note: *For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits Value Set)* ***and*** *a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.*

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

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

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

Note: *For criteria that require a prenatal visit code (Prenatal Visits Value Set) and a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.*



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

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

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

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators. .

Numerator

Timeliness of Prenatal Care A prenatal visit in the first trimester 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 (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Echography of a pregnant uterus.
- Documentation of LMP or EDD in conjunction with *either* of the following.
  - Prenatal risk assessment and counseling/education.
  - Complete obstetrical history.

Note: *For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal 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 linked to an office visit with an appropriate practitioner in order to count for this measure.*
- *The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently.*
- *A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.*
- *Refer to Appendix 1 for the definition of* PCP *and* OB/GYN *and other prenatal practitioners.*
- *The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*

Data Elements for Reporting

Organizations must provide the following data elements.

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

	Administrative	Hybrid
Measurement year	*For each of the 2 rates*	*For each of the 2 rates*
Data collection methodology (Administrative or Hybrid)	*For each of the 2 rates*	*For each of the 2 rates*
Eligible population	*For each of the 2 rates*	*For each of the 2 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*For each of the 2 rates*
Current year's administrative rate (before exclusions)		*For each of the 2 rates*
Minimum required sample size (MRSS) or other sample size		*For each of the 2 rates*
Oversampling rate		*For each of the 2 rates*
Final sample size (FSS)		*For each of the 2 rates*
Number of numerator events by administrative data in FSS		*For each of the 2 rates*
Administrative rate on FSS		*For each of the 2 rates*
Number of original sample records excluded because of valid data errors		*For each of the 2 rates*
Number of employee/dependent medical records excluded		*For each of the 2 rates*
Records added from the oversample list		*For each of the 2 rates*
Denominator		*For each of the 2 rates*
Numerator events by administrative data	*For each of the 2 rates*	*For each of the 2 rates*
Numerator events by medical records		*For each of the 2 rates*
Reported rate	*For each of the 2 rates*	*For each of the 2 rates*
Lower 95% confidence interval	*For each of the 2 rates*	*For each of the 2 rates*
Upper 95% confidence interval	*For each of the 2 rates*	*For each of the 2 rates*

Relative Resource Use for People With Diabetes (RDI)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report only the data elements necessary to calculate the Inpatient Facility Index.

Description

The relative resource use by members with diabetes during the measurement year.

Eligible Population

Note: *Organizations must report the quality measure (CDC) when reporting RDI.*

Product lines	Commercial, Medicaid, Medicare, Marketplace (report each product line separately).
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. Organizations must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *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 two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set). *Pharmacy data.* Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year, on an ambulatory basis (Table CDC-A).

Exclusions *(optional)*

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

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

Note: *If the optional exclusions are applied for the CDC measure, they must be applied for the RDI measure. If the optional exclusions are not applied for the CDC measure, they may not be applied to the RDI measure. Because RDI is administrative only, do not exclude members from this measure based on exclusions found during chart review for the CDC measure. Members must be included in RDI even if they are excluded during chart review for CDC.*

Exclusions *(required)*

Refer to Required Exclusions in the Guidelines for Relative Resource Use.

Categorization of Eligible Population

Major clinical condition	Diabetes.
Risk group	Refer to the *RRU Risk Adjustment* in the *Guidelines for Relative Resource Use.*

Standard Cost Calculations

The organization reports total standard costs of all services for which the organization has paid or expects to pay for the eligible population during the treatment period. Total standard costs are assigned by matching codes for services rendered to codes listed in the NCQA SPTs (the tables will be posted to NCQA's Web site by November 3, 2014).

Apply standard price	SPTs categorize services as Inpatient Facility. Count all services listed in the SPTs rendered to members in the eligible population during the treatment period. Refer to the *Calculating Standard Cost* instructions in the *Guidelines for Relative Resource Use* for steps on categorizing services and linking service data to NCQA's SPTs.
Calculate total cost	Sum the total standard cost for each eligible member. Within each service category, if a member's standard cost exceeds the service category cap amount, report the total standard cost specified in the NCQA Cost Cap Amounts table (released with the SPTs). Sum and report the total standard cost for the eligible population in each service category by member cohort.

Service Frequency Calculations

Total frequency of service

Service frequency counts are reported for all services for which the organization has paid or expects to pay for the eligible population during the treatment period. An organization reports each eligible member's services rendered during the treatment period for the following utilization categories:

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

Inpatient Facility

This category measures the number of acute and nonacute inpatient facility discharges and days regardless of diagnosis. Count each discharge once. Include data from any institution that provides acute or long-term/specialty nonacute care.

Refer to the *Guidelines for Relative Resource Use* to identify acute inpatient (including medicine and surgery) and nonacute discharges and days.

Data Elements for Reporting

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

Table RDI-A-4: Data Elements for Relative Resource Use for People With Diabetes

Metadata ID	Metadata Specification Name
EligiblePopulation	Eligible Population
Exclusions	Exclusions

Table RDI-B-4: Data Elements for Relative Resource Use for People With Diabetes

Gender	Age	Risk Group	Type	Metric Specification Name
Male	18-44	1	Cost	Inpatient Facility
Female	45-54	2	Count	Inpatient Facility: Acute Inpatient: Medical Days
	55-64	3	Count	Inpatient Facility: Acute Inpatient: Medical Discharges
	65-75	4	Count	Inpatient Facility: Acute Inpatient: Surgery Days
		5	Count	Inpatient Facility: Acute Inpatient: Surgery Discharges
		6	Count	Inpatient Facility: Nonacute: Days
		7	Count	Inpatient Facility: Nonacute: Discharges
		8	Mem	Member Months Medical

Table RDI-C-1/2/3: Data Elements for Relative Resource Use for People With Diabetes

Data Element
Eligible Population
Exclusions
Eligible Population per 1,000 MY Medical
Inpatient Facility PMPM
Inpatient Facility: Acute Inpatient: Medical Days per 1,000 MY
Inpatient Facility: Acute Inpatient: Medical Discharges per 1,000 MY
Inpatient Facility: Acute Inpatient: Surgery Days per 1,000 MY
Inpatient Facility: Acute Inpatient: Surgery Discharges per 1,000 MY
Inpatient Facility: Nonacute Days per 1,000 MY
Inpatient Facility: Nonacute Discharges per 1,000 MY
Inpatient Facility Acute Medical ALOS
Inpatient Facility Acute Surgery ALOS
Inpatient Facility Nonacute ALOS
Total Inpatient Facility Acute ALOS
Total Inpatient Facility ALOS

Note: *This table indicates the calculated fields that NCQA provides for the age-gender-risk totals.*

Use of Imaging Studies for Low Back Pain (LBP)

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 – (numerator/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 outpatient or ED encounter with a primary diagnosis of low back pain.

IESD Index Episode Start Date. The earliest date of service for an outpatient or ED encounter during the Intake Period with a principal diagnosis of low back pain.

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

Product line Commercial, Medicaid, Marketplace (report each product line separately).

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 Outpatient or ED visit with a primary diagnosis of low back pain. 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 low back pain (Low Back Pain Value Set).
- Observation visit (Observation Value Set), with a principal diagnosis of low back pain (Low Back Pain Value Set).

- ED visit (ED Value Set), with a principal diagnosis of low back pain (Low Back Pain Value Set). Do not include ED visits that result in an inpatient admission.
- Osteopathic manipulative treatment (Osteopathic Manipulative Treatment Value Set), with a principal diagnosis of low back pain (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 low back pain (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).
- *Recent trauma.* Trauma (Trauma Value Set) any time during the 12 months (1 year) 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.

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 low back pain (Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Data Elements for Reporting

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

Table LBP-4: Data Elements for Use of Imaging Studies for Low Back Pain

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

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

Description

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

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

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

Definitions

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
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

Product lines	Commercial, Medicaid, Marketplace (report each product line separately).
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 the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

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

For adolescents 16–17 years of age on the date of service, a BMI value (BMI Value Set) also meets criteria.

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

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

Exclusions *(optional)*

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 current year's administrative 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 must be from the same data source.

Either of the following meets criteria for BMI percentile:

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

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

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

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile or value, if applicable, is required for numerator compliance. 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 the 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 for 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 or BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to an acute or chronic condition do not count toward the "Counseling for nutrition" and "Counseling for physical activity" indicators.*
- *Refer to Appendix 1 for the definition of* PCP *and* OB/GYN practitioner.

Data Elements for Reporting

Organizations that submit QRS HEDIS 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

	Administrative	Hybrid
Measurement year	*Each of the 3 rates*	*Each of the 3 rates*
Data collection methodology (Administrative or Hybrid)	*Each of the 3 rates*	*Each of the 3 rates*
Eligible population	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 3 rates, for each age stratification and total*
Current year's administrative rate (before exclusions)		*Each of the 3 rates, for each age stratification and total*
Minimum required sample size (MRSS) or other sample size		*Each of the 3 rates*
Oversampling rate		*Each of the 3 rates*
Final sample size (FSS)		*Each of the 3 rates*
Number of numerator events by administrative data in FSS		*Each of the 3 rates, for each age stratification and total*
Administrative rate on FSS		*Each of the 3 rates, for each age stratification and total*
Number of original sample records excluded because of valid data errors		*Each of the 3 rates*
Number of administrative data records excluded		*Each of the 3 rates*
Number of medical records excluded		*Each of the 3 rates*
Number of employee/dependent medical records excluded		*Each of the 3 rates*
Records added from the oversample list		*Each of the 3 rates*
Denominator		*Each of the 3 rates, for each age stratification and total*
Numerator events by administrative data	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Numerator events by medical records		*Each of the 3 rates, for each age stratification and total*
Reported rate	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Lower 95% confidence interval	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Upper 95% confidence interval	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

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

Product lines	Commercial, Medicaid, Marketplace (report each product line separately).
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 (Well-Care Value Set) 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 QRS HEDIS 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

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

2016 and 2017 QRS HEDIS Measure Specifications

(Alphabetical Order)

Adult BMI Assessment (ABA)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

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.

Antidepressant Medication Management (AMM)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

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.

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

Aspirin Use and Discussion (ASP)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- This measure is collected using QHP Enrollee Survey. Marketplace organizations should refer to http://qhpcahps.cms.govt for the complete QRS survey measure set, including the data collection protocols related to the QHP Enrollee Survey.

Description

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

Aspirin Use

A rolling average represents the percentage of members who are currently taking aspirin. A single rate is reported, for which the denominator includes:

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

Discussing Aspirin Risks and Benefits

A rolling average represents the percentage of members who discussed the risks and benefits of using aspirin with a doctor or other health provider. A single rate is reported, for which the denominator includes:

- Women 56–79 years of age.
- Men 46–79 years of age.

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

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

Description

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

Breast Cancer Screening (BCS)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2017.

Description

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

Childhood Immunization Status (CIS)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- Marketplace organizations must report only the following indicator: Combination 3 (and all associated antigens).

Description

The percentage of children 2 years of age who meet criteria for combo 3: 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); and four pneumococcal conjugate (PCV); by their second birthday. The measure calculates a rate for each vaccine and 1 combination rate.

Colorectal Cancer Screening (COL)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

Description

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

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

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

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.

- *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.
- *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.

Human Papillomavirus Vaccine for Female Adolescents (HPV)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.

Description

The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Immunizations for Adolescents (IMA)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- Only Combination 1 and related antigens will be used for QRS reporting and scoring.

Description

The percentage of adolescents 13 years of age who meet the criteria for combo 1: one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- This measure is collected using QHP Enrollee Survey. Marketplace organizations should refer to http://qhpcahps.cms.govt for the complete QRS survey measure set, including the data collection protocols related to the QHP Enrollee Survey.

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.

Medication Management for People With Asthma (MMA)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- Marketplace organizations report the Medication Compliance 75% indicator only.

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.

Plan All-Cause Readmissions (PCR)

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- Marketplace organizations report only members 18–64 years of age

Description

For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS) (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission.

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

QRS SPECIFIC GUIDANCE

- Marketplace organizations must report this measure beginning in 2016.
- Only the *Six or more well-child visits* indicator will be scored for the QRS.

Description

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- Six or more well-child visits.

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. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.

	• An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).
OB/GYN and other prenatal care practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology. • Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).
PCP	Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
Prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
Primary care physician	Includes: • General or family practice physicians. • Geriatricians. • General internal medicine physicians. • General pediatricians. • Obstetricians/gynecologists (OB/GYN).

Appendix 2

Data Element Definitions

APPENDIX 2
DATA ELEMENT DEFINITIONS

	Admin	Hybrid	Research	Meaning
Measurement year	✓	✓		Data year (i.e., year prior to reporting year). For HEDIS 2015, the measurement year is 2014.
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	✓	✓		• Members who meet all criteria for the population. This is the universe of members for each measure. • For administrative measures, the eligible population is 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.
Current year's administrative rate (before exclusions)		✓		This is a calculated field in IDSS. Numerator events by administrative data in eligible population ÷ eligible population.
Minimum required sample size (MRSS) or other sample size		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines.
Oversampling rate		✓		The percentage of additional records needed to replace exclusions and valid data errors in the denominator. The oversample is in 5% increments. Organizations that need more than a 20% oversample must contact NCQA.
Final sample size (FSS)		✓		Minimum required sample size + oversample.
Number of numerator events by administrative data in FSS		✓		Number of members in the final sample size who meet numerator criteria through system/ transactional data.
Administrative rate on FSS		✓		This is a calculated field in IDSS. Numerator events by administrative data in the FSS ÷ FSS.
Number of original sample records excluded because of valid data errors		✓		If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error.

	Admin	Hybrid	Research	Meaning
Number of administrative data records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using system or transactional data.
Number of records excluded because of false positive diagnoses*			✓	This is an optional data element in *Controlling High Blood Pressure*. NCQA will analyze the exclusion criteria. Organizations may choose to report their exclusions using this element, but this element will only be used for analysis and not for calculating the measure.
Number of medical records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using medical record data.
Number of employee/dependent medical records excluded		✓		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee.
Exclusions			✓	The number of required/optional exclusions. NCQA will use this element for research and analysis. The element will not be used for calculating the measure.
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error.
Denominator		✓		MRSS – exclusions + members added from the auxiliary list. This population is the denominator used to report the measure.
Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using system or transactional data.
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. *Administrative Method:* Numerator events by administrative data/ eligible population *Hybrid Method*: Numerator events by administrative data + numerator events by medical records/denominator.
Lower 95% confidence interval	✓	✓		The organization is 95% sure that the reported rate falls between this lower rate and the upper confidence interval. This is a calculated field in IDSS.
Upper 95% confidence interval	✓	✓		The organization is 95% sure that the reported rate falls between this higher rate and the lower confidence interval. This is a calculated field in IDSS.

*Data element is optional.

Standard Administrative Data Element Table

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

Standard Hybrid Data Element Table

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

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

3.2 PQA Measure Specifications

Overview

Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to improving health care quality and patient safety with a focus on the appropriate use of medications and development of strategies for measuring and reporting performance related to medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 150 member organizations. The mission of PQA is to improve the quality of medication management and use across healthcare settings with the goal of improving patients' health through a collaborative process to develop and implement performance measures and recognize examples of exceptional pharmacy quality.

PQA Measure Development Process

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

PQA develops performance measures through a consensus-driven process to draft, test, refine and endorse measures of medication-use quality.

Step 1: PQA workgroups comprised of experts in all phases of drug use and management identify measure concepts that may be appropriate for development into fully specified performance measures or indicators for organizational internal quality improvement. The workgroups focus on specific aspects of the medication-use system and/or specific therapeutic areas.

Step 2: PQA workgroups recommend measure concepts to the PQA Quality Metrics Expert Panel (QMEP) for evaluation and refinement. The QMEP reviews the measure concepts to provide an initial assessment of the key properties of performance measures (i.e., feasibility, usability and scientific validity). The measure concepts that are rated highly on these key properties will undergo technical specification as draft measures.

Step 3: The draft measures are provided to PQA member organizations for their comments prior to preparing technical specifications for pilot testing. PQA staff use member comments and workgroup and QMEP recommendations to formulate a testing plan for each draft measure.

Step 4: PQA selects partners to test the draft measures. These partners are often PQA member health plans or academic institutions with expertise in quality and performance measure testing. The testing partner implements the draft technical specifications within their existing datasets and provides a report to PQA that details testing results and recommendations for modifications of the technical specifications.

Step 5: The workgroup that developed the measure reviews the testing results and provides comment. The QMEP reviews the workgroup comments, testing results, recommendations and potential modifications and provides a final assessment of the feasibility and scientific validity of the draft performance measures.

Step 6: Measures that are recommended by the QMEP for endorsement are posted on the PQA web site for member review, written comments are requested, and a conference call for member organizations is held to gather feedback and address any questions. This process allows members to discuss their views on the measures in advance of the voting period.

Step 7: PQA member organizations vote on endorsement of the Performance Measures and approval of Quality Improvement Indicators.

General Guidelines for the *Proportion of Days Covered Measure* Data Collection

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

PQA Specific Guidelines for National Drug Codes Inclusion

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 http://pqaalliance.org/measures/qrs.asp.

- The NDC lists available in September 2014 will include NDCs that are current through May 31, 2014 and those NDCs with obsolete dates as noted in the PQA Specific Guidelines for National Drug Codes Inclusion.
- The final list of NDCs for 2014 will be available on November 3, 2014. That list will include current NDCs from January 1, 2014 through September 30, 2014 and NDCs with obsolete dates from July 1, 2013 through September 30, 2014.

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	*For each of the 3 rates*
Numerator events by administrative data	*For each of the 3 rates*
Reported rate	*For each of the 3 rates*
Lower 95% confidence interval	*For each of the 3 rates*
Upper 95% confidence interval	*For each of the 3 rates*

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.

Report a rate for each of the following:

- Renin Angiotensin System (RAS) Antagonists
- Diabetes All Class
- Statins

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for the target medication between January 1 and September 30 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 90 days long.
PDC	Proportion of days covered. The number of days that a patient is covered by prescription claims for the same medication or another in its therapeutic category, divided by the number of days in the treatment period.
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	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. 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. 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. 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 last day of the treatment period.
Continuous enrollment	*Treatment period:* The IPSD through the end of the measurement year or until death or disenrollment from the health plan. Exclude disenrolled members who re-enroll after a valid treatment period but before the end of the measurement year. *Note: Do not include members who disenroll and reenroll more than one day later at any time during the measurement year, after the treatment period.*
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Benefit	Pharmacy.

Administrative Specification

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

Rate 1: Renin Angiotensin System (RAS) Antagonists

Additional eligible population criteria	Patients who filled at least two prescriptions for a RAS Antagonist: ACEI/ARB/Direct Renin Inhibitor or ACEI/ARB/Direct Renin Inhibitor Combination (Table PDC-B: RAS Antagonists) on different dates of service during the treatment period.

Table PDC-B: Renin Angiotensin System (RAS) Antagonists

Direct Renin Inhibitor Medications	ARB Medications	ACE Inhibitor Medications	ACE Inhibitor Combination Products	ARB Combination Products	Direct Renin Inhibitor Combination Products
• aliskiren	• candesartan • eprosartan • irbesartan • losartan • olmesartan • telmisartan • valsartan • azilsartan	• benazepril • captopril • enalapril • fosinopril • lisinopril • moexipril • perindopril • quinapril • ramipril • trandolapril	• amlodipine & benazepril • benazepril & HCTZ • captopril & HCTZ • enalapril & HCTZ • fosinopril & HCTZ • lisinopril & HCTZ • moexipril & HCTZ • quinapril & HCTZ • trandolapril-verapamil HCL	• candesartan & HCTZ • eprosartan & HCTZ • telmisartan & amlodipine • irbesartan & HCTZ • losartan & HCTZ • amlodipine & olmesartan • azilsartan & chlorthalidone • olmesartan & HCTZ • telmisartan & HCTZ • aliskiren & valsartan • olmesartan & amlodipine & HCTZ • valsartan & HCTZ • amlodipine & valsartan • amlodipine & valsartan & HCTZ	• aliskiren & amlodipine • aliskiren & amlodipine & HCTZ • aliskiren & HCTZ • aliskiren & valsartan

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

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

Step 1 Determine the treatment period.

Step 2 Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, adjust the prescription start date to be the day after the previous fill has ended.*

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4 Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

* Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and the NDC specifications, RASA tab.

Rate 2: Diabetes medications

Additional eligible population criteria Patients who filled at least two prescriptions for any of the diabetes medications listed in Tables PDC-D, PDC-E, PDC-F, PDC-G, PDC-J, PDC-K, or PDC-L on different dates of service during the treatment period.

Required Exclusions Patients who have one or more prescriptions for insulin in the treatment period (refer to Table PDC-H)

Table PDC-D: Biguanide Medications

Biguanides	Biguanide & Sulfonylurea Combination Products	Biguanide & Thiazolidinedione Combination Products	Biguanide & Meglitinide Combinations	Biguanide & DPP-IV Inhibitor Combinations
• metformin	• glipizide & metformin • glyburide & metformin	• rosiglitazone & metformin • pioglitazone & metformin	• repaglinide & metformin	• sitagliptin & metformin IR & SR • saxagliptin & metformin SR • linagliptin & metformin • alogliptin & metformin

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

Table PDC-E: Sulfonylurea Medications

Sulfonylureas	Sulfonylurea & Biguanide Combination Products	Sulfonylurea & Thiazolidinedione Combination Products
• chlorpropamide • glimepiride • glipizide • glyburide • tolazamide • tolbutamide	• glipizide & metformin • glyburide & metformin	• rosiglitazone & glimepiride • pioglitazone & glimepiride

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

Table PDC-F: Thiazolidinedione Medications

Thiazolidinediones	Thiazolidinedione & Biguanide Combination Products	Thiazolidinedione & Sulfonylurea Combination Products	Thiazolidinedione & DPP IV Inhibitor Combination Products
• pioglitazone • rosiglitazone	• rosiglitazone & metformin • pioglitazone & metformin	• rosiglitazone & glimepiride • pioglitazone & glimepiride	• alogliptin & pioglitazone

Note: Active ingredients are limited to oral formulations only.

Table PDC-G: DPP-IV Inhibitor Medications

DPP-IV Inhibitors	DPP-IV Inhibitor Combination Products
• sitagliptin • linagliptin • saxagliptin • alogliptin	• sitagliptin & metformin IR & SR • saxagliptin & metformin SR • sitagliptin & simvastatin • linagliptin & metformin • alogliptin & metformin • alogliptin & pioglitazone

Note: Active ingredients are limited to oral formulations only.

Table PDC-J: Incretin Mimetic Agents

Incretin Mimetic Agents
• exenatide • albiglutide • liraglutide

Table PDC-K: Meglitinides

Meglitinides
• nateglinide • repaglinide • repaglinide & metformin

Note: Active ingredients are limited to oral formulations only

Table PDC-L: Sodium glucose co-transporter2 (SGLT2) inhibitors

SGLT2 Inhibitors
• canagliflozin • dapagliflozin

Note: Active ingredients are limited to oral formulations only

Table PDC-H: Insulins (Exclusion Table)

Human Insulins
• insulin aspart • insulin aspart Protamine & Aspart • insulin detemir • insulin glargine • insulin glulisine • insulin isophane & regular human insulin • insulin isophane (human N) • insulin lispro • insulin lispro Protamine & Insulin lispro • insulin regular (human R)

Note: The active ingredients are limited to 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.

Step 1 Determine the treatment period.

Step 2 Within the treatment period, count the days the patient was covered by at least one drug from any of the diabetes drugs listed in PDC Tables D-G, J, K or L based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4 Count the number of patients who had a PDC greater than 80 percent.

* Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, Diabetes tab.

Rate 3: Statins

Additional eligible population criteria Patients who filled at least two prescriptions for a statin or statin combination (Table PDC-I: Statin Medications) on different dates of service during the treatment period.

Table PDC-I: Statin Medications

Statin Medications	Statin Combination Products
• lovastatin	• niacin & lovastatin
• rosuvastatin	• atorvastatin & amlodipine
• fluvastatin	• niacin & simvastatin
• atorvastatin	• sitagliptin & simvastatin
• pravastatin	• ezetimibe & simvastatin
• pitavastatin	• ezetimibe & atorvastatin
• simvastatin	

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

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

Step 1 Determine the treatment period.

Step 2 Within the treatment period, count the days the patient was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended.*

Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each patient.

Step 4 Count the number of patients who had a PDC of 80% or greater and then divide by the total number of eligible patients.

* Adjustment of overlap should also occur when there is overlap of a single drug product to a combination product containing the single target drug or when there is an overlap of a combination product to another combination product where at least the target drug is common. Please refer to the definition for *Calculating number of days covered for the numerator* and to the NDC specifications, Statins tab.

4. QRS Survey Measure Specifications

4.1 QRS Survey Measure Descriptions

4.1 QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures[13] that will be collected as part of the QHP Enrollee Survey. The QHP Enrollee Survey is largely based on items from the CAHPS® Surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to CMS' Health Insurance Marketplace Quality Initiatives website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html.

Additional details related to the QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey website at http://qhpcahps.cms.gov.

QRS Survey Measure Descriptions

Access to Care

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

1. Got care for illness/injury as soon as needed
2. Got non-urgent appointment as soon as needed
3. Easy to get care after regular office hours
4. How often it was easy to get necessary care, tests, or treatment
5. Got appointment with specialists as soon as needed

Access to Information

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

1. Written materials or Internet provided information needed about how plan works
2. Found out from health plan about cost for health care service or equipment
3. Found out from health plan about cost for specific prescriptions

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[13] The following QRS survey measures are HEDIS® measures and are addressed in Section 3.1's NCQA Measure Specifications: Aspirin Use and Discussion; Flu Vaccinations for Adults Ages 18-64; Medical Assistance with Smoking Cessation.

Care Coordination

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

1. Doctor seemed informed and up-to-date about care from other health providers
2. Doctor had your medical records
3. Doctor followed up about blood test, x-ray results
4. Got blood test, x-ray results as soon as you needed them
5. Doctor talked about prescription drugs you are taking
6. Got help you needed from doctor's office to manage your care among different providers

Cultural Competence

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

1. How often got an interpreter
2. Forms available in preferred language
3. Forms available in preferred format, such as large print or braille

Plan Administration

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

1. Customer service gave necessary information/help
2. Customer service staff courteous and respectful
3. Wait-time to talk to customer service took longer than expected
4. Forms were easy to fill out
5. Health plan explained purpose of forms

Rating of All Health Care

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

1. Rating of all health care

Rating of Health Plan

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

1. Rating of health plan

Rating of Personal Doctor

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

1. Rating of personal doctor

Rating of Specialist

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

1. Rating of specialist