Effectiveness of Care

# Guidelines for Effectiveness of Care Measures

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| --- | --- | --- |
| Which services count? | Report all services for the Effectiveness of Care measures, whether or not the organization paid for them. For example, report services paid for by a third party, such as a community center; or services for which payment was denied because they were not properly authorized.  The organization must include all paid, suspended, pending and denied claims, and is ultimately responsible for the quality of care it provides to members.  Organizations can choose whether to include reversed claims when reporting services. If an organization includes reversals, it must include these claims in all measures and avoid double counting services (e.g., if a subsequent claim is filed, use only the corrected or adjudicated claim). | |
| Optional exclusions | Some measures in the Effectiveness of Care domain allow the organization to exclude members from the denominator who are identified as having a certain procedure or comorbidity (e.g., exclude women who have had a bilateral mastectomy from the *Breast Cancer Screening* measure).  The technical specifications contain instructions for optional exclusions, where applicable. Look for exclusions only where administrative data indicate that the specified numerator service or procedure did not occur. The organization uses the eligible population to identify members for whom administrative data show that the numerator services or procedures were rendered within the time frame specified in the measure, and then counts the members as having satisfied the measure (i.e., count these members in the numerator).  The organization verifies that the exclusion occurred by the time specified in the measure. For hybrid measures, members from the oversample are used to replace members who met the exclusion criteria and were excluded from the sample. Refer to the *Guidelines for Calculations and Sampling* for more information on how to identify exclusions and substitute medical records. | |
| Measure format | There are 10 possible sections in each measure specification in this domain: | |
|  | 1. Summary of Changes. 2. Description. 3. Calculation. 4. Definitions. 5. Eligible Population. | 1. Administrative Specification. 2. Hybrid Specification. 3. Exclusion (optional). 4. Notes. 5. Data Elements for Reporting. |

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| --- | --- |
| Eligible population criteria | The **eligible population** includes all members who meet the following seven criteria:   1. **Product line** (commercial, Medicaid, Medicare) applicable to the measure. 2. **Age** group and gender requirements. 3. **Continuous enrollment** criteria for the measure. 4. **Allowable gap** in benefits during the continuous enrollment period. There are different allowable gap criteria for the Medicaid product line. 5. **Anchor date** specifies the required enrollment date for the eligible population (e.g., children must be enrolled in the organization on their second birthday for inclusion in the *Childhood Immunization Status* measure). 6. **Benefit** a member must have to be included in the eligible population (e.g., members must have 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 (e.g., members must have a diagnosis of AMI for inclusion in the *Persistence of Beta-Blocker Treatment* *After a Heart Attack* measure). |
| Administrative Specification | The **Administrative Specification** outlines the collection and calculation of a measure using only administrative data, and describes the eligible population, the numerator requirements (i.e., the indicated treatment or procedure) and any optional exclusion allowed for the measure. |
| Hybrid Specification | The **Hybrid Specification** includes sampling requirements for the denominator population, medical record documentation requirements for the numerator and any optional exclusion allowed for the measure. |

Prevention and Screening

## Adult BMI Assessment (ABA)

Summary of Changes to HEDIS 2016

* Revised the age criteria for BMI and BMI percentile in the numerator.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Definitions

|  |  |
| --- | --- |
| BMI | Body mass index. A statistical measure of the weight of a person scaled according to height. |
| BMI percentile | The percentile ranking based on the Centers for Disease Control and Prevention’s (CDC) BMI-for-age growth charts, which indicate the relative position of a patient’s BMI number among those of the same sex and age. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. 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 (i.e., 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 | Members who had an outpatient visit (Outpatient Value Set) during the measurement year or the year prior to the measurement year. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | For members 21 years of age or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.  For members younger than 21 years of age on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year. |

Exclusions *(optional)*

Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size. |
| Numerator | BMI during the measurement year or the year prior to the measurement year as documented through either administrative data or medical record review. |
| *Administrative* | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| *Medical record* | For members 21 years and older on the date of service, documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI value must be from the same data source.  For members younger than 21 years on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The height, weight and BMI percentile must be from the same data source.  For BMI percentile, the following documentation meets criteria:   * BMI percentile documented as a value (e.g., 85th percentile). * BMI percentile plotted on an age-growth chart.   Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100%  or 0%). |

Exclusions *(optional)*

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

*Note*

* *The following notations or examples of documentation are considered “negative findings” and do not count as numerator compliant.*
* *No BMI or BMI percentile documented in medical record or plotted on age-growth chart.*
* *Notation of weight only.*

Data Elements for Reporting

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

Table ABA-1/2/3: Data Elements for Adult BMI Assessment

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

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

Summary of Changes to HEDIS 2016

* Removed the BMI value option for members 16–17 years of age from the numerator.
* Revised the physical activity requirement to indicate that notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations does not meet criteria.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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 lines | Commercial, Medicaid (report each product line separately). |
| Ages | 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:   * 3–11 years. * 12–17 years. * Total.   The total is the sum of the age stratifications. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in continuous enrollment of up to 45 days during the measurement year. 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 (i.e., 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 | An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators |  |
| *BMI Percentile* | BMI percentile (BMI Percentile Value Set) during the measurement year. |
| *Counseling for Nutrition* | Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year. |
| *Counseling for Physical Activity* | Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year. |

Exclusions *(optional)*

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

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.  Organizations may reduce the sample size using current year’s administrative rate 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. * BMI percentile plotted on an age-growth chart. |

|  |  |
| --- | --- |
|  | Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.  Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). |
| *Counseling for Nutrition* | Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | Documentation must include a note indicating the date and at least one of the following:   * Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors). * Checklist indicating nutrition was addressed. * Counseling or referral for nutrition education. * Member received educational materials on nutrition during a face-to-face visit. * Anticipatory guidance for nutrition. * Weight or obesity counseling. |
| *Counseling for Physical Activity* | Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| Medical record | Documentation must include a note indicating the date and at least one of the following:   * Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation). * Checklist indicating physical activity was addressed. * Counseling or referral for physical activity. * Member received educational materials on physical activity during a face-to-face visit. * Anticipatory guidance 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.*
* ***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. Services specific to an acute or chronic condition do not count toward the “Counseling for nutrition” and “Counseling for physical activity” indicators.*
* *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN practitioner.

Data Elements for Reporting

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

Table WCC-1/2: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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

## Childhood Immunization Status (CIS)

Summary of Changes to HEDIS 2016

* Added a *Note* to MMR clarifying that the “14-day rule” does not apply to this vaccine.
* Added a new value set to the administrative method to identify Hepatitis B vaccines administered at birth.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

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 nine separate combination rates.

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| 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. 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 (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled). |
| Anchor date | Enrolled on the child’s second birthday. |
| Benefit | Medical. |
| Event/ diagnosis | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators | For MMR, hepatitis B, VZV and hepatitis A, count any of the following:   * Evidence of the antigen or combination vaccine, ***or*** * Documented history of the illness, ***or*** * A seropositive test result for each antigen.   For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count *only*:   * Evidence of the antigen or combination vaccine.   For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens. |

|  |  |
| --- | --- |
| *DTaP* | At least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| *IPV* | At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| *MMR* | Any of the following on or before the child’s second birthday meet criteria:   * At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set). * At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) ***and*** at least one mumps vaccination *or* history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service. * At least one measles vaccination *or* history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) ***and*** at least one mumps vaccination *or* history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) ***and*** at least one rubella vaccination *or* history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service.   **Note:** General Guideline 39 (i.e., the 14-day rule) does not apply to MMR. |
| *HiB* | At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| *Hepatitis B* | Any of the following on or before the child’s second birthday meet criteria:   * At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service. * One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member’s date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8. * History of hepatitis illness (Hepatitis B Value Set). |
| *VZV* | Either of the following on or before the child’s second birthday meet criteria:   * At least one VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service on or before the child’s second birthday. * History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set). |
| *Pneumococcal conjugate* | At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| *Hepatitis A* | Either of the following on or before the child’s second birthday meet criteria:   * At least one hepatitis A vaccination (Hepatitis A Vaccine Administered Value Set), with a date of service on or before the child’s second birthday. * History of hepatitis A illness (Hepatitis A Value Set). |

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| --- | --- |
| *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 Vaccine [2 Dose Schedule] Administered Value Set) on different dates of service. * At least three doses of the three-dose rotavirus vaccine (Rotavirus Vaccine  [3 Dose Schedule] Administered Value Set) on different dates of service. * At least one dose of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) ***and*** at least two doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set), all on different dates of service. |
| *Influenza* | At least two influenza vaccinations (Influenza Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth. |
| Combination rates | Calculate the following rates for Combination 2–Combination 10. |

Combination Vaccinations for Childhood Immunization Status

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Combination | DTaP | IPV | MMR | HiB | HepB | VZV | PCV | HepA | RV | Influenza |
| Combination 2 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |
| Combination 3 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |
| Combination 4 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |
| Combination 5 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |
| Combination 6 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ |
| Combination 7 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |
| Combination 8 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |
| Combination 9 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |
| Combination 10 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

Exclusion *(optional)*

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

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

|  |  |
| --- | --- |
| *Any particular vaccine* | * Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set). |
| *DTaP* | * Encephalopathy (Encephalopathy Due To Vaccination Value Set) ***with*** a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set). |
| *MMR, VZV and influenza* | * Immunodeficiency (Disorders of the Immune System Value Set). * HIV (HIV Value Set). * Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set). * Anaphylactic reaction to neomycin. |

|  |  |
| --- | --- |
| *IPV* | * Anaphylactic reaction to streptomycin, polymyxin B or neomycin. |
| *Hepatitis B* | * Anaphylactic reaction to common baker’s yeast. |

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year’s administrative rate for the lowest rate or the prior year’s audited, product line-specific results for the lowest rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size. |
| Numerators | For MMR, hepatitis B, 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 DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count *only*:   * Evidence of the antigen or combination vaccine.   For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens. |
| *Administrative* | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| *Medical record* | For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:   * A note indicating the name of the specific antigen and the date of the immunization. * A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.   For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member’s second birthday.  Notes in the medical record indicating that the member received the immunization “at delivery” or “in the hospital” may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the “member is up to date” with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.  Immunizations documented using a generic header or “DTaP/DTP/DT” can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.  For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered. |

Exclusion *(optional)*

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

*Note*

* *This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure’s look-back period and to allow the industry time to adapt to new guidelines.*

Data Elements for Reporting

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

Table CIS-1/2: Data Elements for Childhood Immunization Status

|  |  |  |
| --- | --- | --- |
|  | Administrative | Hybrid |
| Measurement year | ✓ | ✓ |
| Data collection methodology (Administrative or Hybrid) | ✓ | ✓ |
| Eligible population | ✓ | ✓ |
| Number of numerator events by administrative data in eligible population (before exclusions) |  | *Each of the 19 rates* |
| Current year’s administrative rate (before exclusions) |  | *Each of the 19 rates* |
| Minimum required sample size (MRSS) or other sample size |  | ✓ |
| Oversampling rate |  | ✓ |
| Final sample size (FSS) |  | ✓ |
| Number of numerator events by administrative data in FSS |  | *Each of the 19 rates* |
| Administrative rate on FSS |  | *Each of the 19 rates* |
| Number of original sample records excluded because of valid data errors |  | ✓ |
| Number of administrative data records excluded |  | ✓ |
| Number of medical record data records excluded |  | ✓ |
| Number of employee/dependent medical records excluded |  | ✓ |
| Records added from the oversample list |  | ✓ |
| Denominator |  | ✓ |
| Numerator events by administrative data | *Each of the 19 rates* | *Each of the 19 rates* |
| Numerator events by medical records |  | *Each of the 19 rates* |
| Numerator events by supplemental data | *Each of the 19 rates* | *Each of the 19 rates* |
| Reported rate | *Each of the 19 rates* | *Each of the 19 rates* |
| Lower 95% confidence interval | *Each of the 19 rates* | *Each of the 19 rates* |
| Upper 95% confidence interval | *Each of the 19 rates* | *Each of the 19 rates* |

## Immunizations for Adolescents (IMA)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| 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. 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 (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled). |
| Anchor date | Enrolled on the member’s 13th birthday. |
| Benefit | Medical. |
| Event/diagnosis | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators | For meningococcal and Tdap or Td, count *only* evidence of the antigen or combination vaccine. |
| *Meningococcal* | At least one meningococcal conjugate or meningococcal polysaccharide vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the member’s 11th and 13th birthdays. |
| *Tdap/Td* | Any of the following with a date of service on or between the member’s 10th and 13th birthdays meet criteria:   * At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set). * At least one tetanus, diphtheria toxoids (Td) vaccine (Td Vaccine Administered Value Set). |

|  |  |
| --- | --- |
|  | * At least one tetanus vaccine (Tetanus Vaccine Administered Value Set) ***and*** at least one diphtheria vaccine (Diphtheria Vaccine Administered Value Set) on the same date of service or on different dates of service. |
| *Combination 1 (Meningococcal, Tdap/Td)* | Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td). |

Exclusion *(optional)*

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet optional exclusion criteria:

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

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year’s administrative rate for the lowest rate or the prior year’s audited, product line-specific results for the lowest rate. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling.* |
| Numerators | For meningococcal conjugate or polysaccharide and Tdap or Td, count *only* the evidence of the antigen or combination 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. |

Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member’s 13th birthday.

*Note*

* *This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure’s look-back period and to allow the industry time to adapt to new guidelines.*

Data Elements for Reporting

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

Table IMA-1/2: Data Elements for Adolescent Immunization Status

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

## Human Papillomavirus Vaccine for Female Adolescents (HPV)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Age | Female 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. 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 (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled). |
| Anchor date | Enrolled on the member’s 13th birthday. |
| Benefit | Medical. |
| Event/diagnosis | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | At least three HPV vaccinations (HPV Vaccine Administered Value Set), with different dates of service on or between the member’s 9th and 13th birthdays. |

Exclusion *(optional)*

Either of the following meet optional exclusion criteria:

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

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. Organizations that use the Hybrid Method to report the *Immunizations for Adolescents (IMA)* measure may use  the female members from the IMA sample as a start for this measure and, using the sampling methodology in the *Guidelines for Calculations and Sampling*, may draw enough additional female members from the remaining eligible population of this measure until the full sample size and appropriate oversample is reached.  Organizations may reduce the sample size using the current year’s HPV administrative rate or the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size*.* |
| Numerators | At least three HPV vaccinations, with different dates of service, on or between the member’s 9th and 13th birthdays. |
| *Administrative* | Refer to the *Administrative Specification* above 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 either of the following:   * A note indicating the name of the specific antigen and the date of service, ***or*** * A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. |

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member’s 13th birthday.

*Note*

* *This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure’s look-back period and to allow the industry time to adapt to the new guidelines.*

Data Elements for Reporting

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

Table HPV-1/2: Data Elements for Human Papillomavirus Vaccine for Female Adolescents

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

## Lead Screening in Children (LSC)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Eligible Population

|  |  |
| --- | --- |
| Product line | Medicaid. |
| Age | Children who turn 2 years old 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. 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 (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). |
| Anchor date | Enrolled on the child’s second birthday. |
| Benefit | Medical. |
| Event/diagnosis | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child’s second birthday. |

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population.  Organizations that use the Hybrid Method to report the *Childhood Immunization Status* and *Lead Screening in Children* measures may use the same sample for both measures. If an organization applies optional exclusions to the CIS measure and uses the CIS systematic sample, the same children will be excluded from the LSC measure. Excluding these members will not create a statistically significant difference in the LSC eligible population. |

|  |  |
| --- | --- |
|  | Organizations may reduce the sample size based on the current year’s administrative rate or prior year’s audited, product line-specific rate for the lowest rate of all CIS antigens, CIS combinations and LSC rate.  If a separate sample from the CIS measure is used for LSC, 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 LSC. |
| Numerator | At least one lead capillary or venous blood test on or before the child’s second birthday as documented through either administrative data or medical record review. |
| *Administrative* | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| *Medical record* | Documentation in the medical record must include both of the following:   * A note indicating the date the test was performed. * The result or finding. |

Data Elements for Reporting

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

Table LSC-1: Data Elements for Lead Screening in Children

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

## Breast Cancer Screening (BCS)

Summary of Changes to HEDIS 2016

* Added new value sets to identify bilateral mastectomy.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | Women 52–74 years as of December 31 of the measurement year. |
| Continuous enrollment | October 1 two years prior to the measurement year through December 31 of the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). 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 during each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year).  No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year. |
| Anchor date | December 31 of the measurement year. |
| Benefit | Medical. |
| Event/diagnosis | None. |

Administrative Specification

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

Exclusion *(optional)*

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

* Bilateral mastectomy (Bilateral Mastectomy Value Set).
* Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
* Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after   
  February 15.
* Both of the following (on the same or a different date of service):
* Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same date of service).
* Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same date of service).
* Absence of the left breast (Absence of Left Breast Value Set) ***and*** absence of the right breast (Absence of Right Breast Value Set) on the same or different date of service.
* History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
* Left unilateral mastectomy (Unilateral Mastectomy Left Value Set) ***and*** right unilateral mastectomy (Unilateral Mastectomy Right Value Set) on the same or different date of service.

*Note*

* *This measure evaluates primary screening. Do not count biopsies, breast ultrasounds or MRIs because they are not appropriate methods for primary breast cancer screening.*

Data Elements for Reporting

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

Table BCS-1/2/3: Data Elements for Breast Cancer Screening

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

## Cervical Cancer Screening (CCS)

Summary of Changes to HEDIS 2016

* Added an example to the optional exclusions of the hybrid specification.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | Women 24–64 years as of December 31 of the measurement year. |
| Continuous enrollment | *Commercial:* The measurement year and the two years prior to the measurement year.  *Medicaid:* The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 (i.e., 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 | None. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below. |
| *Step 1* | Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year. |

|  |  |
| --- | --- |
| *Step 2* | From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set) with service dates four or less days apart during the measurement year or the four years prior to the measurement year***and*** who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year. |
| *Step 3* | Sum the events from steps 1 and 2 to obtain the rate. |

Exclusion *(optional)*

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

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size*.* |
| Numerator | The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review. |
| *Administrative* | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| *Medical record* |  |
| *Step 1* | Identify the number of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:   * A note indicating the date when the cervical cytology was performed. * The result or finding.   Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.  Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.  **Note:** Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test. |

|  |  |
| --- | --- |
| *Step 2* | From the women who did not meet step 1 criteria, identify the number of women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:   * A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source. * The results or findings.   Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.  Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.  In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.  **Note:** Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test. |
| *Step 3* | Sum the events from steps 1–2 to obtain the rate. |

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history through December 31 of the measurement year. Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

* Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy”.
* Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

Data Elements for Reporting

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

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

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

## Colorectal Cancer Screening (COL)

Summary of Changes to HEDIS 2016

* Clarified in the Hybrid Specification that FOBT tests performed in an office setting or performed on a sample collected via a digital rectal exam (DRE) do not meet criteria.
* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicare (report each product line separately). |
| 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. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | One or more screenings for colorectal cancer. Any of the following meet criteria:   * Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type. * Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year. * Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year. |

Exclusion *(optional)*

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

* Colorectal cancer (Colorectal Cancer Value Set).
* Total colectomy (Total Colectomy Value Set).

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size*.* |
| Numerator | One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:   * FOBT during the measurement year. * Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. * Colonoscopy during the measurement year or the nine years prior to the measurement year. |
| *Administrative* | Refer to *Administrative Specification* to identify positive numerator hits from the administrative data. |
| *Medical record* | Documentation in the medical record must include a note indicating the date  when the colorectal cancer screening was performed. A result is not required if  the documentation is clearly part of the “medical history” section of the record; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).  There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.   * If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. * If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion. * iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT 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 data to NCQA must provide the following data elements.

Table COL-2/3: Data Elements for Colorectal Cancer Screening

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

## Chlamydia Screening in Women (CHL)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:   * 16–20 years. * 21–24 years. * Total.   The total is the sum of the age stratifications. |
| Continuous enrollment | The measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during the measurement year. 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 (i.e., 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 | *Sexually active*. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.  *Claim/encounter data*. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:   * Pregnancy Value Set. * Sexual Activity Value Set. * Pregnancy Tests Value Set.   *Pharmacy data.* Members who were dispensed prescription contraceptives during the measurement year (Table CHL-A). |

Table CHL-A: Prescriptions to Identify Contraceptives

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

**Note:** NCQA will post a comprehensive list of medications and NDC codes to www.ncqa.org by   
November 2, 2015.

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 (Table CHL-E) 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.

### Table CHL-E: Medications to Identify Exclusions

|  |  |
| --- | --- |
| Description | Prescription |
| Retinoid | * Isotretinoin |

**Note:** An NDC list for isotretinoin will be available on www.ncqa.org by November 2, 2015.

Data Elements for Reporting

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

Table CHL-1/2: Data Elements for Chlamydia Screening

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

## Care for Older Adults (COA)

Summary of Changes to HEDIS 2016

* Added “Numerator events by supplemental data” to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

The percentage of adults 66 years and older who had each of the following during the measurement year:

* Advance care planning.
* Medication review.
* Functional status assessment.
* Pain assessment.

Definitions

|  |  |
| --- | --- |
| Medication list | A list of the member’s medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies. |
| Medication review | A review of all a member’s medications, including prescription medications, OTC medications and herbal or supplemental therapies. |

Eligible Population

|  |  |
| --- | --- |
| Product line | Medicare SNP. |
| Ages | 66 years and older 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 | None. |

Administrative Specification

|  |  |
| --- | --- |
| **Denominator** | The eligible population. |
| **Numerators** |  |
| ***Advance Care Planning*** | Evidence of advance care planning during the measurement year (Advance Care Planning Value Set). |
| ***Medication Review*** | Any of the following meet criteria.   * Both of the following on the same date of service during the measurement year: * At least one medication review (Medication Review Value Set) conducted by a prescribing practitioner or clinical pharmacist. * The presence of a medication list in the medical record (Medication List Value Set). * Transitional care management services (TCM 7 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 22 of the year after the measurement year. * Transitional care management services (TCM 14 Day Value Set) where the reported date of service on the claim is on or between January 30 of the measurement year and January 15 of the year after the measurement year.   **Note:** Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. Medication management must be furnished no later than the date of the face-to-face visit. |
| ***Functional Status Assessment*** | At least one functional status assessment (Functional Status Assessment Value Set) during the measurement year. |
| ***Pain Assessment*** | At least one pain assessment (Pain Assessment Value Set) during the measurement year. |

Hybrid Specification

|  |  |
| --- | --- |
| Denominator | A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year’s administrative rate or the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size. |
| Numerators |  |
| *Advance Care Planning* | Evidence of advance care planning as documented through either administrative data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | **Advance care planning** is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include one of the following: |

|  |  |
| --- | --- |
|  | * The presence of an advance care plan in the medical record. * Documentation of an advance care planning **discussion** with the provider *and* the date when it was discussed. The documentation of discussion must be noted during the measurement year. * Notation that the member previously executed an advance care plan.   ***Examples of an advance care plan***   * **Advance directive.** Directive about treatment preferences and the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., living will, power of attorney, health care proxy). * **Actionable medical orders.** Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes). * **Living will.** Legal document denoting preferences for life-sustaining treatment and end-of-life care. * **Surrogate decision maker.** A written document designating someone other than the member to make future medical treatment choices.   ***Examples of an advance care planning discussion***   * Notation in the medical record of a discussion with a provider or initiation of a discussion by a provider during the measurement year. * **Oral statements.** Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Patient designation of an individual who can make decisions on behalf of the patient. Evidence of oral statements must be noted in the medical record during the measurement year. |
| *Medication Review* | At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year ***and*** the presence of a medication list in the medical record, as documented through either administrative data or medical record review. A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner’s signature is considered evidence that the medications were reviewed). |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | Documentation must come from the same medical record and must include one of the following:   * A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed. * Notation that the member is not taking any medication and the date when it was noted.   A review of side effects for a single medication at the time of prescription alone is not sufficient.  An outpatient visit is not required to meet criteria. |

|  |  |
| --- | --- |
| *Functional Status Assessment* | At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review. |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. |
| Medical record | Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.  ***Notations for a complete functional status assessment must include one of the following:***   * Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. * Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances. * Result of assessment using a standardized functional status assessment tool, not limited to: * SF-36®. * Assessment of Living Skills and Resources (ALSAR). * Barthel ADL Index Physical Self-Maintenance (ADLS) Scale. * Bayer ADL (B-ADL) Scale. * Barthel Index. * Extended ADL (EADL) Scale. * Independent Living Scale (ILS). * Katz Index of Independence in ADL. * Kenny Self-Care Evaluation. * Klein-Bell ADL Scale. * Kohlman Evaluation of Living Skills (KELS). * Lawton & Brody’s IADL scales. * Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales. * Notation that at least three of the following four components were assessed: * Cognitive status. * Ambulation status. * Hearing, vision and speech (i.e., sensory ability). * Other functional independence (e.g., exercise, ability to perform job).   A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.The components of the functional status assessment numerator may take place during separate visits within the measurement year. |
| *Pain Assessment* | At least one pain assessment during the measurement year, as documented through either administrative data or medical record review. | |
| Administrative | Refer to *Administrative Specification* to identify positive numerator hits from administrative data. | |

|  |  |
| --- | --- |
| Medical record | Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.  ***Notations for a pain assessment must include one of the following:***   * Documentation that the patient was assessed for pain (which may include positive or negative findings for pain). * Result of assessment using a standardized pain assessment tool, not limited to: * Numeric rating scales (verbal or written). * Face, Legs, Activity, Cry Consolability (FLACC) scale. * Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory). * Pain Thermometer. * Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale). * Visual analogue scale. * Brief Pain Inventory. * Chronic Pain Grade. * PROMIS Pain Intensity Scale. * Pain Assessment in Advanced Dementia (PAINAD) Scale. |

*Note*

* *Notation of a pain management plan alone does not meet criteria.*
* *Notation of a pain treatment plan alone does not meet criteria.*
* *Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.*
* *Refer to Appendix 3 for the definition of* clinical pharmacist *and* prescribing practitioner*.*

Data Elements for Reporting

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

Table COA-3: Data Elements for Care for Older Adults

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