Respiratory Conditions

## Appropriate Testing for Children With Pharyngitis (CWP)

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.

**Note:** ICD-10 codes are not in effect during the Intake Period for the measure. To accommodate the ICD-10 codes in HEDIS 2017, we anticipate the removal of the single diagnosis code requirement from the measure specifications and the addition of comorbid conditions and competing conditions (ICD-10 coding guidelines for respiratory diagnoses encourage multiple codes on claims).

Description

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

Definitions

|  |  |
| --- | --- |
| Intake Period | A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment. |
| Episode Date | The date of service for any outpatient or ED visit during the Intake Period with only a diagnosis of pharyngitis.  Exclude claims/encounters with more than one diagnosis. |
| IESD | Index Episode Start Date. The earliestEpisode Date during the Intake Period that meets all of the following criteria:   * Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date. * A 30-day Negative Medication History prior to the Episode Date. * The member was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date. |
| Negative Medication History | To qualify for Negative Medication History, the following criteria must be met:   * A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. * No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.   A prescription is considered active if the “days supply” indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid (report each product line separately). |
| Ages | Children 2 years as of July 1 of the year prior to the measurement year to 18 years as of June 30 of the measurement year. |
| Continuous enrollment | 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days). |
| Allowable gap | No gaps in enrollment during the continuous enrollment period. |
| Anchor date | Episode Date. |
| Benefits | Medical and pharmacy. |
| Event/ diagnosis | Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period.  Follow the steps below to identify the eligible population. |
| *Step 1* | Identify all members who had an outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the intake period, with only a diagnosis of pharyngitis (Pharyngitis Value Set).  Exclude claims/encounters with more than one diagnosis and ED visits that result in an inpatient admission. |
| *Step 2* | Determine all pharyngitis Episode Dates. For each member identified in step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis. |
| *Step 3* | Determine if antibiotics (Table CWP-C) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to three days after. Exclude Episode Dates if the member did not receive antibiotics on or three days after the Episode Date. |

Table CWP-C: Antibiotic Medications

|  |  |  |
| --- | --- | --- |
| Description | Prescription | |
| Aminopenicillins | * Amoxicillin | * Ampicillin |
| Beta-lactamase inhibitors | * Amoxicillin-clavulanate | |
| First generation cephalosporins | * Cefadroxil * Cefazolin | * Cephalexin |
| Folate antagonist | * Trimethoprim |  |
| Lincomycin derivatives | * Clindamycin |  |
| Macrolides | * Azithromycin * Clarithromycin * Erythromycin | * Erythromycin ethylsuccinate * Erythromycin lactobionate * Erythromycin stearate |
| Miscellaneous antibiotics | * Erythromycin-sulfisoxazole |  |
| Natural penicillins | * Penicillin G potassium * Penicillin G sodium | * Penicillin V potassium |
| Penicillinase-resistant penicillins | * Dicloxacillin |  |
| Quinolones | * Ciprofloxacin * Levofloxacin | * Moxifloxacin * Ofloxacin |
| Second generation cephalosporins | * Cefaclor * Cefprozil | * Cefuroxime |
| Sulfonamides | * Sulfamethoxazole-trimethoprim |  |
| Tetracyclines | * Doxycycline * Minocycline | * Tetracycline |
| Third generation cephalosporins | * Cefdinir * Cefixime * Cefpodoxime | * Ceftibuten * Cefditoren * Ceftriaxone |

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

|  |  |
| --- | --- |
| *Step* *4* | Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date. |
| *Step* *5* | Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days). |
| *Step 6* | Select the IESD. This measure examines the earliest eligible episode per member. |

Administrative Specification

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

Data Elements for Reporting

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

Table CWP-1/2: Data Elements for Appropriate Testing for Children  
With Pharyngitis

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

## Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

Summary of Changes to HEDIS 2016

* Revised the method and value sets to identify acute inpatient events for steps 1 and 2 of the event/diagnosis.
* Clarified when to use admission or discharge dates when determining Negative Diagnosis History.
* 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 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

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 the first COPD diagnosis. |
| IESD | Index Episode Start Date. The earliest date of service for an eligible visit (outpatient, ED or acute inpatient) during the Intake Period with any diagnosis of COPD.  *For an outpatient claim/encounter,* the IESD is the date of service.  *For an acute inpatient claim/encounter,* the IESD is the date of discharge.  *For a transfer or readmission*, the IESD is the discharge date of the original admission. |
| Negative Diagnosis History | A 731-day period beginning 730 days (2 years) prior to the IESD and ending on the IESD, when the member had no claims/encounters containing any diagnosis of COPD.  *For an acute inpatient* *IESD*, use the IESD date of admission to determine the 731-day period. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 42 years or older as of December 31 of the measurement year. |
| Continuous enrollment | 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD. |
| Allowable gap | One gap in enrollment of up to 45 days is allowed in each of the 12-month periods prior to the IESD or in the 6-month period after the IESD, for a maximum of two gaps total. 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 | IESD. | |
| Benefit | Medical. | |
| Event/  diagnosis | The first visit with a diagnosis of COPD during the Intake Period. Follow the steps below to identify the eligible population for the measure. |
| *Step 1* | Identify all members who had any of the following during the Intake Period.   * An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). * Do not include ED visits that result in an inpatient admission. * An acute inpatient discharge with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.   If the member had more than one eligible visit, include only the first visit. |
| *Step 2* | Test for Negative Diagnosis History. Exclude members who had any of the following during the 731-day period prior to the IESD:   * An outpatient visit (Outpatient Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). * Do not include ED visits that result in an inpatient admission. * An acute inpatient discharge with any diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay.   *For an acute inpatient IESD,* use the IESD date of admission to determine the 731-day period. |
| *Step 3* | Calculate continuous enrollment. Members must be continuously enrolled in the organization 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | At least one claim/encounter for spirometry (Spirometry Value Set) during the 730 days (2 years) prior to the IESD through 180 days (6 months) after the IESD. |

Data Elements for Reporting

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

Table SPR-1/2/3: Data Elements for Use of Spirometry Testing   
in the Assessment and Diagnosis of COPD

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

## Pharmacotherapy Management of COPD Exacerbation (PCE)

Summary of Changes to HEDIS 2016

* Revised the method and value sets to identify acute and nonacute inpatient events for steps 1, 3 and 4 of the event/diagnosis.
* Added olodaterol hydrochloride to the description of “Beta 2-agonists” in Table PCE-D.
* 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 COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

**Note:** The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Definitions

|  |  |
| --- | --- |
| Intake Period | An 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year. The Intake Period captures eligible episodes of treatment. |
| Episode Date | The date of service for any acute inpatient discharge or ED claim/encounter during the Intake Period with a principal diagnosis of COPD.  *For an acute inpatient claim/encounter,* the Episode Date is the date of discharge.  *For an ED claim/encounter,* the Episode Date is the date of service. |
| Active prescription | A prescription is considered active if the “days supply” indicated on the date the member filled the prescription is the number of days or more between that date and the relevant date.  *For an acute inpatient claim/encounter,* the relevant date is the date of admission.  *For an ED claim/encounter,* the relevant date is the date of service. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 40 years or older as of January 1 of the measurement year. |
| Continuous enrollment | Episode Date through 30 days after the Episode Date. |

|  |  |  |
| --- | --- | --- |
| Allowable gap | None. | |
| Anchor date | Episode Date. | |
| Benefits | Medical and pharmacy. | |
| Event/ diagnosis | A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.  Follow the steps below to identify the eligible population. |
| *Step 1* | Identify all members who had either of the following during the Intake Period:   * An ED visit (ED Value Set) with a primary diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). * Do not include ED visits that result in an inpatient admission. * An acute inpatient discharge with a primary diagnosis of COPD (COPD Value Set), emphysema (Emphysema Value Set) or chronic bronchitis (Chronic Bronchitis Value Set). To identify acute inpatient discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. |
| *Step 2* | Identify all COPD Episode Dates. For each member identified in step 1, identify all acute inpatient discharges and ED visits. |
| *Step 3* | Test for transfers. Exclude Episode Dates when the member was transferred directly to an acute or nonacute inpatient care setting for any diagnosis. Organizations must identify “transfers” using their own methods and then confirm the acute or nonacute inpatient care setting using codes in the Inpatient Stay Value Set. |
| *Step 4* | Test for readmission and additional ED visits.  Exclude Episode Dates when the member was readmitted to an acute or nonacute inpatient care setting for any diagnosis within 14 days after the Episode Date. To identify readmissions to an acute or nonacute inpatient care setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.   Exclude Episode Dates when the member had an ED visit (ED Value Set) for any diagnosis within 14 days after the Episode Date. |
| *Step 5* | Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from the Episode Date through 30 days after the Episode Date.  **Note:** All Episode Dates that were not excluded remain in the denominator. The denominator for this measure is based on acute inpatient discharges and ED visits, not members. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerators |  |
| *Systemic corticosteroid* | Dispensed prescription for systemic corticosteroid (Table PCE-C) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date. |

Table PCE-C: Systemic Corticosteroids

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description | Prescription | | | |
| Glucocorticoids | * Betamethasone * Dexamethasone | * Hydrocortisone * Methylprednisolone | * Prednisolone * Prednisone | * Triamcinolone |

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

|  |  |
| --- | --- |
| *Bronchodilator* | Dispensed prescription for a bronchodilator (Table PCE-D) on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date. |

Table PCE-D: Bronchodilators

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| Anticholinergic agents | * Albuterol-ipratropium * Aclidinium-bromide | * Ipratropium * Tiotropium | * Umeclidinium |
| Beta 2-agonists | * Albuterol * Arformoterol * Budesonide-formoterol * Fluticasone-salmeterol * Fluticasone-vilanterol | * Formoterol * Indacaterol * Levalbuterol * Mometasone-formoterol * Metaproterenol | * Olodaterol hydrochloride * Pirbuterol * Salmeterol * Umeclidinium-vilanterol |
| Methylxanthines | * Aminophylline * Dyphylline-guaifenesin * Guaifenesin-theophylline | * Dyphylline * Theophylline | |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to 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 PCE-1/2/3: Data Elements for Pharmacotherapy Management   
of COPD Exacerbation

|  |  |
| --- | --- |
|  | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | ✓ |
| Numerator events by administrative data | *Each of the 2 rates* |
| Numerator events by supplemental data | *Each of the 2 rates* |
| Reported rate | *Each of the 2 rates* |
| Lower 95% confidence interval | *Each of the 2 rates* |
| Upper 95% confidence interval | *Each of the 2 rates* |

## Medication Management for People With Asthma (MMA)

Summary of Changes to HEDIS 2016

* Expanded age range up to 85 years for the commercial product line.
* Added the Medicare product line.
* Added Table MMA-A: Asthma Medications and Table MMA-B: Asthma Controller Medications.
* Deleted all “Long-acting, inhaled beta-2 agonists” from Table MMA-A.
* Replaced all references of Table ASM-C to Table MMA-A in step 1.
* Replaced all references of Table ASM-D to Table MMA-B throughout the measure 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 members 5–85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

***Note:*** *For Medicaid, report only members 5–64 years of age. For Medicare, report only members 18–85 years of age.*

Definitions

|  |  |
| --- | --- |
| IPSD | Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year. |
| Treatment period | The period of time beginning on the IPSD through the last day of the measurement year. |
| PDC | Proportion of days covered. The number of days that a member is covered by at least one asthma controller medication, divided by the number of days in the treatment period. |
| Oral medication dispensing event | One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is filled.  Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.  Refer to the *Oral medication dispensing event* definition in ASM for examples. |

|  |  |
| --- | --- |
| Inhaler dispensing event | When *identifying the eligible population*, use the definition below to count inhaler dispensing events.  All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.  Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.  Use the Drug ID field in the NDC list to determine if the medications are the same or different. |
| Injection 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.  Allocate the dispensing events to the appropriate year based on the date when the prescription was filled. |
| Calculating number of days covered for the numerator | If multiple prescriptions for different medications are dispensed on the same  day, calculate number of days covered by a controller medication using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.  If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication. For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller.  Subtract any days supply that extends beyond December 31 of the measurement year.  Use the drug ID provided by the NDC to determine if the prescriptions are the same or different. |

Eligible Population

|  |  |  |
| --- | --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). | |
| Ages | For commercial, ages 5-85 as of December 31 of the measurement year. Report the following age stratifications and total rate: | |
|  | * 5–11 years. * 12–18 years. * 19–50 years. | * 51–64 years. * 65–85 years. * Total. |
|  | For Medicaid, ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate: | |
|  | * 5–11 years. * 12–18 years. * 19–50 years. | * 51–64 years. * Total. |

|  |  |  |
| --- | --- | --- |
|  | For Medicare, ages 18–85 as of December 31 of the measurement year. Report the following age stratifications and total rate: | |
| * 18-50 years. * 51–64 years. | * 65–85 years. * Total. |
| The total is the sum of the age stratifications for each product line. | |
| Continuous enrollment | The measurement year and the year prior to the measurement year. | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 year of continuous enrollment year. | |
| Anchor date | December 31 of the measurement year. | | |
| Benefits | Medical. Pharmacy during the measurement year. | | |
| Event/diagnosis | Follow the steps below to identify the eligible population for the measure. | | |
| *Step 1* | Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years*.*   * At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits. * At least four asthma medication dispensing events (Table MMA-A). | | |

Table MMA-A: Asthma Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description | Prescriptions | | | |
| Antiasthmatic combinations | * Dyphylline-guaifenesin | * Guaifenesin-theophylline | |  |
| Antibody inhibitor | * Omalizumab |  | |  |
| Inhaled steroid combinations | * Budesonide-formoterol | * Fluticasone-salmeterol | | * Mometasone-formoterol |
| Inhaled corticosteroids | * Beclomethasone * Budesonide | * Ciclesonide * Flunisolide | | * Fluticasone CFC free * Mometasone |
| Leukotriene modifiers | * Montelukast | * Zafirlukast | | * Zileuton |
| Mast cell stabilizers | * Cromolyn |  | | |
| Methylxanthines | * Aminophylline | * Dyphylline | * Theophylline | |
| Short-acting, inhaled beta-2 agonists | * Albuterol | * Levalbuterol | * Pirbuterol | |

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

|  |  |
| --- | --- |
| *Step 2* | A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year). |
| *Step 3: Required exclusions* | Exclude members who met any of the following criteria:   * Members who had any diagnosis from any of the following value sets, any time during the member’s history through December 31 of the measurement year: * Emphysema Value Set. * Other Emphysema Value Set. * COPD Value Set. * Obstructive Chronic Bronchitis Value Set. * Chronic Respiratory Conditions Due to Fumes/Vapors Value Set. * Cystic Fibrosis Value Set. * Acute Respiratory Failure Value Set. * Members who had no asthma controller medications (Table MMA-B) dispensed during the measurement year. |

Table MMA-B: Asthma Controller Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description | Prescriptions | | | |
| Antiasthmatic combinations | * Dyphylline-guaifenesin | * Guaifenesin-theophylline |  | |
| Antibody inhibitor | * Omalizumab |  |  | |
| Inhaled steroid combinations | * Budesonide-formoterol | * Fluticasone-salmeterol | * Mometasone-formoterol | |
| Inhaled corticosteroids | * Beclomethasone * Budesonide | * Ciclesonide * Flunisolide | * Fluticasone CFC free * Mometasone | |
| Leukotriene modifiers | * Montelukast | * Zafirlukast | * Zileuton | |
| Mast cell stabilizers | * Cromolyn |  | | |
| Methylxanthines | * Aminophylline | * Dyphylline | | * Theophylline |

**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. |
| Numerators |  |
| *Medication Compliance 50%* | The number of members who achieved a PDC of at least 50% for their asthma controller medications (Table MMA-B) during the measurement year. |
| *Medication Compliance 75%* | The number of members who achieved a PDC of at least 75% for their asthma controller medications (Table MMA-B) during the measurement year.  Follow the steps below to identify numerator compliance. |

|  |  |
| --- | --- |
| *Step 1* | Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (Table MMA-B) during the measurement year. |
| *Step 2* | To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year. |
| *Step 3* | Count the days covered by at least one prescription for an asthma controller medication (Table MMA-B) during the treatment period. To ensure that a days  supply that extends beyond the measurement year is not counted, subtract any  days supply that extends beyond December 31 of the measurement year. |
| *Step 4* | Calculate the member’s PDC using the following equation.Round (using the .5 rule) to two decimal places.  Total Days Covered by a Controller Medication in the Treatment Period (step 3)  Total Days in Treatment Period (step 2) |
| *Medication Compliance 50%* | Sum the number of members whose PDC is ≥50% for their treatment period. |
| *Medication Compliance 75%* | Sum the number of members whose PDC is ≥75% for their treatment period. |

Data Elements for Reporting

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

Table MMA-1/2/3: Data Elements for Medication Management for People With Asthma

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

## Asthma Medication Ratio (AMR)

Summary of Changes to HEDIS 2016

* Expanded age range up to 85 years for the commercial product line.
* Added the Medicare product line.
* Replaced all references of Table ASM-C to Table MMA-A in step 1.
* 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 5–85 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.

**Note:** For Medicaid, report only members 5–64 years of age. For Medicare, report only members 18–85 years of age.

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 on which the prescription is filled.  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 Drug ID to determine if the prescriptions are the same or different.  Refer to the definition of *Oral medication dispensing event* in ASM for examples. |
| Inhaler dispensing event | When *identifying the eligible population*, use the definition below to count inhaler dispensing events.  All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.  Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.  Use the Drug ID field in the NDC list to determine if the medications are the same or different. |
| Injection 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. |

|  |  |
| --- | --- |
|  | Allocate the dispensing events to the appropriate year based on the date when the prescription was filled. |
| Units of medications | 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, 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.  Use the package size and units columns in the NDC list 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, this indicates 3 inhaler canisters were dispensed. |

Eligible Population

|  |  |  |  |
| --- | --- | --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). | | |
| Ages | For commercial, ages 5-85 as of December 31 of the measurement year. Report the following age stratifications and total rate: | | | |
|  | * 5–11 years. * 12–18 years. * 19–50 years. | | * 51–64 years. * 65–85 years. * Total. | |
|  | For Medicaid, ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate: | | | |
|  | * 5–11 years. * 12–18 years. * 19–50 years. | | * 51–64 years. * Total. | |
|  | For Medicare, ages 18–85 as of December 31 of the measurement year. Report the following age stratifications and total rate: | | |
| * 18-50 years. * 51–64 years. | * 65–85 years. * Total. | |
| The total is the sum of the age stratifications for each product line. | | |
| Continuous enrollment | The measurement year and the year prior to the measurement year. | | |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 year of continuous enrollment year. | | |
| 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* | | 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*.*   * At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). * At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits. * At least four asthma medication dispensing events (Table MMA-A). | |
| *Step 2* | A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year). | |
| *Step 3: Required exclusions* | | Exclude members who met any of the following criteria:   * Members who had any diagnosis from any of the following value sets, any time during the member’s history through December 31 of the measurement year: * Emphysema Value Set. * Other Emphysema Value Set. * COPD Value Set. * Obstructive Chronic Bronchitis Value Set. * Chronic Respiratory Conditions Due to Fumes/Vapors Value Set. * Cystic Fibrosis Value Set. * Acute Respiratory Failure Value Set. * Members who had no asthma medications (controller or reliever) dispensed (Table AMR-A) during the measurement year. | |

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. |
| *Step 1* | For each member, count the units of controller medications (Table AMR-A) dispensed during the measurement year. Refer to the definition of *Units of medications*. |
| *Step 2* | For each member, count the units of reliever medications (Table AMR-A) 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. |

Units of Controller Medications (step 1)

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. |

Table AMR-A: Asthma Controller and Reliever Medications

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ASTHMA CONTROLLER MEDICATIONS | | | | |
| Description | Prescriptions | | | |
| Antiasthmatic combinations | * Dyphylline-guaifenesin | * Guaifenesin-theophylline | | |
| Antibody inhibitors | * Omalizumab |  |  | |
| Inhaled steroid combinations | * Budesonide-formoterol | * Fluticasone-salmeterol | * Mometasone-formoterol | |
| Inhaled corticosteroids | * Beclomethasone * Budesonide * Ciclesonide | * Flunisolide * Fluticasone CFC free * Mometasone |  | |
| Leukotriene modifiers | * Montelukast | * Zafirlukast | * Zileuton | |
| Mast cell stabilizers | * Cromolyn |  | | |
| Methylxanthines | * Aminophylline | * Dyphylline | * Theophylline | |
| ASTHMA RELIEVER MEDICATIONS | | | | |
| Description | Prescriptions | | | |
| Short-acting, inhaled beta-2 agonists | * Albuterol | * Levalbuterol | | * Pirbuterol |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to 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 AMR-1/2/3: Data Elements for Asthma Medication Ratio

|  |  |
| --- | --- |
| Data Elements | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *For each age stratification and total* |
| Number of required 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* |

Cardiovascular Conditions

## Controlling High Blood Pressure (CBP)

Summary of Changes to HEDIS 2016

* Revised a value set used to identify the event/diagnosis.
* Added HCPCS codes to identify outpatient visits.
* Renamed the Outpatient CPT Value Set to Outpatient Without UBREV Value Set.
* Clarified how to assign the diabetes flag.
* Removed the criteria for polycystic ovaries when assigning a flag of “not diabetic” in the event/diagnosis.
* Clarified the denominator section of the Hybrid Specification to state that if the hypertension diagnosis is not confirmed, the member is excluded and replaced by a member from the oversample.
* Added a method and value sets to identify nonacute inpatient admissions for optional exclusions.
* Added a *Note* to clarify when organizations may change the diabetes flag that was assigned based on administrative data.

Description

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

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

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

Definitions

|  |  |
| --- | --- |
| Adequate control | Adequate control is defined as meeting any of the following criteria:   * Members 18–59 years of age whose BP was <140/90 mm Hg. * Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. * Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. |
| Representative BP | The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.” |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18–85 years as of December 31 of the measurement year. |
| Continuous enrollment | The measurement year. |

|  |  |
| --- | --- |
| Allowable gap | No more than one gap in continuous enrollment of up to 45 days during the measurement year. 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 are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year. |
| *Diabetes Flag for Numerator Assessment* | After the Eligible Population is identified, assign each member either a ***diabetic*** or ***not diabetic*** flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for members with diabetes is different than the threshold for members without diabetes). |
| *Step 1* | Assign a flag of ***diabetic*** to members identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.  *Claim/encounter data.* Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):   * At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. * At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).   *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A). |
| *Step 2* | From the members identified in Step 1, assign a flag of ***not diabetic*** to members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.  ***Note****: Members classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as* ***not diabetic*** in this step*.* |
| *Step 3* | For members who were not assigned a flag in step 1 or step 2, assign a flag of ***not diabetic***. |

\_\_\_\_\_\_\_\_\_\_\_\_

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Hybrid Specification

|  |  |  |
| --- | --- | --- |
| Denominator | A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. The organization may reduce the sample size using the prior year’s audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.  To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record anytime during the member’s history on or before June 30 of the measurement year: | |
| * Hypertension. * HTN. * High BP (HBP). * Elevated BP (↑BP). * Borderline HTN. | * Intermittent HTN. * History of HTN. * Hypertensive vascular disease (HVD). * Hyperpiesia. * Hyperpiesis. |
| It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:   * Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis that is not part of the office visit note; see ***Note*** at the end of this section). * Office note. * Subjective, Objective, Assessment, Plan (SOAP) note. * Encounter form. * Diagnostic report. * Hospital discharge summary.   Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.  If the diagnosis of hypertension cannot be confirmed, the member is excluded and replaced by the next member from the oversample. | |
| Identifying  the medical record | Use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.  Use the following steps to find the appropriate medical record to review. | |
| *Step 1* | Identify the member’s PCP.  If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.  If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.  If a practitioner other than the member’s PCP manages the hypertension, the organization may use the medical record of that practitioner. | |

|  |  |
| --- | --- |
| *Step 2* | Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.  *If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30,* the diagnosis of hypertension and the BP reading may be identified through two different medical records.  *If a member has the same PCP for the entire measurement year,* but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member’s hypertension after June 30, the organization may use the PCP’s chart to confirm the diagnosis and use the specialist’s chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may use this chart for the most recent BP reading. If the member did not have any visit with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis. |
| Numerator | The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:   * Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg. * Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. * Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.   To determine if the member’s BP is adequately controlled, the representative BP must be identified. |
| Administrative | None. |
| Medical record | Follow the steps below to determine representative BP. |
| *Step 1* | Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed.  Do not include BP readings:   * Taken during an acute inpatient stay or an ED visit. * Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). * Obtained the same day as a major diagnostic or surgical procedure (e.g., EKG/ ECG, stress test, administration of IV contrast for a radiology procedure, endoscopy). * Reported by or taken by the member.   If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading. |

|  |  |
| --- | --- |
| *Step 2* | Determine numerator compliance based on the following criteria:   * Members 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg. * Members 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. * Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.   The member is not compliant if the BP reading does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). |
| *Step 3* | A single rate is reported for all three groups. Sum the numerator events from Step 2 to obtain the rate. |

Exclusions *(optional)*

* Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
* Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
* Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

*Note*

* *Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note then it would be considered a dated problem list and the date of the visit must be used.*
* *Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.*
* *Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the member during numerator assessment. The only exception is if the member is flagged as a diabetic but medical record evidence contains information that classifies the member as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis, as described in Substituting Medical Records in the Guidelines for Calculations and Sampling. In this case, the diabetes flag may be changed to “not diabetic,” but the member may not be removed from the sample.*

Data Elements for Reporting

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

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

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

## Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

Summary of Changes to HEDIS 2016

* Added a method and value sets to identify acute inpatient discharges and transfer setting (acute or nonacute inpatient) for the event/diagnosis.
* 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 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Definition

|  |  |
| --- | --- |
| Treatment days (covered days) | The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval). |
| 180-day measurement interval | The 180 day period that includes the discharge date and the 179 days after discharge. |

Eligible Population

|  |  |
| --- | --- |
| Product lines | Commercial, Medicaid, Medicare (report each product line separately). |
| Ages | 18 years and older as of December 31 of the measurement year. |
| Continuous enrollment | Discharge date through 179 days after discharge. |
| Allowable gap | No more than one gap in enrollment of up to 45 days within the 180 days of the event. 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 | Discharge date. |
| Benefit | Medical and pharmacy. |
| Event/diagnosis | An acute inpatient discharge with any diagnosis of AMI (AMI Value Set) from July 1 of the year prior to the measurement year through June 30 of the measurement year. 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. |

|  |  |
| --- | --- |
|  | *Transfers to an acute inpatient care setting.* Include hospitalizations in which the member was transferred directly to another acute inpatient care setting for any diagnosis. Count the discharge from the subsequent acute inpatient stay, not the initial discharge. The discharge date from the subsequent acute inpatient stay must occur on or before June 30 of the measurement year. Organizations must identify “transfers” using their own methods and then confirm the acute inpatient care setting. To confirm the acute inpatient care setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).   *Transfers to a nonacute inpatient care setting.* Exclude from the denominator, hospitalizations in which the member was transferred directly to a nonacute inpatient care setting for any diagnosis. Organizations must identify “transfers” using their own methods and then confirm the nonacute inpatient setting. To confirm the nonacute inpatient setting:   1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute inpatient care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.   If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year that meets the event/ diagnosis criteria, only include the first discharge. |

Administrative Specification

|  |  |
| --- | --- |
| Denominator | The eligible population. |
| Numerator | A 180-day course of treatment with beta-blockers (Table PBH-B).  Identify all members in the denominator population whose dispensed days supply is ≥135 days in the 180-day measurement interval. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.  To determine continuity of treatment during the 180-day period, identify all prescriptions filled within 180-day measurement interval, and add the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days +  45 gap days = 180 days).  To account for members who are on beta-blockers prior to admission, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval. |

Table PBH-B: Beta-Blocker Medications

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| Noncardioselective beta-blockers | * Carvedilol * Labetalol * Nadolol | * Penbutolol * Pindolol * Propranolol | * Timolol * Sotalol |
| Cardioselective beta-blockers | * Acebutolol * Atenolol | * Betaxolol * Bisoprolol | * Metoprolol * Nebivolol |
| Antihypertensive combinations | * Atenolol-chlorthalidone * Bendroflumethiazide-nadolol * Bisoprolol-hydrochlorothiazide | | * Hydrochlorothiazide-metoprolol * Hydrochlorothiazide-propranolol |

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

Exclusion *(optional)*

Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member’s history through the end of the continuous enrollment period meet criteria:

* Asthma (Asthma Value Set).
* COPD (COPD Value Set).
* Obstructive chronic bronchitis (Obstructive Chronic Bronchitis Value Set).
* Chronic respiratory conditions due to fumes and vapors (Chronic Respiratory Conditions Due to Fumes/Vapors Value Set).
* Hypotension, heart block >1 degree or sinus bradycardia (Beta-Blocker Contraindications Value Set).
* A medication dispensing event indicative of a history of asthma (Table PBH-D).
* Intolerance or allergy to beta-blocker therapy.

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

|  |  |  |  |
| --- | --- | --- | --- |
| Description | Prescription | | |
| Bronchodilator combinations | * Albuterol-ipratropium * Budesonide-formoterol | * Fluticasone-salmeterol * Mometasone-formoterol | |
| Inhaled corticosteroids | * Beclomethasone * Budesonide * Ciclesonide | * Flunisolide * Fluticasone * Fluticasone CFC free | * Mometasone |

**Note:** NCQA will post a comprehensive list of medications and NDC codes to 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 PBH-1/2/3: Data Elements for Persistence of Beta-Blocker Treatment   
After a Heart Attack

|  |  |
| --- | --- |
|  | 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 | ✓ |

## Statin Therapy for Patients With Cardiovascular Disease (SPC)

## Summary of Changes to HEDIS 2016

* First-year measure.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Definitions

|  |  |  |
| --- | --- | --- |
| IPSD | Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate intensity during the measurement year. | |
| Treatment period | The period of time beginning on the IPSD through the last day of the measurement year. | |
| PDC | Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period. | |
| Calculating number of days covered  for multiple prescriptions | If multiple prescriptions for different medications are dispensed on the same day, calculate the number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day in the treatment period only once toward the numerator.  If multiple prescriptions for the same medication are dispensed on the same day or on different days, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-day supply. Sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.  Use the drug ID provided by the NDC to determine if the prescriptions are the same or different. |

Eligible Population: Rate 1—Received Statin Therapy

|  |  |  |
| --- | --- | --- |
| Product line | | Commercial, Medicaid, Medicare (report each product line separately). |
| Age | | Report two age/gender stratifications and a total rate.   * Males 21–75 years as of December 31 of the measurement year. * Females 40–75 years as of December 31 of the measurement year. * Total. |
| Continuous enrollment | | The measurement year and the year prior to the measurement year. |
| Allowable gap | | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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. Pharmacy during the measurement year. |
| Event/Diagnosis | Follow the steps below to identify the eligible population. | |
| ***Step 1:*** | Members are identified for the eligible population in two ways: by event or by diagnosis. 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.  *Event.* Any of the following during the year prior to the measurement year meet criteria:   * *MI.* Discharged from an inpatient setting with an MI (MI Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *CABG*. Discharged from an inpatient setting with a CABG (CABG Value Set). To identify discharges:  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.  * *PCI*. Members who had PCI (PCI Value Set) in any setting. * *Other revascularization*. Members who had any other revascularization procedures (Other Revascularization Value Set) in any setting.   *Diagnosis.* Identify members as having ischemic vascular disease (IVD) 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.   * At least one outpatient visit (Outpatient Value Set) with an IVD diagnosis (IVD Value Set), ***or*** * At least one acute inpatient encounter (Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set). | |

|  |  |
| --- | --- |
| ***Step 2: Required exclusions*** | Exclude members who meet any of the following criteria:   * Pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. * In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year. * Dispensed at least one prescription for clomiphene (Table SPC-A) during the measurement year or the year prior to the measurement year. * ESRD (ESRD Value Set) during the measurement year or the year prior to the measurement year. * Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. * Myalgia, myositis, myopathy, or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. |

**Table SPC-A: Medications to Identify Exclusions**

|  |  |
| --- | --- |
| **Description** | **Prescription** |
| Estrogen agonists | * Clomiphene |

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

Administrative Specification: Rate 1—Received Statin Therapy

|  |  |
| --- | --- |
| Denominator | The Rate 1 eligible population. |
| Numerator | The number of members who had at least one dispensing event for a high or moderate-intensity statin medication (Table SPC-B) during the measurement year. |

### Table SPC-B: High and Moderate-Intensity Statin Medications

|  |  |  |
| --- | --- | --- |
| Description | Prescription | |
| High-intensity statin therapy | * Atorvastatin 40–80 mg * Amlodipine-atorvastatin 40-80 mg * Ezetimibe-atorvastatin 40-80 mg | * Rosuvastatin 20–40 mg * Simvastatin 80 mg * Ezetimibe-simvastatin 80 mg |
| Moderate-intensity statin therapy | * Atorvastatin 10–20 mg * Amlodipine-atorvastatin 10-20 mg * Ezetimibe-atorvastatin 10-20 mg * Rosuvastatin 5–10 mg * Simvastatin 20–40 mg * Ezetimibe-simvastatin 20-40 mg * Niacin-simvastatin 20-40 mg * Sitagliptin-simvastatin 20-40 mg | * Pravastatin 40–80 mg * Aspirin-pravastatin 40-80 mg * Lovastatin 40 mg * Niacin-lovastatin 40 mg * Fluvastatin XL 80 mg * Fluvastatin 40 mg bid * Pitavastatin 2–4 mg |

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

Eligible Population: Rate 2—Statin Adherence 80%

|  |  |
| --- | --- |
| Product line | Commercial, Medicaid, Medicare (report each product line separately). |
| Age | Report two age/gender stratifications and a total rate.   * Males 21–75 years as of December 31 of the measurement year. * Females 40–75 years as of December 31 of the measurement year. * Total. |
| Continuous enrollment | The measurement year and the year prior to the measurement year. |
| Allowable gap | No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. 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 during the measurement year and the year prior. Pharmacy during the measurement year. |
| Event/Diagnosis | All members who meet the numerator criteria for Rate 1. |

Administrative Specification: Rate 2—Statin Adherence 80%

|  |  |
| --- | --- |
| Denominator | The Rate 2 eligible population. |
| Numerator | The number of members who achieved a PDC of at least 80% during the treatment period. |
|  | Follow the steps below to identify numerator compliance. |
| *Step 1* | Identify the IPSD. The IPSD is the earliest dispensing event for any high or moderate-intensity statin medication (Table SPC-B) during the measurement year. |
| *Step 2* | To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year. |
| *Step 3* | Count the days covered by at least one prescription for statin medication (Table SPC-B) during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year. |
| *Step 4* | Calculate the member’s PDC using the following equation.Round (using the .5 rule) to two decimal places.  Total Days Covered by a Statin Medication in the Treatment Period (step 3)  Total Days in Treatment Period (step 2) |
| *Step 5* | Sum the number of members whose PDC is ≥80% for the treatment period. |

Data Elements for Reporting

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

Table SPC-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease

|  |  |
| --- | --- |
| Data Elements | Administrative |
| Measurement year | ✓ |
| Data collection methodology (Administrative) | ✓ |
| Eligible population | *Each rate, for each age/gender stratification and total* |
| Number of required exclusions | *Rate 1, for each age/gender stratification and total* |
| Numerator events by administrative data | *Each rate, for each age/gender stratification and total* |
| Numerator events by supplemental data | *Each rate, for each age/gender stratification and total* |
| Reported rate | *Each rate, for each age/gender stratification and total* |
| Lower 95% confidence interval | *Each rate, for each age/gender stratification and total* |
| Upper 95% confidence interval | *Each rate, for each age/gender stratification and total* |