

Health Insurance Exchange

2022 Quality Rating System Measure Technical Specifications

October 2021

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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Technical Assistance and Contact Information

The following links and contact information should be used to obtain additional details and technical assistance related to the Quality Rating System (QRS) measure set for 2022 (Measurement Year 2021).

Website Links

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

Contact Information

- For questions regarding the QRS clinical measure specifications, please contact the appropriate measure steward:
 - NCQA for the HEDIS® measures: via the Policy Clarification Support (PCS) system available at <https://my.ncqa.org/>
 - Pharmacy Quality Alliance (PQA) for the PQA measures: <https://www.pqaalliance.org/QRS>
- For questions regarding the general guidelines for data collection, please contact NCQA via the PCS system available at <https://my.ncqa.org/>
- For questions regarding QRS survey measures, the QHP Enrollee Survey, or QRS requirements, please contact the Marketplace Service Desk (MSD) via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515 (1-855-267-1515). Reference the “Marketplace Quality Initiative (MQI)-QRS”.

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

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1. Introduction

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Introduction

Document Purpose

This document includes the measure specifications and guidelines for data collection for the 2022 QR) measure set. Qualified Health Plan (QHP) issuers will need to reference this document in order to collect and submit QRS measure data to the CMS in accordance with the QRS 2022 requirements. The document specifically details the following:

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

Beginning with the 2022 ratings year, CMS is aligning with the new NCQA HEDIS timeline and publishing the 2022 QRS Measure Technical Specifications in spring 2021. Prior to the 2022 ratings year, CMS published the annual QRS Measure Technical Specifications in the fall alongside the annual QRS and QHP Enrollee Survey Technical Guidance.

The annual timeline for finalizing the QRS measure set is shown in Exhibit 1.

Exhibit 1. Annual Timeline for Finalizing the QRS Measure Set

Date	Description
February	Publication of Draft Call Letter: CMS proposes changes to the QRS and QHP Enrollee Survey program operations and provides stakeholders with the opportunity to submit feedback via a 30-day public comment period. The Draft Call Letter may propose the addition or removal of measures from the QRS measure set for the upcoming ratings year (e.g., the Draft 2021 Call Letter includes proposed measure set changes for the 2022 QRS measure set).
March	Publication of QRS Measure Technical Specifications: CMS provides measure specifications for all potential measures in the QRS measure set (i.e., any measures proposed for addition and removal in the Draft Call Letter).
May	Publication of Final Call Letter: CMS communicates final changes to the QRS and QHP Enrollee Survey program operations and addresses the themes of public comment. CMS will finalize the measure set changes proposed in the Draft Call Letter for the upcoming ratings year.
August/September	Publication of QRS and QHP Enrollee Survey Technical Guidance: CMS provides technical guidance regarding data collection, data validation, and data submission for the QRS and QHP Enrollee Survey. CMS also finalizes the measure set for the ratings year. The final measure set will align with measure changes proposed in the Final Call Letter.

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. This document includes the measure specifications for all potential measures in the 2022 QRS measure set (i.e., any measures proposed for addition and removal in the *Draft 2021 Call Letter for the QRS and QHP Enrollee Survey* [Draft 2021 Call Letter]).²

² The Draft 2021 Call Letter for the QRS and QHP Enrollee Survey is available at: <https://www.cms.gov/files/document/draft-2021-call-letter-qrs-qhp-enrollee-survey.pdf>

1. Introduction

In the fall of 2021, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2022* (2022 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the *Final 2021 QRS and QHP Enrollee Survey Call Letter* (Final 2021 Call Letter). The 2022 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2022 QRS ratings year. The 2022 QRS and QHP Enrollee Survey Technical Guidance and *Final 2022 QRS and QHP Enrollee Survey Call Letter* will be posted to the CMS Marketplace Quality Initiative (MQI) website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page>).

Background

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

Finalized Data Submission Requirements for the 2022 Ratings Year

In May 2021, CMS published the [Final 2021 Call Letter](#) which announced finalized changes proposed to the QRS measure set for 2022. CMS has updated this document, the *2022 QRS Measure Technical Specifications*, to provide guidance on the finalized data submission requirements for the 2022 ratings year. Specifically, CMS has added callout boxes summarizing the final decision regarding measures and/or measure rates proposed for addition and those proposed for removal in the Draft 2021 Call Letter. The final decisions for the QRS measure set for 2022 include:

- CMS finalized the transition from the *Childhood Immunization Status (Combination 3)* to the *Childhood Immunization Status (Combination 10)* measure
- CMS finalized the removal of the *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure
- CMS did not finalize the transition from the *Comprehensive Diabetes Care: HbA1c Control (<8%)* to the *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* measure
- CMS finalized the transition from the *Follow-up After Hospitalization for Mental Illness (7-Day Follow-up)* to the *Follow-up After Hospitalization for Mental Illness (7-Day Follow-up and 30-Day Follow-up)*

For more details on the final 2022 QRS measure set, please refer to the [2022 QRS and QHP Enrollee Survey Technical Guidance](#).

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

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

2. QRS Measure Set

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QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 2 includes the list of all potential QRS measures for 2022 as proposed in the Draft 2021 Call Letter. Measures denoted with a caret (^) are under consideration for retirement or removal from the QRS measure set. If these measures are removed as proposed, they will not be collected for the 2022 ratings year. Measures denoted with an asterisk (*) are under consideration for addition to the QRS measure set. If these measures are finalized as proposed, they will be required for 2022 QRS data collection but will not be included in 2022 QRS scoring. CMS will communicate final changes to the 2022 QRS measure set in the Final 2021 Call Letter, which CMS anticipates publishing in late spring of 2021.

The measure set includes a subset of NCQA's HEDIS measures and PQA measures. The survey measures in the QRS measure set will be collected as part of the QHP Enrollee Survey, which is largely based on items from the Consumer Assessment of Healthcare Providers and Systems⁵ (CAHPS®) surveys. For a crosswalk that maps each QRS survey measure to the relevant QHP Enrollee Survey item(s), refer to the annual QRS and QHP Enrollee Survey: Technical Guidance.

Some measures have multiple indicators (or rates). QHP issuers are required to collect and submit validated data for every indicator associated with a measure, unless a specific indicator is shown in parentheses next to the measure, in which case only the indicator must be reported (e.g., for *Immunizations for Adolescent [Combination 2]*, only Combination 2 must be reported).

Exhibit 2. Proposed 2022 QRS Measures

Measure Title	Measure Steward	National Quality Forum (NQF) ID ⁶
QRS Clinical Measures		
Annual Dental Visit	NCQA	1388
Annual Monitoring for Persons on Long-term Opioid Therapy	PQA	3541
Antidepressant Medication Management	NCQA	0105
Appropriate Testing for Pharyngitis	NCQA	0002
Appropriate Treatment for Upper Respiratory Infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Avoidance of Antibiotic Treatment for with Acute Bronchitis/Bronchiolitis	NCQA	0058
Breast Cancer Screening	NCQA	2372
Cervical Cancer Screening	NCQA	0032
Child and Adolescent Well-Care Visits	NCQA	N/A
Childhood Immunization Status (Combination 3) [^]	NCQA	0038
Childhood Immunization Status (Combination 10) [*]	NCQA	0038
Chlamydia Screening in Women	NCQA	0033
Colorectal Cancer Screening	NCQA	0034
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	0055
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) [^]	NCQA	0575
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) [*]	NCQA	0059
Comprehensive Diabetes Care: Medical Attention for Nephropathy [^]	NCQA	0062
Controlling High Blood Pressure	NCQA	0018

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

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

2. QRS Measure Set

Measure Title	Measure Steward	National Quality Forum (NQF) ID ⁶
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up) [^]	NCQA	0576
Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up and 30- Day Follow-Up)*	NCQA	0576
Immunizations for Adolescents (Combination 2)	NCQA	1407
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	NCQA	0004
International Normalized Ratio Monitoring for Individuals on Warfarin	PQA	0555
Plan All-Cause Readmissions	NCQA	1768
Prenatal and Postpartum Care	NCQA	1517
Proportion of Days Covered	PQA	0541
Use of Imaging Studies for Low Back Pain	NCQA	0052
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024
Well-Child Visits in the First 30 Months of Life	NCQA	1392
QRS Survey Measures		
Access to Care	AHRQ, CMS	0006
Access to Information	AHRQ, CMS	0007
Care Coordination	AHRQ, CMS	0006
Flu Vaccinations for Adults Ages 18-64	NCQA	0039
Medical Assistance With Smoking and Tobacco Use Cessation	NCQA	0027
Plan Administration	AHRQ, CMS ⁷	0006
Rating of All Health Care	AHRQ	0006 ⁷
Rating of Health Plan	AHRQ	0006 ⁷
Rating of Personal Doctor	AHRQ	0006 ⁷
Rating of Specialist	AHRQ	0006 ⁷

⁷ Measure consists of CAHPS survey items and a survey item developed by CMS for purposes of the QHP Enrollee Survey.

3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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**Measurement Year 2021 (MY 2021)
HEDIS® General Guidelines for the
QRS Measure Technical
Specifications**

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HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided “as is” without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications.

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

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

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes (“UB”) contained in the measure specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. All uses of the UB Codes may require a license from the AHA. Anyone desiring to use the UB Codes in a commercial Product(s) to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.

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Overview

HEDIS MY 2021

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

How HEDIS Is Developed

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

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

This publication contains specifications for Measurement Year 2021 (MY 2021). MY 2021 refers to the 2021 calendar year and data that is reported on June 15, 2022.

Please note that this publication includes the specifications for measures and/or measure rates that are proposed for inclusion in the 2022 QRS measure set in the Draft 2021 Call Letter. Please reference the Final 2021 Call Letter, anticipated April-May 2021, for finalized changes.

The 2022 QRS and QHP Enrollee Survey Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2022 ratings year. CMS anticipates publishing 2022 QRS and QHP Enrollee Survey Guidance in fall 2021.

- Revised measures** For specific revisions, refer to each measure’s *Summary of Changes*. Please refer to the Final 2021 Call Letter or 2022 QRS and QHP Enrollee Survey Guidance for data submission requirements for the 2022 ratings year.
- Added the HbA1c Poor Control (>9.0%) indicator to the *Comprehensive Diabetes Care (CDC)* measure.
 - Added the 30-Day Follow-up indicator to the *Follow-up After Hospitalization for Mental Illness (FUH)* measure.
 - Added hepatitis A, rotavirus, influenza and Combination 10 indicators to the *Childhood Immunization Status (CIS)* measure.

Additional Resources

QRS and QHP Enrollee Survey Technical Guidance

Technical specification updates. The CMS publishes guidance for QHP in the Exchanges to specify requirements for participating in the QRS, including the clinical and survey measures that must be reported. The *2022 QRS and QHP Enrollee Guidance* will be posted to the CMS MQI website in fall 2021 (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page>).

NCQA will freeze the specifications on March 31, 2021, with the release of the *MY 2021 HEDIS for QRS Technical Update*:

- **The HEDIS for QRS Technical Update memo** will be posted to the NCQA website (www.ncqa.org).
- The following are available for free order in the NCQA Store. Once ordered, they will be made available in the My Downloads section of My NCQA on March 31, 2021.
 - **MY 2021 Quality Rating System (QRS) HEDIS Value Set Directory:** <https://store.ncqa.org/my-2021-quality-rating-system-qrs-hedis-value-set-directory.html>
 - **HEDIS MY 2021 Medication List Directory:** <https://store.ncqa.org/hedis-my-2021-medication-list-directory.html>
 - **HEDIS MY 2021 Risk Adjustment Tables:** <https://store.ncqa.org/hedis-my-2021-risk-adjustment-tables.html>

Referring to HEDIS Measures and Rates

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

Specifically, for *unadjusted* measures:

- Refer to all *unadjusted* HEDIS measures as “**Health plan HEDIS measures.**”
- Calculated measure results (“rates”) based on *unadjusted* HEDIS specifications that *have not* been certified through NCQA’s Measure Certification Program™ may not be called “Health Plan HEDIS Rates” until they are audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Refer to these rates as “**Uncertified, Unaudited Health Plan HEDIS Rates.**”
- Calculated measure rates that are based on *unadjusted* HEDIS specifications that *have* been certified through NCQA’s Measure Certification Program may not be called “Health Plan HEDIS Rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Refer to these rates as “**Unaudited Health Plan HEDIS rates.**”

Specifically, for *adjusted* measures pursuant to NCQA’s Rules for Allowable Adjustment of HEDIS:

- Refer to all *adjusted* HEDIS measures as “**Adjusted HEDIS measures.**”
- Calculated measure rates that are based on *adjusted* HEDIS specifications that *have not* been certified through NCQA’s Measure Certification Program may not be called “Adjusted HEDIS Rates” until they are audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Refer to these rates as “**Adjusted, Uncertified, Unaudited HEDIS Rates.**”
- Calculated measure rates that are based on *adjusted* HEDIS specifications that *have* been certified through NCQA’s Measure Certification Program may not be called “Adjusted HEDIS Rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Refer to these rates as “**Adjusted, Unaudited HEDIS rates.**”

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

If You Have Questions About the Specifications or General Guidelines for Data Collection

Policy Clarification Support

NCQA provides different types of policy support to customers, including a function that allows customers to submit specific policy interpretation questions to NCQA staff through My NCQA at <https://my.ncqa.org>.

FAQs and Policy Updates

The FAQs and Policy Updates clarify HEDIS for QRS uses and specifications; and are posted to the NCQA website (www.ncqa.org) on the 15th of each month.

Reporting Hotline for Fraud and Misconduct

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

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

How to Report

- Toll-Free Telephone:
 - English-speaking USA and Canada: **844-440-0077** (not available from Mexico).
 - Spanish-speaking North America: **800-216-1288** (from Mexico, user must dial 001-800-216-1288).
- **Website:** <https://www.lighthouse-services.com/ncqa>.
- **Email:** reports@lighthouse-services.com (must include NCQA's name with the report).
- **Fax:** 215-689-3885 (must include NCQA's name with the report).

Reporting Data Errors to NCQA

Because audited HEDIS data are used to establish plans' Accreditation status in many state and federal programs, NCQA must be made aware of data problems in any previously reported rate. NCQA reserves the right to publicly display the information on the reported issue, including, but not limited to, the affected organization, the specific data error and the associated resolution. We will display the information on a dedicated public-facing webpage on the NCQA website (www.ncqa.org). NCQA may also revise affected products.

Organizations must immediately report any error in a measure rate or in its component (in any previous submission, regardless of timing) that is >5% higher or lower than what was reported originally. These should be reported to NCQA through PCS system via My NCQA (<https://my.ncqa.org>) by selecting Product/Program Type as HEDIS Audit and General Content Area as Data Errors. The report to NCQA must include:

Overview

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

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

General Guidelines for Data Collection

General Guidelines for Data Collection

These MY 2021 HEDIS for QRS General Guidelines for the *MY 2021 Quality Rating System Measure Technical Specifications* are unique to the issuers offering plans on the Exchanges and participating in the CMS Quality Rating System (QRS).^{1,2}

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to the guidelines.

MY 2021 HEDIS for QRS Data Collection

1. Exchange Product Line

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

2. Reporting Units (Product)

Organizations must collect HEDIS for QRS measure data for each product (i.e., EPO, HMO, POS, PPO) offered through an Exchange in 2022 that had more than 500 enrollees as of July 1 in the prior year (i.e., July 1, 2021) and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., January 1, 2022). Reporting units that are decertified or discontinued before June 15 of the ratings year (i.e., July 15, 2022) are exempt from QRS reporting requirements.

All enrollees in QHPs offered on an Exchange that provide family and/or adult-only medical coverage should be included (unless noted otherwise in the *MY 2021 Quality Rating System Measure Technical Specifications*). At this time, organizations should not include indemnity plans (i.e., fee for service plans), child-only plans, or stand-alone dental plans in the reporting unit. Organizations should not include any enrollees from health plans offered outside of the Exchange or non-QHPs. Non-QHPs are health plans that are offered outside of the Exchange and designated with a HIOS variant ID-00. Organizations should not include any enrollees from basic health plans (BHP).

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

Combining products into one reporting unit is not allowed.

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

²A QHP issuer has a certification issued by or recognized by an Exchange to demonstrate that each health plan offered in the Exchange is a QHP and meets the requirements described in 45 CFR 155.2. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIOS) Issuer ID. Each QHP issuer is defined by a State geographic unit. A QHP issuer must operate on an Exchange for at least one year before it is required to collect QRS measure data. Final rule—<https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and>

Definitions

EPO Exclusive provider organization. A type of health insurance product that usually limits coverage to care from providers, or groups of providers, who have contracts with the health insurance issuer to be part of a network of participating providers. EPO members will generally not be reimbursed or receive benefits for out-of-network services; however, some EPOs will provide partial reimbursement for emergency situations.

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

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

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

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

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

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

3. Minimum Enrollment Threshold

Organizations are required to submit data for each product offered through an Exchange in 2022 that had more than 500 enrollees as of July 1, 2021, and continues to have more than 500 enrollees as of January 1 of the ratings year (i.e., 2022).

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

Include SHOP and individual Exchange members in the same Exchange reporting unit (do not separate).

The NCQA HEDIS Compliance Audit™

The HEDIS Compliance Audit is required for all HEDIS for QRS measures in MY 2021, including the sample frame used to administer the QHP Enrollee Survey.

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

5. Audit Preparation

Contract with an audit firm. The organization requests an application for a HEDIS for QRS Audit from an NCQA Licensed Organization (www.ncqa.org/hedis-quality-measurement/data-reporting-services/hedis-compliance-audit-program) and is responsible for determining fees and entering into contracts. The first activity in audit preparation is contract execution. An organization contacts NCQA Licensed Organizations (LO) for bids and selects a firm to conduct the HEDIS audit.

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

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

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

Medical record review validation (MRRV). The medical record review (MRR) validation 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 *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization contracts with an NCQA Licensed Organization. <i>Contracting can occur after this date, but it could be difficult for organizations to meet all audit requirements if this doesn't occur by early October.</i>	October 1, 2021
Measure certification deadline.	October 1, 2021
Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor.	December 1, 2021
Audit visits (onside or remote) begin. Visits are not to be held prior to the start of the reporting year.	After January 1, 2022
Organization submits the completed current year’s Roadmap to the auditor. <i>The auditor must receive the Roadmap by January 31 or at least two weeks before the site visit, whichever is earlier.</i>	January 14–31, 2022
Auditor completes the survey sample frame validation. <i>This is only the date the sample frame must be approved. Approval in the Healthcare Organization Questionnaire (HOQ) must be done by the HOQ closing deadline.</i>	January 28, 2022
Organization completes and stops all nonstandard supplemental data collection and entry. <i>There are NO exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates.</i>	March 1, 2022
Auditor finalizes approval of all supplemental data. PSV for nonstandard supplemental data must not occur prior to March 1, unless the organization finished all supplemental data processes, collection and entry. <i>There are NO exceptions!</i>	March 31, 2022
Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year’s specifications.</i>	By April 15, 2022
Audit (onsite or remote) visits completed.	April 29, 2022
Preliminary rate review is completed by the auditor. <i>NCQA encourages preliminary rate review to take place earlier in the audit process.</i>	By April 29, 2022

HEDIS AUDIT TIMELINE	
Task	NCQA Deadline
Organization completes the medical record abstraction process for all measures and sends the final numerator-compliant counts for all measures and exclusions for MRRV. <i>There are NO exceptions! Failure to meet this deadline could result in inability to use medical record data to report rates.</i>	May 6, 2022
Auditor picks measures from each measure group and all exclusions, selects 16 records from each for MRRV review and informs the organization of the selections; organization sends selected records to the auditor for validation; auditor shares the results and corrective actions with the organization. <i>It is up to the organization and auditor to determine the timing.</i>	May 6–27, 2022
Organization completes all audit corrective actions and follow-up requests.	By May 27, 2022
Organization submits the plan-locked Exchange submission to auditor. <i>There are NO exceptions! Data must be final. The lock should be removed only to correct data at the auditor's request.</i>	June 1, 2022
Auditor reviews all IDSS warnings, performs final rate review, ensures that the MRR numerator counts entered in IDSS match the lists submitted on May 6, 2022.	June 15, 2022
Organization submits the auditor-locked Exchange IDSS submission, with attestation, to NCQA.	June 15, 2022
Licensed Organization submits Exchange Final Audit Reports to NCQA.	July 15, 2022

6. Reporting

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

For Performance Measures

Rate/Result	Comment
R	<i>Reportable.</i> A reportable rate was submitted for the measure.
NA	<i>Small Denominator.</i> The organization followed the specifications, but the denominator was too small to report a valid rate. Note: <i>Organizations report their data regardless of denominator size. The IDSS automatically assigns NA when the denominator is too small to report a valid rate.</i>
NB*	<i>No Benefit (Benefit Not Offered).</i> The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	<i>Not Reported.</i> The organization chose not to report the measure.
BR	<i>Biased Rate.</i> The calculated rate was materially biased.

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

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

In Which Reports Do Exchange Members Remain?

7. Eligible Population

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

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

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

8. The “Working Aged” and Retirees

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

9. Members in Hospice

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

Organizations should attempt to remove these members prior to determining a measure’s eligible population and drawing the sample for hybrid measures. If a member is found to be in hospice or using hospice services during medical record review, the member is removed as a valid data error from the sample and replaced by a member from the sample and replaced by a member from the oversample. Documentation that a member is near the end of life (e.g., comfort care, DNR, DNI) or is in palliative care does not meet criteria for the hospice exclusion.

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

Note

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

10. Deceased Members

Members who die during the measurement year are treated as an optional exclusion. Refer to the “Optional Exclusions” guideline in the *Guidelines for HEDIS Effectiveness of Care Measures*. These members may be identified using various methods that include, but are not limited to, enrollment data, medical record, claims/encounter data or supplemental data.

Organizations should attempt to remove these members prior to drawing the sample for hybrid measures. If during medical record review a member is found to be deceased, the member can be removed as a valid data error from the sample and replaced by a member from the oversample.

The exclusion of deceased members is subject to auditor review.

Note

- NCQA does not require organizations to develop databases or other methods to identify deceased members.
- Supplemental data may be used for excluding deceased members for all applicable measures, including measures that say, “supplemental data may not be used for the measure” (e.g., URI).

Membership Changes

11. Members Who Switch Organizations

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

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

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

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

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

This guideline must be used consistently across all measures.

13. Members Who Switch Products/Product Lines

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

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

Measures without a continuous enrollment requirement. Members who enrolled in different products or product lines are reported in the product and product line-specific HEDIS report in which they were enrolled on the date of service (outpatient, ED or observation visits) or date of discharge requirement (inpatient stays).

Required Enrollment Periods and Benefits

14. Continuous Enrollment

Continuous enrollment specifies the minimum amount of time that a member must be enrolled in an organization before becoming eligible for a measure. It ensures that the organization has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure.

To be considered continuously enrolled, a member must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap.

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

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

15. Continuous Enrollment Over Multiple Years

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

16. Anchor Dates

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

17. Required Benefits

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

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

At the organization level: Organizations report HEDIS for QRS measures requiring a specific benefit provided to members directly or through a contractor. Organizations are not required to report HEDIS for QRS measures specifying a benefit that it does not offer. Before reporting a measure specifying a benefit, the organization must be able to determine if a member has the required benefit.

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

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

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

For measures with a continuous enrollment criterion, the required benefits must be active for the period of continuous enrollment, accounting for any allowable gap. Exclude a member if the period when the benefit is exhausted exceeds any allowable gap or anchor date.

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

This guideline must be used consistently across all measures.

18. Accessing Medical Records Prior to Enrollment

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

HEDIS for QRS Data Submission and Reporting to NCQA

19. Reporting Date

For MY 2021 HEDIS for QRS, all organizations reporting audited data to NCQA through the IDSS must submit data to NCQA on or before June 15, 2022.

Note: *Organizations must submit and “plan-lock” audited HEDIS for QRS data to allow auditors sufficient time to review, approve and audit lock all submissions by the June 15 deadline. For MY 2021 HEDIS for QRS reporting, organizations are required to “plan-lock” audited HEDIS for QRS data no later than **June 1, 2022.***

20. Required Data Elements

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

Data Collection Methods and Data Sources

21. Data Collection Methods

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

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

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

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

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

Survey Method: Requires organizations to collect data through the QHP Enrollee Survey. HEDIS for QRS materials include the specifications for NCQA clinical survey measures. For additional details on the QHP Enrollee Survey data collection protocols, refer to the *Qualified Health Plan Enrollee Experience Survey: Technical Specifications*, which will be available on the CMS QHP Enrollee Survey page of the MQI website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page>).

Note: *Supplemental data are considered an administrative data source; however, for all non-survey measures, numerator events identified using supplemental data are reported separately from numerator events identified by administrative (claims/encounter) and medical record data, as indicated in the applicable Data Elements for Reporting tables.*

Any data found in a supplemental data source are considered a supplemental data hit if the member would not be compliant for the measure/indicator without the data source. If supplemental data are not used, report zero in the "Numerator events by supplemental data" element. For all other measures, numerator events identified using supplemental data are reported in the "Numerator events by administrative data" element.

Refer to General Guideline 22: Supplemental Data for supplemental data requirements.

22. Supplemental Data

Supplemental data uses. Organizations may find information about services for their members in administrative data, medical records and other data sources. When evidence to support the measure is found in multiple data sources, a hierarchy is applied. Supplemental data are considered last as long as the specifications are followed as written (e.g., if the organization uses a combination of data sources to identify the HbA1c control indicators in the *Comprehensive Diabetes Care* measure, the most recent test must be used regardless of data source).

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

Supplemental data may help determine:

- Numerators that are labeled as *numerators* in the specification.
- Optional exclusions.
- Members in hospice and members who have died.
- Eligible population-required exclusions that are labeled as *Required Exclusions* in the specification.

Supplemental data may not be used for:

- Denominator events. Organizations *may not* create and use records to identify denominator events, other than for optional and required exclusions.
- Clinical conditions that change. Organizations *may not* create and use records, on an ongoing basis, for exclusions for clinical conditions that change.
- Correcting bills or identifying valid data errors. Organizations *may not* use supplemental data to adjust incorrect billing practices or to identify valid data errors. This practice results in a change in claims data and is not allowed.
- Measures where the specification specifically indicates supplemental data cannot be used, except for applying the hospice exclusion and for excluding deceased members.

Supplemental Data Definitions

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

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

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

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

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

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

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

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

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

- A copy of the information from the member's chart from the service provider or the PCP.
- A copy of the clinical report or clinical summary from the visit for service, such as lab or radiology reports (i.e., forms from the rendering provider proving the service occurred).

General Guidelines for Data Collection

- A screen shot of:
 - Online electronic health record (EHR) records.
 - State- or county-sponsored immunization registry records.

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

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

Certified eCQM vendor data

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

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

Audit requirements. The auditor confirms that the data meet all the requirements above. If all the requirements are met, data from certified eCQM vendors are not required to undergo primary source verification, unless requested by the auditor. Refer to *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures* for more details.

CCDs

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

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

Audit requirements. The auditor confirms that the data meet all requirements. Primary source verification is required (e.g., go back to each unique EHR) to validate the CCDs' accuracy. This level of validation is required for at least the first year, or the first submission by the EHR, but may continue in subsequent years until the auditor is certain the data are accurate, reliable and have not changed.

Required Data Elements

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

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

- Payment status, when applicable.
- Evidence that tests or services were performed, not just ordered.
 - When data are abstracted from medical record sources to be used as supplemental data, codes alone (without additional documentation of the service provided) do not meet criteria for proof of service. If a provider performs a service, it is expected that there is additional documentation in the medical record or in the primary source document. Auditors must validate, through primary source verification, all elements required by the administrative measure specification.
- Evidence of provider accountability from the practitioner or practitioner group (signed contracts with accountability tied to passwords, e-signatures or TIN/NPI data). For home visits, if clinical services are rendered, there must be evidence of accountability by the practitioner, and at a minimum include the date, name and signature on each in-home form. Documentation of the practitioner's TIN/NPI is not required; however, documentation of TIN/NPI with date, name and signature is preferred.
- More than a simple yes or no attestation on provider forms. Forms must have all necessary data elements and be signed by the rendering practitioner.
- All data elements for a measure must be captured for member-reported services (date and place of service, procedure, prescription, test result or finding, practitioner type). Refer to *General Guideline 30: Member-Reported Services and Biometric Values* for more information about member-reported data.

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

When pharmacy data are classified as supplemental data, the following data elements must be present: the generic name (or brand name), strength/dose, route and date when the medication was dispensed to the member. Dispensed date is required; other dates (e.g., start date, shipped date) cannot be used as a proxy. Data elements must map to a medication listed in the Medication List Directory to be eligible for use. Generic documentation in the medical record (e.g., that a patient “was prescribed” or “is taking” a medication) that does not include drug name, strength/dose and dispense date does not meet criteria.

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

Supplemental Data Timeline

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

Identifying and Validating Supplemental Data

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

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

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

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

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

23. Obtaining Information for the Systematic Sample

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

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

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

Organizations must be able to determine that a test or service was *performed* within the time frame specified, not merely ordered. Only completed events count toward HEDIS for QRS compliance.

Documentation in a medical record of a diagnosis or procedure code alone does not comply with the numerator criteria.

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

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

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

Manually updating the sample. Organizations may compare only the numerator-negative members in the sample to screen shots of the refreshed data; they are not required to update every measure manually or to reassess denominator compliance for every member in the sample.

Records used for numerator compliance are subject to medical record review validation.

Automated updates to the sample. Organizations may use an automated process that loads the entire sample for each measure and compares it to the refreshed data. All data must be used consistently in the samples.

- If recent data contradict numerator compliance, those data must be used.
- If recent data exclude a member, those data must be used and the oversample must provide a substitute member.
- If the oversample is exhausted, the organization must use the Sampling Guidelines to ensure meeting the MRSS is possible.
- The auditor must review and approve the timing, processes and results of the refresh, but does not need to include the records used for numerator compliance in the medical record review validation.

24. Date of Service for Laboratory Tests

Laboratory tests can have multiple dates of service; an order date (the date the provider ordered the test), a collection date (the date when the specimen was drawn), a result/reported date (the date when results were calculated and reported), a claim date (the date of service on the claim) and a documented date (the date the provider documented the result in the medical record).

Order date and documented date are not eligible for use in HEDIS reporting.

For laboratory tests identified using claims data (numerator events by administrative data) use the claim date of service.

When abstracting laboratory tests from the medical record for use in hybrid reporting or for nonstandard supplemental data, the documentation must include the test date and the result (or evidence that the test was performed). The result/reported date may be used as the test date.

Organizations may consider all events with dates no more than seven days apart to be the same test and may use the collected date for reporting. For example:

- If a member had an HbA1c sample collected on December 28 of the measurement year and an HbA1c result on January 2 of the year after the measurement year, the dates are within seven days and can be considered the same test. The result is present, and the collection date is eligible for use in reporting.
- If a member had an HbA1c sample collected on December 28 of the measurement year and an HbA1c result on January 15 of the year after the measurement year, the dates are not within seven days and cannot be considered the same test. The December 28 test is used for reporting and the result is missing.
- If a test had a collection date of December 1 and a reported date of December 8, these dates are not more than seven days apart and can be considered the same test.
- If a test had a collection date of December 1 and a reported date of December 9, these dates are more than seven days apart and cannot be considered the same test.

25. Date Specificity

HEDIS for QRS requires that a date be specific enough to determine that an event occurred during the time established in the measure. For example, in the *Childhood Immunization Status* measure, members must receive three hepatitis B vaccines. Assume a member was born on February 5, 2019.

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 (the child’s second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2021, the organization cannot count the immunization because the date is not specific enough to confirm that it occurred prior to the member’s second birthday.

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

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

26. Collecting Data for Measures With Multiple Numerator Events

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

- *Childhood Immunization Status.*
- *Immunizations for Adolescents.*
- *Well-Child Visits in the First 30 Months of Life.*

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

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

If the organization has one event from the medical record and one from administrative data and dates are less than 14 days apart (or the organization cannot determine if the dates are at least 14 days apart), it must use only the medical record event. The 14-day threshold does not apply when using only medical record data. For example, the organization may count two influenza vaccines identified through medical record data that are not 14 days apart.

27. Measures That Use Medication Lists

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

If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, if there are both NDC codes and RxNorm codes on the same date of service, use only one data source for that date of service (use only NDC codes or only RxNorm codes) for reporting.

28. Identifying Events/Diagnoses Using Laboratory or Pharmacy Data

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

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

Diagnosis codes on pharmacy claims may not be used.

29. Member-Collected Samples

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.

30. Member-Reported Services and Biometric Values

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

HEDIS Coding Conventions

31. Coding Systems Included in HEDIS Reporting

HEDIS measures include codes from the following coding systems:

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

32. Presentation of Codes in HEDIS for QRS Value Set

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

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

33. Telehealth

Synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) are considered separate modalities for HEDIS reporting.

Synchronous telehealth requires real-time interactive audio and video telecommunications. A measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.

A measure will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.

Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not “real-time” but still requires two-way interaction between the member and provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging or email. A measure will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.

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

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

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

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

35. Visits that Result in an Inpatient Stay

Some measures require exclusion of online assessments, telephone, outpatient, ED or observation visits that result in an inpatient stay or observation stay.

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

36. Principal vs. Secondary Diagnosis

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

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

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

37. Code Modifiers

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

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

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

38. SNOMED Codes

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

39. Uniform Bill Code Specificity

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

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

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

40. Mapping Proprietary or Other Codes

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

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

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

The organization documents the process for implementing codes. Auditors may request additional information.

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41. Retiring Codes

NCQA annually tracks billing, diagnostic and procedure codes that are designated obsolete. NCQA does not remove codes in the year in which they receive the designation of obsolete because of the look-back period in many HEDIS for QRS measures. Obsolete codes are deleted from the HEDIS for QRS specifications one year after the look-back period is exhausted. For example, since the *Comprehensive Diabetes Care* measure counts a diagnosis of diabetes in the measurement year or the year prior to the measurement year, diabetes diagnosis codes, for this measure, have a two-year look-back period.

A code that is designated obsolete effective January 1, 2018, is deleted from the specifications in HEDIS QRS MY 2021 after the two-year look-back period (2020 and 2019) plus one additional year (2018) is exhausted.

42. Reporting Tables

Cells in the data element tables are shaded according to how data are reported:

- *No shading*: Data are reported by the organization.
- *Light gray shading*: Data are calculated by IDSS.
- *Solid black shading*: Data are not used or reported.

Reported by the organization
Calculated by IDSS
Data not used

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Guidelines for Calculations and Sampling

Guidelines for Calculations and Sampling

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

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to the guidelines.

How to Use the Administrative Method

Step 1 Identify the eligible population and remove all required exclusions. All required exclusions must be removed from the final eligible population.

Step 2 Search administrative systems to identify numerator events for all members in the eligible population.

Step 3 If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured.

Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.

Step 4 Exclude from the eligible population, members from step 3 for whom administrative system data identified an exclusion to the service or procedure being measured.

Step 5 Calculate the rate.

Guidelines for the Hybrid Method

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

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

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

Drawing the sample prior to the reporting year Organizations are strongly encouraged to draw samples no earlier than January 2022 for the 2021 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 these dates.

Membership-dependent denominators

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

- *Childhood Immunization Status.*
- *Immunizations for Adolescents.*
- *Cervical Cancer Screening.*
- *Colorectal Cancer Screening.*

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

- Oversample to account for individuals included in the sample who were found to be noncompliant with the denominator criteria, subsequent to December 31 of the measurement year.
- On or after December 31 of the measurement year, verify that members included in the sample remain eligible for the particular measure. Another record must be substituted for a member who does not meet all the denominator criteria.
 - For example, for the *Childhood Immunization Status* measure, on December 5 of the measurement year, an organization draws a sample of children who turn 2 years of age during the measurement year. On or after December 31 of the measurement year, the organization must ensure that all members included in the sample remain eligible for the measure (i.e., meet the continuous enrollment criteria, are members of the organization as of their second birthday).
 - Any ineligible member (i.e., does not meet one or more denominator criterion) 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. Use Table 1 to determine the appropriate sample size for measures. For hybrid measures reported in the prior year, use the last two columns of Table 1 to determine whether the prior year’s audited result can be used to reduce the current year’s sample size.

Use Table 2 if the prior year’s rate is used to determine the current year’s sample. The organization may use the product line-specific rate derived from administrative data for the current measurement year and Table 2 to reduce the required sample size. The required sample size decreases as the organization’s rate improves; for example, the organization calculates a 77 percent administrative rate for the commercial product line for a new measure and decides to implement the Hybrid Method.

Instead of using a sample size of 411, the organization reduces the sample size for this measure for its Exchange product line by using the 77 percent administrative rate and Table 2. According to Table 2, the minimum required sample size is 296. The sample size can be reduced even when the original eligible member (EM) population is less than 411.

Organization responsibility for chart review

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

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

Statistical assumptions for sample size

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

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

Table 1: Sample Size Information for Hybrid Measures

MY 2021 HEDIS for QRS Measures	Sample Size	Prior Year's Rate May Be Used to Reduce MY 2021 Sample Size ³
Cervical Cancer Screening	411	Y
Childhood Immunization Status	411	N ⁴
Colorectal Cancer Screening	411	Y
Comprehensive Diabetes Care	411	N ⁵
Controlling High Blood Pressure	411	Y
Immunizations for Adolescents	411	Y ⁶
Prenatal and Postpartum Care	411	Y ⁶
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	411	Y ⁶

Finalized Data Submission Requirements for the 2022 Ratings Year

In the Final 2021 Call Letter, CMS finalized the transition from the *Childhood Immunization Status (Combination 3)* to the *Childhood Immunization Status (Combination 10)* measure. Because the Combination 10 indicator is required for reporting, the sample size for this measure may be reduced using only the current year's administrative rate. The lowest rate from all indicators must be used; the prior year's reported rate may not be used to reduce the sample size.

In the Final 2021 Call Letter, CMS did not finalize the transition from the *Comprehensive Diabetes Care: HbA1c Control (<8%)* to the *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* measure. For the 2022 ratings year, CMS will collect the *Comprehensive Diabetes Care: HbA1c Control (<8%)* measure. CMS will not collect the *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* measure. As a result, the sample size for this measure may be reduced based on the current year's administrative rate or the prior year's rate for this measure; the lowest rate from all the indicators must be used.

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

⁴ Please reference the Final 2021 Call Letter and 2022 QRS and QHP Enrollee Survey Guidance for final decisions on which measures (or indicators) are required for reporting.

If the Combination 10 indicator is required for reporting, the sample size for this measure may be reduced using only the current year's administrative rate. The lowest rate from all indicators must be used; the prior year's reported rate may not be used to reduce the sample size.

If the Combination 10 indicator is not required for reporting, the sample size for this measure may be reduced based on the current year's administrative rate or the prior year's rate for this measure; the lowest rate from all the indicators must be used.

⁵ Please reference the Final 2021 Call Letter and 2022 QRS and QHP Enrollee Survey Guidance for final decisions on which measures (or indicators) are required for reporting.

If the HbA1c Poor Control (>9%) indicator is required for reporting, the sample size for this measure may be reduced using only the current year's administrative rate. If reducing the sample size based on the product-line-specific rate for this measure, the organization must first take the inverse of the HbA1c Poor Control rate (100 minus the HbA1c Poor Control rate) and then reduce using the lowest rate among all reported indicators. The prior year's reported rate may not be used to reduce the sample size.

If the HbA1c Poor Control indicator is not required for reporting, then the sample size for this measure may be reduced based on the current year's administrative rate or the prior year's rate for this measure; the lowest rate from all the indicators must be used.

⁶ If reducing the sample size based on the current year's administrative rate or the prior year's product line-specific rate for this measure, the lowest rate from all the indicators must be used.

Guidelines for Calculations and Sampling

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 or the prior year’s reported rate to determine the sample size. Table 1 must be used first to determine if a prior year’s rate can be used to reduce the sample size for a particular measure.

If the Current Year’s Administrative Rate or the Prior Year’s Reported Rate Is...	...the Minimum Sample Size Is:	If the Current Year’s Administrative Rate or the Prior Year’s Reported Rate Is...	...the Minimum Sample Size Is:
≤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	74%	321
70%	348	92%	134
71%	342	93%	120
72%	335	94%	106
73%	328	≥95%	100

Note: Table 2 reflects the MRSS. When reducing, an organization’s sample size may be between the allowed minimum sample size in Table 2 and 411. Truncate the decimal portion of the rate to obtain a whole number.

Systematic Sampling Methodology

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

- Step 1** Determine the EM population. Develop a list of EMs, including full name (last, first), date of birth and event (if applicable).
- Step 2** Determine the minimum required sample size (MRSS) from Table 1 or Table 2. This number becomes the denominator for the measure. Use either Table 1 or Table 2, as appropriate, to determine the MRSS. (Refer to *Determining the required sample size* for instructions.) If the EM is \leq MRSS, proceed to step 4.
- Note:** *The MRSS may only be the appropriate value from Table 1 or Table 2.*
- To use a larger MRSS, an organization must provide written rationale to NCQA through PCS via My NCQA (<https://my.ncqa.org>).
- Step 3** Determine the oversample. The oversample should be an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the MRSS is met; keep substitution criteria in mind.
- Written approval from NCQA must be obtained to use an oversampling rate larger than 20 percent. Refer to *Oversample requests to NCQA* for details.
- The oversample records should be used, and reported, only to replace cases taken out of the MRSS because of valid data errors, false positives and so on; otherwise, these records should not be reported on in the final denominator.
- Step 4** If $EM \leq MRSS$, all eligible members are included in the sample. The MRSS must be reported as the EM or less than the EM if sample size reduction is applied.
- If $EM > MRSS$ + all oversample records, go to step 5.
- If $MRSS < EM \leq MRSS$ + all oversample records, proceed to step 8.
- Step 5** Sort the list of EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable).
- Sort EMs from A to Z in even measurement years and from Z to A in odd measurement years.
- For example, for MY 2021 HEDIS for QRS, sort the list of EMs from Z to A.
- Note:** *Sort order applies to all components. For HEDIS MY 2021, sort all fields by descending order (i.e., last name descending, first name descending, date of birth descending, event descending).*
- Step 6** Calculate $N = EM / (MRSS + \text{all oversample records})$. Round *down* to a whole number.
- Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation: $N = EM / (MRSS + \text{all oversample records})$, where EM = the eligible member population (step 1) and MRSS = the minimum required sample size (step 2).

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

Use the 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 in the RAND table.

Step 8 Select the sample, choosing every i^{th} member using the formula: $i^{th} \text{ member} = START + [(i-1) \times (EM/MRSS + \text{all oversample records})]$, (rounding $[(i-1) \times EM / (MRSS + \text{all oversample records})]$ per the .5 rule to the nearest whole number greater than 0).

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

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

Continue choosing every i^{th} member until the oversample is met. This set of members becomes the oversample. The oversample records should be used and reported only to replace cases taken out of the MRSS because of valid data errors, false positives, and so on, otherwise, these records should not be reported in the final denominator.

Note: From step 4, if $MRSS < EM \leq MRSS + \text{all oversample records}$, sort the EMs in alphabetical order (by applicable measurement year) by last name, first name, date of birth and event (if applicable). Choose the first MRSS EMs as the primary sample and the remaining EMs as the oversample.

The oversample list is only used to replace exclusions. All exclusions must be documented because they may be subject to audit.

Oversample requests to NCQA

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

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

Oversampling methodology

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

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

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

The recommended methodology for substitution is:

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

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

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

HEDIS MY 2021 RAND Table for Measures Using the Hybrid Method

Measure	RAND
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	.81
Childhood Immunization Status	.57
Immunizations for Adolescents	.78
Cervical Cancer Screening	.64
Colorectal Cancer Screening	.21
Controlling High Blood Pressure	.13
Comprehensive Diabetes Care	.33
Prenatal and Postpartum Care	.30

Example 1

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

- Step 1** EM = 9,000.
- Step 2** From Table 2, the MRSS is 296.
- Step 3** Oversample = $296 \times .05 = 14.8$ (the next whole number *above* is 15, so the oversample = 15).
- Step 4** Because $9,000 > 296$ (MRSS) and 311 (296 + oversample) go to step 5.
- Step 5** Sort the list alphabetically and in this order: last name, first name, date of birth.
- Step 6** $N = 9,000/311$ (MRSS + oversample) = 28.

Guidelines for Calculations and Sampling

- Step 7** For this example, assume that $RAND = 0.66$, so $START = 0.66 \times 28 = 18.48$.
Rounding using the .5 rule, $START = 18$. The 18th sorted member is chosen *first*.
The 2nd member chosen is the $18 + [(2-1) \times (9,000/311)] = 18 + 29 = 47$ th sorted member, after rounding the term $[(2-1) \times (9,000/311)]$ to 29, using the .5 rule.
The 3rd member chosen is the $18 + [(3-1) \times (9,000/311)] = 18 + 58 = 76$ th sorted member.
The 296th member (the last one in the primary list) is the $18 + [(296-1) \times (9,000/311)] = 18 + 8,537 = 8,555$ th sorted member.
The last member in the oversample* is the $18 + [(311-1) \times (9,000/311)] = 18 + 8,971 = 8,989$ th sorted member.

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

Example 2

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

- Step 1** EM = 389.
Step 2 From Table 1, the MRSS is 411. Since $389 < 411$, skip to step 4.
Step 3 Skip this step.
Step 4 Include all 389 members in your primary list.

Example 3

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

- Step 1** EM = 436.
Step 2 From Table 1, the MRSS is 411.
Step 3 Oversample = $411 \times .10 = 41.1$ (the next whole number above is 42, so oversample = 42).
Step 4 Because $411 < 436 \leq (411 + 42)$, skip to step 8.
Step 5 Skip this step.
Step 6 Skip this step.
Step 7 Skip this step.
Step 8 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the oversample list*.

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

Example 4

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

Step 1 EM = 400.

Step 2 From Table 2, the MRSS is 388.

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

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

Step 5 *Skip this step.*

Step 6 *Skip this step.*

Step 7 *Skip this step.*

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

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

Complex Probability Sampling

Organization responsibility

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

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

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

Hybrid Method: Three Approaches

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

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

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

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

References

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

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

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Guidelines for HEDIS Effectiveness of Care Measures

5. **Anchor date** specifies the required enrollment date for the eligible population (e.g., children must be enrolled in the organization on their second birthday for inclusion in the *Childhood Immunization Status* measure).
6. **Benefit** a member must have during the continuous enrollment period to be included in the eligible population (e.g., members must have both medical and pharmacy benefits for inclusion in the *Antidepressant Medication Management* measure).
7. **Event/diagnosis** specifies the medical event or diagnosis requirements for the eligible population.

Administrative Specification

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

Hybrid Specification

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

Guidelines for Access/Availability of Care Measures

Guidelines for Risk Adjusted Utilization Measures

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Administrative Specification

Denominator The eligible population.

Numerator One or more dental visits with a dental practitioner during the measurement year. Any visit with a dental practitioner during the measurement year meets criteria.

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

Data Elements for Reporting

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

Table ADV-4: Data Elements for Annual Dental Visit

Element	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

Eligible Population

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

Product line	Exchange.
Ages	Women 52–74 years as of December 31 of the measurement year.
Continuous enrollment	October 1 two years prior to the measurement year through December 31 of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to the measurement year). No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusion	Members receiving palliative care (<u>Palliative Care Assessment Value Set</u> ; <u>Palliative Care Encounter Value Set</u> ; <u>Palliative Care Intervention Value Set</u>) during the measurement year.
Exclusions	<p>Exclude members who meet any of the following criteria:</p> <p><i>Note: Supplemental and medical record data may not be used for these exclusions.</i></p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Device Value Set</u>; <u>Frailty Diagnosis Value Set</u>; <u>Frailty Encounter Value Set</u>; <u>Frailty Symptom Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), telephone visits (<u>Telephone Visits Value Set</u>), e-visits or virtual check-ins (<u>Online Assessments Value Set</u>), nonacute inpatient encounters

- (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
- At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
- A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

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

Exclusion (optional)

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

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set).
- Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set). Note: the “clinical” mastectomy value sets identify mastectomy; the word “clinical” refers to the data source, not to the type of mastectomy.

- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes from the table below that indicate a mastectomy on **both** the left **and** right side on the same or different dates of service.

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

Note

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

Data Elements for Reporting

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

Table BCS-4: Data Elements for Breast Cancer Screening

Element	Administrative
Measurement year	✓
Eligible population	✓
Number of optional exclusions	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Required exclusion	Members receiving palliative care (<u>Palliative Care Assessment Value Set</u> ; <u>Palliative Care Encounter Value Set</u> ; <u>Palliative Care Intervention Value Set</u>) during the measurement year.

Administrative Specification

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

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

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

Exclusion (optional)

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

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population.</p> <p>Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
Numerator	<p>The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.</p>
Medical record	<p>Appropriate screenings are defined by any of the following:</p> <ul style="list-style-type: none"> • Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. <ul style="list-style-type: none"> – Documentation in the medical record must include both of the following: <ul style="list-style-type: none"> ▪ A note indicating the date when the cervical cytology was performed. ▪ The result or finding. – Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening. – Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. <p>Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.</p> <ul style="list-style-type: none"> • Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing.

Cervical Cancer Screening

- Documentation in the medical record must include both of the following:
 - a. A note indicating the date when the hrHPV test was performed.
Generic documentation of “HPV test” can be counted as evidence of hrHPV test.
 - b. The results or findings.
- Do not count biopsies, because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

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

Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through December 31 of the measurement year. The following examples meet criteria for documentation of hysterectomy with no residual cervix:

- Documentation of “complete,” “total” or “radical” hysterectomy (abdominal, vaginal or unspecified).
- Documentation of “vaginal hysterectomy.”
- Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy.”
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.
 - Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

Data Elements for Reporting

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

Table CCS-4: Data Elements for Cervical Cancer Screening

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

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Eligible Population

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

Product lines	Exchange.
Ages	3–21 years as of December 31 of the measurement year. Report three age stratifications and total rate: <ul style="list-style-type: none">• 3–11 years.• 12–17 years.• 18–21 years.• Total. The total is the sum of the age stratifications for each product line.
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	One or more well-care visits (<u>Well-Care Value Set</u>) during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Note

- Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal care practitioners.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/>).

Data Elements for Reporting

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

Table WCV-4: Data Elements for Child and Adolescent Well-Care Visits

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Numerator events by supplemental data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- Added hepatitis A, rotavirus, influenza and Combination 10.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 3, Combination 10 and related antigens.
- This measure includes changes that were proposed in the Draft 2021 Call Letter. Please reference the Final 2021 Call Letter and 2022 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting this measure.

Finalized Data Submission Requirements for the 2022 Ratings Year

In the Final 2021 Call Letter, CMS finalized the transition from the *Childhood Immunization Status (Combination 3)* to the *Childhood Immunization Status (Combination 10)* measure. CMS will collect Combination 10 for the 2022 ratings year. CMS will not collect Combination 3 for the 2022 ratings year.

Description

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

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

Administrative Specification

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

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

- Evidence of the antigen or combination vaccine.

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

DTaP

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

IPV

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

MMR

Any of the following meet criteria:

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

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

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

Childhood Immunization Status

- HiB** At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Hepatitis B** Any of the following on or before the child's second birthday meet criteria:
- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
 - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
 - History of hepatitis illness (Hepatitis B Value Set).
- VZV** Either of the following meets criteria:
- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
 - History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.
- Pneumococcal conjugate** At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
- Hepatitis A** Either of the following meets criteria:
- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set) with a date of service on or between the child's first and second birthdays.
 - History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday.
- Rotavirus** Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth.
- At least two doses of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service.
 - At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service.
 - At least one dose of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.

- Influenza**
- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set) with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.
 - One of the two vaccinations can be an LAIV vaccination (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday.

Combination rates Calculate the following rates for Combination 3 and Combination 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Exclusion (optional)

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

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

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

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population.</p> <p>Organizations may reduce the sample size using the current year's administrative rate. The lowest rate for all reported indicators must be used when reducing the sample size. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
Numerators	<p>For MMR, hepatitis B, VZV and hepatitis A, count any of the following:</p> <ul style="list-style-type: none">• Evidence of the antigen or combination vaccine.• Documented history of the illness.• A seropositive test result. <p>For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count <i>only</i>:</p> <ul style="list-style-type: none">• Evidence of the antigen or combination vaccine. <p>For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.</p>
Medical record	<p>For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:</p> <ul style="list-style-type: none">• A note indicating the name of the specific antigen and the date of the immunization.• A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. <p>For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.</p> <p>Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator <i>only</i> for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.</p> <p>Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.</p> <p>Immunizations documented using a generic header (e.g., polio vaccine) or "IPV/OPV" can be counted as evidence of IPV. The burden on organizations to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.</p>

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

Exclusion (optional)

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

Note

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

Data Elements for Reporting

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

Table CIS-4: Data Elements for Childhood Immunization Status

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 12 rates</i>
Current year’s administrative rate (before exclusions)		<i>Each of the 12 rates</i>
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	<i>Each of the 12 rates</i>	<i>Each of the 12 rates</i>
Numerator events by medical records		<i>Each of the 12 rates</i>
Numerator events by supplemental data	<i>Each of the 12 rates</i>	<i>Each of the 12 rates</i>
Reported rate	<i>Each of the 12 rates</i>	<i>Each of the 12 rates</i>

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

Eligible Population

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

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

Contraceptive Medications

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

Administrative Specification

Denominator The eligible population.

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

Exclusion (optional)

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

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

Retinoid Medications

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

Data Elements for Reporting

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

Table CHL-4: Data Elements for Chlamydia Screening in Women

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

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

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

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

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

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	<ul style="list-style-type: none"> <li style="margin-right: 20px;">• Donepezil <li style="margin-right: 20px;">• Galantamine • Rivastigmine
Miscellaneous central nervous system agents	<ul style="list-style-type: none"> • Memantine
Dementia combinations	<ul style="list-style-type: none"> • Donepezil-memantine

Administrative Specification

Denominator The eligible population.

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

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

Exclusion (optional)

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

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set).

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population.</p> <p>Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p>
Numerator	<p>One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:</p> <ul style="list-style-type: none"> • FOBT during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year. • CT colonography during the measurement year or the four years prior to the measurement year. • FIT-DNA during the measurement year or the two years prior to the measurement year.
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.</p>
Medical record	<p>Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the member's "medical history"; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).</p> <p>A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.</p> <p>For pathology reports that do not indicate the type of screening and for incomplete procedures:</p> <ul style="list-style-type: none"> • Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy. • Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
 - *If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.*
 - *If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.*
 - *If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.*

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

Exclusion (optional)

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

Data Elements for Reporting

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

Table COL-4: Data Elements for Colorectal Cancer Screening

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

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- Added the Hemoglobin A1c (HbA1c) Poor Control (>9.0%) indicator.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Organizations report only the following indicators: HbA1c control <8%, HbA1c poor control >9.0%, eye exam (retinal) performed, medical attention for nephropathy.
- This measure includes changes that were proposed in the Draft 2021 Call Letter. Please reference the Final 2021 Call Letter and 2022 QRS and QHP Enrollee Survey Guidance for guidance on reporting this measure.

Finalized Data Submission Requirements for the 2022 Ratings Year

In the Final 2021 Call Letter, CMS finalized the removal of the *Comprehensive Diabetes Care: Medical Attention for Nephropathy* measure from the QRS measure set and will not collect the measure for the 2022 ratings year.

In the Final 2021 Call Letter, CMS did not finalize the transition from the *Comprehensive Diabetes Care: HbA1c Control (<8%)* to the *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* measure. For the 2022 ratings year, CMS will collect the *Comprehensive Diabetes Care: HbA1c Control (<8%)* measure. CMS will not collect the *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* measure.

Description

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

- HbA1c control (<8.0%).*
- HbA1c poor control (>9.0%).*
- Eye exam (retinal) performed.
- Medical attention for nephropathy.

*Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

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

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

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

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

Diabetes Medications

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

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusions Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Poor Control >9% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is $\leq 9.0\%$.

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

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Compliant

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

HbA1c Control <8%

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

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

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Compliant
<u>HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set</u>	Compliant
<u>HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Not compliant

Eye Exam

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

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

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- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set or Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year.
- Any code in the Diabetic Retinal Screening Negative In Prior Year Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **with** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) **and** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **and** a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) **and** a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

**Medical Attention
for Nephropathy**

A nephropathy screening or monitoring test **or** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).

- Evidence of nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor and ARB Medications List).

ACE Inhibitor and ARB Medications

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

Exclusions (optional)

- Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
- Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Hybrid Specification

Denominator

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

Organizations may reduce the sample size using the current year’s administrative rate. Organizations must first take the inverse of the HbA1c Poor Control (>9.0%) rate (100 minus the HbA1c Poor Control rate) and then reduce using the lowest rate among all the reported CDC indicators. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

HbA1c Poor Control >9%	<p>The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.</p> <p>Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).</p>
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
Medical record	<p>At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.</p> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.</p>
HbA1c Control <8%	The <i>most recent</i> HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.
<u>Medical record</u>	<p>At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.</p> <p>Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.</p>
Eye Exam	<p>Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:</p> <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A <i>negative</i> retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year. • Bilateral eye enucleation any time during the member’s history through December 31 of the measurement year.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.

Medical record

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

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
- Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
- Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
- Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
 - Documentation does not have to state specifically “no diabetic retinopathy” to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates “diabetes without complications” does not meet criteria.

Medical Attention for Nephropathy

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

Administrative

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

Medical record

Any of the following during the measurement year meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
 - 24-hour urine for albumin or protein.
 - Timed urine for albumin or protein.
 - Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
 - Urine for albumin/creatinine ratio.
 - 24-hour urine for total protein.
 - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.

- Documentation of a nephrectomy.
- Documentation of medical attention for any of the following (no restriction on provider type):
 - Diabetic nephropathy.
 - ESRD.
 - Chronic renal failure (CRF).
 - Chronic kidney disease (CKD).
 - Renal insufficiency.
 - Proteinuria.
 - Albuminuria.
 - Renal dysfunction.
 - Acute renal failure (ARF).
 - Dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:
 - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.
 - Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
 - Documentation that the member took an ACE inhibitor/ARB during the measurement year.

Exclusions (optional)

Refer to *Administrative Specification* for exclusion criteria.

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year **and** who had a diagnosis of polycystic ovarian syndrome, 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 the HbA1c indicators must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *To facilitate HEDIS reporting the denominator for all rates must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam*

Comprehensive Diabetes Care

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

- If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source.
- If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.

Data Elements for Reporting

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

Table CDC-4: Data Elements for Comprehensive Diabetes Care

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	Each of the 4 rates	Each of the 4 rates
Eligible population	Each of the 4 rates	Each of the 4 rates
Number of required exclusions	Each of the 4 rates	Each of the 4 rates
Number of numerator events by administrative data in eligible population (before exclusions)		Each of the 4 rates
Current year's administrative rate (before exclusions)		Each of the 4 rates
Minimum required sample size (MRSS)		Each of the 4 rates
Oversampling rate		Each of the 4 rates
Number of oversample records		Each of the 4 rates
Number of medical 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
Numerator events by supplemental data	Each of the 4 rates	Each of the 4 rates
Reported rate	Each of the 4 rates	Each of the 4 rates

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

Eligible Population

Note: Members in hospice are excluded from the eligible population. If a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

Product line	Exchange.
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).

Required exclusion Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

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

- Members 66–80 years of age as of December 31 of the measurement year with frailty **and** advanced illness. Members must meet *both* of the following frailty and advanced illness criteria to be excluded:
- At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
- Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the discharge date for the stay.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
 - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set). To identify an acute inpatient discharge:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
 3. Identify the discharge date for the stay.
 - A dispensed dementia medication (Dementia Medications List).
- Members 81 years of age and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Administrative Specification

Denominator The eligible population.

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

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

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

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

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

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Exclusions (optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 3. Identify the admission date for the stay.

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population.</p> <p>Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate. Refer to the Guidelines for Calculations and Sampling for information on reducing the sample size.</p>
Identifying the medical record	<p>All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.</p> <p>Use the following guidance to find the appropriate medical record to review.</p> <ul style="list-style-type: none">• Identify the member’s PCP.• If the member had more than one PCP for the time-period, identify the PCP who most recently provided care to the member.• If the member did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the member.• If a practitioner other than the member’s PCP manages the hypertension, the organization may use the medical record of that practitioner.
Numerator	<p>The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member’s BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a member’s BP is adequately controlled, the representative BP must be identified.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.</p>

Medical record

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

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

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

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

The member is not compliant if the BP reading is $\geq 140/90$ mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Exclusions (optional)

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

Note

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

Controlling High Blood Pressure

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

Data Elements for Reporting

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

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

	Admin	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Flu Vaccinations for Adults Ages 18–64 (FVA)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

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

Description

The percentage of members 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the QHP Enrollee Survey was completed.

Eligible Population

Product line	Exchange.
Ages	18–64 years as of July 1 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Protocol and Survey Instrument

Collected annually by CMS as part of the QHP Enrollee Survey.

Flu Vaccinations for Adults Ages 18–64 Eligibility Flag

The issuer assigns a *Flu Vaccinations for Adults Ages 18–64* Eligibility Flag for each member in the QHP Enrollee Survey sample frame data file.

Flu Vaccinations for Adults Ages 18–64 Eligibility Flag
1 = Eligible (the member was born on or between July 2, 1956, and July 1, 2003)
2 = Ineligible (the member was born before July 2, 1956, or after July 1, 2003)

Flu Vaccinations for Adults Ages 18–64

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

Questions Included in the Measure

Table FVA: Flu Vaccinations for Adults Ages 18–64

QHP Enrollee Survey	Question	Response Choices
Q47	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 (2021 for the survey fielded in 2022).

Calculation of Flu Vaccinations for Adults Ages 18–64

Denominator The number of members with a Flu Vaccinations for Adults Ages 18–64 Eligibility Flag of “Eligible” who responded “Yes” or “No” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

Numerator The number of members in the denominator who responded “Yes” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

- Discharge condition** Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table CC_Mapping. For direct transfers, use the primary discharge diagnosis from the last discharge.
- Exclude diagnoses that cannot be mapped to Table CC_Mapping.
- Comorbidities** Refer to *Risk Adjustment Comorbidity Category Determination* in the *Guidelines for Risk Adjusted Utilization Measures*.

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender. Use the Commercial Risk Weights for risk adjustment. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

- Step 1** For each IHS discharge that is an observation stay, link the observation stay IHS weight.
- Step 2** For each IHS with a surgery, link the surgery weight.
- Step 3** For each IHS with a discharge CC Category, link the primary discharge weights.
- Step 4** For each IHS with a comorbidity HCC Category, link the comorbidity weights.
- Step 5** Link the age and gender weights for each IHS.
- Step 6** Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, primary discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS.

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

OR

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

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

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

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

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

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

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

Note: When calculating variance at the IHS level, do not round. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.

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

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient admissions:

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

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

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

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

- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- Planned admissions using any of the following:
 - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
 - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
 - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
 - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

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

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

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

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

- Acute inpatient stay 1: May 1–10.

- *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute inpatient stay 3: May 30–June 5.*

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

Reporting: Number of Members in Plan Population

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

Reporting: Number of Outliers

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

Plan All-Cause Readmissions

Calculated: Expected Readmission Rate

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

Reporting: Variance

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

Calculated: O/E Ratio

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

Note

- Supplemental data may not be used for this measure.

Table PCR-4: Plan Population and Outlier Rate

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

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

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Definitions

First trimester	280–176 days prior to delivery (or EDD).
Last enrollment segment	The period of continuous enrollment segment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date. Use <i>General Guideline 13: Members Who Switch Products/Product Lines</i> in the <i>General Guidelines for Data Collection and Reporting</i> to determine continuous enrollment.

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to *General Guideline 9: Members in Hospice*.

Product line	Exchange.
Ages	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting. Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and

October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

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

Step 1 Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: The intent is to identify the date of delivery (the date of the “procedure”). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

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

Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 1 Identify women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).

These women must have a prenatal visit during the first trimester.

Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the woman’s enrollment start date during the pregnancy meet criteria.

Step 3 Identify prenatal visits that occurred during the required time frame (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- 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; Telephone Visits Value Set; Online Assessments Value Set) **with** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

- Postpartum Care** A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:
- A postpartum visit ([Postpartum Visits Value Set](#)).
 - Cervical cytology ([Cervical Cytology Lab Test Value Set](#); [Cervical Cytology Result or Finding 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).

Exclude services provided in an acute inpatient setting ([Acute Inpatient Value Set](#); [Acute Inpatient POS Value Set](#)).

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 administrative rate or the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required timeframe. Refer to the *Administrative Specification* to identify the required time frame for each woman based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

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.

- Documentation indicating the woman is pregnant or references to the pregnancy; for example:
 - Documentation in a standardized prenatal flow sheet, **or**
 - Documentation of LMP, EDD or gestational age, **or**
 - A positive pregnancy test result, **or**
 - Documentation of gravidity and parity, **or**
 - Documentation of complete obstetrical history, **or**
 - Documentation of prenatal risk assessment and counseling/ education.

Prenatal and Postpartum Care

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

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative

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

Medical record

Postpartum visit to an OB/GYN or other prenatal care practitioner or PCP on or between 7 and 84 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and **one** of the following. Do not include postpartum care provided in an acute inpatient setting.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
 - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
 - Infant care or breastfeeding.
 - Resumption of intercourse, birth spacing or family planning.
 - Sleep/fatigue.
 - Resumption of physical activity.
 - Attainment of healthy weight.

Note

- *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
 - *For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
 - *For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis, rather than assessing treatment for emergent events.*
- *Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal practitioner.*
- *For both rates, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

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

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

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Eligible population	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>For each of the 2 rates</i>
Current year's administrative rate (before exclusions)		<i>For each of the 2 rates</i>
Minimum required sample size (MRSS)		<i>For each of the 2 rates</i>
Oversampling rate		<i>For each of the 2 rates</i>
Number of oversample records		<i>For each of the 2 rates</i>
Number of original sample records excluded because of valid data errors		<i>For each of the 2 rates</i>
Number of employee/dependent medical records excluded		<i>For each of the 2 rates</i>
Records added from the oversample list		<i>For each of the 2 rates</i>
Denominator		<i>For each of the 2 rates</i>
Numerator events by administrative data	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>
Numerator events by medical records		<i>For each of the 2 rates</i>
Reported rate	<i>For each of the 2 rates</i>	<i>For each of the 2 rates</i>

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Calculation

The measure is reported as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Definitions

Intake Period	January 1–December 31 of the measurement year. The Intake Period is used to identify the first eligible encounter with a primary diagnosis of low back pain.
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
Negative Diagnosis History	A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

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

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

Event/diagnosis	Follow the steps below to identify the eligible population.
Step 1	<p>Identify all members in the specified age range who had any of the following during the Intake Period:</p> <ul style="list-style-type: none">• An outpatient visit (<u>Outpatient Value Set</u>), observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).<ul style="list-style-type: none">– Do not include visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).• Osteopathic or chiropractic manipulative treatment (<u>Osteopathic and Chiropractic Manipulative Treatment Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).• Physical therapy visit (<u>Physical Therapy Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).• Telephone visit (<u>Telephone Visits Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).• E-visit or virtual check-in (<u>Online Assessments Value Set</u>) with a principal diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>).
Step 2	Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.
Step 3	Test for Negative Diagnosis History. Exclude members with a diagnosis of uncomplicated low back pain (<u>Uncomplicated Low Back Pain Value Set</u>) during the 180 days (6 months) prior to the IESD.
Step 4: Required exclusions	<p>Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:</p> <ul style="list-style-type: none">• Cancer. Cancer any time during the member’s history through 28 days after the IESD. Any of the following meet criteria:<ul style="list-style-type: none">– <u>Malignant Neoplasms Value Set</u>.– <u>Other Neoplasms Value Set</u>.– <u>History of Malignant Neoplasm Value Set</u>.– <u>Other Malignant Neoplasm of Skin Value Set</u>.• Recent trauma. Trauma (<u>Trauma Value Set</u>) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.• Intravenous drug abuse. IV drug abuse (<u>IV Drug Abuse Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.• Neurologic impairment. Neurologic impairment (<u>Neurologic Impairment Value Set</u>) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.

- **HIV.** HIV (HIV Value Set) any time during the member’s history through 28 days after the IESD.
- **Spinal infection.** Spinal infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- **Major organ transplant.** Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time in the member’s history through 28 days after the IESD.
- **Prolonged use of corticosteroids.** 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.

To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

No gaps are allowed.

Corticosteroid Medications

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

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

Administrative Specification

Denominator The eligible population.

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

Note

- Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
- Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.

Data Elements for Reporting

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

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

Element	Administrative
Measurement year	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Reported rate	✓

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

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

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

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

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

Definitions

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

Eligible Population

Note: Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid Method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced with a member from the oversample. Refer to General Guideline 9: Members in Hospice.

Product line Exchange.

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

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

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

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

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

Exclusions (optional)

Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these members must do so for all rates.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.

Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

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

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

Medical record Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

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

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

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline 39: Member-Reported Services and Biometric Values* are eligible for use in reporting.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Counseling for Nutrition

Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical record

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity

Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical record

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

Exclusions (optional)

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

Note

- The following notations or examples of documentation do not count as numerator compliant:
 - BMI
 - No BMI percentile documented in medical record or plotted on age-growth chart.
 - Notation of BMI value only.
 - Notation of height and weight only.
 - Nutrition
 - No counseling/education on nutrition and diet.
 - Counseling/education before or after the measurement year.
 - Notation of “health education” or “anticipatory guidance” without specific mention of nutrition.
 - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.
 - Documentation related to a member’s “appetite” does not meet criteria.
 - Physical Activity
 - No counseling/education on physical activity.
 - Notation of “cleared for gym class” alone without documentation of a discussion.
 - Counseling/education before or after the measurement year.
 - Notation of “health education” or “anticipatory guidance” without specific mention of physical activity.
 - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.
 - Notation solely related to screen time (computer or television) without specific mention of physical activity.
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.

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

 - Notation that a member with chronic knee pain is able to run without limping.
 - Notation that a member has exercise-induced asthma.
 - Notation that a member with diarrhea is following the BRAT diet.
 - Notation that a member has decreased appetite as a result of an acute or chronic condition.
 - Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.
- Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.
- The Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting; therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.
- Refer to Appendix 1 for the definition of PCP and OB/GYN and other prenatal practitioner.

Data Elements for Reporting

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

Table WCC-4: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Element	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	<i>Each of the 3 rates</i>	<i>Each of the 3 rates</i>
Eligible population	<i>For each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Number of numerator events by administrative data in eligible population (before exclusions)		<i>Each of the 3 rates, for each age stratification and total</i>
Current year's administrative rate (before exclusions)		<i>Each of the 3 rates, for each age stratification and total</i>
Minimum required sample size (MRSS)		<i>Each of the 3 rates</i>
Oversampling rate		<i>Each of the 3 rates</i>
Number of oversample records		<i>Each of the 3 rates</i>
Number of medical records excluded because of valid data errors		<i>Each of the 3 rates</i>
Number of administrative data records excluded		<i>Each of the 3 rates</i>
Number of medical records excluded		<i>Each of the 3 rates</i>
Number of employee/dependent medical records excluded		<i>Each of the 3 rates</i>
Records added from the oversample list		<i>Each of the 3 rates</i>
Denominator		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by administrative data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by medical records		<i>Each of the 3 rates, for each age stratification and total</i>
Numerator events by supplemental data	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>
Reported rate	<i>Each of the 3 rates, for each age stratification and total</i>	<i>Each of the 3 rates, for each age stratification and total</i>

Well-Child Visits in the First 30 Months of Life (W30)

SUMMARY OF CHANGES TO MY 2021 HEDIS FOR QRS

- No changes to this measure.

Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. *Well-Child Visits in the First 15 Months*. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. *Well-Child Visits for Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Note

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

Eligible Population: Rate 1—Well-Child Visits in the First 15 Months

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

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

Administrative Specification: Rate 1—Well-Child Visits in the First 15 Months

Denominator	The Rate 1 eligible population.
Numerator	Six or more well-child visits (<u>Well-Care Value Set</u>) on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Eligible Population: Rate 2—Well-Child Visits for Age 15 Months–30 Months

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

Product lines	Exchange.
Ages	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification: Rate 2—Well-Child Visits for Age 15 Months–30 Months

Denominator	The Rate 2 eligible population.
Numerator	Two or more well-child visits (<u>Well-Care Value Set</u>) on different dates of service between the child’s 15-month birthday plus 1 day and the 30-month birthday. 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 American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (<https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/>).

Data Elements for Reporting

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

Table W30-4: Data Elements for Well-Child Visits in the First 30 Months of Life

	Administrative
Measurement year	✓
Eligible population	Each of the 2 rates
Numerator events by administrative data	Each of the 2 rates
Numerator events by supplemental data	Each of the 2 rates
Reported rate	Each of the 2 rates

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Appendix 1: Practitioner Types

APPENDIX 1 PRACTITIONER TYPES

clinical pharmacist

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

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

dental practitioner

A practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.

Certified and licensed dental hygienists are considered dental practitioners.

mental health provider

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

- An individual (normally with a master’s or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- A certified Community Mental Health Center (CMHC), or the comparable term (e.g. behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
 - Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
 - The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
 - The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
 - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:
 - Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State’s Medicaid Plan to be considered a CCBHC.
 - Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

OB/GYN and other prenatal care practitioner

Includes:

- Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
- Certified nurse midwives, nurse practitioners or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).

Appendix 1—Practitioner Types

PCP

Primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services.

Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHC) are considered PCPs. This must be reviewed and approved by an auditor.

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

prescribing practitioner

A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

primary care physician

Includes:

- General or family practice physicians.
- Geriatricians.
- General internal medicine physicians.
- General pediatricians.
- Obstetricians/gynecologists (OB/GYN).

Appendix 2: Data Element Definitions

APPENDIX 2

DATA ELEMENT DEFINITIONS

Element	Admin	Hybrid	Research	Meaning
Measurement year	✓	✓		Data year (i.e., year prior to reporting year).
Data collection methodology (Administrative or Hybrid)	✓	✓		Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample.
Eligible population	✓	✓		<ul style="list-style-type: none"> • Members who meet all criteria for the population. This is the universe of members for each measure. • For administrative measures, the eligible population is reported after evaluation for optional exclusion criteria and after required exclusions are applied. • For hybrid measures, the eligible population of members is reported prior to optional exclusions and after required exclusions are applied (see Guidelines for Calculations and Sampling for the three approaches to conducting the Hybrid Method).
Number of optional exclusions			✓	Number of members excluded from the eligible population because they did not meet the numerator criteria and did meet the optional exclusion criteria.
Number of required exclusions			✓	Number of members excluded from the eligible population because they did meet the required exclusion criteria (labeled "required exclusions" in the specification).
Number of numerator events by administrative data in eligible population (before exclusions)		✓		The number of members in the eligible population who met the numerator criteria. This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.
Current year's administrative rate (before exclusions)		✓		<p>This is a calculated field in IDSS.</p> <p>Numerator events by administrative data in eligible population ÷ eligible population.</p> <p><i>This rate may or may not include numerator events by supplemental data.</i></p>
Minimum required sample size (MRSS)		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines.

Element	Admin	Hybrid	Research	Meaning
Oversampling rate		✓		The percentage of additional records used only to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA. <i>The oversample rate should reflect the true percentage that an organization needs to maintain the MRSS and should not result in an amount larger than the eligible population.</i>
Number of oversample records		✓		This is a calculated field in IDSS. MRSS * oversample rate. Oversample records should be used only to replace cases taken out of the MRSS because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.
Number of original sample records excluded because of valid data errors		✓		If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error.
Number of administrative data records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using system or transactional data. <i>These members are only excluded from the MRSS, they are not removed from the eligible population.</i>
Number of medical records excluded		✓		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using medical record data.
Number of employee/dependent medical records excluded		✓		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee. <i>Employees/dependents are only excluded from the MRSS, they are not removed from the eligible population.</i>
Exclusions			✓	The number of required/optional exclusions. NCQA will use this element for research and analysis. The element will not be used for calculating the measure.
Records added from the oversample list		✓		Replacement records for members in the denominator who had an exclusion or valid data error. <i>This number should not exceed the number of oversample records and should be accounted for in the exclusion categories above.</i>

Appendix 2—Data Element Definitions

Element	Admin	Hybrid	Research	Meaning
Denominator		✓		This population is the denominator used to report the measure. MRSS – exclusions + members added from the oversample list.
Numerator events by administrative data	✓	✓		The number of members in the denominator who met numerator criteria using transactional data.
Numerator events by supplemental data	✓	✓		The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
Numerator events by medical records		✓		The number of members in the denominator who met numerator criteria using medical record data.
Reported rate	✓	✓		This is a calculated field in IDSS. <i>Administrative Method:</i> Numerator events by administrative data ÷ eligible population. <i>Hybrid Method:</i> (Numerator events by administrative data + numerator events by medical records) ÷ denominator. Measures that collect numerator events by supplemental data: <i>Administrative:</i> (Numerator events by administrative data + numerator events by supplemental data) ÷ eligible population. <i>Hybrid:</i> (Numerator events by administrative data + numerator events by supplemental data + numerator events by medical records) ÷ denominator.

*Data element is optional.

Standard Administrative Data Element Table

Element	Administrative	XML Element Name
Measurement year	✓	MeasurementYear
Eligible population	✓	EligiblePopulation
Number of optional exclusions	✓	ExclusionAdminOptional
Number of required exclusions	✓	ExclusionAdminRequired
Numerator events by administrative data	✓	NumeratorByAdmin
Numerator events by supplemental data	✓	NumeratorBySupplemental
Reported rate	✓	Rate

Standard Hybrid Data Element Table

Element	Administrative	Hybrid	XML Element Name
Measurement year	✓	✓	MeasurementYear
Data collection methodology (Administrative or Hybrid)	✓	✓	CollectionMethod
Eligible population	✓	✓	EligiblePopulation
Number of required exclusions	✓	✓	ExclusionAdminRequired
Number of numerator events by administrative data in eligible population (before exclusions)		✓	NumeratorByAdminElig
Current year's administrative rate (before exclusions)		✓	Cyar
Minimum required sample size (MRSS)		✓	MinReqSampleSize
Oversampling rate		✓	OversampleRate
Number of oversample records		✓	OversampleRecordsNumber
Number of medical records excluded because of valid data errors		✓	ExclusionValidDataErrors
Number of administrative data records excluded		✓	ExclusionAdminOptional
Number of medical records excluded		✓	ExclusionMedRecsOptional
Number of employee/dependent medical records excluded		✓	ExclusionEmployeeOrDep
Records added from the oversample list		✓	OversampleRecsAdded
Denominator		✓	Denominator
Numerator events by administrative data	✓	✓	NumeratorByAdmin
Numerator events by supplemental data	✓	✓	NumeratorBySupplemental
Numerator events by medical records		✓	NumeratorByMedicalRecords
Reported rate	✓	✓	Rate

Note: The XML Element Name column provides a crosswalk to the data element names used in IDSS.

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3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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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 member. Then, round the PDC to the nearest hundredth (e.g., 79.996% is rounded to 80.00%, 79.992% is rounded to 79.99%).

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

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

International Normalized Ratio Monitoring for Individuals on Warfarin (INR)

Summary of Changes to the 2022 PQA INR Measure Specification for QRS

- Added clarification on the definition of Hospital Stay.
- Added definition of INR test.
- Removed reference to laboratory claims in step #7 for the eligible population.

Description

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

A higher rate indicates better performance

Definitions

Warfarin	See Medication Table INR-A: Warfarin.
Prescription Claims	Paid, reversed, and rejected prescription claims are included when calculating the measure.
Index Prescription Start Date (IPSD)	The earliest date of service (paid, reversed, or rejected claim) for warfarin during the measurement year.
Treatment Period	<p>The period of time beginning on the IPSD and ending with the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year. If the days' supply extends beyond the end of the measurement year, the treatment period ends on December 31 of the measurement year.</p> <p>The last prescription claim for warfarin should be used to determine the end of the treatment period even if there is days' supply from a previous prescription claim for warfarin that extends beyond the days' supply for the last prescription claim during the treatment period.</p> <p><i>For example: if a member has prescription claims on December 1 for a 5 days' supply and on November 30 for a 10 days' supply, the end of the treatment period is December 5.</i></p> <p>If two prescription claims for warfarin occur on the same date of service, the date of service with the longest days' supply is used to determine the end of the treatment period.</p> <p>Gaps in prescription claims for warfarin can occur during the treatment period.</p>
Hospital Stay	Any medical claim indicating a hospital stay (with appropriate revenue code) during the measurement year. See Value Set, Hospital Stay.
INR Test	Gaps in prescription claims for warfarin can occur during the treatment period. Any lab or medical claim for an INR test during the measurement year. See Value Set, INR Test.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous enrollment	The treatment period.
Allowable gap	None.
Benefit	Medical and Pharmacy.
Denominator Exclusions	<ul style="list-style-type: none"> • Exclude members whose IPSD or last prescription claim for warfarin during the measurement year are missing the days' supply. • Exclude members with a laboratory or medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion

Event/Diagnosis Members dispensed warfarin during the measurement year.

Use the steps below to determine the eligible population.

- Step 1** Identify members aged 18 years and older as of the first day of the measurement year.
- Step 2** Identify members who meet the continuous enrollment criteria.
- Step 3** Identify members with ≥ 1 prescription claims for warfarin (Medication Table INR-A) during the measurement year.
- Step 4** Determine each member's treatment period. The member's treatment period begins on the IPSD and extends through the last day of supply for warfarin (date of service plus the days' supply for the last prescription claim for warfarin minus 1) during the measurement year.
- Step 5** Identify members with a treatment period that is ≥ 56 days during the measurement year.
- Step 6** Exclude members whose IPSD or last prescription claim for warfarin during the measurement year are missing the days' supply.
- Step 7** Exclude members with a medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.

Administrative Specification

Denominator	The eligible population.
Numerator	Members who received at least one INR monitoring test during or was hospitalized during each 56-day interval during the treatment period.

Use the steps below to determine the members for the numerator.

- Step 1** For each member in the denominator, determine the start and end dates for each full 56-day interval.

3.2 PQA Measure Specifications

For example: a member has his/her first prescription claim for warfarin during the measurement year on January 1 and last prescription claim for warfarin during the measurement year on April 1 for a 30-days' supply. As a result, the member's treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 26 and ends on April 22.

Note: Only full 56-day intervals are used for evaluating members for the numerator.

Days after the last full interval are not included.

- Step 2** For each member in the denominator, determine if there was an INR test (Value Set, INR Test) or a hospital stay of >48 hours (Value Set, Hospital Stay) during each interval.

Note: Hospital stays are only applied to the 56-day interval in which the admission date falls. If hours are not available, hospital stays of at least three days meet the numerator criteria. However, the entire hospital stay does not need to fall within the 56-day interval in which the admission date falls.

For example: a member has their warfarin fill during the measurement year on January 1 and last warfarin fill during the measurement year on April 1 for a 30-days' supply. As a result, his/her treatment period is from January 1 through April 30, or 120 days. During the treatment period, the member has 2 full intervals. Interval 1 starts on January 1 and ends on February 25. Interval 2 starts on February 2/26 and ends on April 22. The member is admitted to the hospital on February 25 and discharged on February 27 and also has an INR test on March 12. The hospital stay from February 25 through February 27 meets the numerator criteria for interval 1 and the INR test meets the numerator criteria for interval 2. The member meets the numerator criteria in each interval and would be counted in the numerator.

- Step 3** Count the members with an INR test or hospitalization during all intervals as numerator compliant.

Medication Table

Table INR-A: Warfarin

Warfarin
<ul style="list-style-type: none"> warfarin

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

Summary of Changes to the 2022 PQA AMO Measure Specification for QRS

- Removed reference to LOINC codes in the Drug Test definition.
- Removed Measure Rate step under the Administrative Specification section.

Description

The percentage of members 18 years and older who are prescribed long-term opioid therapy and have not received a drug test at least once during the measurement year.

A lower rate indicates better performance.

Definitions

Opioid Analgesics	See Medication Table AMO: Opioid Analgesics. Includes opioid medications indicated for pain.
Long-Term Opioid Therapy	≥90 days' cumulative supply of any combination of opioid analgesics (See Medication Table AMO: Opioid Analgesics) during the measurement year identified using prescription claims.
Prescription Claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Drug Test	Any drug screens/tests for at least one of the following targeted drug classes: amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, and opiates/opioids. <ul style="list-style-type: none"> • ≥1 claim with specified Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes. See Value Set, Drug Test Value.

Eligible Population

Ages	18 years and older as of the first day of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Benefit	Medical and Pharmacy.
Denominator Exclusions	Exclude members who met ≥1 of the following during the measurement year: <ul style="list-style-type: none"> • Hospice- Refer to General Guideline 9: Members in Hospice. • Cancer- Any member with non-melanoma skin cancer during the measurement year. See Value Set, Cancer

3.2 PQA Measure Specifications

Event/Diagnosis Members who are prescribed long-term opioid therapy.

Use the steps below to determine the eligible population.

Step 1 Identify members aged 18 years and older as of the first day of the measurement year.

Step 2 Identify members who meet the continuous enrollment criteria.

Step 3 Identify members who are prescribed ≥ 90 days' cumulative supply of any combination of opioid analgesics (Medication Table AMO: Opioid Analgesics) during the measurement year. The cumulative days' supply does not have to be consecutive. Exclude days' supply that extends beyond the end of the measurement year.

NOTE:

- The prescriptions can be for the same or different opioids.
- If multiple prescriptions for the same or different opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.
- If multiple prescriptions for the same or different opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Step 4 Exclude members who met ≥ 1 of the following during the measurement year:

- Hospice- Refer to General Guideline 9: Members in Hospice.
- Cancer- Any member with ≥ 1 claim for cancer during the measurement year. See Value Set, Cancer.

Administrative Specification

Denominator The eligible population.

Numerator Members in the denominator who have not received a drug test during the measurement year. See Value Set, Drug Test.

Medication Table

Table AMO: Opioid Analgesics^{a,b}

Opioids		
<ul style="list-style-type: none">• benzhydrocodone• buprenorphine• butorphanol• codeine• dihydrocodeine• fentanyl	<ul style="list-style-type: none">• hydrocodone• hydromorphone• levorphanol• meperidine• methadone• morphine	<ul style="list-style-type: none">• oxycodone• oxymorphone• pentazocine• tapentadol• tramadol

^a Includes opioid medications indicated for pain; includes combination products.

^b Excludes the following: medications prescribed or provided as part of medication-assisted treatment for opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products); and formulations delivered by the intravenous (IV) or epidural (EP) route (IV and EP routes are excluded because they are not commonly prescribed as chronic pain medications).

This measure was developed by IMPAQ International, LLC and Health Services Advisory Group, Inc. (HSAG).

4. QRS Survey Measure Specifications

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QRS Survey Measure Descriptions

Overview

This section includes descriptions for the QRS survey measures⁸ that will be collected as part of the 2022 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 2022 QHP Enrollee Survey item(s), please see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page.html>.

Additional details related to the 2022 QHP Enrollee Survey and data collection protocols are included on the CMS QHP Enrollee Survey page of the CMS Marketplace Quality Initiatives website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/Consumer-Experience-Surveys/Surveys-page.html/>

QRS Survey Measure Descriptions

Access to Care

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- In the last 6 months, when you needed care right away, in an emergency room, doctor's office, or clinic, how often did you get care as soon as you needed? Include in person, telephone or video appointments.⁹ (*Question #22*)
- In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? Include in person, telephone or video appointments. (*Question #23*)
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? Include in person, telephone or video appointments. (*Question #25*)
- In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed? Include in person, telephone or video appointments. (*Question #41*)

Access to Information

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works? (*Question #3*)
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment before you got it? (*Question #4*)
- In the last 6 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines? (*Question #5*)

⁸ The following QRS survey measures are HEDIS® measures and are addressed in NCQA's Measure Specifications: Flu Vaccinations for Adults Ages 18-64 and Medical Assistance with Smoking Cessation.

⁹ Multiple screener questions were collapsed into the first question in the series. As a result, the *Access to Care* screening question was combined with the first question of that series. In previous years the "emergency room, doctor's office, or clinic" language was part of the screener question. This change does not impact scoring of the *Access to Care* measure for the QRS.

Care Coordination

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- When you visited your personal doctor for a scheduled appointment in the last 6 months, how often did he or she have your medical records or other information about your care? Include in person, telephone or video appointments. (Question #33)
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? (Question #34)
 - In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? (Question #35)
 - In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? (Question #43)
 - In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? (Question #36)
 - In the last 6 months, how often did you get the help that you needed from your personal doctor's office to manage your care among these different providers and services?¹⁰(Question #39)
-

Plan Administration

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed? (Question #6)
 - In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? (Question #7)
 - In the last 6 months, how often did the time that you waited to talk to your health plan's customer service staff take longer than you expected? (Question #8)
 - In the last 6 months, how often were the forms from your health plan easy to fill out? (Question #9)
 - In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out? (Question #10)
-

Rating of All Health Care

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? Include in person, telephone or video appointments. (Question #27)
-

¹⁰ Enrollees must answer affirmatively to the screener question: "In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?" in order to respond to this question.

Rating of Health Plan

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan in the last 6 months? (*Question #20*)
-

Rating of Personal Doctor

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor? (*Question #40*)
-

Rating of Specialist

This QRS survey measure is based on enrollee responses to the 2022 QHP Enrollee Survey on the following:

- We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist? (*Question #44*)
-