

Health Insurance Exchange

2023 Quality Rating System Measure Technical Specifications

March 2022

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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 2023 (Measurement Year 2022).

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 2023 Quality Rating System (QRS) measure set. Qualified Health Plan (QHP) issuers will need to reference this document in order to collect and submit QRS measure data to the Centers for Medicare & Medicaid Services (CMS) in accordance with the QRS 2023 requirements. The document specifically details the following:

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

CMS anticipates updating this document on an annual basis to reflect any changes to the measure set, including changes to the measure specifications or data collection guidelines. 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 2022 Call Letter for the QRS and QHP Enrollee Survey*).²

In the fall of 2022, CMS intends to publish the *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023* (2023 QRS and QHP Enrollee Survey Technical Guidance), reflecting applicable finalized changes announced in the *Final 2022 QRS and QHP Enrollee Survey Call Letter*. The 2023 QRS and QHP Enrollee Survey Technical Guidance will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2023 QRS ratings year.

Background

In accordance with the requirements specified in the annual Quality Rating System and Qualified Health Plan 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.

² The Draft 2022 Call Letter for the QRS and QHP Enrollee Survey is available at: <https://www.cms.gov/files/document/2022-call-letter-qrs-qhp-enrollee-survey.pdf>

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

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

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2. QRS Measure Set

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QRS Measure Set

The QRS measure set consists of measures that address areas of clinical quality management; enrollee experience; and plan efficiency, affordability, and management. Exhibit 1 includes the list of all potential QRS measures for 2023 as proposed in the *Draft 2022 Call Letter for the QRS and QHP Enrollee Survey*. Measures denoted with a strikethrough (–) 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 2023 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 2023 QRS data collection but will not be included in 2023 QRS scoring. CMS will communicate final changes to the 2023 QRS measure set in the *Final 2022 Call Letter for the QRS and QHP Enrollee Survey*, which CMS anticipates publishing in late spring of 2022.

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 1. Proposed 2023 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 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 10) | NCQA | 0038 |
| Chlamydia Screening in Women | NCQA | 0033 |
| Colorectal Cancer Screening | NCQA | 0034 |
| Eye Exam for Patient with Diabetes | NCQA | 0055 |
| Hemoglobin A1c (HbA1c) Control for Patient with Diabetes: HbA1c control (<8.0%) | NCQA | 0575 |
| Controlling High Blood Pressure | NCQA | 0018 |
| 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 |

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 |
|---|------------------------|--|
| Initiation and Engagement of Substance Use Disorder Treatment | NCQA | 0004 |
| International Normalized Ratio Monitoring for Individuals on Warfarin | PQA | 0555 |
| Kidney Health Evaluation for Patients with Diabetes* | NCQA | N/A |
| 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 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 2022 (MY 2022) HEDIS® General Guidelines for the QRS Measure Technical Specifications

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Overview

HEDIS MY 2022

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 2022 (MY 2022). MY 2022 refers to the 2022 calendar year and data that is reported on June 15, 2023.

Please note that this publication includes the specifications for measures and/or measure rates that are proposed for inclusion in the 2023 QRS measure set in the *Draft 2022 Call Letter for the Quality Rating System (QRS) and Qualified Health Plan (QHP) Enrollee Experience Survey* (Draft 2022 Call Letter). Refer to the *Final 2022 Call Letter for the QRS and QHP Enrollee Experience Survey* (Final 2021 Call Letter), anticipated April-May 2022, for finalized changes.

The *Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2023 (2023 QRS and QHP Enrollee Survey Technical Guidance)* will announce which measures eligible QHP issuers are required to collect and submit to CMS for the 2023 ratings year.

New measures

- *Kidney Health Evaluation for Patients With Diabetes (KED).*
- Measures Reported Using Electronic Clinical Data Systems (ECDS).
 - *Childhood Immunization Status (CIS-E).*
 - *Immunizations for Adolescents (IMA-E).*
 - *Breast Cancer Screening (BCS-E).*
 - *Colorectal Cancer Screening (COL-E).*

Retired measures

- *Comprehensive Diabetes Care (CDC)*—Medical Attention for Nephropathy.

Revised measures

- For specific revisions, refer to each measure’s *Summary of Changes*.
- The former *Comprehensive Diabetes Care (CDC)* measure has been separated into two standalone measures¹:
 - *Hemoglobin A1c Control for Patients With Diabetes (HBD).*
 - *Eye Exam for Patients With Diabetes (EED).*

¹ The Hemoglobin A1c (HbA1c) Control for Patient With Diabetes: HbA1c control (<8.0%) measure (formerly Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Control [<8.0%]) and the Eye Exam for Patient With Diabetes measure (formerly Comprehensive Diabetes Care: Eye Exam (Retinal) Performed) were formerly considered standalone measures in the QRS measure set, and will continue to be.

Overall changes

- Revised the format of the Data Elements for Reporting tables in all measures.
- Removed the “Measurement year” data element from the Data Elements for Reporting tables in all measures.
- Added the “Benefit” data element to the Data Elements for Reporting tables for measures that require a benefit other than medical.
- Added the “Number of required exclusions” data element to all measures with the hospice exclusion.
- Updated Appendix 2 to align with the restructuring of the Data Elements for Reporting tables.

Additional Resources

QRS and QHP Enrollee Survey Technical Guidance

Technical specification updates. The Centers for Medicare & Medicaid Services (CMS) publishes guidance for Qualified Health Plans (QHP) in the Exchanges to specify requirements for participating in the Quality Rating System (QRS), including the clinical and survey measures that must be reported. The *2023 QRS and QHP Enrollee Survey Technical Guidance* will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2022 (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/ACA-MQI/ACA-MQI-Landing-Page>).

Additionally, CMS publishes an updated version of the QRS Measure Technical Specifications, which includes guidance on the finalized data submission requirements for the QRS measure set. Specifically, CMS includes callout boxes summarizing the final decision regarding measures and/or measure rates proposed for addition and those proposed for removal in the Draft Call Letter and finalized via the Final Call Letter. CMS anticipates releasing an updated version of the QRS Measure Technical Specifications for years when refinements to the QRS measures and/or measure rates are addressed via the QRS and QHP Enrollee Survey Call Letter process and finalized via the Final Call Letter. The updated 2023 QRS Measure Technical Specifications will be posted to the CMS Marketplace Quality Initiatives (MQI) website in the fall of 2022 (<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, 2022, with the release of the *MY 2022 HEDIS for QRS Technical Update*:

- **The HEDIS for QRS Technical Update memo** will be posted to the NCQA website (<https://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, 2022.
 - **MY 2022 Quality Rating System (QRS) HEDIS Value Set Directory:** <https://store.ncqa.org/my-2022-quality-rating-system-grs-hedis-value-set-directory.html>
 - **HEDIS MY 2022 Medication List Directory:** <https://store.ncqa.org/hedis-my-2022-medication-list-directory.html>
 - **HEDIS MY 2022 Risk Adjustment Tables:** <https://store.ncqa.org/hedis-my-2022-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.**” Such uncertified rates may only be used for internal, quality improvement purposes and no incentive payments may be made on such rates (e.g., trend analysis).
- 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.**”

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 (<https://my.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.

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:

- 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 2022 HEDIS for QRS General Guidelines for the MY 2022 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).^{2,3}

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Removed the HEDIS Audit Timeline from *General Guideline 5: Audit Preparation*. It will be posted online and published in *Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.
- Updated the Comments for NA in *General Guideline 6: Reporting*.
- Removed the General Guideline for the “Working Aged” and Retirees (formerly *General Guideline 8*); renumbered subsequent guidelines.
- Clarified in *General Guideline 21: Supplemental Data* (formerly *General Guideline 22*) that “shipped date” meets criteria for dispensed date.
- Removed the certified eCQM vendor data definition from *General Guideline 21: Supplemental Data* (formerly *General Guideline 22*).
- Added *General Guideline 23: Race and Ethnicity (RES) Stratification*.
- Added a note to *General Guideline 27: Measures That Use Medication Lists*.
- Updated *General Guideline 32: Presentation of Codes in HEDIS*.
- Updated *General Guideline 42: Reporting Tables* to clarify the format of the restructured data element tables.

MY 2022 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 (EPO, HMO, POS, PPO) offered through an Exchange in 2023 that had more than 500 enrollees as of July 1 in the prior year (July 1, 2022) and continues to have more than 500 enrollees as of January 1 of the ratings year (January 1, 2023). Reporting units that are decertified or discontinued before June 15 of the ratings year (June 15, 2023) 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 2022 Quality Rating System Measure Technical Specifications*). At this time, organizations should not include indemnity plans (i.e., fee-for-service plans),

² The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–309) (collectively referred to as the Affordable Care Act) established an Affordable Insurance Exchange (or Exchange) within each state Exchange.

³ A QHP issuer has a certification issued by or recognized by an Exchange to demonstrate that each health plan offered in the Exchange is a QHP and meets the requirements described in 45 CFR 155.2. Each QHP issuer is defined by a separate federal Health Insurance Oversight (HIO) Issuer ID. Each QHP issuer is defined by a State geographic unit. A QHP issuer must operate on an Exchange for at least one year before it is required to collect QRS measure data. Final rule—<https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and>

child-only plans or stand-alone dental plans in the reporting unit. Organizations should not include any enrollees from health plans offered outside 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.

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

Combining products into one reporting unit is not allowed.

Definitions

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

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

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

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

The level of benefits or reimbursement is generally determined by whether the member uses the in-network or out-of-network services. Common uses of "POS" include references to products that enroll each member in 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 2023 that had more than 500 enrollees as of July 1, 2022, and continues to have more than 500 enrollees as of January 1 of the ratings year (2023).

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 2022, 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 (<https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/>) 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. Organizations must follow the HEDIS Audit Timeline, which will be posted on the NCQA website (<https://www.ncqa.org/hedis/measures/>) on March 31, 2022, and is published in *Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*.

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 | <p><i>Small Denominator.</i> The organization followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate.</p> <p>a. For Effectiveness of Care (EOC) measures, when the denominator is <30.</p> <p>b. For all risk-adjusted utilization measures, when the denominator is <150.</p> <p>c. For measures reported using ECDS, when the denominator is <30.</p> <p>NA (<i>Not Applicable</i>) is a status, not an audit designation. Measure rates that result in NA are considered Reportable (R), but the denominator is too small to report.</p> |
| NB | <p><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).</p> <p>Benefits are assessed at the global level, not the service level (refer to <i>General Guideline 16: Required Benefits</i>).</p> |
| NR | <i>Not Reported.</i> The organization chose not to report the measure. |
| BR | <i>Biased Rate.</i> The calculated rate was materially biased. |

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

In Which Reports Do 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. Members in Hospice

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

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

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

Note

- *Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say, "supplemental data may not be used for the measure" (e.g., PCR).*
- *For ECDS reporting, hospice data from Monthly Membership Detail Data Files must be flagged for the administrative Source System of Record.*

9. 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 can be used for excluding deceased members for all applicable measures, including measures that say, "supplemental data may not be used for the measure" (e.g., URI).*

Membership Changes

10. 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 13: 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.

11. 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.

12. 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

13. 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 *Child and Adolescent Well-Care Visits* 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).

14. 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.

15. 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.

16. 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.

17. 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

18. Reporting Date

For MY 2022 HEDIS for QRS, all organizations reporting audited data to NCQA through the IDSS must submit data to NCQA on or before June 15, 2023.

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 2022 HEDIS for QRS reporting, organizations are required to “plan-lock” audited HEDIS for QRS data no later than **June 1, 2023**.

19. 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 *General Guideline 42: Reporting Tables* and *Appendix 2: Data Element Definitions*.

Data Collection Methods and Data Sources

20. Data Collection Methods

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

- Administrative Method.
- Hybrid Method.
- Survey Method.
- ECDS 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>).

ECDS Method: Refer to the *Guidelines for Measures Reported Using Electronic Clinical Data Systems* for additional information for this data collection method.

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 21: Supplemental Data for supplemental data requirements.

21. 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 *Hemoglobin A1c Control for Patients With Diabetes* 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 Preproduction Processing section of the HEDIS Roadmap. These data are loaded as administrative data.*

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

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

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

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

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

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

Continuity of Care Documents. CCDs are used for the electronic exchange of clinical data without loss of meaning. The files provide a summary of a patient's care as a snapshot in time, but they are not a replacement for an EHR. These files are typically XML-based and are considered nonstandard supplemental data for at least the first year of use. The organization must demonstrate the accuracy of these (through primary source verification) 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 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 or shipped to the member. For mail order prescriptions "shipped date" meets criteria for dispense date. "Start date" documented in the medical record does not meet criteria. 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 for data collection and validation deadlines (refer to *General Guideline 5: Audit Preparation* for more information about the timeline).

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*.

22. 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.

23. Race and Ethnicity Stratification

The following measures instruct the organization to categorize members by the race and ethnicity stratification (RES):

- *Colorectal Cancer Screening.*
- *Controlling High Blood Pressure.*
- *Hemoglobin A1c Control for Patients With Diabetes.*
- *Prenatal and Postpartum Care.*
- *Child and Adolescent Well-Care Visits.*

Reporting categories

NCQA requires reporting race and ethnicity as defined by the Office of Management and Budget (OMB) Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.^{4,5,6}

Race and ethnicity values must be rolled up into the OMB categories specified in this guideline. If more detailed race or ethnicity information is collected, these data must be aggregated and reported in the OMB categories provided. For health plans using the CMS classification scheme for race and ethnicity, refer to Table RES-A-4 for a crosswalk to HEDIS for QRS reporting.

⁴ Office of Management and Budget Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>

⁵ 2020 Census Questions: Race. <https://2020census.gov/en/about-questions/2020-census-questions-race.html>

⁶ 2020 Census Questions: Hispanic Origin. <https://2020census.gov/en/about-questions/hispanic-origin.html>

Report member race and ethnicity separately. If a combined race/ethnicity category question is used to collect data, data must be disaggregated, and race and ethnicity categories must be reported separately. When using the combined race/ethnicity data format for collection, refer to Table RES-B-4 for a crosswalk of reporting categories.

Determining race reporting category

Report members in only one of the nine race stratifications listed below and the total.

- *White*: Identification with one or more nationalities or ethnic groups originating in Europe, the Middle East or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun and Chaldean.
- *Black or African American*: Identification with one or more nationalities or ethnic groups originating in any of the Black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian and Bahamian.
- *American Indian and Alaska Native*: Identification with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as “American Indian” or “Alaska Native” and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government and Nome Eskimo Community.
- *Asian*: Identification with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali or Mien.
- *Native Hawaiian and Other Pacific Islander*: Identification with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese or Yapese.
- *Some Other Race*: People whose race information has been collected but does not fit into any of the other seven race categories. This category includes people who may be Mulatto, Creole and Mestizo or another race not specified in the Census “Race” categories.
- *Two or More Races*: People with any combination of races, including “Some Other Race.”
- *Asked but No Answer*: People who the organization asked to identify race but who declined to provide a response.
- *Unknown*: People for whom the organization did not obtain race information and for whom the organization did not receive a declined response (“Asked but No Answer”).
- *Total*: Total of all categories above.

Note: The “Asked but No Answer” category is not reported using indirect data.

Determining ethnicity reporting category

Report members in only one of the four ethnicity stratifications listed below and the total.

- *Hispanic/Latino*: Identification with one or more nationalities or ethnic groups originating in Mexico, Puerto Rico, Cuba, Central and South America and other Spanish cultures. Examples of these groups include, but are not limited to, Mexican or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican and Colombian. “Hispanic, Latino or Spanish origin” also includes groups such as Guatemalan, Honduran, Spaniard, Ecuadorian, Peruvian or Venezuelan.
- *Not Hispanic/Latino*: People not of Hispanic, Latino or Spanish culture or origin.
- *Asked but No Answer*: People who the organization asked to identify ethnicity but who declined to provide a response.
- *Unknown*: People for whom the organization did not obtain ethnicity information and for whom the organization did not receive a declined response (“Asked but No Answer”).
- *Total*: Total of all categories above.

Note: The “Asked but No Answer” category is not reported using indirect data.

Data source

Approved data sources include data collected directly from members or data obtained through indirect methods. NCQA strongly encourages plans to report directly collected data when available and emphasizes the importance of improving completeness of directly collected member race and ethnicity data.

For each measure with the race and ethnicity stratification, plans will report each race and ethnicity value by data source. Plans will report the number of members in the eligible population from direct and indirect data sources, and the number of members in the numerator from direct and indirect data sources. IDSS will calculate the total number of members in the eligible population and numerator (combining both direct and indirect data sources).

Direct data

Data collected directly from members method reflects members’ self-identification and is the preferred data source.

Directly collected data includes any source for which the member self-identified race or ethnicity. This includes data collected directly from members by the health plan, as well as third-party data collected directly from a member by another entity (e.g., the state or CMS). Direct sources may include, but are not limited to:

- Surveys.
- Health risk assessments.
- Disease management registries.
- Case management systems.
- Electronic health records.
- CMS/state databases.
- Enrollment information furnished by enrolling entities (e.g., state Medicaid agencies, employers).

Indirect data

Plans may choose to report race and ethnicity data supplemented by indirect methods. Indirect assignment of race and ethnicity values include using an alternate data source, such as nationally representative data obtained from databases like the American Community survey, to assign a race or ethnicity value to a member based on their primary location of residence. Some commonly used indirect methods combine geographic data with additional imputation methods such as surname analysis.

NCQA reiterates that directly collected race and ethnicity is considered the gold standard and is highly preferred to indirectly assigned race and ethnicity. For plans choosing to use indirect methods to report the HEDIS for QRS race and ethnicity stratification, NCQA emphasizes the following:

- When applying indirect methods that involve assignment of race or ethnicity based on geographic data and member's location of residence, the smallest geographic unit possible is preferred. For example, geographic assignment at the Census block level is likely to be more accurate than assignment using Census tract or ZIP code-level data.
- Indirect data sources and methods should be evaluated for reliability and validity and selection of a source and method should be prioritized based on demonstrated validity and reliability for the population in which it will be applied (e.g., age group, geography, product line).
- Indirect methods of race and ethnicity assignment are to be used for population-level reporting and analysis but are not appropriate for member-level intervention.

Sampling

For measures collected using the Hybrid Method with the race and ethnicity stratification, follow the guidelines for sampling outlined in *Guidelines for Calculation and Sampling Guidelines for the Hybrid Method*. The race and ethnicity stratifications are applied to the eligible population and denominator after hybrid sampling.

Reporting

Reporting of the race and ethnicity stratification follows the parameters for denominator size outlined in *General Guideline 6: Reporting*.

Table RES-A-4: CMS Categories Crosswalked to HEDIS/OMB Race and Ethnicity

| CMS Category | HEDIS/OMB Race | HEDIS/OMB Ethnicity |
|-------------------------------|--|---------------------|
| White | White | Unknown |
| Black | Black | Unknown |
| American Indian/Alaska Native | American Indian/Alaska Native | Unknown |
| Asian/Pacific Islander | Asian | Unknown |
| Hispanic | Unknown | Hispanic/Latino |
| Other | Some Other Race | Unknown |
| Unknown | Unknown | Unknown |
| (No equivalent category) | Native Hawaiian and Other Pacific Islander | Unknown |
| (No equivalent category) | Two or more races | Unknown |

Table RES-B-4: Combined Categories Crosswalked to HEDIS/OMB Race and Ethnicity

| Race/Ethnicity Combined Category | HEDIS/OMB Race | HEDIS/OMB Ethnicity |
|--|--|---------------------|
| White | White | Not Hispanic/Latino |
| Black | Black | Not Hispanic/Latino |
| American Indian/Alaska Native | American Indian/Alaska Native | Not Hispanic/Latino |
| Asian | Asian | Not Hispanic/Latino |
| Native Hawaiian and Other Pacific Islander | Native Hawaiian and Other Pacific Islander | Not Hispanic/Latino |
| Hispanic/Latino/White | White | Hispanic/Latino |
| Hispanic/Latino/Black | Black | Hispanic/Latino |
| Other | Some Other Race | Unknown |
| Multiple races marked | Two or more races | Unknown |
| Unknown | Unknown | Unknown |

Note

- *Reporting of stratified race and ethnicity data for these select HEDIS measures in the QRS Program was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and 2023 QRS and QHP Enrollee Survey Technical Guidance for guidance on this reporting requirement.*
- *Race is a social construct, not biological; stratifying HEDIS for QRS measures by race and ethnicity is intended to be used to further understanding of racial and ethnic disparities in care and to hold health plans accountable to address such disparities, with the goal of achieving equitable health care and outcomes. Data are not to be used to further bias in health care or suggest that race and ethnicity are biological determinants of health.*
- *When multiple sources of data are used for race and ethnicity, there may be disagreements in the data collected. When this happens, data sources should be prioritized based on evaluation of anticipated accuracy. This includes use of specific categories over nonspecific categories, most frequent or consistently reported category and selection of data with clear provenance (source, method of collection) over data without clear provenance.*
- *Race and ethnicity data may come from different categories of data source (direct, indirect). In such cases, use the data source that applies to the data element (race, ethnicity). If the same data element is received from two different data sources, prioritize data sources based on the note above.*

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 for QRS 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 7 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 7 days and may 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 7 days and may not 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 7 days apart and may 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 7 days apart and may not 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, 2020.

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 2022, 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.

Note: RxNorm codes may not be used to assess the numerator in the Asthma Medication Ratio measure.

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).
- 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

HEDIS for QRS measure specifications reference value sets and single codes (referred to as “direct reference” codes) that must be used for HEDIS for QRS reporting.

| | |
|-------------------------------|---|
| Value sets | A value set contains one or more codes that meet criteria for a service or condition. In the specifications, value set references are capitalized and underlined (e.g., <u>Essential Hypertension Value Set</u>). Organizations refer to the Value Set Directory (VSD) for codes in the value sets. |
| Direct reference codes | <p>A direct reference code is a single code that meets criteria for a service or condition. Direct reference codes are listed in the measure specification and are also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS).</p> <p>Note: Value sets that contain only one code will be phased out (and turned into direct reference codes) as measures are digitalized.</p> |

Refer to *ECDS Guideline 7* in the *Guidelines for Measures Reported Using Electronic Clinical Data Systems* for information on how codes are presented for measures reported using ECDS.

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.

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 a **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 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" 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-digit 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 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.

41. Retiring Codes

NCQA annually tracks 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 Asthma Medication Ratio measure counts a principal diagnosis of asthma in the measurement year or the year prior to the measurement year, asthma codes, for this measure, have a 2-year look-back period. A code that is designated obsolete effective January 1, 2020, is deleted from the specifications in HEDIS MY 2022 after the 2-year look-back period (2021, 2022) plus one additional year (2020) is exhausted.

A code that is designated obsolete effective January 1, 2020, is deleted from the specifications in HEDIS QRS MY 2022 after the 2-year look-back period (2021 and 2022) plus one additional year (2020) is exhausted.

HEDIS Specification Tables

42. Reporting Tables

The reporting tables in the measure specifications outline the data elements required for reporting. Refer to *Appendix 2: Data Element Definitions* for additional information.

Format

The reporting tables in the measure specifications follow a standard format corresponding to the structure of the IDSS submission XML file:

- *Metric*: For single-metric measures, the metric describes the subject of the measure. For multi-metric measures, the metrics describe the various concepts evaluated in the measure (e.g., screening, follow-up, influenza, Tdap). For wide tables, the metric column may be shown above the table.
- *Stratification*: Only applies to measures that include one or more stratifications (e.g., age, gender). For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.
- *Data Element*: The data elements required for reporting (depending on data collection method).

- **Reporting Instructions:** These instructions specify how the data elements must be reported (e.g., for each metric, repeat per metric), or the units or formula for IDSS calculated data elements.
- **A:** This column is used in hybrid measures to indicate which data elements are required for reporting for the Administrative Method. For the Hybrid Method, all data elements must be reported, unless otherwise specified in the measure specifications.

For administrative-only measures, all data elements must be reported.

Example Data Elements for Reporting Table

| Metric | Stratification1 | Stratification2 | Data Element | Reporting Instructions | A |
|---------|-----------------|-----------------|--------------|------------------------|---|
| Metric1 | Level1 | Level1 | DataElement1 | Instruction1 | ✓ |
| Metric2 | Level2 | Level2 | DataElement2 | Instruction2 | ✓ |
| | Total | Level3 | DataElement3 | Instruction3 | |
| | | Total | DataElement4 | Instruction4 | |
| | | | DataElement5 | Instruction5 | ✓ |
| | | | DataElement6 | Instruction6 | |
| | | | Rate | Calculation / (Units) | ✓ |

HEDIS for QRS measures consist of one-to-many indicators for reporting. Each indicator corresponds to a unique combination of a metric and any stratifications (if applicable). For example, a measure with 2 metrics; 3 age stratifications and a total; and 3 gender stratifications and a total consists of 24 indicators.

Example:

$$\# \text{ of indicators} = \# \text{ of metrics} \times (\# \text{ of stratifications 1} + \text{total}) \times (\# \text{ of stratifications 2} + \text{total})$$

Shading

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 2022 HEDIS FOR QRS

- Updated Table 1: Sample Size Information for Hybrid Measures.
- Updated the HEDIS MY 2022 RAND Table for Measures Using the Hybrid Method.

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 2023 for the 2022 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 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.*
- *Hemoglobin A1c Control for Patients With Diabetes.*
- *Eye Exam for Patients With Diabetes.*
- *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 column of Table 1 to determine whether the prior year's audited result can be used to reduce the current year's sample size.

Use Table 2 if the prior year's rate is used to determine the current year's sample. The organization may also 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% 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% 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% 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% 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 2022 HEDIS for QRS Measures | Sample Size | Prior Year's Rate May Be Used to Reduce MY 2022 Sample Size ⁷ |
|---|-------------|--|
| Cervical Cancer Screening | 411 | Y |
| Childhood Immunization Status | 411 | N ⁸ |
| Colorectal Cancer Screening | 411 | Y |
| Hemoglobin A1c Control for Patients With Diabetes | 411 | Y ⁹ |
| Eye Exam for Patients With Diabetes | 411 | Y ⁹ |
| Controlling High Blood Pressure | 411 | Y |
| Immunizations for Adolescents | 411 | Y ⁸ |
| Prenatal and Postpartum Care | 411 | Y ⁸ |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | 411 | Y ⁸ |

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 |

⁷ 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.

⁸ 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.

⁹ If the same sample is used for the two diabetes measures, reduce using the lowest rate of the two rates (HBD and EED measures). If separate samples are used for these measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the 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: |
|---|--------------------------------|---|--------------------------------|
| 64% | 380 | 87% | 196 |
| 65% | 376 | 88% | 184 |
| 66% | 371 | 89% | 172 |
| 67% | 366 | 90% | 159 |
| 68% | 360 | 91% | 147 |
| 69% | 354 | 94% | 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 ≤MRSS, proceed to step 4.
- 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%. 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 ≤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 ≤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 2022 HEDIS for QRS, sort the list of EMs from A to Z.
- Note:** Sort order applies to all components. For HEDIS MY 2022, sort all fields by ascending order (i.e., last name ascending, first name ascending, date of birth ascending, event ascending).
- Step 6** Calculate $N = EM / (MRSS + \text{all oversample records})$. Round *down* to a whole number.
- Determine N, which is used in the formula to determine which member will start your sample. N is calculated using the equation: $N = EM / (MRSS + \text{all oversample records})$, where EM = the eligible member population (step 1) and MRSS = the minimum required sample size (step 2).
- Step 7** Calculate $START = (RAND \times N)$. Before choosing members, determine the member to start with (START). It is important that the sample be selected from a single pass through the member list. START can have many values and still allow only one pass.
- 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% 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% of charts are expected to be inappropriate for the measure.

To determine the oversample, multiply the MRSS by the oversample percentage 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 2022 RAND Table for Measures Using the Hybrid Method

| Measure | RAND |
|---|------|
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | .23 |
| Childhood Immunization Status | .55 |
| Immunizations for Adolescents | .04 |
| Cervical Cancer Screening | .34 |
| Colorectal Cancer Screening | .05 |
| Controlling High Blood Pressure | .82 |
| Hemoglobin A1c Control for Patients With Diabetes and Eye Exam for Patients With Diabetes | .21* |
| Prenatal and Postpartum Care | .10 |

*The RANDs for these measures are the same. Organizations may choose to use the same sample for the two measures. If organizations use different samples for these measures, a different MRSS is used in the sampling protocol.

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%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling scheme.

- Step 1** EM = 9,000.
- Step 2** From Table 2, the MRSS is 296.
- Step 3** Oversample = $296 \times .05 = 14.8$ (the next whole number *above* is 15, so the oversample = 15).
- Step 4** Because $9,000 > 296$ (MRSS) and 311 (296 + oversample) go to step 5.
- Step 5** Sort the list alphabetically and in this order: last name, first name, date of birth.
- Step 6** $N = 9,000/311$ (MRSS + oversample) = 28.
- Step 7** For this example, assume that $RAND = 0.66$, so $START = 0.66 \times 28 = 18.48$.
Rounding using the .5 rule, $START = 18$. The 18th sorted member is chosen *first*.
The 2nd member chosen is the $18 + [(2-1) \times (9,000/311)] = 18 + 29 = 47$ th sorted member, after rounding the term $[(2-1) \times (9,000/311)]$ to 29, using the .5 rule.
The 3rd member chosen is the $18 + [(3-1) \times (9,000/311)] = 18 + 58 = 76$ th sorted member.
The 296th member (the last one in the primary list) is the $18 + [(296-1) \times (9,000/311)] = 18 + 8,537 = 8,555$ th sorted member.
The last member in the oversample* is the $18 + [(311-1) \times (9,000/311)] = 18 + 8,971 = 8,989$ th sorted member.

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

Example 2

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

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

Example 3

The eligible member population for *Childhood Immunization Status* is 436. The sample size will not be adjusted using this year's administrative rate. Based on experience with this population, about 10% 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%. Based on experience, estimate a 5% oversample rate. Follow the systematic sampling scheme.

Step 1 EM = 400.

Step 2 From Table 2, the MRSS is 388.

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

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

Step 5 Skip this step.

Step 6 Skip this step.

Step 7 Skip this step.

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

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

Complex Probability Sampling

Organization responsibility

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

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

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

Substituting Medical Records

Acceptable circumstances for substitution:

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

1. Errors in sampling data

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

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

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

2. Optional exclusion to treatment being measured

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

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

All exclusions must be available for auditor review.

3. Employee/dependent was selected for the sample

An employee of the organization or the vendor, or the employee's dependent, was selected for the sample, and the medical record must be reviewed to determine compliance with the measure. The organization or vendor may exclude employees and their dependents in this situation *only*. Employee and employee dependents are not excluded from administrative reporting and should not be removed before the sample is drawn.

Hybrid Method: Three Approaches

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

- Approach 1*** Remove members that meet the optional exclusion criteria after the sample is drawn by searching the administrative systems prior to beginning medical record review. Substitute excluded members with members from the oversample population.
- Approach 2*** Remove members that meet the optional exclusion criteria during or after the medical record review. Substitute excluded members with members from the oversample population.
- Approach 3*** Remove members that meet the optional exclusion criteria from the eligible population by searching administrative systems prior to selecting the sample.

References

- Deming, W.E. On the interpretation of censuses as samples. 1941. *Journal of the American Statistical Association*. 36: 45–9.
- Fleiss, L. *Statistical Methods for Rates and Proportions*. 2nd Ed. (New York: John Wiley & Sons, Inc.): 38–42.

Guidelines for HEDIS Effectiveness of Care Measures

Guidelines for HEDIS Effectiveness of Care Measures

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- No changes to the guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- *Antidepressant Medication Management (AMM).*
- *Appropriate Testing for Pharyngitis (CWP).*
- *Appropriate Treatment for Upper Respiratory Infection (URI).*
- *Asthma Medication Ratio (AMR).*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB).*
- *Breast Cancer Screening (BCS).*
- *Cervical Cancer Screening (CCS).*
- *Child and Adolescent Well-Care Visits (WCV).*
- *Childhood Immunization Status (CIS).*
- *Chlamydia Screening in Women (CHL).*
- *Colorectal Cancer Screening (COL).*
- *Controlling High Blood Pressure (CBP).*
- *Eye Exam for Patients With Diabetes (EED).*
- *Flu Vaccinations for Adults Ages 18–64 (FVA).*
- *Follow-Up After Hospitalization for Mental Illness (FUH).*
- *Hemoglobin A1c Control for Patients With Diabetes (HBD).*
- *Immunizations for Adolescents (IMA).*
- *Kidney Health Evaluation for Patients With Diabetes (KED).*
- *Medical Assistance with Smoking and Tobacco Use Cessation (MSC).*
- *Use of Imaging Studies for Low Back Pain (LBP).*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).*
- *Well-Child Visits in the First 30 Months of Life (W30).*

Guidelines

Which services count?

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

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

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

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

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

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

Optional exclusions

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

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

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

Measure format

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

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

Eligible population criteria

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

1. **Product line** (Exchange) applicable to the measure.
2. **Age** group and gender requirements.
3. **Continuous enrollment** criteria for the measure.

4. **Allowable gap** in benefits during the continuous enrollment period.
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 Access/Availability of Care Measures

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- No changes to the guidelines.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measures:

- *Annual Dental Visit (ADV)*.
- *Initiation and Engagement of Substance Use Disorder Treatment (IET)*.
- *Prenatal and Postpartum Care (PPC)*.

Continuous Enrollment

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

Which Services Count?

Report all services for Access/Availability of Care measures, whether or not the organization paid for them (e.g., report services paid for by a third party such as a community center, or services for which payment was denied because they were not properly authorized). Include all paid, suspended, pending and denied claims.

Organizations are ultimately responsible for the quality of care they provide to members and for ensuring that certain services have been provided, even if another community practitioner provides the services.

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

Hybrid Methodology

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

Guidelines for Risk Adjusted Utilization Measures

Guidelines for Risk Adjusted Utilization Measures

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added instructions to Guideline 5 for identifying admissions dates for observation stays without a recorded admission date.

HEDIS FOR QRS SPECIFIC GUIDANCE

These guidelines apply to the following measure:

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

Guidelines

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

The organization may have:

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

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

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

Count the service as denied if:

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

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

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

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

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

4. **Mental health and chemical dependency transfers.** Unless otherwise specified in the measure, count as a separate admission a transfer within the same institution but to a different level of care (e.g., a transfer between inpatient and residential care). Each level must appropriately include discharges and length of stay (count inpatient days under inpatient; count residential days under residential).
5. **Observation stays without an admission and/or discharge date.** For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.
6. **Direct transfers.** A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example:
 - A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer.
 - A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer.
 - A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct stays.
 - A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer.

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

Risk Adjustment Comorbidity Category Determination

Step 1 Identify all diagnoses for encounters during the classification period for each denominator unit of the measure. Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set).
- Telephone visits (Telephone Visits Value Set).
- Observation visits (Observation Value Set).
- ED visits (ED Value Set).
- Inpatient events:
 - Nonacute inpatient encounters (Nonacute Inpatient Value Set).
 - Acute inpatient encounters (Acute Inpatient Value Set).
 - Acute and nonacute inpatient discharges (Inpatient Stay Value Set).

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

Exclude the principal discharge diagnosis on the IHS.

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

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

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

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

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

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

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

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

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

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

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

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

Example: Table HCC—Rank

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

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

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

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

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

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

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

Example: Table HCC—Comb

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

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MY 2022 HEDIS for QRS Measure Technical Specifications

(Alphabetical Order)

Annual Dental Visit (ADV)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS measures do not define benefits at the service or metal level (e.g., the QHP is required to offer a dental benefit but enrollees may choose not to purchase that service). The organization is accountable for reporting the measure and must include all members who elect to purchase the dental benefit.

Description

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

Eligible Population

| | |
|------------------------------|---|
| Product line | Exchange. |
| Ages | 2–20 years as of December 31 of the measurement year. Report six age stratifications and a total rate. <ul style="list-style-type: none">• 2–3 years.• 4–6 years.• 7–10 years.• 11–14 years.• 15–18 years.• 19–20 years.• Total. The total is the sum of the age stratifications. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. |
| Anchor date | December 31 of the measurement year. |
| Benefit | Dental. |
| Event/diagnosis | None. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

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

Administrative Specification

Denominator The eligible population.

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

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

Data Elements for Reporting

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

Table ADV-4: Data Elements for Annual Dental Visit

| Metric | Age | Data Element | Reporting Instructions |
|-------------------|-------|------------------------|-------------------------|
| AnnualDentalVisit | 2-3 | Benefit | Metadata |
| | 4-6 | EligiblePopulation | For each Stratification |
| | 7-10 | ExclusionAdminRequired | For each Stratification |
| | 11-14 | NumeratorByAdmin | For each Stratification |
| | 15-18 | Rate | (Percent) |
| | 19-20 | | |
| | Total | | |

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Corrected the example in the definition of *treatment days*.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

Description

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

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

Definitions

| | |
|------------------------------------|--|
| Intake period | The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year. |
| IPSD | Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History. |
| Negative Medication History | A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication. |
| Treatment days | The actual number of calendar days covered with prescriptions within the specified measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 82 days counted in the 232-day interval. |

Eligible Population

| | |
|------------------------------|---|
| Product line | Exchange. |
| Ages | 18 years and older as of April 30 of the measurement year. |
| Continuous enrollment | 105 days prior to the IPSD through 231 days after the IPSD. |
| Allowable gap | One gap in enrollment of up to 45 days. |
| Anchor date | IPSD. |
| Benefits | Medical and pharmacy. |
| Event/diagnosis | Follow the steps below to identify the eligible population, which is used for both rates. |

Step 1

Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List) during the Intake Period.

**Step 2:
Required exclusion**

Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set **with** Major Depression Value Set.
- A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set **with** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** Outpatient POS Value Set **with** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set **with** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** Partial Hospitalization POS Value Set **with** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set **with** Major Depression Value Set.
- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** Community Mental Health Center POS Value Set **with** Major Depression Value Set.
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set **with** Major Depression Value Set.
- Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set **with** Major Depression Value Set.
- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** Telehealth POS Value Set **with** Major Depression Value Set.
- An observation visit (Observation Value Set) **with** any diagnosis of major depression (Major Depression Value Set).
- An ED visit (ED Value Set) **with** any diagnosis of major depression (Major Depression Value Set).

- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set **with** ED POS Value Set **with** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) **with** any diagnosis of major depression (Major Depression Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) **with** any diagnosis of major depression (Major Depression Value Set).

Exclude members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Step 3 Test for Negative Medication History. Exclude members who were dispensed a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

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

Antidepressant Medications

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

**Effective
Continuation
Phase Treatment**

At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List) beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Note

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

Data Elements for Reporting

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

Table AMM-4: Data Elements for Antidepressant Medication Management

| Metric | Data Element | Reporting Instructions |
|--------------|-------------------------|------------------------|
| Acute | Benefit | Metadata |
| Continuation | EligiblePopulation | Repeat per Metric |
| | ExclusionAdminRequired | Repeat per Metric |
| | NumeratorByAdmin | For each Metric |
| | NumeratorBySupplemental | For each Metric |
| | Rate | (Percent) |

Appropriate Testing for Pharyngitis (CWP)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added step 8 to the event/diagnosis.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Standardized medication names in the medication tables (this change does not impact drugs that are included in the Medication List Directory).
- Removed “Dicloxacillin” from the [CWP Antibiotics Medications List](#).

Description

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

Definitions

| | |
|--|---|
| Intake Period | A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment. |
| Episode Date | The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the Intake Period with a diagnosis of pharyngitis. |
| Negative Medication History | <p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none">• A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.• No prescriptions dispensed more than 30 days prior to the Episode Date that are active on the Episode Date.<ul style="list-style-type: none">– A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period. |
| Negative Comorbid Condition History | A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition. |
| Negative Competing Diagnosis | The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis. |

Eligible Population

| | | | |
|--|---|--|--|
| Product line | Exchange. | | |
| Ages | <p>Members who were 3 years or older as of the Episode Date.</p> <p>Report three age stratifications and a total rate:</p> <table><tr><td><ul style="list-style-type: none">• 3–17 years.• 18–64 years.</td><td><ul style="list-style-type: none">• 65 years and older.• Total.</td></tr></table> <p>The total is the sum of the age stratifications.</p> | <ul style="list-style-type: none">• 3–17 years.• 18–64 years. | <ul style="list-style-type: none">• 65 years and older.• Total. |
| <ul style="list-style-type: none">• 3–17 years.• 18–64 years. | <ul style="list-style-type: none">• 65 years and older.• Total. | | |

| | |
|------------------------------|---|
| Continuous enrollment | 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days). |
| Allowable gap | None. |
| Anchor date | None. |
| Benefits | Medical and pharmacy. |
| Event/diagnosis | Follow the steps below to identify the eligible population. |
| Step 1 | Identify all members who had an outpatient visit (<u>Outpatient Value Set</u>), a telephone visit (<u>Telephone Visits Value Set</u>), an e-visit or virtual check-in (<u>Online Assessments Value Set</u>), an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) during the intake period, with a diagnosis of pharyngitis (<u>Pharyngitis Value Set</u>). |
| Step 2 | Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits or virtual check-ins with a diagnosis of pharyngitis. Do not include visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>). |
| Step 3 | Determine if antibiotics (<u>CWP Antibiotic Medications List</u>) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to 3 days after. Exclude Episode Dates if the member did not receive antibiotics on or up to 3 days after the Episode Date. |

CWP Antibiotic Medications

| Description | Prescription |
|----------------------------------|--|
| Aminopenicillins | <ul style="list-style-type: none"> Amoxicillin Ampicillin |
| Beta-lactamase inhibitors | <ul style="list-style-type: none"> Amoxicillin-clavulanate |
| First generation cephalosporins | <ul style="list-style-type: none"> Cefadroxil Cephalexin Cefazolin |
| Folate antagonist | <ul style="list-style-type: none"> Trimethoprim |
| Lincomycin derivatives | <ul style="list-style-type: none"> Clindamycin |
| Macrolides | <ul style="list-style-type: none"> Azithromycin Erythromycin Clarithromycin |
| Natural penicillins | <ul style="list-style-type: none"> Penicillin G benzathine Penicillin G sodium Penicillin G potassium Penicillin V potassium |
| Quinolones | <ul style="list-style-type: none"> Ciprofloxacin Moxifloxacin Levofloxacin Ofloxacin |
| Second generation cephalosporins | <ul style="list-style-type: none"> Cefaclor Cefuroxime Cefprozil |
| Sulfonamides | <ul style="list-style-type: none"> Sulfamethoxazole-trimethoprim |

Appropriate Testing for Pharyngitis

| Description | Prescription |
|---------------------------------|--|
| Tetracyclines | <ul style="list-style-type: none">• Doxycycline• Minocycline• Tetracycline |
| Third generation cephalosporins | <ul style="list-style-type: none">• Cefdinir• Cefixime• Cefpodoxime• Cefibuten• Cefditoren• Ceftriaxone |

Step 4

Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

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

Step 5

Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication ([CWP Antibiotic Medications List](#)) was dispensed 30 days prior to the Episode Date or was active on the Episode Date.

Step 6

Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis ([Competing Diagnosis Value Set](#)) on or 3 days after the Episode Date.

Step 7

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

Step 8

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

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

Required exclusion

Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator A group A streptococcus test (Group A Strep Tests Value Set) in the 7-day period from 3 days prior to the Episode Date through 3 days after the Episode Date.

Data Elements for Reporting

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

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

| Metric | Age | Data Element | Reporting Instructions |
|-------------------------------|-------|-------------------------|-------------------------|
| AppropriatePharyngitisTesting | 3-17 | Benefit | Metadata |
| | 18-64 | EligiblePopulation | For each Stratification |
| | 65+ | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

Appropriate Treatment for Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Replaced all references to “[CWP Antibiotic Medications List](#)” with “[AAB Antibiotic Medications List](#).”
- Standardized medication names in the medication tables (this change does not impact drugs that are included in the Medication List Directory).

Description

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

Calculation

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

Definitions

| | |
|--|---|
| Intake Period | A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment. |
| Episode Date | The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the Intake Period with a diagnosis of URI. |
| Negative Medication History | <p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none">• A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.• No prescriptions dispensed more than 30 days prior to the Episode Date that are active on the Episode Date. <p>A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.</p> |
| Negative Comorbid Condition History | A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition. |
| Negative Competing Diagnosis | The Episode Date and 3 days following the Episode Date when the member had no claims/encounters with a competing diagnosis. |

Eligible Population

| | |
|------------------------------|---|
| Product line | Exchange. |
| Ages | <p>Members who were 3 months of age or older as of the Episode Date.</p> <p>Report three age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 3 months–17 years. • 18–64 years. • 65 years and older. • Total. <p>The total is the sum of the age stratifications.</p> |
| Continuous enrollment | 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days). |
| Allowable gap | None. |
| Anchor date | None. |
| Benefits | Medical and pharmacy. |
| Event/diagnosis | Follow the steps below to identify the eligible population: |
| Step 1 | Identify all members who had an outpatient visit (<u>Outpatient Value Set</u>), a telephone visit (<u>Telephone Visits Value Set</u>), an e-visit or virtual check-in (<u>Online Assessments Value Set</u>) an observation visit (<u>Observation Value Set</u>) or an ED visit (<u>ED Value Set</u>) during the Intake Period, with a diagnosis of URI (<u>URI Value Set</u>). |
| Step 2 | <p>Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a URI diagnosis.</p> <p>Exclude visits that result in an inpatient stay (<u>Inpatient Stay Value Set</u>).</p> |
| Step 3 | <p>Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:</p> <ul style="list-style-type: none"> • <u>HIV Value Set</u>. • <u>HIV Type 2 Value Set</u>. • <u>Malignant Neoplasms Value Set</u>. • <u>Other Malignant Neoplasm of Skin Value Set</u>. • <u>Emphysema Value Set</u>. • <u>COPD Value Set</u>. • <u>Comorbid Conditions Value Set</u>. • <u>Disorders of the Immune System Value Set</u>. |
| Step 4 | Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (<u>AAB Antibiotic Medications List</u>) was dispensed 30 days prior to the Episode Date or was active on the Episode Date. |

Appropriate Treatment for Upper Respiratory Infection

Step 5 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 days total).

Step 7 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

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

Required exclusion Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

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

AAB Antibiotic Medications

| Description | Prescription | |
|----------------------------------|---|--------------------------------|
| Aminoglycosides | • Amikacin • Gentamicin | • Streptomycin • Tobramycin |
| Aminopenicillins | • Amoxicillin | • Ampicillin |
| Beta-lactamase inhibitors | • Amoxicillin-clavulanate • Ampicillin-sulbactam | • Piperacillin-tazobactam |
| First-generation cephalosporins | • Cefadroxil • Cefazolin | • Cephalexin |
| Fourth-generation cephalosporins | • Cefepime | |
| Ketolides | • Telithromycin | |
| Lincomycin derivatives | • Clindamycin | • Lincomycin |
| Macrolides | • Azithromycin • Clarithromycin | • Erythromycin |

Appropriate Treatment for Upper Respiratory Infection

| Description | Prescription | | |
|-------------------------------------|---|--|---|
| Miscellaneous antibiotics | <ul style="list-style-type: none"> • Aztreonam • Chloramphenicol • Dalfopristin-quinupristin | <ul style="list-style-type: none"> • Daptomycin • Linezolid • Metronidazole | <ul style="list-style-type: none"> • Vancomycin |
| Natural penicillins | <ul style="list-style-type: none"> • Penicillin G benzathine-procaine • Penicillin G potassium | <ul style="list-style-type: none"> • Penicillin G procaine • Penicillin G sodium | <ul style="list-style-type: none"> • Penicillin V potassium • Penicillin G benzathine |
| Penicillinase resistant penicillins | <ul style="list-style-type: none"> • Dicloxacillin • Nafcillin | <ul style="list-style-type: none"> • Oxacillin | |
| Quinolones | <ul style="list-style-type: none"> • Ciprofloxacin • Gemifloxacin | <ul style="list-style-type: none"> • Levofloxacin • Moxifloxacin | <ul style="list-style-type: none"> • Ofloxacin |
| Rifamycin derivatives | <ul style="list-style-type: none"> • Rifampin | | |
| Second-generation cephalosporins | <ul style="list-style-type: none"> • Cefaclor • Cefotetan | <ul style="list-style-type: none"> • Cefoxitin • Cefprozil | <ul style="list-style-type: none"> • Cefuroxime |
| Sulfonamides | <ul style="list-style-type: none"> • Sulfadiazine | <ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim | |
| Tetracyclines | <ul style="list-style-type: none"> • Doxycycline • Minocycline | <ul style="list-style-type: none"> • Tetracycline | |
| Third-generation cephalosporins | <ul style="list-style-type: none"> • Cefdinir • Cefditoren • Cefixime | <ul style="list-style-type: none"> • Cefotaxime • Cefpodoxime • Ceftazidime | <ul style="list-style-type: none"> • Ceftibuten • Ceftriaxone |
| Urinary anti-infectives | <ul style="list-style-type: none"> • Fosfomycin • Nitrofurantoin | <ul style="list-style-type: none"> • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim | |

Note

- Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
- Supplemental data may not be used for this measure.

Data Elements for Reporting

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

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

| Metric | Age | Data Element | Reporting Instructions |
|-------------------------|-------|------------------------|-------------------------|
| AppropriateURITreatment | 3m-17 | Benefit | Metadata |
| | 18-64 | EligiblePopulation | For each Stratification |
| | 65+ | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | Rate | (Percent) |

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

Description

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is dispensed.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

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

Inhaler dispensing event

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

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

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

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

Injection dispensing event

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

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

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

| | | | |
|---|--|---|--|
| Units of medication | <p>When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event.</p> <p>Use the package size and units columns in the medication lists to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.</p> | | |
| Eligible Population | | | |
| Product lines | Exchange. | | |
| Ages | <p>Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and a total rate:</p> <table> <tr> <td> <ul style="list-style-type: none"> • 5–11 years. • 12–18 years. • 19–50 years. </td><td> <ul style="list-style-type: none"> • 51–64 years. • Total. </td></tr> </table> | <ul style="list-style-type: none"> • 5–11 years. • 12–18 years. • 19–50 years. | <ul style="list-style-type: none"> • 51–64 years. • Total. |
| <ul style="list-style-type: none"> • 5–11 years. • 12–18 years. • 19–50 years. | <ul style="list-style-type: none"> • 51–64 years. • Total. | | |
| Continuous enrollment | <p>The total is the sum of the age stratifications.</p> <p>The measurement year and the year prior to the measurement year.</p> | | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. | | |
| Anchor date | December 31 of the measurement year. | | |
| Benefits | Medical. Pharmacy during the measurement year. | | |
| Event/diagnosis | Follow the steps below to identify the eligible population. | | |
| Step 1 | <p>Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</p> <ul style="list-style-type: none"> • At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>). • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>). • At least one acute inpatient discharge with a principal diagnosis of asthma (<u>Asthma Value Set</u>) on the discharge claim. To identify an acute inpatient discharge: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. | | |

- At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) **and** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2

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

Step 3: Required exclusions

Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
 - Emphysema Value Set.
 - Other Emphysema Value Set.
 - COPD Value Set.
 - Obstructive Chronic Bronchitis Value Set.
 - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
 - Cystic Fibrosis Value Set.
 - Acute Respiratory Failure Value Set.
- Members who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification**Denominator**

The eligible population.

Numerator

The number of members who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.

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

Use all the medication lists in the Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1

For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5 Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Asthma Controller Medications

| Description | Prescriptions | Medication Lists | Route |
|------------------------------|--------------------------|---|------------|
| Antiasthmatic combinations | • Dyphylline-guaifenesin | Dyphylline Guaifenesin Medications List | Oral |
| Antibody inhibitors | • Omalizumab | Omalizumab Medications List | Injection |
| Anti-interleukin-4 | • Dupilumab | Dupilumab Medications List | Injection |
| Anti-interleukin-5 | • Benralizumab | Benralizumab Medications List | Injection |
| Anti-interleukin-5 | • Mepolizumab | Mepolizumab Medications List | Injection |
| Anti-interleukin-5 | • Reslizumab | Reslizumab Medications List | Injection |
| Inhaled steroid combinations | • Budesonide-formoterol | Budesonide Formoterol Medications List | Inhalation |
| Inhaled steroid combinations | • Fluticasone-salmeterol | Fluticasone Salmeterol Medications List | Inhalation |
| Inhaled steroid combinations | • Fluticasone-vilanterol | Fluticasone Vilanterol Medications List | Inhalation |
| Inhaled steroid combinations | • Formoterol-mometasone | Formoterol Mometasone Medications List | Inhalation |
| Inhaled corticosteroids | • Beclomethasone | Beclomethasone Medications List | Inhalation |
| Inhaled corticosteroids | • Budesonide | Budesonide Medications List | Inhalation |
| Inhaled corticosteroids | • Ciclesonide | Ciclesonide Medications List | Inhalation |
| Inhaled corticosteroids | • Flunisolide | Flunisolide Medications List | Inhalation |
| Inhaled corticosteroids | • Fluticasone | Fluticasone Medications List | Inhalation |
| Inhaled corticosteroids | • Mometasone | Mometasone Medications List | Inhalation |
| Leukotriene modifiers | • Montelukast | Montelukast Medications List | Oral |
| Leukotriene modifiers | • Zafirlukast | Zafirlukast Medications List | Oral |
| Leukotriene modifiers | • Zileuton | Zileuton Medications List | Oral |
| Methylxanthines | • Theophylline | Theophylline Medications List | Oral |

Asthma Medication Ratio

Asthma Reliever Medications

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

Note

- Do not use RxNorm codes when assessing the numerator.
- When mapping NDC codes, medications described as “injection,” “prefilled syringe,” “subcutaneous,” “intramuscular” or “auto-injector” are considered “injection” (route) medications.
- When mapping NDC codes, medications described as “metered dose inhaler,” “dry powder inhaler” or “inhalation powder” are considered “inhalation” (route) medications.
- Do not map medications described as “nasal spray” to “inhalation” medications.

Data Elements for Reporting

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

Table AMR-4: Data Elements for Asthma Medication Ratio

| Metric | Age | Data Element | Reporting Instructions |
|-----------------------|-------|-------------------------|-------------------------|
| AsthmaMedicationRatio | 5-11 | Benefit | Metadata |
| | 12-18 | EligiblePopulation | For each Stratification |
| | 19-50 | ExclusionAdminRequired | For each Stratification |
| | 51-64 | NumeratorByAdmin | For each Stratification |
| | Total | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

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

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Standardized medication names in the medication tables (this change does not impact drugs that are included in the Medication List Directory).

Description

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

Calculation

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

Definitions

| | |
|--|--|
| Intake Period | A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment. |
| Episode Date | The date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the Intake Period with a diagnosis of acute bronchitis/bronchiolitis. |
| Negative Medication History | <p>To qualify for Negative Medication History, the following criteria must be met:</p> <ul style="list-style-type: none"> • A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions that were dispensed more than 30 days prior to the Episode Date and are active on the Episode Date. <p>A prescription is considered active if the “days supply” indicated on the date when the member was dispensed the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.</p> |
| Negative Comorbid Condition History | A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition. |
| Negative Competing Diagnosis | The Episode Date and 3 days following the Episode Date when the member had no claims/encounters with any competing diagnosis. |
| Negative Comorbid Condition History | A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition. |

Negative Competing Diagnosis The Episode Date and 3 days following the Episode Date when the member had no claims/encounters with any competing diagnosis.

Eligible Population

Product line Exchange.

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

Report three age stratifications and a total rate:

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

The total is the sum of the age stratifications.

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

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

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

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

Step 2 Determine all acute bronchitis/bronchiolitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis.

Do not include visits that result in an inpatient stay ([Inpatient Stay Value Set](#)).

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

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

- Step 4** Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was dispensed 30 days prior to the Episode Date or was active on the Episode Date.
- Step 5** Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis Value Set.
 - Competing Diagnosis Value Set.
- Step 6** Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
- Step 7** Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.
- Note:** The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.
- Required exclusion** Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the Episode Date.

AAB Antibiotic Medications

| Description | Prescription | |
|----------------------------------|---|--|
| Aminoglycosides | <ul style="list-style-type: none"> • Amikacin • Gentamicin | <ul style="list-style-type: none"> • Streptomycin • Tobramycin |
| Aminopenicillins | <ul style="list-style-type: none"> • Amoxicillin | <ul style="list-style-type: none"> • Ampicillin |
| Beta-lactamase inhibitors | <ul style="list-style-type: none"> • Amoxicillin-clavulanate • Ampicillin-sulbactam | <ul style="list-style-type: none"> • Piperacillin-tazobactam |
| First-generation cephalosporins | <ul style="list-style-type: none"> • Cefadroxil | <ul style="list-style-type: none"> • Cefazolin • Cephalexin |
| Fourth-generation cephalosporins | <ul style="list-style-type: none"> • Cefepime | |
| Ketolides | <ul style="list-style-type: none"> • Telithromycin | |
| Lincomycin derivatives | <ul style="list-style-type: none"> • Clindamycin | <ul style="list-style-type: none"> • Lincomycin |
| Macrolides | <ul style="list-style-type: none"> • Azithromycin • Clarithromycin | <ul style="list-style-type: none"> • Erythromycin |

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

| Description | Prescription | | |
|-------------------------------------|---|--|---|
| Miscellaneous antibiotics | <ul style="list-style-type: none"> • Aztreonam • Chloramphenicol • Dalfopristin-quinupristin | <ul style="list-style-type: none"> • Daptomycin • Linezolid • Metronidazole | <ul style="list-style-type: none"> • Vancomycin |
| Natural penicillins | <ul style="list-style-type: none"> • Penicillin G benzathine-procaine • Penicillin G potassium | <ul style="list-style-type: none"> • Penicillin G procaine • Penicillin G sodium | <ul style="list-style-type: none"> • Penicillin V potassium • Penicillin G benzathine |
| Penicillinase resistant penicillins | <ul style="list-style-type: none"> • Dicloxacillin | <ul style="list-style-type: none"> • Nafcillin | <ul style="list-style-type: none"> • Oxacillin |
| Quinolones | <ul style="list-style-type: none"> • Ciprofloxacin • Gemifloxacin | <ul style="list-style-type: none"> • Levofloxacin • Moxifloxacin | <ul style="list-style-type: none"> • Ofloxacin |
| Rifamycin derivatives | <ul style="list-style-type: none"> • Rifampin | | |
| Second generation cephalosporin | <ul style="list-style-type: none"> • Cefaclor • Cefotetan | <ul style="list-style-type: none"> • Cefoxitin • Cefprozil | <ul style="list-style-type: none"> • Cefuroxime |
| Sulfonamides | <ul style="list-style-type: none"> • Sulfadiazine | <ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim | |
| Tetracyclines | <ul style="list-style-type: none"> • Doxycycline | <ul style="list-style-type: none"> • Minocycline | <ul style="list-style-type: none"> • Tetracycline |
| Third generation cephalosporins | <ul style="list-style-type: none"> • Cefdinir • Cefditoren • Cefixime | <ul style="list-style-type: none"> • Cefotaxime • Cefpodoxime • Ceftazidime | <ul style="list-style-type: none"> • Ceftibuten • Ceftriaxone |
| Urinary anti-infectives | <ul style="list-style-type: none"> • Fosfomycin • Nitrofurantoin | <ul style="list-style-type: none"> • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim | |

Note

- Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.
- Supplemental data may not be used for this measure.

Data Elements for Reporting

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

Table AAB-4: Data Elements for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

| Metric | Age | Data Element | Reporting Instructions |
|------------------------------|-------|------------------------|-------------------------|
| AvoidanceAntibioticTreatment | 3m-17 | Benefit | Metadata |
| | 18-64 | EligiblePopulation | For each Stratification |
| | 65+ | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | Rate | (Percent) |

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Clarified in *Optional exclusions* that unilateral mastectomy and bilateral modifier must be from the same procedure.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Optional ECDS reporting for Breast Cancer Screening was proposed for addition in the Draft 2022 Call Letter. Refer to *Measures Reported Using Electronic Clinical Data Systems* below for the specifications. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

Description

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

Eligible Population

| | |
|------------------------------|---|
| 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 exclusions | Exclude members who meet either of the following criteria: <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i>. • 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 | Exclude members who meet any of the following criteria: Note: <i>Supplemental and medical record data may not be used for these exclusions.</i> |

- 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) 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"> • Donepezil • 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 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](#)) (same procedure).
- Unilateral mastectomy found in clinical data ([Clinical Unilateral Mastectomy Value Set](#)) with a bilateral modifier ([Clinical Bilateral Modifier Value Set](#)) (same procedure). 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 (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same procedure) | <ul style="list-style-type: none"> • Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same procedure) |
| <ul style="list-style-type: none"> • Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side modifier (Clinical Left Modifier Value Set) (same procedure) | <ul style="list-style-type: none"> • Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side modifier (Clinical Right Modifier Value Set) (same procedure) |
| <ul style="list-style-type: none"> • Absence of the left breast (Absence of Left Breast Value Set) | <ul style="list-style-type: none"> • Absence of the right breast (Absence of Right Breast Value Set) |
| <ul style="list-style-type: none"> • Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) | <ul style="list-style-type: none"> • Right unilateral mastectomy (Unilateral Mastectomy Right Value Set) |

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 toward 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

| Metric | Data Element | Reporting Instructions |
|-----------------------|-------------------------|-------------------------------|
| BreastCancerScreening | EligiblePopulation | Report once |
| | ExclusionAdminOptional | Report once |
| | ExclusionAdminRequired | Report once |
| | NumeratorByAdmin | Report once |
| | NumeratorBySupplemental | Report once |
| | Rate | (Percent) |

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

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

| | |
|------------------------------|---|
| 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 exclusions | <p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i>. • 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 | <p>The number of women who were screened for cervical cancer. Either of the following meets criteria:</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 (<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 2 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 4 years prior to the measurement year and who were 30 years or older as of the date of testing. |

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

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

Exclusion (optional)

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

| Metric | Data Element | Reporting Instructions | A |
|-------------------------|---------------------------|------------------------|---|
| CervicalCancerScreening | CollectionMethod | Report once | ✓ |
| | EligiblePopulation | Report once | ✓ |
| | ExclusionAdminRequired | Report once | ✓ |
| | NumeratorByAdminElig | Report once | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Report once | |
| | OversampleRate | Report once | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Report once | |
| | ExclusionAdminOptional | Report once | |
| | ExclusionMedRecsOptional | Report once | |
| | ExclusionEmployeeOrDep | Report once | |
| | OversampleRecsAdded | Report once | |
| | Denominator | Report once | |
| | NumeratorByAdmin | Report once | ✓ |
| | NumeratorByMedicalRecords | Report once | |
| | NumeratorBySupplemental | Report once | ✓ |
| | Rate | (Percent) | ✓ |

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and 2023 QRS and QHP Enrollee Survey Technical Guidance for guidance on reporting 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

| | |
|------------------------|---|
| Product line | Exchange. |
| Stratifications | <p>Report the following stratifications by race and total, and stratifications by ethnicity and total:</p> <ul style="list-style-type: none"> • <i>Race</i>: <ul style="list-style-type: none"> – White. – Black or African American. – American Indian and Alaska Native. – Asian. – Native Hawaiian and Other Pacific Islander. – Some Other Race. – Two or More Races. – Asked but No Answer. – Unknown. – Total. • <i>Ethnicity</i>: <ul style="list-style-type: none"> – Hispanic/Latino. – Not Hispanic/Latino. – Asked but No Answer. – Unknown. – Total. |

Note: *Stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.*

Child and Adolescent Well-Care Visits

| | |
|------------------------------|---|
| Ages | 3–21 years as of December 31 of the measurement year. Report three age stratifications and a total rate: <ul style="list-style-type: none">• 3–11 years.• 12–17 years.• 18–21 years.• Total. <p>The total is the sum of the age stratifications for each product line.</p> |
| 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. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

Administrative Specification

| | |
|--------------------|--|
| Denominator | The eligible population. |
| Numerator | One or more well-care visits (<u>Well-Care Value Set</u>) during the measurement year. <p>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.</p> |

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

| Metric | Age | Data Element | Reporting Instructions |
|---------------------------|-------|-------------------------|-------------------------|
| ChildAdolescentWellVisits | 3-11 | EligiblePopulation | For each Stratification |
| | 12-17 | ExclusionAdminRequired | For each Stratification |
| | 18-21 | NumeratorByAdmin | For each Stratification |
| | Total | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

Table WCV-B-4: Data Elements for Child and Adolescent Well-Care Visits: Stratifications by Race

| Metric | Race | Source | Data Element | Reporting Instructions |
|---------------------------|---------------------------------------|----------|--------------------|-------------------------|
| ChildAdolescentWellVisits | White | Direct | EligiblePopulation | For each Stratification |
| | BlackOrAfricanAmerican | Indirect | Numerator | For each Stratification |
| | AmericanIndianAndAlaskaNative | Total | Rate | (Percent) |
| | Asian | | | |
| | NativeHawaiianAndOtherPacificIslander | | | |
| | SomeOtherRace | | | |
| | TwoOrMoreRaces | | | |
| | AskedButNoAnswer* | | | |
| | Unknown | | | |
| | | | | |

Table WCV-C-4: Data Elements for Child and Adolescent Well-Care Visits: Stratifications by Ethnicity

| Metric | Ethnicity | Source | Data Element | Reporting Instructions |
|---------------------------|---------------------|----------|--------------------|-------------------------|
| ChildAdolescentWellVisits | HispanicOrLatino | Direct | EligiblePopulation | For each Stratification |
| | NotHispanicOrLatino | Indirect | Numerator | For each Stratification |
| | AskedButNoAnswer* | Total | Rate | (Percent) |
| | Unknown | | | |

*AskedButNoAnswer is only reported for Source='Direct.'

Childhood Immunization Status (CIS)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised optional exclusions for immunocompromising conditions (e.g., immunodeficiency) to be required exclusions.
- Revised optional exclusions for anaphylaxis due to vaccine.
- Added anaphylaxis due to vaccine as numerator compliant for specific indicators.
- Updated value sets and logic for the MMR numerator, because single antigen vaccines are no longer used.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 10 and related antigens.
- Optional ECDS reporting for *Childhood Immunization Status* was proposed for addition in the Draft 2022 Call Letter. Please see the *Measures Reported Using Electronic Clinical Data Systems* section below for the specification. Refer to the Final 2022 Call Letter and the *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

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 one separate combination rate.

Eligible Population

| | |
|------------------------------|--|
| 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. |

Required exclusions

Exclude members who meet either of the following criteria:

- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.
- Members who had any of the following on or before their second birthday:
 - Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set).
 - 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).
 - Intussusception (Intussusception Value Set).

Administrative Specification

Denominator

The eligible population.

Numerators

DTaP

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

- At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).
- Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).

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

Either of the following meets 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.
- All of the following any time on or before the child's second birthday (on the same or different date of service):
 - History of measles illness (Measles Value Set).
 - History of mumps illness (Mumps Value Set).
 - History of rubella illness (Rubella Value Set).

HiB

Either of the following on or before the child's second birthday meets criteria:

- 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. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

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).
- Anaphylaxis due to the Hepatitis B vaccine (SNOMED CT code 428321000124101).

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.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103).

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 rate Calculate the following rate for Combination 10.

Combination Vaccinations for Childhood Immunization Status

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

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

Numerators

For DTaP, count any of the following:

- Evidence of the antigen or combination vaccine.
- Anaphylaxis due to the vaccine.
- Encephalitis due to the vaccine.

For hepatitis B, count any of the following:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test result.
- Anaphylaxis due to the vaccine.

For MMR, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine.
- Documented history of the illness.
- A seropositive test result.

For HiB and rotavirus, count *either*:

- Evidence of the antigen or combination vaccine.
- Anaphylaxis due to the vaccine.

For IPV, pneumococcal conjugate and influenza, count only:

- Evidence of the antigen or combination vaccine.

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

Administrative

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

Medical record

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

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

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

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

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

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

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

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

| Metric | Data Element | Reporting Instructions | A |
|-----------------------|---------------------------|------------------------|---|
| DTaP | CollectionMethod | Repeat per Metric | ✓ |
| IPV | EligiblePopulation | Repeat per Metric | ✓ |
| MMR | ExclusionAdminRequired | Repeat per Metric | ✓ |
| HiB | NumeratorByAdminElig | For each Metric | |
| HepatitisB | CYAR | (Percent) | |
| VZV | MinReqSampleSize | Repeat per Metric | |
| PneumococcalConjugate | OversampleRate | Repeat per Metric | |
| HepatitisA | OversampleRecordsNumber | (Count) | |
| Rotavirus | ExclusionValidDataErrors | Repeat per Metric | |
| Influenza | ExclusionEmployeeOrDep | Repeat per Metric | |
| Combo10 | OversampleRecsAdded | Repeat per Metric | |
| | Denominator | Repeat per Metric | |
| | NumeratorByAdmin | For each Metric | ✓ |
| | NumeratorByMedicalRecords | For each Metric | |
| | NumeratorBySupplemental | For each Metric | ✓ |
| | Rate | (Percent) | ✓ |

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

Description

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

Eligible Population

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

Contraceptive Medications

| Description | Prescription |
|----------------|---|
| Contraceptives | <ul style="list-style-type: none"> • Desogestrel-ethinyl estradiol • Dienogest-estradiol multiphasic • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate biphasic • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-folic acid-levonorgestrel • Ethinyl estradiol-levonorgestrel • 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 |

Required exclusion Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

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

| Metric | Age | Data Element | Reporting Instructions |
|--------------------|------------|-------------------------|-------------------------------|
| ChlamydiaScreening | 16-20 | EligiblePopulation | For each Stratification |
| | 21-24 | ExclusionAdminOptional | For each Stratification |
| | Total | ExclusionAdminRequired | For each Stratification |
| | | NumeratorByAdmin | For each Stratification |
| | | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |
| | | | |

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity.
- Revised the Reporting Instructions for the “NumeratorByAdminElig” data element in *Table COL-A-4: Data Elements for Colorectal Cancer Screening* to “For each Stratification” to indicate that it is a stratified value.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.
- Optional ECDS reporting for *Colorectal Cancer Screening* was proposed for addition in the Draft 2022 Call Letter. Refer to *Measures Reported Using Electronic Clinical Data Systems* below for the specification. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.
- As announced in the Draft 2022 Call Letter, NCQA will update the specifications for the *Colorectal Cancer Screening* measure to align with updated guidelines released by the U.S. Preventive Services Task Force (USPSTF). The revised specifications will be included in the HEDIS for QRS Technical Update memo that will be posted to the NCQA website (<https://www.ncqa.org>).

Description

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

Eligible Population

| | |
|-----------------------|---|
| Product line | Exchange. |
| Stratification | Report the following stratifications by race and total, and stratifications by ethnicity and total: <ul style="list-style-type: none"> • <i>Race:</i> <ul style="list-style-type: none"> – White. – Black or African American. – American Indian and Alaska Native. – Asian. – Native Hawaiian and Other Pacific Islander. – Some Other Race. – Two or More Races. – Asked but No Answer. – Unknown. – Total. |

- *Ethnicity:*
 - Hispanic/Latino.
 - Not Hispanic/Latino.
 - Asked but No Answer.
 - Unknown.
 - Total.

Note: *Stratifications are mutually exclusive and the sum of all categories in each stratification is the Total population.*

| | |
|------------------------------|---|
| 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 | <p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none">• Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i>.• 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 (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: |

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.
 - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) 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"> • Donepezil • 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 4 years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the 9 years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the 4 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 2 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 4 years prior to the measurement year.• Colonoscopy during the measurement year or the 9 years prior to the measurement year.• CT colonography during the measurement year or the 4 years prior to the measurement year.• FIT-DNA during the measurement year or the 2 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. <p>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</p> |

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-A-4: Data Elements for Colorectal Cancer Screening

| Metric | Data Element | Reporting Instructions | A |
|---------------------------|---------------------------|------------------------|---|
| ColorectalCancerScreening | CollectionMethod | Report once | ✓ |
| | EligiblePopulation | Report once | ✓ |
| | ExclusionAdminRequired | Report once | ✓ |
| | NumeratorByAdminElig | Report once | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Report once | |
| | OversampleRate | Report once | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Report once | |
| | ExclusionAdminOptional | Report once | |
| | ExclusionMedRecsOptional | Report once | |
| | ExclusionEmployeeOrDep | Report once | |
| | OversampleRecsAdded | Report once | |
| | Denominator | Report once | |
| | NumeratorByAdmin | Report once | ✓ |
| | NumeratorByMedicalRecords | Report once | |
| | NumeratorBySupplemental | Report once | ✓ |
| | Rate | (Percent) | ✓ |

Table COL-B-4: Data Elements for Colorectal Cancer Screening: Stratifications by Race

| Metric |
|---------------------------|
| ColorectalCancerScreening |

| Race | Source | Data Element | Reporting Instructions | A |
|---------------------------------------|----------|--------------------|---------------------------|---|
| White | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| BlackOrAfricanAmerican | Indirect | EligiblePopulation | For each Stratification | ✓ |
| AmericanIndianAndAlaskaNative | Total | Denominator | For each Stratification | |
| Asian | | Numerator | For each Stratification | ✓ |
| NativeHawaiianAndOtherPacificIslander | | Rate | (Percent) | ✓ |
| SomeOtherRace | | | | |
| TwoOrMoreRaces | | | | |
| AskedButNoAnswer* | | | | |
| Unknown | | | | |

Table COL-C-4: Data Elements for Colorectal Cancer Screening: Stratifications by Ethnicity

| Metric | Ethnicity | Source | Data Element | Reporting Instructions | A |
|---------------------------|---------------------|----------|--------------------|---------------------------|---|
| ColorectalCancerScreening | HispanicOrLatino | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| | NotHispanicOrLatino | Indirect | EligiblePopulation | For each Stratification | ✓ |
| | AskedButNoAnswer* | Total | Denominator | For each Stratification | |
| | Unknown | | Numerator | For each Stratification | ✓ |
| | | | Rate | (Percent) | ✓ |

*AskedButNoAnswer is only reported for Source='Direct.'

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity.
- Updated the Administrative Specification to make it consistent with the Hybrid Specification; replaced the visit type requirement with a visit type exclusion.
- Clarified in the numerator of the Hybrid Specification that BP readings taken by the member are eligible for use in reporting.
- Clarified in the numerator of the Hybrid Specification that ranges and thresholds do not meet criteria.
- Clarified in the numerator of the Hybrid Specification that a BP documented as an “average BP” (e.g., “average BP: 139/70”) is eligible for use.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting 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

| | |
|------------------------|---|
| Product line | Exchange. |
| Stratifications | Report the following stratifications by race and total, and stratifications by ethnicity and total: <ul style="list-style-type: none">• <i>Race:</i><ul style="list-style-type: none">– White.– Black or African American.– American Indian and Alaska Native.– Asian.– Native Hawaiian and Other Pacific Islander. |

- Some Other Race.
- Two or More Races.
- Asked but No Answer.
- Unknown.
- Total.
- *Ethnicity:*
 - Hispanic/Latino.
 - Not Hispanic/Latino.
 - Asked but No Answer.
 - Unknown.
 - Total.

Note: Stratifications are mutually exclusive and the sum of all categories in each stratification is the Total population.

| | |
|------------------------------|--|
| Ages | 18–85 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in continuous enrollment of up to 45 days during the measurement year. |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | <p>Members who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year (count services that occur over both years). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria:</p> <ul style="list-style-type: none"> • Outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • A telephone visit (<u>Telephone Visits Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). • An e-visit or virtual check-in (<u>Online Assessments Value Set</u>) with any diagnosis of hypertension (<u>Essential Hypertension Value Set</u>). |
| Required exclusions | <p>Exclude members who meet any of the following criteria:</p> <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i>. • 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

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:
 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).
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 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.
- 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 the measurement year. Exclude BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; ED POS Value Set).

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

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

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

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

Exclusions (optional)

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
 - 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 <i>Guidelines for Calculations and Sampling</i> 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 | <p>Identify the most recent BP reading noted during the measurement year.</p> <p>The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.</p> <p>Do not include BP readings:</p> <ul style="list-style-type: none">• 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. <p>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.</p> |

BP readings taken by the member and documented in the member's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

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).

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

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.*
- *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

| Metric | Data Element | Reporting Instructions | A |
|---------------|---------------------------|------------------------|---|
| ControlHighBP | CollectionMethod | Report once | ✓ |
| | EligiblePopulation | Report once | ✓ |
| | ExclusionAdminRequired | Report once | ✓ |
| | NumeratorByAdminElig | Report once | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Report once | |
| | OversampleRate | Report once | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Report once | |
| | ExclusionAdminOptional | Report once | |
| | ExclusionMedRecsOptional | Report once | |
| | ExclusionEmployeeOrDep | Report once | |
| | OversampleRecsAdded | Report once | |
| | Denominator | Report once | |
| | NumeratorByAdmin | Report once | ✓ |
| | NumeratorByMedicalRecords | Report once | |
| | NumeratorBySupplemental | Report once | ✓ |
| | Rate | (Percent) | ✓ |

Table CBP-B-4: Data Elements for Controlling High Blood Pressure: Stratifications by Race

| Metric | Race | Source | Data Element | Reporting Instructions | A |
|---------------|---------------------------------------|----------|--------------------|---------------------------|---|
| ControlHighBP | White | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| | BlackOrAfricanAmerican | Indirect | EligiblePopulation | For each Stratification | ✓ |
| | AmericanIndianAndAlaskaNative | Total | Denominator | For each Stratification | |
| | Asian | | Numerator | For each Stratification | ✓ |
| | NativeHawaiianAndOtherPacificIslander | | Rate | (Percent) | ✓ |
| | SomeOtherRace | | | | |
| | TwoOrMoreRaces | | | | |
| | AskedButNoAnswer* | | | | |
| | Unknown | | | | |

Table CBP-C-4: Data Elements for Controlling High Blood Pressure: Stratifications by Ethnicity

| Metric | Ethnicity | Source | Data Element | Reporting Instructions | A |
|---------------|---------------------|----------|--------------------|---------------------------|---|
| ControlHighBP | HispanicOrLatino | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| | NotHispanicOrLatino | Indirect | EligiblePopulation | For each Stratification | ✓ |
| | AskedButNoAnswer* | Total | Denominator | For each Stratification | |
| | Unknown | | Numerator | For each Stratification | ✓ |
| | | | Rate | (Percent) | ✓ |

*AskedButNoAnswer is only reported for Source='Direct. '

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Updated the Hybrid Specification to clarify the rules for sample size reduction.
- Revised the Reporting Instructions for the “NumeratorByAdminElig” data element in Table EED-3: Data Elements for *Eye Exam for Patients With Diabetes* to “For each Stratification” to indicate that it is a stratified value.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Eligible Population

| | |
|------------------------------|--|
| Product lines | 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. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | <p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none">• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>).• At least one acute inpatient discharge with a diagnosis of diabetes (<u>Diabetes Value Set</u>) on the discharge claim. To identify an acute inpatient discharge:<ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). |

2. Exclude nonacute inpatient stays (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), e-visits or virtual check-ins (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 during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

| Description | Prescription | | |
|--|---|---|--|
| Alpha-glucosidase inhibitors | • Acarbose | • Miglitol | |
| Amylin analogs | • Pramlintide | | |
| Antidiabetic combinations | • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin | • Empagliflozin-metformin • Glimepiride-pioglitazone • 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 | • Albiglutide • Dulaglutide • Exenatide | • Liraglutide (excluding Saxenda®) • Semaglutide | |
| Sodium glucose cotransporter 2 (SGLT2) inhibitor | • Canagliflozin | • Dapagliflozin (excluding Farxiga®) | • Empagliflozin |
| Sulfonylureas | • Chlorpropamide • Glimepiride | • Glipizide • Glyburide | • Tolazamide • Tolbutamide |

| Description | Prescription |
|---|---|
| Thiazolidinediones | <ul style="list-style-type: none"> • Pioglitazone • Rosiglitazone |
| Dipeptidyl peptidase-4 (DDP-4) inhibitors | <ul style="list-style-type: none"> • Alogliptin • Saxagliptin • Linagliptin • 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 who meet any of the following criteria:

- 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.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.
- 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 (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), 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) 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"> • Donepezil • 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 Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set or Automated Eye Exam 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.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the *Hemoglobin A1c Control for Patients With Diabetes (HBD)* and *Eye Exam for Patients With Diabetes (EED)* measures may use the same sample for both measures.

Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of HBD and EED measures.

If separate samples are used for the HBD and EED measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

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

Numerator

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

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

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

Administrative

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

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

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and 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.

Note

- *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.*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; 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 this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*

Data Elements for Reporting

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

Table EED-4: Data Elements for Eye Exam for Patients With Diabetes

| Metric | Data Element | Reporting Instructions | A |
|---------------|---------------------------|-------------------------------|----------|
| EyeExams | CollectionMethod | Report once | ✓ |
| | EligiblePopulation | Report once | ✓ |
| | ExclusionAdminRequired | Report once | ✓ |
| | NumeratorByAdminElig | Report once | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Report once | |
| | OversampleRate | Report once | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Report once | |
| | ExclusionEmployeeOrDep | Report once | |
| | OversampleRecsAdded | Report once | |
| | Denominator | Report once | |
| | NumeratorByAdmin | Report once | ✓ |
| | NumeratorByMedicalRecords | Report once | |
| | NumeratorBySupplemental | Report once | ✓ |
| | Rate | (Percent) | ✓ |

Flu Vaccinations for Adults Ages 18–64 (FVA)

SUMMARY OF CHANGES TO MY 2022 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.

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 6 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, 1957, and July 1, 2004) |
| 2 = Ineligible (the member was born before July 2, 1957, or after July 1, 2004) |

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 (2022 for the survey fielded in 2023).

Calculation of Flu Vaccinations for Adults Ages 18–64

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

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

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Updated the steps for identifying acute readmission or direct transfer in the event/diagnosis.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added psychiatric collaborative care management to the numerator.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

| | | | |
|---|---|---|---|
| Product line | Exchange. | | |
| Ages | 6 years and older as of the date of discharge. Report three age stratifications and a total rate: <table> <tr> <td> <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. </td><td> <ul style="list-style-type: none"> • 65 years and older. • Total. </td></tr> </table> | <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. | <ul style="list-style-type: none"> • 65 years and older. • Total. |
| <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. | <ul style="list-style-type: none"> • 65 years and older. • Total. | | |
| Continuous enrollment | The total is the sum of the age stratifications. Date of discharge through 30 days after discharge. | | |
| Allowable gap | None. | | |
| Anchor date | None. | | |
| Benefits | Medical and mental health (inpatient and outpatient). | | |
| Event/diagnosis | <p>An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (<u>Mental Illness Value Set</u>; <u>Intentional Self-Harm Value Set</u>) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. <p>The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p> | | |

| | |
|--|---|
| Acute readmission or direct transfer | <p>Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:</p> <ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period).4. Identify the discharge date for the stay. <p>Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (<u>Mental Health Diagnosis Value Set</u>; <u>Intentional Self-Harm Value Set</u>), count only the last discharge.</p> <p>If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.</p> |
| Nonacute readmission or direct transfer | <p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:</p> <ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim.3. Identify the admission date for the stay. <p>These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.</p> |
| Required exclusion | <p>Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i>.</p> |

Administrative Specification

| | |
|-------------------------|--|
| Denominator | The eligible population. |
| Numerator | |
| 30-Day Follow-Up | A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge. |
| 7-Day Follow-Up | <p>A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.</p> <p>For both indicators, any of the following meet criteria for a follow-up visit:</p> <ul style="list-style-type: none">• An outpatient visit (<u>Visit Setting Unspecified Value Set</u>) with (<u>Outpatient POS Value Set</u>) with a mental health provider.• An outpatient visit (<u>BH Outpatient Value Set</u>) with a mental health provider. |

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) **with** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) **with** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: Visit Setting Unspecified Value Set **with** Telehealth POS Value Set **with** a mental health provider.
- An observation visit (Observation Value Set) **with** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), **with** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) **with** a mental health provider.
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).
- Refer to Appendix 1 for the definition of mental health provider. Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.

Data Elements for Reporting

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

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

| Metric | Age | Data Element | Reporting Instructions |
|---------------|-------|-------------------------|--|
| FollowUp30Day | 6-17 | Benefit | Metadata |
| FollowUp7Day | 18-64 | EligiblePopulation | For each Stratification, repeat per Metric |
| | 65+ | ExclusionAdminRequired | For each Stratification, repeat per Metric |
| | Total | NumeratorByAdmin | For each Metric and Stratification |
| | | NumeratorBySupplemental | For each Metric and Stratification |
| | | Rate | (Percent) |

Hemoglobin A1c Control for Patients With Diabetes (HBD)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added instructions to report rates stratified by race and ethnicity.
- Revised the optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
- Updated the Hybrid Specification to clarify the rules for sample size reduction.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- Organizations report only the HbA1c control <8% indicator.
- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following level during the measurement year:

- HbA1c control (<8.0%).

Eligible Population

| | |
|-----------------------|--|
| Product line | Exchange. |
| Stratification | <p>For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:</p> <ul style="list-style-type: none">• <i>Race:</i><ul style="list-style-type: none">– White.– Black or African American.– American Indian and Alaska Native.– Asian.– Native Hawaiian and Other Pacific Islander.– Some Other Race.– Two or More Races.– Asked but No Answer.– Unknown.– Total.• <i>Ethnicity:</i><ul style="list-style-type: none">– Hispanic/Latino.– Not Hispanic/Latino.– Asked but No Answer. |

- Unknown.
- Total.

Note: Stratifications are mutually exclusive and the sum of all categories in each stratification is the Total population.

| | |
|------------------------------|---|
| 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. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | <p>There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>). • At least one acute inpatient discharge with a diagnosis of diabetes (<u>Diabetes Value Set</u>) on the discharge claim. To identify an acute inpatient discharge: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. • At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), telephone visits (<u>Telephone Visits Value Set</u>), e-visits or virtual check-ins (<u>Online Assessments Value Set</u>), ED visits (<u>ED Value Set</u>), nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim. 3. Identify the discharge date for the stay. <p>Only include nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) without telehealth (<u>Telehealth Modifier Value Set</u>; <u>Telehealth POS Value Set</u>).</p> |

Hemoglobin A1c Control for Patients With Diabetes

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

Diabetes Medications

| Description | Prescription | | |
|--|---|---|--|
| Alpha-glucosidase inhibitors | • Acarbose | • Miglitol | |
| Amylin analogs | • Pramlintide | | |
| Antidiabetic combinations | • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin | • Empagliflozin-metformin • Glimepiride-pioglitazone • 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 | • Albiglutide • Dulaglutide • Exenatide | • Liraglutide (excluding Saxenda®) • 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 who meet any of the following criteria:

- 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.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.
- 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 (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), 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) 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

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

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

| Value Set | Numerator Compliance |
|---|----------------------|
| <u>HbA1c Level Less Than 7.0 Value Set</u> | Compliant |
| <u>HbA1c Level 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 |

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Hemoglobin A1c Control for Patients With Diabetes (HBD) and Eye Exam for Patients With Diabetes (EED) measures may use the same sample for both measures.

Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of the HBD and EED measures.

If separate samples are used for the HBD and EED measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

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

Numerator**HbA1c Control
<8%**

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

Administrative

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

Medical record

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

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

Note

- If a combination of administrative, supplemental or hybrid data are used, the most recent HbA1c result must be used, regardless of data source.

Data Elements for Reporting

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

Table HBD-A-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes

| Metric | Data Element | Reporting Instructions | A |
|----------------------|---------------------------|------------------------|---|
| AdequateHbA1cControl | CollectionMethod | Report once | ✓ |
| | EligiblePopulation* | Report once | ✓ |
| | ExclusionAdminRequired* | Report once | ✓ |
| | NumeratorByAdminElig | Report once | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Report once | |
| | OversampleRate | Report once | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Report once | |
| | ExclusionEmployeeOrDep | Report once | |
| | OversampleRecsAdded | Report once | |
| | Denominator | Report once | |
| | NumeratorByAdmin | Report once | ✓ |
| | NumeratorByMedicalRecords | Report once | |
| | NumeratorBySupplemental | Report once | ✓ |
| | Rate | (Percent) | ✓ |

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Hemoglobin A1c Control for Patients With Diabetes

Table HBD-B-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Race

| Metric | | | | |
|----------------------|--|--|--|--|
| AdequateHbA1cControl | | | | |

| Race | Source | Data Element | Reporting Instructions | A |
|---------------------------------------|----------|---------------------|---------------------------|---|
| White | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| BlackOrAfricanAmerican | Indirect | EligiblePopulation* | For each Stratification | ✓ |
| AmericanIndianAndAlaskaNative | Total | Denominator | For each Stratification | |
| Asian | | Numerator | For each Stratification | ✓ |
| NativeHawaiianAndOtherPacificIslander | | Rate | (Percent) | ✓ |
| SomeOtherRace | | | | |
| TwoOrMoreRaces | | | | |
| AskedButNoAnswer** | | | | |
| Unknown | | | | |

Table HBD-C-4: Data Elements for Hemoglobin A1c Control for Patients With Diabetes: Stratifications by Ethnicity

| Metric | | | | |
|----------------------|--|--|--|--|
| AdequateHbA1cControl | | | | |

| Ethnicity | Source | Data Element | Reporting Instructions | A |
|---------------------|----------|---------------------|---------------------------|---|
| HispanicOrLatino | Direct | CollectionMethod | Repeat per Stratification | ✓ |
| NotHispanicOrLatino | Indirect | EligiblePopulation* | For each Stratification | ✓ |
| AskedButNoAnswer** | Total | Denominator | For each Stratification | |
| Unknown | | Numerator | For each Stratification | ✓ |
| | | Rate | (Percent) | ✓ |

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the administrative method.

**AskedButNoAnswer is only reported for Source='Direct.'

Immunizations for Adolescents (IMA)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised the optional exclusions for anaphylaxis due to vaccine to be numerator compliant for specific indicators.
- Clarified in the example for the two-dose HPV vaccination series that the second vaccine must be on or after July 25.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS only reports Combination 2 and related antigens.
- Optional ECDS reporting for *Immunizations for Adolescents* was proposed for addition in the Draft 2022 Call Letter. Refer to “Measures Reported Using Electronic Clinical Data Systems” below for the specification. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

| | |
|------------------------------|--|
| Product line | Exchange. |
| Age | Adolescents who turn 13 years of age during the measurement year. |
| Continuous enrollment | 12 months prior to the member's 13th birthday. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. |
| Anchor date | Enrolled on the member's 13th birthday. |
| Benefit | Medical. |
| Event/diagnosis | None. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

Administrative Specification

| | |
|--------------------|---|
| Denominator | The eligible population. |
| Numerators | For meningococcal, Tdap and HPV count <i>only</i> evidence of the antigen or combination vaccine. |

**Meningococcal
serogroups
A, C, W, Y**

Either of the following meets criteria:

- At least one meningococcal serogroups A, C, W, Y vaccine ([Meningococcal Immunization Value Set](#); [Meningococcal Vaccine Procedure Value Set](#)), with a date of service on or between the member's 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday

Tdap

Any of the following meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine ([Tdap Immunization Value Set](#); [Tdap Vaccine Procedure Value Set](#)), with a date of service on or between the member's 10th and 13th birthdays.
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine ([Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set](#)) any time on or before the member's 13th birthday.
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine ([Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set](#)) any time on or before the member's 13th birthday.

HPV

Any of the following meet criteria:

- At least two HPV vaccines ([HPV Immunization Value Set](#); [HPV Vaccine Procedure Value Set](#)), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.
- At least three HPV vaccines ([HPV Immunization Value Set](#); [HPV Vaccine Procedure Value Set](#)), with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

**Combination 2
(Meningococcal,
Tdap, HPV)**

Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations may reduce the sample size using current year's administrative rate or prior year's audited, product line-specific rate for the lowest rate across all antigens and combinations. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling*.

Numerators

For meningococcal, Tdap and HPV, count *either*:

- Evidence of the antigen or combination vaccine.
- Anaphylaxis due to the vaccine.

Administrative

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

Medical record

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

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

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

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

Immunizations documented using a generic header or “Tdap/Td” can be counted as evidence of Tdap. The burden on organizations to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

Note

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

Data Elements for Reporting

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

Table IMA-4: Data Elements for Immunizations for Adolescents

| Metric | Data Element | Reporting Instructions | A |
|---------------|---------------------------|------------------------|---|
| Meningococcal | CollectionMethod | Repeat per Metric | ✓ |
| Tdap | EligiblePopulation | Repeat per Metric | ✓ |
| HPV | ExclusionAdminRequired | Repeat per Metric | ✓ |
| Combo2 | NumeratorByAdminElig | For each Metric | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Repeat per Metric | |
| | OversampleRate | Repeat per Metric | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Repeat per Metric | |
| | ExclusionEmployeeOrDep | Repeat per Metric | |
| | OversampleRecsAdded | Repeat per Metric | |
| | Denominator | Repeat per Metric | |
| | NumeratorByAdmin | For each Metric | ✓ |
| | NumeratorByMedicalRecords | For each Metric | |
| | NumeratorBySupplemental | For each Metric | ✓ |
| | Rate | (Percent) | ✓ |

Initiation and Engagement of Substance Use Disorder Treatment (IET)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Replaced “alcohol and other drug (AOD)” references with “substance use disorder (SUD).”
- Changed the start of the Intake Period to November 15 of the year prior to the measurement year.
- Changed from a member-based measure to an SUD diagnosis episode-based measure.
- Revised the age stratifications.
- Revised the negative diagnosis history from 60 days to 194 days.
- Added a Negative Medication History to the denominator.
- Revised the Continuous Enrollment criteria from 108 days to 242 days.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Revised the numerator criteria for Initiation of SUD Treatment and Engagement of SUD Treatment.

Description

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
- *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Definitions

| | |
|-------------------------|--|
| Intake Period | November 15 of the year prior to the measurement year–November 14 of the measurement year. The Intake Period is used to capture new SUD episodes. |
| SUD Episode | <p>An encounter during the Intake Period with a diagnosis of SUD.</p> <p><i>For visits that result in an inpatient stay, the inpatient discharge is the SUD Episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).</i></p> |
| SUD Episode Date | <p>The date of service for an encounter during the Intake period with a diagnosis of SUD.</p> <p><i>For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay), the SUD Episode Date is the date of service.</i></p> <p><i>For an inpatient stay or for medically managed withdrawal event (i.e., detoxification) that occurred during an inpatient stay, the SUD Episode Date is the date of discharge.</i></p> <p><i>For medically managed withdrawal (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD Episode Date is the date of service.</i></p> |

For direct transfers, the SUD Episode Date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Date of service for services billed weekly or monthly For an opioid treatment service that bills monthly or weekly (ODU Weekly Non Drug Service Value Set; ODU Monthly Office Based Treatment Value Set; ODU Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).

Direct transfer A **direct transfer** is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

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

Use the following method to identify admissions to and discharges from inpatient settings.

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

Eligible Population

Product line Exchange.

Ages 13 years and older as of the SUD Episode Date. Report three age stratifications and a total rate.

- | | |
|----------------|--------------|
| • 13–17 years. | • 65+ years. |
| • 18–64 years. | • Total. |

The total is the sum of the age stratifications.

SUD diagnosis cohort stratification Report the following SUD diagnosis cohorts and a total:

- Alcohol use disorder.
- Opioid use disorder.
- Other substance use disorder.
- Total.

The total is the sum of the SUD diagnosis cohort stratifications.

Continuous enrollment 194 days prior to the SUD Episode Date through 47 days after the SUD Episode Date (242 total days).

Allowable gap None.

Anchor date None.

Benefit Medical, pharmacy and chemical dependency (inpatient and outpatient).
Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.

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

Follow the steps below to identify the denominator for both rates.

Step 1

Identify all SUD episodes. Any of the following meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) and **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** (Partial Hospitalization POS Value Set) and **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) **with** (Non-residential Substance Abuse Treatment Facility POS Value Set) and **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** (Community Mental Health Center POS Value Set) and **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) and **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An observation visit (Observation Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge **with** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set).

Step 2

Test for Negative SUD Diagnosis History. Exclude SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) with a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD Episode Date.

If the SUD Episode was an inpatient stay, use the admission date to determine Negative SUD History.

For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD Episode), use the earliest date of service to determine the Negative SUD Diagnosis History (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history).
For direct transfers, use the first admission date to determine the Negative SUD Diagnosis History.

Step 3

Test for Negative SUD Medication History. Exclude SUD episodes if any of the following occurred during the 194 days prior to the SUD Episode Date:

- An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List).
- An SUD medication administration event (Naltrexone Injection Value Set; Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Step 4 Exclude SUD Episodes that do not meet continuous enrollment criteria. Members must be continuously enrolled from 194 days before the SUD Episode Date through 47 days after the SUD Episode Date (242 total days), with no gaps.

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

Step 5 Identify the SUD diagnosis cohort for each SUD Episode.

- If the SUD Episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort.
- If the SUD Episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort.
- If the SUD Episode has a diagnosis of SUD that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other substance use disorder cohort.

Include SUD Episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD Episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusion Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of SUD Treatment Initiation of SUD treatment within 14 days of the SUD Episode Date. Follow the steps below to identify numerator compliance.

Step 1 *If the SUD Episode was an inpatient discharge*, the inpatient stay is considered initiation of treatment and the SUD Episode is compliant.

Step 2 *If the SUD Episode was an opioid treatment service that bills monthly (OPUD Monthly Office Based Treatment Value Set)*, the opioid treatment service is considered initiation of treatment and the SUD Episode is compliant.

Step 3 For remaining SUD Episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD Episode Date or during the 13 days after the SUD Episode Date (14 total days).

- An acute or nonacute inpatient admission **with** a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set

Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An outpatient visit (BH Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** (Partial Hospitalization POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) **with** (Non-residential Substance Abuse Treatment Facility POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** (Community Mental Health Center POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List;

Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD Episode Date must be with different providers in order to count.

Exclude the member from the denominator for both indicators (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1

Identify all SUD Episodes compliant for the Initiation of SUD Treatment numerator. SUD Episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2

Identify SUD Episodes that had at least one weekly or monthly opioid treatment service with medication administration (ODD Monthly Office Based Treatment Value Set; ODD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD Episode is compliant.

Step 3

Identify SUD Episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD Episode is compliant. Any of the following meet criteria:

- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List) or a medication administration event (Naltrexone Injection Value Set).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set).

Step 4

For remaining SUD Episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit.
- Engagement medication treatment event.

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

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

Engagement visits Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) **with** (Outpatient POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An outpatient visit (BH Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) **with** (Partial Hospitalization POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) **with** (Non-residential Substance Abuse Treatment Facility POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A community mental health center visit (Visit Setting Unspecified Value Set) **with** (Community Mental Health Center POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telehealth visit: (Visit Setting Unspecified Value Set) **with** (Telehealth POS Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A substance use disorder service (Substance Use Disorder Services Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- A telephone visit (Telephone Visits Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) **with** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (ODD Weekly Non Drug Service Value Set).

**Engagement
medication
treatment events**

Either of the following meets criteria for a medication treatment event:

- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List).
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

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

Opioid Use Disorder Treatment Medications

| Description | Prescription | Medication Lists |
|-----------------|--|---|
| Antagonist | • Naltrexone (oral) | • <u>Naltrexone Oral Medications List</u> |
| Antagonist | • Naltrexone (injectable) | • <u>Naltrexone Injection Medications List</u> |
| Partial agonist | • Buprenorphine (sublingual tablet) | • <u>Buprenorphine Oral Medications List</u> |
| Partial agonist | • Buprenorphine (injection) | • <u>Buprenorphine Injection Medications List</u> |
| Partial agonist | • Buprenorphine (implant) | • <u>Buprenorphine Implant Medications List</u> |
| Partial agonist | • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) | • <u>Buprenorphine Naloxone Medications List</u> |

Note

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

Initiation and Engagement of Substance Use Disorder Treatment

- *Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.*

Data Elements for Reporting

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

Table IET-4: Data Elements for Initiation and Engagement of Substance Use Disorder Treatment

| Metric | Diagnosis | Age | Data Element | Reporting Instructions |
|------------|-----------|-------|------------------------|--|
| Initiation | Alcohol | 13-17 | Benefit | Metadata |
| Engagement | Opioid | 18-64 | EligiblePopulation | For each Stratification, repeat per Metric |
| | Other | 65+ | ExclusionAdminRequired | For each Stratification, repeat per Metric |
| | Total | Total | NumeratorByAdmin | For each Metric and Stratification |
| | | | Rate | (Percent) |

Kidney Health Evaluation for Patients With Diabetes (KED)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure was proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

Product line Exchange.

Ages 18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate:

- | | |
|----------|----------|
| • 18–64. | • 75–85. |
| • 65–74. | • Total. |

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

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

Step 1 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), e-visits or virtual check-ins (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 during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

| Description | Prescription | | |
|------------------------------|---|---|--|
| Alpha-glucosidase inhibitors | • Acarbose | • Miglitol | |
| Amylin analogs | • Pramlintide | | |
| Antidiabetic combinations | • Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin | • Empagliflozin-metformin • Glimepiride-pioglitazone • 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 | |

| Description | Prescription |
|--|--|
| Meglitinides | <ul style="list-style-type: none"> • Nateglinide • Repaglinide |
| Glucagon-like peptide-1 (GLP1) agonists | <ul style="list-style-type: none"> • Albiglutide • Dulaglutide • Exenatide • Liraglutide (excluding Saxenda®) • Semaglutide |
| Sodium glucose cotransporter 2 (SGLT2) inhibitor | <ul style="list-style-type: none"> • Canagliflozin • Dapagliflozin (excluding Farxiga®) • Empagliflozin |
| Sulfonylureas | <ul style="list-style-type: none"> • Chlorpropamide • Glimepiride • Glipizide • Glyburide • Tolazamide • Tolbutamide |
| Thiazolidinediones | <ul style="list-style-type: none"> • Pioglitazone • Rosiglitazone |
| Dipeptidyl peptidase-4 (DDP-4) inhibitors | <ul style="list-style-type: none"> • 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.*

Step 2:
Required
exclusions

Exclude members who meet any of the following criteria:

- Members with evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Step 3

Exclude members who meet any of the following criteria:

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

- Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty **and** advanced illness. Members must meet **BOTH** of the following frailty and advanced illness criteria to be excluded:
 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):
 - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), 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) 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).
- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

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

Administrative Specification

Denominator The eligible population.

Numerator

- Kidney Health Evaluation** Members who received **both** an eGFR and a uACR during the measurement year on the same or different dates of service:
- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
 - At least one uACR identified by either of the following:
 - **Both** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) **and** a urine creatinine test (Urine Creatinine Lab Test Value Set) **with** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
 - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

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.

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.

Data Elements for Reporting

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

Table KED-4: Data Elements for Kidney Health Evaluation for Patients With Diabetes

| Metric | Age | Data Element | Reporting Instructions |
|------------------------|-------|-------------------------|-------------------------|
| KidneyHealthEvaluation | 18-64 | EligiblePopulation | For each Stratification |
| | 65-74 | ExclusionAdminOptional | For each Stratification |
| | 75-85 | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | NumeratorBySupplemental | For each Stratification |
| | | Rate | (Percent) |

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- No changes to this measure.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

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

- *Advising Smokers and Tobacco Users to Quit.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- *Discussing Cessation Medications.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- *Discussing Cessation Strategies.* A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Eligible Population

| | |
|------------------------------|--|
| Product line | Exchange. |
| Ages | 18 years and older as of December 31 of the measurement year. |
| Continuous enrollment | The last 6 months of 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. |
| Current enrollment | Currently enrolled at the time the survey is completed. |

Protocol and Survey Instrument

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

Questions Included in the Measure

Table MSC: Medical Assistance With Smoking and Tobacco Use Cessation

| Question | Response Choices |
|---|--|
| Q48 Do you now smoke cigarettes or use tobacco every day, some days, or not at all? | Every day Some days Not at all → If Not at all, Go to Question 52 Don't know → If Don't know, Go to Question 52 |
| Q49 In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? | Never Sometimes Usually Always |
| Q50 In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication. | Never Sometimes Usually Always |
| Q51 In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program. | Never Sometimes Usually Always |

Calculation of Medical Assistance With Smoking and Tobacco Use Cessation

Rolling averages are calculated using the formula below.

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

Advising Smokers and Tobacco Users to Quit

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q48 = "Every day" or "Some days."

Q49 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to Q49.

Discussing Cessation Medications

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:

Q48 = "Every day" or "Some days."

Q50 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator The number of members in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q50.

Discussing Cessation Strategies

Denominator The number of members who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices *must* be as follows to be included in the denominator:
Q48 = “Every day” or “Some days.”
Q51 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator The number of members in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q51.

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

For members 18–64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Definitions

| | |
|-------------------------------|--|
| IHS | Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator. |
| Index Admission Date | The IHS admission date. |
| Index Discharge Date | The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year. |
| Index Readmission Stay | An acute or observation inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date. |
| Index Readmission Date | The admission date associated with the Index Readmission Stay. |
| Planned hospital Stay | A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the numerator. |
| Plan population | <p>Members in the eligible population prior to exclusion of outliers (denominator steps 1–5). The plan population is only used as a denominator for the Outlier Rate.</p> <p>The plan population is based on members, not discharges. Count members only once in the plan population.</p> <p>Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest Index Hospital Stay. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.</p> |

| | |
|------------------------------|---|
| Outlier | Members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest Index Hospital Stay. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period. |
| Nonoutlier | Members in the eligible population who are not considered outliers. |
| Classification Period | 365 days prior to and including an Index Discharge Date. |

Eligible Population

| | |
|------------------------------|--|
| Product line | Exchange. |
| Ages | 18–64 years as of the Index Discharge Date. |
| Continuous enrollment | 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date. |
| Anchor date | Index Discharge Date. |
| Benefit | Medical. |
| Event/diagnosis | <p>An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year.</p> <p>The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year.</p> <p>Follow the steps below to identify acute inpatient and observation stays.</p> |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

Administrative Specification

| | |
|--------------------|---|
| Denominator | The eligible population. |
| Step 1 | <p>Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:</p> <ol style="list-style-type: none">1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>).2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).3. Identify the discharge date for the stay. |

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

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

Step 2

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

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

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

Step 3

Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4

Exclude hospital stays for the following reasons:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

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

Step 5

Calculate continuous enrollment.

Step 6

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

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

Step 7

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

Risk Adjustment Determination

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

Observation stay

Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries

Determine if the member underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.

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

Risk Adjustment Weighting

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

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

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

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

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

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

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

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

Note: 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).
- A planned hospital stay 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.

Plan All-Cause Readmissions

- *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 the earliest Index Discharge Date. |
| Step 2 | Report the count of members in the plan population for each age group as the MemberCount. |

Reporting: Number of Outliers

- | | |
|---------------|---|
| Step 1 | Determine the member's age as of the earliest Index Discharge Date. |
| Step 2 | Report the count of outlier members for each age group as the OutlierMemberCount. |

Calculated: Outlier Rate

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

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group. Report these values as the Denominator.

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Index Stays (Denominator) for each group and totals. Calculated by IDSS at the ObservedRate.

Reporting: Count of Expected 30-Day Readmissions

- | | |
|---------------|--|
| Step 1 | Calculate the Count of Expected Readmissions among nonoutlier members for each age group. |
| Step 2 | Round to four decimal places using the .5 rule and report these values as the ExpectedCount. |

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions (ExpectedCount) divided by the Count of Index Stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate.

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 report these values as the CountVariance.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Expected 30-Day Readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

Note

- Supplemental data may not be used for this measure.

Data Elements for Reporting

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

Table PCR-4: Plan Population and Outlier Rate

| Metric | Age | Data Element | Reporting Instructions |
|--------------------------|-------|--------------------|--|
| PlanAllCauseReadmissions | 18-44 | MemberCount | For each Stratification |
| | 45-54 | OutlierMemberCount | For each Stratification |
| | 55-64 | OutlierRate | OutlierMembercount / MemberCount (Per mille) |
| | 18-64 | Denominator | For each Stratification |
| | | ObservedCount | For each Stratification |
| | | ObservedRate | ObservedCount / Denominator (Percent) |
| | | ExpectedCount | For each Stratification |
| | | ExpectedRate | ExpectedCount / Denominator (Percent) |
| | | CountVariance | For each Stratification |
| | | OE | ObservedCount / ExpectedCount |

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added instructions to report rates stratified by race and ethnicity.
- Removed the definition of *last enrollment segment* and clarified continuous enrollment requirements for steps 1 and 2 of the Timeliness of Prenatal Care numerator.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Clarified that services provided during a telephone visit, e-visit or virtual check-in may be used for Administrative and Hybrid collection methods.
- Added new data elements tables for race and ethnicity stratification reporting.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting 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).

Eligible Population

Product line Exchange.

Stratification Report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race*:
 - White.
 - Black or African American.
 - American Indian and Alaska Native.
 - Asian.
 - Native Hawaiian and Other Pacific Islander.
 - Some Other Race.
 - Two or More Races.
 - Asked but No Answer.

- Unknown.
- Total.
- Ethnicity:
 - Hispanic/Latino.
 - Not Hispanic/Latino.
 - Asked but No Answer.
 - Unknown.
 - Total.

Note: Stratifications are mutually exclusive and the sum of all categories in each stratification is the Total population.

| | |
|------------------------------|--|
| Ages | None specified. |
| Continuous enrollment | 43 days prior to delivery through 60 days after delivery. |
| Allowable gap | None. |
| Anchor date | Date of delivery. |
| Benefit | Medical. |
| Event/diagnosis | <p>Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting.</p> <p>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.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> |
| Step 1 | <p>Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.</p> <p>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.</p> |
| Step 2 | Exclude non-live births (<u>Non-live Births Value Set</u>). |
| Step 3 | Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

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 who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

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

Step 2 Identify women who were not continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after their 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 | <p>A systematic sample drawn from the eligible population for each product line.</p> <p>Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lower of the two indicators. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.</p> |
| Numerator | |
| <i>Timeliness of Prenatal Care</i> | A prenatal visit during the required timeframe. Refer to the <i>Administrative Specification</i> 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. |
| <u>Administrative</u> | Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data. |
| <u>Medical record</u> | <p>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 <i>one</i> of the following.</p> <ul style="list-style-type: none"> • Documentation indicating the woman is pregnant or references to the pregnancy; for example: <ul style="list-style-type: none"> – 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. • 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: <ul style="list-style-type: none"> – 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. |
| <i>Postpartum Care</i> | A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review. |
| <u>Administrative</u> | Refer to <i>Administrative Specification</i> 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 enrolled during the first trimester allow more flexibility than criteria for women who were enrolled.*
 - *For women who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
 - *For women who were not enrolled at least 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 and for both Administrative and Hybrid data collection methods, 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

| Metric | Data Element | Reporting Instructions | A |
|------------------------|---------------------------|------------------------|---|
| TimelinessPrenatalCare | CollectionMethod | For each Metric | ✓ |
| PostpartumCare | EligiblePopulation* | For each Metric | ✓ |
| | ExclusionAdminRequired* | For each Metric | ✓ |
| | NumeratorByAdminElig | For each Metric | |
| | CYAR | (Percent) | |
| | MinReqSampleSize | Repeat per Metric | |
| | OversampleRate | Repeat per Metric | |
| | OversampleRecordsNumber | (Count) | |
| | ExclusionValidDataErrors | Repeat per Metric | |
| | ExclusionEmployeeOrDep | Repeat per Metric | |
| | OversampleRecsAdded | Repeat per Metric | |
| | Denominator | Repeat per Metric | |
| | NumeratorByAdmin | For each Metric | ✓ |
| | NumeratorByMedicalRecords | For each Metric | |
| | Rate | (Percent) | ✓ |

Prenatal and Postpartum Care

Table PPC-B-4: Data Elements for Prenatal and Postpartum Care: Stratifications by Race

| Metric |
|------------------------|
| TimelinessPrenatalCare |
| PostpartumCare |

| Race | Source | Data Element | Reporting Instructions | A |
|---------------------------------------|----------|---------------------|--|---|
| White | Direct | CollectionMethod | For each Metric, repeat per Stratification | ✓ |
| BlackOrAfricanAmerican | Indirect | EligiblePopulation* | For each Stratification, repeat per Metric | ✓ |
| AmericanIndianAndAlaskaNative | Total | Denominator | For each Stratification, repeat per Metric | |
| Asian | | Numerator | For each Metric and Stratification | ✓ |
| NativeHawaiianAndOtherPacificIslander | | Rate | (Percent) | ✓ |
| SomeOtherRace | | | | |
| TwoOrMoreRaces | | | | |
| AskedButNoAnswer** | | | | |
| Unknown | | | | |

Table PPC-C-4: Data Elements for Prenatal and Postpartum Care: Stratifications by Ethnicity

| Metric | Ethnicity | Source | Data Element | Reporting Instructions | A |
|------------------------|---------------------|----------|---------------------|--|---|
| TimelinessPrenatalCare | HispanicOrLatino | Direct | CollectionMethod | For each Metric, repeat per Stratification | ✓ |
| PostpartumCare | NotHispanicOrLatino | Indirect | EligiblePopulation* | For each Stratification, repeat per Metric | ✓ |
| | AskedButNoAnswer** | Total | Denominator | For each Stratification, repeat per Metric | |
| | Unknown | | Numerator | For each Metric and Stratification | ✓ |
| | | | Rate | (Percent) | ✓ |

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the administrative method.

**AskedButNoAnswer is only reported for Source='Direct.'

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Expanded the age range to increase the upper age limit to 75 years.
- Added age stratifications.
- Added required exclusions for osteoporosis, lumbar surgery, spondylopathy, fragility fractures and palliative care.
- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Added exclusions for members with advanced illness and frailty.

Description

The percentage of members 18–75 years of age with a principal diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Calculation

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

Definitions

| | |
|-----------------------------------|---|
| Intake Period | January 1–December 3 of the measurement year. The Intake Period is used to identify the first eligible encounter with a principal 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

| | |
|------------------------------|---|
| Product line | Exchange. |
| Ages | <p>18 years as of January 1 of the measurement year to 75 years as of December 31 of the measurement year.</p> <p>Report two age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 18–64. • 65–75. • Total. <p>The total is the sum of the age stratifications.</p> |
| Continuous enrollment | 180 days (6 months) prior to the IESD through 28 days after the IESD. |
| Allowable gap | None. |

| | |
|--|---|
| 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 • Methylprednisolone • Triamcinolone • Dexamethasone • Betamethasone/Betamethasone acetate |

- *Osteoporosis*. Osteoporosis therapy (Osteoporosis Medication Therapy Value Set, Long-Acting Osteoporosis Medications Value Set) or a dispensed prescription to treat osteoporosis (Osteoporosis Medication List) any time during the member's history through 28 days after the IESD

Osteoporosis Medications

| Description | Prescription |
|-----------------|---|
| Bisphosphonates | <ul style="list-style-type: none"> • Alendronate • Alendronate-cholecalciferol • Ibandronate • Risedronate • Zoledronic acid |
| Other agents | <ul style="list-style-type: none"> • Abaloparatide • Denosumab • Raloxifene • Romosozumab • Teriparatide |

- **Fragility fracture.** Fragility fracture (Fragility Fractures Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- **Lumbar surgery.** Lumbar surgery (Lumbar Surgery Value Set) any time during the member's history through 28 days after the IESD.
- **Spondylopathy.** Spondylopathy (Spondylopathy Value Set) any time during the member's history through 28 days after the IESD.
- **Palliative care.** Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Members in hospice or using hospice services any time during the measurement year. Refer to *General Guideline 8: Members in Hospice*.

Step 5: Exclusions Exclude members who meet any of the following criteria:

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

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

Dementia Medications

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

Step 6 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

| Metric | Age | Data Element | Reporting Instructions |
|--------------------|-------|------------------------|-------------------------|
| LowBackPainImaging | 18-64 | EligiblePopulation | For each Stratification |
| | 65-75 | ExclusionAdminRequired | For each Stratification |
| | Total | NumeratorByAdmin | For each Stratification |
| | | Rate | (Percent) |

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

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.
- Clarified in the *Notes* that services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the BMI Percentile indicator.
- Revised the Reporting Instructions for the “NumeratorByAdminElig” data element in Table WCC-4 to read “For each Metric and Stratification,” to indicate that the value is stratified.

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

Product line Exchange.

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

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

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

Anchor date December 31 of the measurement year.

Benefit Medical.

| | |
|---------------------------|--|
| Event/diagnosis | Members who had an outpatient visit (<u>Outpatient Value Set</u>) with a PCP or an OB/GYN during the measurement year. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

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 30: 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 BMI Percentile, 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 care practitioner.

Data Elements for Reporting

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

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

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

| Metric | Age | Data Element | Reporting Instructions | A |
|----------------------------|-------|---------------------------|--|---|
| BMIPercentile | 3-11 | CollectionMethod | For each Metric, repeat per Stratification | ✓ |
| NutritionCounseling | 12-17 | EligiblePopulation* | For each Metric and Stratification | ✓ |
| PhysicalActivityCounseling | Total | ExclusionAdminRequired* | For each Metric and Stratification | ✓ |
| | | NumeratorByAdminElig | For each Metric and Stratification | |
| | | CYAR | Only for Total (Percent) | |
| | | MinReqSampleSize | Repeat per Metric and Stratification | |
| | | OversampleRate | Repeat per Metric and Stratification | |
| | | OversampleRecordsNumber | (Count) | |
| | | ExclusionValidDataErrors | Repeat per Metric and Stratification | |
| | | ExclusionAdminOptional | Repeat per Metric and Stratification | |
| | | ExclusionMedRecsOptional | Repeat per Metric and Stratification | |
| | | ExclusionEmployeeOrDep | Repeat per Metric and Stratification | |
| | | OversampleRecsAdded | Repeat per Metric and Stratification | |
| | | Denominator | For each Stratification, repeat per Metric | |
| | | NumeratorByAdmin | For each Metric and Stratification | ✓ |
| | | NumeratorByMedicalRecords | For each Metric and Stratification | |
| | | NumeratorBySupplemental | For each Metric and Stratification | ✓ |
| | | Rate | (Percent) | ✓ |

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the administrative method.

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

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Clarified that members in hospice or using hospice services any time during the measurement year are a required exclusion.

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

| | |
|------------------------------|--|
| Product line | 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. |
| Required exclusion | Members in hospice or using hospice services any time during the measurement year. Refer to <i>General Guideline 8: Members in Hospice</i> . |

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

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

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

| | |
|------------------------------|--|
| Product line | 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

| Metric | Data Element | Reporting Instructions |
|-----------------|-------------------------|------------------------|
| Age15Months | EligiblePopulation | For each Metric |
| Age15To30Months | ExclusionAdminRequired | For each Metric |
| | NumeratorByAdmin | For each Metric |
| | NumeratorBySupplemental | For each Metric |
| | Rate | (Percent) |

Measures Reported Using Electronic Clinical Data Systems

Guidelines for Measures Reported Using Electronic Clinical Data Systems (ECDS)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added optional ECDS reporting to HEDIS for QRS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- The inclusion of optional ECDS reporting for select HEDIS measures was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on methods for measure reporting.

Description

HEDIS for QRS quality measures reported using ECDS inspire innovative use of electronic clinical data to document high-quality patient care that demonstrates commitment to evidence-based practices. Organizations that report HEDIS for QRS using ECDS encourage exchange of the information needed to provide high-quality services, ensuring that the information reaches the right people at the right time.

The ECDS reporting standard represents a step forward in adapting HEDIS for QRS to accommodate the expansive information available in electronic clinical datasets used for patient care and quality improvement.

ECDS are the network of data containing a plan member's personal health information and records of their experiences within the health care system. They may also support other care-related activities directly or indirectly, including evidence-based decision support, quality management and outcome reporting. Data in these systems are structured such that automated quality measurement queries can be consistently and reliably executed, providing results quickly and efficiently to the team responsible for the care of health plan members.

Health plans that establish an enterprise network of interoperable electronic data systems will foster a member-centered, team-based approach to improving health care quality and better communication across health care service providers.

Disclaimer

The specifications included in this publication provide a summary of the measures that may be reported using ECDS. The specifications are for reference purposes only and should not be used for programming or reporting of the measures. The full HEDIS digital measure specifications may be purchased in the NCQA Store via NCQA's Digital Measure Packages. Organizations are accountable for all potential updates included in the Digital Measure Packages.

For reporting HEDIS for QRS measures, organizations can use NCQA's Digital Measure Packages. The packages provided are not specific to the Exchange product line and may include programming that is not relevant for QRS.

Guidelines

HEDIS for QRS measures reported using ECDS follow the *General Guidelines for Data Collection and Reporting*, unless there is an ECDS-specific guideline listed below that overrides those rules. This hierarchy only exists in specific cases where there is an ECDS guideline listed. If no ECDS-specific guideline is listed, then organizations should default to those found in *General Guidelines for Data Collection and Reporting*.

1. Initial Population

The Initial Population for any HEDIS for QRS measure reported using ECDS includes all members who satisfy criteria, including age and participation criteria. Refer to the logic in the digital measure package for criteria used to define the Initial Population.

2. HEDIS Definitions and Requirements for ECDS Reporting

| | |
|-------------------------------|---|
| QDE | Quality data element. Contains the structured definitional language used to describe data required for performance measurement. These definitions are characteristics that identify the required information, explicit meaning and any restrictions on its contained values. QDE definitions are typically represented by clinical terminology as codable concepts in the form of direct reference codes, value sets or value set groupings. QDE are modular components that form a quality measure specification when assembled by measure logic. |
| Master data management | Organizational policies and procedures for governance of quality measure data; specifically, defining creation of a master data file for quality reporting. An organization must use a master data management process to verify data integrity across the multiple data systems used in HEDIS ECDS reporting, ensuring consistent identification and classification of QDE and standardized data reconciliation procedures. Reconciliation procedures include, but are not limited to, validation, deduplication and reliability checks to correct latent data errors related to either the acquisition of encrypted data or ETL (extract, transform and load) integration of data into a master file. |
| FHIR | Fast Healthcare Interoperability Resources. A specification standard for exchanging healthcare information electronically that supports the exchange of structured and standardized data. ¹⁴ |
| Resources | Exchangeable content in FHIR are resources defined and represented in common ways. They are built from data types that define common reusable patterns of elements and share a common set of metadata. |
| CQL | Clinical Quality Language. ¹⁵ A Health Level Seven International (HL7) authoring language providing the ability to express logic that is human readable yet structured enough to process a measure query electronically. CQL can be shared between measures and decision support systems, extending its value to quality improvement. |
| Participation | The identifiers and descriptors for each organization's coverage used to define a member's eligibility for measure reporting. Allocation for HEDIS is based on a member's eligibility during the Participation Period. |
| Audit requirements | Measures reported using ECDS must follow all requirements of the HEDIS Compliance Audit. |

¹⁴<https://www.hl7.org/fhir/overview.html>

¹⁵<https://ecqi.healthit.gov/cql-clinical-quality-language>

3. Data Collection Methods

Measures reported using ECDS are specified for the Electronic Method of data collection.

Electronic Method Electronic transactional data may be used to identify the Initial Population.

To qualify for HEDIS ECDS reporting, data must use standard layouts, meet the measure technical specification requirements and be accessible by the care team upon request. Organizations meet this requirement if they are able to provide the requested information (e.g., phone, secure email, direct feed, provider portal, file request) to providers who are treating their members. Organizations should have documented processes for tracking these requests to be reviewed as part of the HEDIS audit.

Practitioners or practitioner groups that are accountable for clinical services provided to members must not be prevented from accessing any data used by a health plan for quality measure reporting, regardless of the initial Source System of Record (SSoR).

SSoR HEDIS for QRS measures reported using ECDS are reported by each SSoR accessed to produce a measure result. The SSoR is the authoritative data source containing the elements the organization uses for reporting digital quality measure results.

An SSoR may contain standard and nonstandard electronic clinical data. Refer to *General Guideline 21: Supplemental Data* for electronic clinical data proof-of-service and verification requirements. Each electronic data source used for HEDIS ECDS reporting must have:

- Policies and procedures for establishing and maintaining database management systems.
- Standard layout requirements.
- An automated process for incremental loading of all data elements.

Each SSoR is a database where semantic differences in data have been resolved through integrity testing, and the data structure is standardized so it can be electronically extracted for HEDIS ECDS reporting.

Source priority When quality data elements to support the measure are identified in multiple data sources, a hierarchy is applied.

Each SSoR used for HEDIS ECDS reporting is categorized using the following priority:

1. Electronic health record (EHR)/personal health record (PHR) (the system of data origin such as laboratory, pharmacy, pathology, radiology).
2. Health information exchange (HIE)/clinical registry.
3. Case management registry.
4. Administrative.

Organizations compare the list of all unique systems containing relevant member data and assign members based on the highest-ranked data category in the hierarchy. SSoRs are mapped using the data type that is loaded to the master file that identifies member eligibility for each component of a quality measure. The applied hierarchy does not imply relevance or validity of a data source; rather, it is applied in cases where a member's data are in multiple locations.

Members are assigned to only one SSoR category for each measure element (e.g., Initial Population, Denominator, Exclusions, Numerator).

For example, if administrative data are used to identify the Initial Population, the member is assigned to the Administrative category for the Initial Population. If a Numerator event is identified through a query of the organization's case management system, the member is assigned to that category for the Numerator even though that member may have been included in the measure's Initial Population using administrative data.

Organizations must complete data collection for the SSoRs by the supplemental data collection deadline. Refer to *General Guideline 5: Audit Preparation* for information about the timeline. When appropriate, an SSoR can be refreshed according to the organization's scheduled refreshes and accounted appropriately for the measure. Refer to *General Guideline 22: Obtaining Information for the Systematic Sample*.

4. Types of ECDS Data

Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to, member eligibility files, EHRs, PHRs, clinical registries, HIEs, administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

The data within these systems come in a variety of formats. The format type determines how the source is audited.

| | |
|-----------------------------|---|
| Structured data | Health care data residing in discrete, static fields using internationally recognized vocabulary standards are accepted as structured clinical data for ECDS reporting if it can be electronically extracted by a digital measure specification from an integrated data warehouse in a consistent and reliable fashion. |
| Semistructured data | Semistructured health care data are acceptable for use in ECDS reporting, if each QDE conforms to a uniform semantic structure and prescribed hierarchy, as specified by the logical definitions and attributes contained within each digital measure specification. |
| Member-reported data | Member-reported services are acceptable if the information is recorded, dated and maintained in the member's legal health record. The member-reported data must follow <i>General Guideline 30: Member-Reported Services and Biometric Values</i> . |

Data sources are categorized using the following criteria:

| | |
|----------------|---|
| EHR/PHR | EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information curated directly in the PHR by the patient through an application programming interface (API). |
|----------------|---|

This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings generated as a result of

samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).

HIE/clinical registry

HIEs and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives.

Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record.¹⁶ HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery.

Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.¹⁷

Case management system

A shared database of member information collected through a collaborative process of member assessment, care planning, care coordination or monitoring of a member's functional status and care experience.

Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.

Administrative

Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending and denied) during the period defined by each measure's participation as well as member management files, member eligibility and enrollment files, electronic member rosters, internal audit files, and member call service databases.

5. Member Allocation for HEDIS ECDS Reporting

Member eligibility is determined by participation in the organization during the Participation Period. Include all eligible members with the measure-specified benefits during the specified Participation Period. Members must be allocated to a product/product line for HEDIS ECDS reporting. Unless otherwise specified in the guidance section of the measures, members must be enrolled with no gap of more than 45 days during each year of the specified Participation Period.

6. HEDIS Digital Measure Format

HEDIS digital measure specifications are expressed using the CQL standard for representing a clinical quality measure (CQM) as an electronic document that references FHIR.⁵ In several sections, reporting organizations must program the logic for measure components not included in the digital measure specifications (e.g., stratifications). For each measure-specific instance of this, refer to the human-readable file contained in the measure package for guidance.

¹⁶<https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>

¹⁷<https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries>

HEDIS digital measures are published in a format which allows them to be directly consumed by the reporting system. Each digital measure includes both the human-readable technical documentation and the machine-readable files necessary for implementation. Each HEDIS digital measure includes the following files:

- **Measure-specific human-readable file:** A human-readable document representing the measure narrative in a way that is easy to understand for persons not familiar with computer coded files.
 1. *{measure id}_HEDIS_MY{MY}-{version}.html*: Contains a measure header table with text descriptions of the measure elements (Initial Population, Denominator, Exclusions, Numerator) and the data element types, and references.

This file also contains human-readable versions of the measure logic expressed in CQL. This portion of the file outlines the population criteria measure logic definitions, functions and relevant value sets formatted for easy review by measure implementors. Each measure section expressed in CQL corresponds with the descriptive text found in the measure header.
- **Technical Release Notes file:** Contains a comprehensive list of updates made to measures since their prior release. The *Summary of Changes* section in the *HEDIS Volume 2 Technical Specifications* publication at the beginning of every measure and in Appendix 1 previews the updates.
- **Expression Logical Model (ELM) files:** The machine-readable representation of the FHIR/CQL that has been designed for implementation of the quality measure. The ELM file provides the semantics necessary to retrieve the correct data from the measure reporting database.
 1. *{library name or measure ID}-{library or measure version}.cql*: A FHIR/CQL representation of all the data and the expressions created in the CQL library.
 2. *{library name or measure ID}-{library or measure version}.xml*: A standardized, machine-friendly representation of the FHIR/CQL in Extensible Markup Language (XML) format.
 3. *{library name or measure ID}-{library or measure version}.json*: A standardized, machine-friendly representation of the FHIR/CQL in JavaScript Object Notation (JSON) format.
- **Value set files:** A FHIR representation of the value sets applicable to the measure in JSON format.

Note: NCQA recommends that all files in a measure package be housed in the same place and that naming conventions be preserved because the computer-readable files reference the library files by name.

Complete measure packages for HEDIS digital measures are released by NCQA in conjunction with this publication and are available for download from the NCQA Store.

7. Presentation of Codes in HEDIS Digital Measures

HEDIS digital measures reference single codes and value sets that must be used for HEDIS reporting.

Value sets

If there is more than one eligible code to identify a data element, a value set is used. Organizations can refer to the Value Set Directory (VSD) for codes in the value sets, which are also in the measure package in JSON format.

Value sets are listed in the *Data criteria (element level)* section of the measure with an accompanying uniform resource identifier (URI). The OID listed in the URI is the key to locating codes in the HEDIS VSD or HEDIS Medication List Directory (MLD). The OID must be used to identify the correct value set to be used for each specific data element in the digital measures for HEDIS reporting.

Note: Value sets specified as a medication resource are found in the MLD.

**Direct reference
codes**

If only a single code is required to identify a data element, the code is listed in the *Data criteria (element level)* section of the human-readable file under the *Direct Reference Codes and Codesystems* heading. These codes are also included in the Direct Reference Codes spreadsheet of the VSD.

Childhood Immunization Status (CIS-E)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added optional ECDS reporting to HEDIS for QRS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS reports only Combination 10 and related antigens.
- This measure includes optional ECDS reporting that was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and the *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting for reporting this measure.

| | |
|--|---|
| 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 one combination rate. |
| Measurement period | January 1–December 31. |
| Clinical recommendation statement | This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (ACIP 2020). This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (ACIP 2020). |
| Citations | Advisory Committee on Immunization Practices (ACIP). 2020. "Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2020." February 4, 2020. https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html |
| Characteristics | |
| Scoring | Proportion. |
| Type | Process. |
| Stratification | 1. Exchange. |
| Risk adjustment | None. |
| Improvement notation | A higher rate indicates better performance. |

| Definitions | |
|-----------------------------|--|
| Participation | The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period. |
| Participation Period | 12 months prior to the member's second birthday. |
| Initial Population | Children who turn 2 years of age during the Measurement Period and also meet the criteria for Participation. |
| Exclusions | <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the Measurement Period. • Any of the following on or before the child's second birthday: <ul style="list-style-type: none"> – Severe combined immunodeficiency. – Immunodeficiency. – HIV. – Lymphoreticular cancer, multiple myeloma or leukemia. – Intussusception. |
| Denominator | The Initial Population, minus Exclusions. |
| Numerator | <p>Numerator 1—DTaP Children with any of the following on or before the child's second birthday meet criteria:</p> <ul style="list-style-type: none"> • At least four DTaP vaccinations, with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine. • Encephalitis due to the diphtheria, tetanus or pertussis vaccine. <p>Numerator 2—IPV At least three IPV vaccinations, 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.</p> <p>Numerator 3—MMR Children with either of the following meet criteria:</p> <ul style="list-style-type: none"> • At least one MMR vaccination on or between the child's first and second birthdays. • All of the following any time on or before the child's second birthday (on the same or different date of service): <ul style="list-style-type: none"> – History of measles illness. – History of mumps illness. – History of rubella illness. |

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| | <p>Numerator 4—HiB Children with either of the following on or before the child’s second birthday meet criteria:</p> <ul style="list-style-type: none"> • At least three HiB vaccinations, with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the HiB vaccine. <p>Numerator 5—Hepatitis B Children with any of the following on or before the child’s second birthday meet criteria:</p> <ul style="list-style-type: none"> • At least three hepatitis B vaccinations, with different dates of service. <ul style="list-style-type: none"> – One of the three vaccinations can be a newborn hepatitis B vaccination during the 8-day period that begins on the date of birth and ends 7 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 B illness. • Anaphylaxis due to the hepatitis B vaccine. <p>Numerator 6—VZV Children with either of the following meet criteria:</p> <ul style="list-style-type: none"> • At least one VZV vaccination, with a date of service on or between the child’s first and second birthdays. • History of varicella zoster (e.g., chicken pox) illness on or before the child’s second birthday. <p>Numerator 7—Pneumococcal Conjugate At least four pneumococcal conjugate vaccinations, 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.</p> <p>Numerator 8—Hepatitis A Children with either of the following meet criteria:</p> <ul style="list-style-type: none"> • At least one hepatitis A vaccination with a date of service on or between the child’s first and second birthdays. • History of hepatitis A illness on or before the child’s second birthday. <p>Numerator 9—Rotavirus Children with any of the following meet criteria:</p> <ul style="list-style-type: none"> • At least two doses of the two-dose rotavirus vaccine on different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. • At least three doses of the three-dose rotavirus vaccine on different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. • At least one dose of the two-dose rotavirus vaccine and at least two doses of the three-dose rotavirus vaccine, all on different dates of service, on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. |
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| | <ul style="list-style-type: none"> Anaphylaxis due to the rotavirus vaccine on or before the child's second birthday. <p>Numerator 10—Influenza</p> <ul style="list-style-type: none"> At least two influenza vaccinations, 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. <ul style="list-style-type: none"> One of the two vaccinations may be an LAIV vaccination administered on the child's second birthday. Do not count an LAIV vaccination administered before the child's second birthday. <p>Numerator 13—Combination 10 Members who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.</p> |
| Data criteria (element level) | |
| <p>Value Sets:</p> <ul style="list-style-type: none"> CISE_HEDIS_MY2022-1.0.0 <ul style="list-style-type: none"> Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240) Disorders of the Immune System (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1139) DTaP Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1744) DTaP Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1745) Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241) Haemophilus Influenzae Type B (HiB) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1753) Haemophilus Influenzae Type B (HiB) Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1754) Hepatitis A (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1117) Hepatitis A Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1757) Hepatitis A Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1758) Hepatitis B (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1266) Hepatitis B Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1759) Hepatitis B Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1760) HIV (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1110) HIV Type 2 (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1406) Inactivated Polio Vaccine (IPV) Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1765) | |

- Inactivated Polio Vaccine (IPV) Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1766>)
- Influenza Immunization (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1767>)
- Influenza Vaccine Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1768>)
- Influenza Virus LAIV Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1974>)
- Influenza Virus LAIV Vaccine Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1973>)
- Intussusception (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1415>)
- Malignant Neoplasm of Lymphatic Tissue
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1319>)
- Measles (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1171>)
- Measles, Mumps and Rubella (MMR) Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1773>)
- Measles, Mumps and Rubella (MMR) Vaccine Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1774>)
- Mumps (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1181>)
- Newborn Hepatitis B Vaccine Administered
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1397>)
- Pneumococcal Conjugate Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1781>)
- Pneumococcal Conjugate Vaccine Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1782>)
- Rotavirus (2 Dose Schedule) Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1785>)
- Rotavirus (3 Dose Schedule) Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1786>)
- Rotavirus Vaccine (2 Dose Schedule) Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1787>)
- Rotavirus Vaccine (3 Dose Schedule) Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1788>)
- Rubella (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1232>)
- Severe Combined Immunodeficiency
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1416>)
- Varicella Zoster (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1258>)
- Varicella Zoster (VZV) Immunization
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1793>)
- Varicella Zoster (VZV) Vaccine Procedure
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1794>)

• **NCQA_Hospice-1.0.0**

- Hospice Encounter (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761>)
- Hospice Intervention (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762>)

Direct Reference Codes and Codesystems:

• CISE_HEDIS_MY2022-1.0.0

- codesystem "SNOMEDCT": 'http://snomed.info/sct'
- code "Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)": '433621000124101' from "SNOMEDCT" display 'Anaphylaxis due to Haemophilus influenzae type b vaccine (disorder)'
- code "Anaphylaxis due to Hepatitis B vaccine (disorder)": '428321000124101' from "SNOMEDCT" display 'Anaphylaxis due to Hepatitis B vaccine (disorder)'
- code "Anaphylaxis due to rotavirus vaccine (disorder)": '428331000124103' from "SNOMEDCT" display 'Anaphylaxis due to rotavirus vaccine (disorder)'

• NCQA_Terminology-1.0.0

- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "managed care policy": 'MCPOL' from "coverage-type"
- code "retiree health program": 'RETIRE' from "coverage-type"
- code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

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

| Metric | Data Element | Reporting Instructions |
|-----------------------|----------------------------|------------------------|
| DTaP | InitialPopulation | Repeat per Metric |
| IPV | ExclusionsByEHR | Repeat per Metric |
| MMR | ExclusionsByCaseManagement | Repeat per Metric |
| HiB | ExclusionsByHIERegistry | Repeat per Metric |
| HepatitisB | ExclusionsByAdmin | Repeat per Metric |
| VZV | Exclusions | (Sum over SSoRs) |
| PneumococcalConjugate | Denominator | Repeat per Metric |
| HepatitisA | NumeratorByEHR | For each Metric |
| Rotavirus | NumeratorByCaseManagement | For each Metric |
| Influenza | NumeratorByHIERegistry | For each Metric |
| Combo10 | NumeratorByAdmin | For each Metric |
| | Numerator | (Sum over SSoRs) |
| | Rate | (Percent) |

Immunizations for Adolescents (IMA-E)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added optional ECDS reporting to HEDIS for QRS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- HEDIS for QRS only reports Combination 2 and related antigens.
- This measure includes optional ECDS reporting that was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and the *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

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| Description | The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. |
| Measurement period | January 1–December 31. |
| Clinical recommendation statement | <p>HPV: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated (Meites, Kempe, and Markowitz 2016).</p> <p>Tdap: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Liang et al. 2018).</p> <p>Meningococcal: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Cohn et al. 2013).</p> |
| Citations | <p>Cohn, A.C., J.R. MacNeil, T.A. Clark, I.R. Ortega-Sanchez, E.Z. Briere, H.C. Meissner, C.J. Baker, N.E. Messonnier, Centers for Disease Control and Prevention (CDC). 2013. "Prevention and Control of Meningococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." <i>MMWR Recomm Rep</i> 62(RR- 2):1–28.</p> <p>Jiang, J.L., T. Tiwari, P. Moro, N.E. Messonnier, A. Reingold, M. Sawyer, T.A. Clark. 2018. "Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." <i>MMWR Morb Mortal Wkly Rep</i> 67(2):1–44. DOI: 10.15585/mmwr.rr6702a1.</p> |

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| | Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." <i>MMWR Morb Mortal Wkly Rep</i> 65:1405-08. DOI: 10.15585/mmwr.mm6549a5. |
| Characteristics | |
| Scoring | Proportion. |
| Type | Process. |
| Stratification | 1. Exchange. |
| Risk adjustment | None. |
| Improvement notation | A higher rate indicates better performance. |
| Definitions | |
| Participation | The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period. |
| Participation Period | 12 months prior to the member's 13th birthday. |
| Initial Population | Adolescents who turn 13 years of age during the Measurement Period who also meet criteria for Participation. |
| Exclusions | Members in hospice or using hospice services any time during the Measurement Period. |
| Denominator | The Initial Population, minus Exclusions. |
| Numerator | <p>Numerator 1—Meningococcal Serogroups A, C, W, Y Members with either of the following meet criteria:</p> <ul style="list-style-type: none"> At least one meningococcal serogroups A, C, W, Y vaccine, with a date of service on or between the member's 11th and 13th birthdays. Anaphylaxis due to the meningococcal vaccine any time on or before the member's 13th birthday. <p>Numerator 2—Tdap Members with any of the following meet criteria:</p> <ul style="list-style-type: none"> At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, with a date of service on or between the member's 10th and 13th birthdays. Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday. |

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| | <ul style="list-style-type: none"> Encephalitis due to the tetanus, diphtheria or pertussis vaccine any time on or before the member's 13th birthday. <p>Numerator 3—HPV Members with any of the following meet criteria:</p> <ul style="list-style-type: none"> At least two HPV vaccines, on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25. At least three HPV vaccines, with different dates of service on or between the member's 9th and 13th birthdays. Anaphylaxis due to the HPV vaccine any time on or before the member's 13th birthday. <p>Numerator 5—Combination 2: Meningococcal, Tdap, HPV Adolescents who are Numerator compliant for all three indicators (Meningococcal, Tdap, HPV).</p> |
| Data criteria (element level) | |
| <p>Value Sets:</p> <ul style="list-style-type: none"> IMAE_HEDIS_MY2022-1.0.0 <ul style="list-style-type: none"> Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2240) Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2241) HPV Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1763) HPV Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1764) Meningococcal Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1777) Meningococcal Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1778) Tdap Immunization (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1791) Tdap Vaccine Procedure (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1792) NCQA_Hospice-1.0.0 <ul style="list-style-type: none"> Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761) Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762) <p>Direct Reference Codes and Codesystems:</p> <ul style="list-style-type: none"> IMAE_HEDIS_MY2022-1.0.0 <ul style="list-style-type: none"> codesystem "SNOMEDCT": 'http://snomed.info/sct' code "Anaphylaxis due to human papillomavirus vaccine (disorder)": '428241000124101' from "SNOMEDCT" display 'Anaphylaxis due to human papillomavirus vaccine (disorder)' code "Anaphylaxis due to meningococcal vaccine (disorder)": '428301000124106' from "SNOMEDCT" display 'Anaphylaxis due to meningococcal vaccine (disorder)' | |

• **NCQA_Terminology-1.0.0**

- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- codesystem "coverage-type": 'http://terminology.hl7.org/V3-ActCoverageTypeCode'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "managed care policy": 'MCPOL' from "coverage-type"
- code "retiree health program": 'RETIRE' from "coverage-type"
- code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table IMA-E-4: Data Elements for Immunizations for Adolescents

| Metric | Data Element | Reporting Instructions |
|---------------|---------------------------|------------------------|
| Meningococcal | InitialPopulation | Repeat per Metric |
| Tdap | Exclusions | Repeat per Metric |
| HPV | Denominator | Repeat per Metric |
| Combo2 | NumeratorByEHR | For each Metric |
| | NumeratorByCaseManagement | For each Metric |
| | NumeratorByHIERegistry | For each Metric |
| | NumeratorByAdmin | For each Metric |
| | Numerator | (Sum over SSoRs) |
| | Rate | (Percent) |

Breast Cancer Screening (BCS-E)**SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS**

- Added optional ECDS reporting to HEDIS for QRS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes optional ECDS reporting that was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.

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| Description | The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. |
| Measurement period | January 1–December 31. |
| Clinical recommendation statement | The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation) |
| Citations | U.S. Preventive Services Task Force. 2016. “Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement. <i>Ann Intern Med</i> 164(4):279–96. |
| Characteristics | |
| Scoring | Proportion. |
| Type | Process. |
| Stratification | 1. Exchange. |
| Risk adjustment | None. |
| Improvement notation | A higher rate indicates better performance. |
| Definitions | |
| Participation | The identifiers and descriptors for each organization’s coverage used to define members’ eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period. |
| Participation Period | October 1 two years prior to the Measurement Period through the end of the Measurement Period. |

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| Initial Population | Women 52–74 years of age by the end of the Measurement Period who also meet the criteria for Participation. |
| Exclusions | <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the Measurement Period. • Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the Measurement Period. • Members 66 years of age and older by the end of the Measurement Period, with frailty and advanced illness. • Members receiving palliative care during the Measurement Period. |
| Denominator | The Initial Population, minus Exclusions. |
| Numerator | One or more mammograms any time on or between October 1 two years prior to the Measurement Period and the end of the Measurement Period. |
| Data criteria (element level) | |
| Value Sets: <ul style="list-style-type: none"> • BCSE_HEDIS_MY2022-1.0.0 <ul style="list-style-type: none"> – Absence of Left Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1329) – Absence of Right Breast (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1330) – Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1042) – Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1043) – Clinical Bilateral Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1951) – Clinical Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1949) – Clinical Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1950) – Clinical Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1948) – History of Bilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1331) – Left Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1148) – Mammography (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1168) – Right Modifier (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1230) – Unilateral Mastectomy (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1256) – Unilateral Mastectomy Left (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1334) – Unilateral Mastectomy Right (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1335) • NCQA_AdvancedIllnessandFrailty-1.0.0 <ul style="list-style-type: none"> – Acute Inpatient (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810) – Advanced Illness (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465) – Dementia Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729) | |

- ED (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086>)
- Frailty Device (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530>)
- Frailty Diagnosis (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531>)
- Frailty Encounter (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532>)
- Frailty Symptom (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533>)
- Nonacute Inpatient (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189>)
- Observation (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191>)
- Online Assessments (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446>)
- Outpatient (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202>)
- Telephone Visits (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246>)
- **NCQA_Claims-1.0.0**
 - Inpatient Stay (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395>)
 - Nonacute Inpatient Stay (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398>)
- **NCQA_Hospice-1.0.0**
 - Hospice Encounter (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761>)
 - Hospice Intervention (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762>)
- **NCQA_PalliativeCare-1.0.0**
 - Palliative Care Assessment
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225>)
 - Palliative Care Encounter
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450>)
 - Palliative Care Intervention
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224>)

Direct Reference Codes and Codesystems:

- **NCQA_PalliativeCare-1.0.0**
 - codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
 - code "Encounter for palliative care": 'Z51.5' from "ICD-10" display 'Encounter for palliative care'
- **NCQA_Terminology-1.0.0**
 - codesystem "claim-type": 'http://terminology.hl7.org/CodeSystem/claim-type'
 - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
 - codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
 - code "active": 'active' from "ConditionClinicalStatusCodes"
 - code "Institutional": 'institutional' from "claim-type"
 - code "managed care policy": 'MCPOL' from "coverage-type"
 - code "Professional": 'professional' from "claim-type"
 - code "retiree health program": 'RETIRE' from "coverage-type"
 - code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

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

| Metric | Data Element | Reporting Instructions |
|-----------------------|----------------------------|------------------------|
| BreastCancerScreening | InitialPopulation | Report once |
| | ExclusionsByEHR | Report once |
| | ExclusionsByCaseManagement | Report once |
| | ExclusionsByHIERegistry | Report once |
| | ExclusionsByAdmin | Report once |
| | Exclusions | (Sum over SSoRs) |
| | Denominator | Report once |
| | NumeratorByEHR | Report once |
| | NumeratorByCaseManagement | Report once |
| | NumeratorByHIERegistry | Report once |
| | NumeratorByAdmin | Report once |
| | Numerator | (Sum over SSoRs) |
| | Rate | (Percent) |

Colorectal Cancer Screening (COL-E)

SUMMARY OF CHANGES TO MY 2022 HEDIS FOR QRS

- Added optional ECDS reporting to HEDIS for QRS.

HEDIS FOR QRS SPECIFIC GUIDANCE

- This measure includes stratifications for race and ethnicity that were proposed to be added to the QRS measure set in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.
- This measure includes optional ECDS reporting that was proposed in the Draft 2022 Call Letter. Refer to the Final 2022 Call Letter and *2023 QRS and QHP Enrollee Survey Technical Guidance* for guidance on reporting this measure.
- As announced in the Draft 2022 Call Letter, NCQA will update the specifications for the *Colorectal Cancer Screening* measure to align with updated guidelines released by the U.S. Preventive Services Task Force (USPSTF). The revised specifications will be included in the HEDIS for QRS Technical Update memo that will be posted to the NCQA website (<https://www.ncqa.org>).

| | |
|--|--|
| Description | The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. |
| Measurement period | January 1–December 31. |
| Clinical recommendation statement | The U.S. Preventive Services Task Force recommends screening for colorectal cancer starting at age 50. Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA test (FIT-DNA) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year. (A recommendation) |
| Citations | U.S. Preventive Services Task Force. 2016. “Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement.” <i>JAMA</i> 315(23): 2564– 75. |
| Characteristics | |
| Scoring | Proportion. |
| Type | Process. |
| Stratification | <ol style="list-style-type: none"> Exchange. Exchange: Race – White. Exchange: Race – Black or African American. Exchange: Race – American Indian and Alaska Native. Exchange: Race – Asian. Exchange: Race – Native Hawaiian and Other Pacific Islander. |

| | |
|---|---|
| Risk adjustment Improvement notation | <p>7. Exchange: Race – Some Other Race.</p> <p>8. Exchange: Race – Two or More Races.</p> <p>9. Exchange: Race – Asked but No Answer.</p> <p>10. Exchange: Race – Unknown.</p> <p>11. Exchange: Ethnicity – Hispanic/Latino.</p> <p>12. Exchange: Ethnicity – Not Hispanic/Latino.</p> <p>13. Exchange: Ethnicity – Asked but No Answer.</p> <p>14. Exchange: Ethnicity – Unknown.</p> <p>None.</p> <p>A higher rate indicates better performance.</p> |
| Definitions | |
| Participation Participation Period | <p>The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.</p> <p>The Measurement Period and the year prior to the Measurement Period.</p> |
| Initial Population | <p>Members 51–75 years as of the end of the Measurement Period who also meet the criteria for Participation.</p> |
| Exclusions | <ul style="list-style-type: none"> • Members in hospice or using hospice services any time during the Measurement Period. • Members with colorectal cancer or a total colectomy any time during the member's history through the end of the Measurement Period. • Members 66 years of age and older by the end of the Measurement Period, with frailty and advanced illness. • Members receiving palliative care during the Measurement Period. |
| Denominator | <p>The Initial Population, minus Exclusions.</p> |
| Numerator | <p>Members with one or more screenings for colorectal cancer. Any of the following meet criteria:</p> <ul style="list-style-type: none"> • Fecal occult blood test during the Measurement Period. • Flexible sigmoidoscopy during the Measurement Period or the four years prior to the Measurement Period. • Colonoscopy during the Measurement Period or the nine years prior to the Measurement Period. • CT colonography during the Measurement Period or the four years prior to the Measurement Period. • FIT-DNA test during the Measurement Period or the two years prior to the Measurement Period. |

Data criteria (element level)**Value Sets:**

- **COLE_HEDIS_MY2022-1.0.0**

- Colonoscopy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1064>)
- Colorectal Cancer (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1065>)
- CT Colonography (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1421>)
- FIT DNA Lab Test (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1749>)
- FIT DNA Test Result or Finding (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1750>)
- Flexible Sigmoidoscopy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1102>)
- FOBT Lab Test (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1959>)
- FOBT Test Result or Finding (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1960>)
- History of Colonoscopy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1910>)
- History of Flexible Sigmoidoscopy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1911>)
- History of Total Colectomy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1912>)
- Total Colectomy (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1250>)

- **NCQA_AdvancedIllnessandFrailty-1.0.0**

- Acute Inpatient (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1810>)
- Advanced Illness (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1465>)
- Dementia Medications (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1729>)
- ED (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1086>)
- Frailty Device (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1530>)
- Frailty Diagnosis (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1531>)
- Frailty Encounter (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1532>)
- Frailty Symptom (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1533>)
- Nonacute Inpatient (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1189>)
- Observation (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1191>)
- Online Assessments (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1446>)
- Outpatient (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1202>)
- Telephone Visits (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1246>)

- **NCQA_Claims-1.0.0**

- Inpatient Stay (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1395>)
- Nonacute Inpatient Stay (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1398>)

- **NCQA_Hospice-1.0.0**

- Hospice Encounter (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761>)
- Hospice Intervention (<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762>)

- **NCQA_PalliativeCare-1.0.0**

- Palliative Care Assessment
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2225>)
- Palliative Care Encounter
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1450>)
- Palliative Care Intervention
(<https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2224>)

Direct Reference Codes and Codesystems:

- **NCQA_PalliativeCare-1.0.0**

- codesystem "ICD-10": 'http://hl7.org/fhir/sid/icd-10-cm'
- code "Encounter for palliative care": 'Z51.5' from "ICD-10" display 'Encounter for palliative care'

- **NCQA_Terminology-1.0.0**

- codesystem "claim-type": 'http://terminology.hl7.org/CodeSystem/claim-type'
- codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
- codesystem "coverage-type": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
- code "active": 'active' from "ConditionClinicalStatusCodes"
- code "Institutional": 'institutional' from "claim-type"
- code "managed care policy": 'MCPOL' from "coverage-type"
- code "Professional": 'professional' from "claim-type"
- code "retiree health program": 'RETIRE' from "coverage-type"
- code "subsidized health program": 'SUBSIDIZ' from "coverage-type"

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table COL-E-4: Metadata Elements for Colorectal Cancer Screening

| Metric | Data Element | Reporting Instructions |
|---------------------------|----------------------------|------------------------|
| ColorectalCancerScreening | InitialPopulation | Report once |
| | ExclusionsByEHR | Report once |
| | ExclusionsByCaseManagement | Report once |
| | ExclusionsByHIERegistry | Report once |
| | ExclusionsByAdmin | Report once |
| | Exclusions | (Sum over SSoRs) |
| | Denominator | Report once |
| | NumeratorByEHR | Report once |
| | NumeratorByCaseManagement | Report once |
| | NumeratorByHIERegistry | Report once |
| | NumeratorByAdmin | Report once |
| | Numerator | (Sum over SSoRs) |
| | Rate | (Percent) |

Table COL-E-A-4: Data Elements for Colorectal Cancer Screening: Stratifications by Race

| Metric |
|---------------------------|
| ColorectalCancerScreening |

| Race | Source | Data Element | Reporting Instructions |
|---------------------------------------|----------|-------------------|-------------------------|
| White | Direct | InitialPopulation | For each Stratification |
| BlackOrAfricanAmerican | Indirect | Exclusions | For each Stratification |
| AmericanIndianAndAlaskaNative | Total | Denominator | For each Stratification |
| Asian | | Numerator | For each Stratification |
| NativeHawaiianAndOtherPacificIslander | | Rate | (Percent) |
| SomeOtherRace | | | |
| TwoOrMoreRaces | | | |
| AskedButNoAnswer* | | | |
| Unknown | | | |

Table COL-E-B-4: Data Elements for Colorectal Cancer Screening: Stratifications by Ethnicity

| Metric |
|---------------------------|
| ColorectalCancerScreening |

Measures Reported Using ECDS—Colorectal Cancer Screening

| Ethnicity | Source | Data Element | Reporting Instructions |
|---------------------|---------------|---------------------|-------------------------------|
| HispanicOrLatino | Direct | InitialPopulation | For each Stratification |
| NotHispanicOrLatino | Indirect | Exclusions | For each Stratification |
| AskedButNoAnswer* | Total | Denominator | For each Stratification |
| Unknown | | Numerator | For each Stratification |
| | | Rate | (Percent) |

*AskedButNoAnswer is only reported for Source='Direct.'

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).

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

| Data Element | Description | Admin | Hybrid | Meaning |
|------------------------|--|-------|--------|---|
| CollectionMethod | 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. Only reported for measures allowing both the Administrative and the Hybrid Method. |
| Benefit | Benefit | ✓ | ✓ | For measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML. |
| EligiblePopulation | 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 <i>Guidelines for Calculations and Sampling</i> for the three approaches to conducting the Hybrid Method). |
| ExclusionAdminOptional | Number of optional exclusions | ✓ | | For measures that only allow the Administrative Method, the number of members excluded from the eligible population because they did not meet the numerator criteria and did meet the optional exclusion criteria. |
| ExclusionAdminRequired | Number of required exclusions | ✓ | ✓ | Number of members excluded from the eligible population based on transaction data because they did not meet the required exclusion criteria (labeled “required exclusions” in the specification). |
| NumeratorByAdminElig | Number of numerator events by administrative data in eligible population (before exclusions) | | ✓ | <p>The number of members in the eligible population who met the numerator criteria.</p> <p><i>This may or may not include supplemental data, it depends on when an organization loads its supplemental data for reporting.</i></p> |
| CYAR | Current year’s administrative rate (before exclusions) | | ✓ | <p>This is a calculated field in IDSS.</p> <p>NumeratorByAdminElig / EligiblePopulation</p> <p><i>This rate may or may not include numerator events by supplemental data.</i></p> |

| Data Element | Description | Admin | Hybrid | Meaning |
|--------------------------|---|-------|--------|---|
| MinReqSampleSize | Minimum required sample size (MRSS) | | ✓ | When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 in the sampling guidelines. |
| OversampleRate | Oversampling rate | | ✓ | The percentage of additional records used only to replace exclusions and valid data errors in the denominator reported as a proportion 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> |
| OversampleRecordsNumber | Number of oversample records | | ✓ | This is a calculated field in IDSS. $\text{MinReqSampleSize} \times \text{OversampleRate}$ (rounded up to next whole number) <i>Oversample records should be used only to replace cases taken out of the MRSS because of valid data errors, false positives, etc., otherwise, not all records will be reported in the final denominator.</i> |
| ExclusionValidDataErrors | Number of original sample records excluded because of valid data errors | | ✓ | If 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. |
| ExclusionAdminOptional | Number of administrative data records excluded | | ✓ | For measures that allow the Administrative and Hybrid Method, the 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 transactional data. <i>These members are only excluded from the MRSS, they are not removed from the eligible population.</i> |
| ExclusionMedRecsOptional | 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. |
| ExclusionEmployeeOrDep | 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> |
| OversampleRecsAdded | 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

| Data Element | Description | Admin | Hybrid | Meaning |
|---------------------------|---|-------|--------|---|
| Denominator | Denominator | | ✓ | This population is the denominator used to report the measure. MRSS – exclusions + members added from the oversample list. |
| NumeratorByAdmin | Numerator events by administrative data | ✓ | ✓ | The number of members in the denominator who met numerator criteria using transactional data. |
| NumeratorBySupplemental | 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. |
| NumeratorByMedicalRecords | Numerator events by medical records | | ✓ | The number of members in the denominator who met numerator criteria using medical record data. |
| Rate | Reported rate | ✓ | ✓ | <p>This is a calculated field in IDSS.</p> <p><i>Administrative Method:</i> $\text{NumeratorByAdmin} \div \text{EligiblePopulation}$.</p> <p><i>Hybrid Method:</i> $(\text{Numerator events by administrative data} + \text{numerator events by medical records}) \div \text{denominator}$.</p> <p><u>Measures that collect numerator events by supplemental data:</u></p> <p><i>Administrative:</i> $(\text{Numerator events by administrative data} + \text{numerator events by supplemental data}) \div \text{eligible population}$.</p> <p><i>Hybrid:</i> $(\text{Numerator events by administrative data} + \text{numerator events by supplemental data} + \text{numerator events by medical records}) \div \text{denominator}$.</p> |

Reporting Instruction Explanations

| Reporting Instructions | Explanation |
|---|--|
| Metadata | For Measures requiring a benefit other than Medical, the Benefit flag is reported in the Metadata section of the submission XML. |
| For each Metric | Report independent values for each metric. |
| For each Stratification* | Report independent values for each stratification. |
| For each Metric and Stratification* | Report independent values for each metric and stratification. |
| Report once | For single Indicator measures. |
| Repeat per Metric | The same value is repeated across all Metrics. Used e.g., when the same Eligible Population or Denominator is used for the calculation of multiple rates within a measure (e.g., CIS, IMA). |
| Repeat per Stratification* | The same value is repeated across all Stratifications. This is common for measures using the Hybrid collection method where a single sample is drawn for all stratifications. The sample corresponds to the Total stratification but plans only report the individual stratifications. Therefore, plans must repeat the sample data elements for all stratifications. |
| Repeat per Metric and Stratification* | The same value is repeated across all Metrics and Stratifications. For example, the Hybrid sample data elements for WCC when reporting using the Hybrid collection method. |
| For each Stratification, repeat per Metric* | Report independent values for each stratification but repeat these for the same stratifications over multiple metrics. |
| For each Metric, repeat per Stratification* | Report independent values for each Metric but repeat these for all Stratifications within each Metric (e.g., CollectionMethod). |
| Only for Total | Only used for CYAR in stratified measures. Plans report NumeratorByAdminElig (Number of numerator events by administrative data in eligible population (before exclusions)) for each stratification, but IDSS calculates the CYAR (Current year's administrative rate (before exclusions)), only at the total stratification. Only this total CYAR can be used to reduce the minimum required sample size for measures where this is allowed. Refer to the <i>Guidelines for Calculations and Sampling</i> for more information. |

*For measures with multiple stratifications, the reporting instructions apply for all stratification combinations.

Standard Administrative Data Element Table

| Metric | Stratification (e.g., Age) | Data Element | Reporting Instructions |
|------------------|----------------------------|-------------------------|------------------------|
| Added by measure | Added by measure | Benefit* | Added by measure |
| | | EligiblePopulation | |
| | | ExclusionAdminOptional | |
| | | ExclusionAdminRequired | |
| | | NumeratorByAdmin | |
| | | NumeratorBySupplemental | |
| | | Rate | |

*Only applies for measures that require a benefit other than medical.

Standard Hybrid Data Element Table

| Metric | Stratification (e.g., Age) | Data Element | Reporting Instructions | A |
|------------------|----------------------------|---------------------------|------------------------|---|
| Added by measure | Added by measure | CollectionMethod | Added by measure | ✓ |
| | | Benefit* | | ✓ |
| | | EligiblePopulation | | ✓ |
| | | ExclusionAdminRequired | | |
| | | NumeratorByAdminElig | | |
| | | CYAR | | |
| | | MinReqSampleSize | | |
| | | OversampleRate | | |
| | | OversampleRecordsNumber | | |
| | | ExclusionValidDataErrors | | |
| | | ExclusionAdminOptional | | |
| | | ExclusionMedRecsOptional | | |
| | | ExclusionEmployeeOrDep | | |
| | | OversampleRecsAdded | | |
| | | Denominator | | ✓ |
| | | NumeratorByAdmin | | |
| | | NumeratorByMedicalRecords | | ✓ |
| | | NumeratorBySupplemental | | ✓ |
| | | Rate | | |

*Only applies for measures that require a benefit other than medical.

Standard ECDS Data Element Table

| Metric | Stratification (e.g., Age) | Data Elements | Reporting Instructions |
|------------------|-------------------------------|-----------------------------------|------------------------|
| Added by Measure | Added by measure | Benefit* | Added by measure |
| | | InitialPopulationByEHR | |
| | | InitialPopulationByCaseManagement | |
| | | InitialPopulationByHIERegistry | |
| | | InitialPopulationByAdmin | |
| | | InitialPopulation | |
| | | ExclusionsByEHR | |
| | | ExclusionsByCaseManagement | |
| | | ExclusionsByHIERegistry | |
| | | ExclusionsByAdmin | |
| | | Exclusions | |
| | | Denominator | |
| | | NumeratorByEHR | |
| | | NumeratorByCaseManagement | |
| | | NumeratorByHIERegistry | |
| | | NumeratorByAdmin | |
| | | Numerator | |
| | | Rate | |

*Only applies for measures that require a benefit other than medical.

Note: Not all measures use metrics, age and initial population/exclusions by data source. Refer to the measure specification for details.

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3. QRS Clinical Measure Specifications

3.1 NCQA Measure Specifications

3.2 PQA Measure Specifications

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3.2 PQA Measure Specifications

Overview

Pharmacy Quality Alliance (PQA, Inc.)

PQA is a consensus-based, multi-stakeholder membership organization committed to optimizing health by advancing the quality of medication use. Established in 2006, PQA is a 501(c)3 designated non-profit alliance with over 240 member organizations.

PQA Measure Development Process

PQA uses a systematic, transparent, consensus-based process to draft, test, refine, and endorse measures of medication-use quality. PQA evaluates measures against the following standard criteria: importance, scientific acceptability, feasibility, and usability. The end-product of measure development is an evidence-based, precisely specified, valid, reliable, feasible, and usable measure that is linked to national quality goals.

Measure Conceptualization: The goal of the measure conceptualization phase is to generate and prioritize a list of measure concepts to be developed. This ensures that PQA devotes resources to developing measures that are high-impact and address areas of need. The measure conceptualization phase includes the following activities:

1. Environmental Scan
2. Measure Concept Advisory Group Input
3. Comment Period

Measure Specification: During the measure specification phase, the goal is to create and refine initial specifications to produce a draft measure that is ready to be tested. The measure specification phase includes the following activities:

1. Initial Specification and Feasibility Testing
2. Technical Expert Panel Input

Measure Testing: The goal of measure testing is to apply the measure specifications to test data representative of the intended measure population to determine the measure's scientific acceptability. PQA will evaluate whether the measure meets the criteria of reliability (the measure consistently captures true differences in quality, as opposed to differences due to chance variation) and validity (the measure truly captures the intended concept of quality). Beyond scientific acceptability, measure testing may also inform remaining specification questions, such as the appropriateness of exclusions given their frequency in test data. The answers to these questions may result in additional refinement of the measure specifications. The measure testing phase includes the following activities:

1. Testing Plan Development
2. Initial Quality Metrics Expert Panel (QMEP) Review
3. Assess Need for Stratification or Risk Adjustment
4. Measure Testing
5. Face Validity Assessment
6. Final QMEP Review

Measure Endorsement: After QMEP approval, the measure is considered by PQA's membership for an endorsement vote. By the time a measure is approved by the QMEP to move forward for endorsement

3.2 PQA Measure Specifications

consideration, it has gone through PQA's consensus-based development process and is found to meet PQA's measure criteria. The measure endorsement process consists of the following activities:

1. Comment Period and Member Webinar
2. Membership Vote

Measure Implementation and Maintenance: The measurement lifecycle does not end when a measure is endorsed. In addition to PQA's role as a measure developer, PQA is a measure steward, which entails responsibility for supporting measures through implementation with outreach and education, supporting measure use with technical assistance, and measure maintenance to ensure that PQA measures remain current, appropriate, and impactful in-light of new treatments coming to the market or the emergence of new clinical evidence or standards.

1. Measure Implementation
2. Technical Assistance
3. Measure Maintenance

Updated: 1/24/2022

General Guidelines for the *Proportion of Days Covered*, *Annual Monitoring for Persons on Long-Term Opioid Therapy* and *International Normalized Ratio Monitoring for Individuals on Warfarin* Measure Data Collection

Refer to NCQA's "General Guidelines for Data Collection" in Section 3.1 for details that will inform appropriate data collection for the *Proportion of Days Covered*, *Annual Monitoring for Persons on Long-term Opioid Therapy*, and *International Normalized Ratio Monitoring for Individuals on Warfarin* measures. All general guidelines apply, with the exception, of the following items specified below.

PQA Posting of the Value Sets

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

The final Value Sets, including National Drug Code (NDC) lists, for 2023 will be available on March 31, 2022. The NDC lists will include current NDCs from January 1, 2021 through December 31, 2021, and NDCs with obsolete dates of July 1, 2020 or after.

Required Data Elements for PQA Measures

The reporting tables in the measure specifications outline the data elements required for reporting. Refer to *General Guideline 42: Reporting Tables* for more information.

Proportion of Days Covered (PDC): 3 Rates

Summary of Changes

- Added insulin glargine biosimilars (insulin glargine-aglr and insulin glargine-yfng) to medication table INSULINS: Insulin Exclusion.
- Added rosuvastatin +/- ezetimibe to medication table STATINS: Statins.

Description

The percentage of members 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80% during the measurement year.

A higher rate indicates better performance.

Report a rate for each of the following:

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

Definitions

| | |
|---|---|
| Proportion of Days Covered (PDC) | The proportion of days in the treatment period covered by prescription claims for the same medication or another in its therapeutic category. |
| PDC Threshold | The PDC level above which the medication has a reasonable likelihood of achieving most of the potential clinical benefit (80% for diabetes and cardiovascular drugs, and many chronic conditions). |
| Index Prescription Start Date (IPSD) | The earliest date of service for a target medication during the measurement year. |
| Prescription Claims | Only paid, non-reversed prescription claims are included in the data set to calculate the measure. |
| Treatment Period | The member's treatment period begins on the IPSD and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period should be at least 91 days. |
| Calculating Number of Days Covered for the Numerator | <p>If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on the same day, count the number of days covered using the prescription with the longest days' supply.</p> <p>If multiple prescriptions for different target medications (i.e., two or more products within the same therapeutic category, but with different generic ingredients) are dispensed on different days with overlapping days' supply, count each day covered by a target medication only once within the treatment period.</p> <p><i>For example: if a prescription for simvastatin and a prescription for atorvastatin are filled 5 days apart and each has a 30-day supply, then the total days covered is 35.</i></p> |

3.2 PQA Measure Specifications

If multiple prescriptions for the same target medication (i.e., one or more products with the same generic ingredient) are dispensed on the same day or different days where the days' supply overlap, adjust the prescription start date to be the day after the previous fill has ended.

For example: if three prescriptions for the same target medication are dispensed on the same day, each with a 30-day supply, then a total of 90 days are covered.

Overlap adjustment should also occur when there is an overlap of a single target drug product to a combination product containing the single target drug (i.e., same generic ingredient) or when there is an overlap of a combination product to another combination product where at least one of the target drugs (i.e., same generic ingredient) is common.

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

The NDC list for each class of medications includes flags for each target medication. The flags will help determine whether the prescription (NDC) includes the same or different target medication.

Eligible Population

| | |
|------------------------------|---|
| Ages | 18 years and older as of the first day of the measurement year. |
| Continuous Enrollment | <p>The treatment period.</p> <p>Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data.</p> <p><i>For example: if a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.</i></p> |
| Benefit | Medical and Pharmacy. |

Administrative Specification

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

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

| | |
|--|--|
| Additional Eligible Population Criteria | Members who filled at least two prescriptions for any RAS Antagonist: ACEI/ARB/direct renin inhibitor or ACEI/ARB/direct renin inhibitor Combination (Medication Table RASA: RAS Antagonists) on different dates of service during the treatment period. The prescriptions can be for the same or different medications. |
| Denominator | The eligible population. |

Required Exclusions

Any members with one or more of the following:

- Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.
- Sacubitril/valsartan: A prescription claim for sacubitril/valsartan during the treatment period (Medication Table SAC-VAL Exclusion: Sacubitril/Valsartan).

Table RASA: Renin Angiotensin System (RAS) Antagonists

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

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

Table SAC-VAL Exclusion: Sacubitril/Valsartan

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

Numerator

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

Measure Calculation

- Step 1** Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.
- Step 2** Within the treatment period, count the days the member was covered by at least one drug in the class based on the prescription fill date and days of supply. If prescriptions for the same target drug (generic ingredient) overlap, then adjust the prescription start date to be the day after the previous fill has ended. *
- Step 3** Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each 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%).

3.2 PQA Measure Specifications

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.*

Rate 2: Diabetes All Class (PDC-DR)

Additional Eligible Population Criteria

Members who filled at least two prescriptions for any of the diabetes medications listed in the Medication Tables BG: Biguanides, SFU: Sulfonylureas, TZD: Thiazolidinediones, DPP4: DPP-4 Inhibitors, GLP1: GLP-1 Receptor Agonists, MEG: Meglitinides, or SGLT2: SGLT2 Inhibitors on different dates of service in the treatment period. The prescriptions can be for the same or different medications and can be from any of these seven tables.

Denominator

The eligible population.

Required Exclusions

Any member with one or more of the following:

- Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice.
- ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set.
- Insulin: Any member with ≥ 1 prescription claim for insulin in the treatment period. See Medication Table INSULINS: Insulin Exclusion.

Medication Tables

Table BG: Biguanides

Biguanide Medications and Combinations

- metformin (+/- alogliptin, canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, glipizide, glyburide, linagliptin, pioglitazone, repaglinide, rosiglitazone, saxagliptin, sitagliptin)

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

Table SFU: Sulfonylureas

Sulfonylurea Medications and Combinations

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

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

Table TZD: Thiazolidinediones

Thiazolidinedione Medications and Combinations

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

NOTE: Active ingredients are limited to oral formulations only.

Table DPP4: DPP-4 Inhibitors

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

NOTE: Active ingredients are limited to oral formulations only.

Table GLP1: GLP-1 Receptor Agonists

| GLP-1 Receptor Agonists | | |
|--|--|---|
| <ul style="list-style-type: none"> albiglutide dulaglutide | <ul style="list-style-type: none"> exenatide liraglutide | <ul style="list-style-type: none"> lixisenatide semaglutide |

NOTE: Excludes products indicated only for weight loss.

Table MEG: Meglitinides

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

NOTE: Active ingredients are limited to oral formulations only.

Table SGLT2: Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors

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

NOTE: Active ingredients are limited to oral formulations only.

Table INSULINS: Insulin Exclusion

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

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

Numerator The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold.

Measure Calculation

- Step 1** Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.
- Step 2** Within the treatment period, count the days the member was covered by at least one diabetes medication (Medication Tables BG, SFU, TZD, DPP4, GLP1, MEG, or SGLT2) based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. *
- 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%).

3.2 PQA Measure Specifications

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.*

Rate 3: Statins (PDC-STA)

| | |
|--|--|
| Additional Eligible Population Criteria | Members with at least two prescription claims for any statin (Medication Table STATINS) on different dates of service in the treatment period. The prescription claims can be for the same or different medications. |
| Denominator | The eligible population. |
| Required Exclusions | Any member with one or more of the following: <ul style="list-style-type: none">• Hospice: Members in hospice are excluded from the eligible population. Refer to General Guideline 8: Members in Hospice.• ESRD: An ESRD diagnosis is defined as having at least one claim with any of the listed ESRD diagnoses, including primary diagnosis or any other diagnosis fields during the measurement year. See PQA ESRD Value Set. |

Table STATINS: Statins

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

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

| | |
|----------------------------|---|
| Numerator | The number of members who met the PDC threshold during the measurement year. Follow the steps below to determine whether the member meets the PDC threshold. |
| Measure Calculation | <p>Step 1 Determine the member's treatment period, defined as the IPSD to the end of the measurement year, disenrollment, or death.</p> <p>Step 2 Within the treatment period, count the days the member was covered by at least one drug in the class based on the date of service and days' supply on prescription claims. If the days' supply for prescription claims with the same target drug (generic ingredient) overlap, then adjust the prescription claim's start date to be the day after the last days' supply for the previous prescription claim. *</p> <p>Step 3 Divide the number of covered days found in Step 2 by the number of days found in Step 1. Multiply this number by 100 to obtain the PDC (as a percentage) for each 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%).</p> <p>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.</p> <p><i>*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.</i></p> |

Data Elements for Reporting

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

Table PDC: Data Elements for Proportion of Days Covered

| Metric | Data Element | Reporting Instructions |
|----------------|------------------------|------------------------|
| RASAntagonists | Benefit | Metadata |
| Diabetes | EligiblePopulation | For each Metric |
| Statins | ExclusionAdminRequired | For each Metric |
| | NumeratorByAdmin | For each Metric |
| | Rate | (Percent) |

International Normalized Ratio Monitoring for Individuals on Warfarin (INR)

Summary of Changes

- Corrected order of steps for the Event/Diagnosis.
- Updated continuous enrollment criteria.
- Updated definition for prescription claims limiting to paid, non-reversed prescription claims.
- Removed exclusion of individuals whose IPSD or last prescription claim for warfarin during the measurement year are missing the days' supply.

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, non-reversed 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 | <p>The treatment period.</p> <p>Exclude members with more than one 1-day gap in enrollment during the treatment period. Note: This allows for a one-day gap to compensate for discrepancies in the enrollment data.</p> <p><i>For example: if a member is eligible from 1/1-4/1 and 4/3-12/31, he/she would still be continuously enrolled despite the one-day gap in eligibility on 4/2.</i></p> |
| Allowable gap | None. |
| Benefit | Medical and Pharmacy. |
| Required Exclusions | <ul style="list-style-type: none"> 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 | <p>Members dispensed warfarin during the measurement year.</p> <p>Use the steps below to determine the eligible population.</p> <p>Step 1 Identify members aged 18 years and older as of the first day of the measurement year.</p> <p>Step 2 Identify members with ≥ 1 prescription claims for warfarin (Medication Table INR-A) during the measurement year.</p> <p>Step 3 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.</p> <p>Step 4 Identify members with a treatment period that is ≥ 56 days during the measurement year.</p> <p>Step 5 Identify members who meet the continuous enrollment criteria.</p> <p>Step 6 Exclude members with a medical claim for INR home monitoring during the measurement year. See Value Set, INR Home Monitoring Exclusion.</p> |

Administrative Specification

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

3.2 PQA Measure Specifications

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.

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).

Data Elements for Reporting

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

Table INR: Data Elements for International Normalized Ratio Monitoring for Individuals on Warfarin

| Metric | Data Element | Reporting Instructions |
|--------------------|------------------------|------------------------|
| WarfarinMonitoring | Benefit | Metadata |
| | EligiblePopulation | Report once |
| | ExclusionAdminRequired | Report once |
| | NumeratorByAdmin | Report once |
| | Rate | (Percent) |

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

Summary of Changes

- Noted that Opioid Analgesics are limited to opioid medications indicated for pain in the definitions.
- Added palliative care exclusion (see Value Set, Palliative Care)
- Removed LOINC codes from Value Set, Drug Test.
- Modified “prescriptions” to “prescription claims”.
- Modified “dispensed on different days” to “with different dates of service”.

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 | Limited to opioid medications indicated for pain. 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. |

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. |

| | |
|----------------------------|--|
| Required Exclusions | <p>Exclude members who met ≥ 1 of the following during the measurement year:</p> <ul style="list-style-type: none"> • Hospice- Refer to General Guideline 8: Members in Hospice. • Cancer- Any member with non-melanoma skin cancer during the measurement year. See Value Set, Cancer • Palliative Care- Any member in palliative care during the measurement year. See Value Set, Palliative Care. |
| Event/Diagnosis | <p>Members who are prescribed long-term opioid therapy.</p> <p>Use the steps below to determine the eligible population.</p> <p>Step 1 Identify members aged 18 years and older as of the first day of the measurement year.</p> <p>Step 2 Identify members who meet the continuous enrollment criteria.</p> <p>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.</p> <p>NOTE:</p> <ul style="list-style-type: none"> • The prescriptions claims can be for the same or different opioids. • For multiple claims for the same or different opioids with the same date of service, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • For multiple claims for the same or different opioids with different dates of service, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. <p>Step 4 Exclude members who met ≥ 1 of the following during the measurement year:</p> <ul style="list-style-type: none"> • Hospice- Refer to General Guideline 8: Members in Hospice. • Cancer- Any member with ≥ 1 claim for cancer during the measurement year. See Value Set, Cancer. • Palliative Care- Any member in palliative care during the measurement year. See Value Set, Palliative Care. |

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. |

3.2 PQA Measure Specifications

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).

Data Elements for Reporting

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

Table AMO: Annual Monitoring for Persons on Long-Term Opioid Therapy

| Metric | Data Element | Reporting Instructions |
|---------------------------------|------------------------|------------------------|
| LongTermOpioidTherapyMonitoring | Benefit | Metadata |
| | EligiblePopulation | Report once |
| | ExclusionAdminRequired | Report once |
| | NumeratorByAdmin | Report once |
| | Rate | (Percent) |

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 2023 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 2023 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 2023 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. (*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 2023 QHP Enrollee Survey on the following:

- In the last 6 months, how often did 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*)

Care Coordination

This QRS survey measure is based on enrollee responses to the 2023 QHP Enrollee Survey on the following:

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.

4.1 QRS Survey Measure Specifications

- 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 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?⁹(*Question #39*)
 - 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*)
-

Plan Administration

This QRS survey measure is based on enrollee responses to the 2023 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 2023 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*)
-

Rating of Health Plan

This QRS survey measure is based on enrollee responses to the 2023 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*)
-

⁹ 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 Personal Doctor

This QRS survey measure is based on enrollee responses to the 2023 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 2023 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*)
-