Appendix 1

HEDIS 2016  
Summary Table of Measures,  
Product Lines and Changes

**APPENDIX 1**

**SUMMARY TABLE OF MEASURES, PRODUCT LINES AND CHANGES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **General Guidelines for Data Collection and Reporting** | ✓ | ✓ | ✓ | * Updated deadlines in *General Guideline 9*. * Removed the May 1 task “Auditor selects measures for MMRV and informs the plan of the selections”from the Audit Timeline in *General Guideline 9.* * Revised the audit results in *General Guideline 10.* * Deleted the Measure Rotation guidelines *(*formerly *General Guidelines 12–16).* * Revised General Guideline 23 (formerly *General Guideline 28*). * Updated submission dates in *General Guideline 30* (formerly *General Guideline 35*). * Added a note to *General Guideline 33* (formerly *General Guideline 38*) to clarify how supplemental data numerator events are counted for EOC and EOC-like measures. * Revised *General Guideline 34* (formerly *General Guideline 39*) to clarify that supplemental data should be the last data source considered and to remove the requirement that supplemental data may only be used to identify eligible-population required exclusions related to the timing of the denominator event or diagnosis. |
| **Guidelines for Calculations and Sampling** | ✓ | ✓ | ✓ | * No changes. |
| **EFFECTIVENESS OF CARE** | | | | |
| **Guidelines for Effectiveness of Care** | ✓ | ✓ | ✓ | * No changes. |
| Adult BMI Assessment | ✓ | ✓ | ✓ | * 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. |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | ✓ | ✓ |  | * 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. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **EFFECTIVENESS OF CARE** | | | | |
| Childhood Immunization Status | ✓ | ✓ |  | * 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. |
| Immunizations for Adolescents | ✓ | ✓ |  | * 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. |
| Human Papillomavirus Vaccine for Female Adolescents | ✓ | ✓ |  | * 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. |
| Lead Screening in Children |  | ✓ |  | * 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. |
| Breast Cancer Screening | ✓ | ✓ | ✓ | * 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. |
| Cervical Cancer Screening | ✓ | ✓ |  | * 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. |
| Colorectal Cancer Screening | ✓ |  | ✓ | * 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. |
| Chlamydia Screening in Women | ✓ | ✓ |  | * 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. |
| Care for Older Adults |  |  | ✓  (SNP only) | * 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. |
| Appropriate Testing for Children With Pharyngitis | ✓ | ✓ |  | * 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. |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD | ✓ | ✓ | ✓ | * 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. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **EFFECTIVENESS OF CARE** | | | | |
| Pharmacotherapy Management of COPD Exacerbation | ✓ | ✓ | ✓ | * 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. | |
| Medication Management for People With Asthma | ✓ | ✓ | ✓ | * 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. | |
| Asthma Medication Ratio | ✓ | ✓ | ✓ | * 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. | |
| Controlling High Blood Pressure | ✓ | ✓ | ✓ | * 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. | |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **EFFECTIVENESS OF CARE** | | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | ✓ | ✓ | ✓ | * 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. |
| Statin Therapy for Patients With Cardiovascular Disease | ✓ | ✓ | ✓ | * First-year measure. |
| Comprehensive Diabetes Care | ✓ | ✓ | ✓ | * Added a method and value sets to identify discharges for the applicable required exclusions for the *HbA1c Control (<7.0%) for a Selected Population* indicator. * Revised the requirements for urine protein testing for the *Medical Attention for Nephropathy* indicator; a screening or monitoring test meets criteria, whether the result is positive or negative. * Removed the optional exclusion for polycystic ovaries. * Added a *Note* clarifying optional exclusions. * 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. |
| Statin Therapy for Patients With Diabetes | ✓ | ✓ | ✓ | * First-year measure. |
| Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis | ✓ | ✓ | ✓ | * Added a method and value sets to identify nonacute inpatient discharges 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. |
| Osteoporosis Management in Women Who Had a Fracture |  |  | ✓ | * Defined “active prescription.” * Revised the method and value sets to identify acute and nonacute inpatient events for steps 1 and 2 of the event/diagnosis. * Clarified when to use admission or discharge dates when determining Negative Diagnosis History. * Clarified that bone mineral density tests that occur in an inpatient setting (either during an inpatient IESD or during the 180-day (6-month) period after the IESD) meet numerator criteria. * Added long-acting osteoporosis therapy administered during an inpatient IESD to 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. |
| Antidepressant Medication Management | ✓ | ✓ | ✓ | * Added a method and value sets to identify acute and nonacute inpatient discharges for required exclusions (step 2). * Changed the description of “SSNRI antidepressants” to “SNRI antidepressants” in Table AMM-C. * Added levomilnacipran to the description of “SNRI antidepressants” in TableAMM-C. * 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. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **EFFECTIVENESS OF CARE** | | | | |
| Follow-Up Care for Children Prescribed ADHD Medication | ✓ | ✓ |  | * Added value sets to identify acute inpatient encounters for step 4 of the event/diagnosis (for both Initiation and C&M Phase). * 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. |
| Follow-Up After Hospitalization for Mental Illness | ✓ | ✓ | ✓ | * Added value sets to identify acute inpatient discharges, readmissions and transfer settings 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. |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications |  | ✓ |  | * Added Other Bipolar Disorders Value Set to step 1 of 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. |
| Diabetes Monitoring for People With Diabetes and Schizophrenia |  | ✓ |  | * Removed the optional exclusion for polycystic ovaries. * 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. |
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia |  | ✓ |  | * Added a method and value sets to identify discharges for step 2 of 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. |
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia |  | ✓ |  | * Revised the IPSD time frame. * 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. |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics | ✓ | ✓ |  | * 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. |
| Annual Monitoring for Patients on Persistent Medications | ✓ | ✓ | ✓ | * Added value sets to identify acute and nonacute inpatient encounters for the optional exclusions. * 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. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare | |
| **EFFECTIVENESS OF CARE** | | | | | |
| Medication Reconciliation Post-Discharge |  |  | ✓ | * Added Medicare as a product line. * Expanded the age range to include Medicare beneficiaries 18 years and older. * Clarified that the time frame for medication reconciliation is the discharge date through 30 days after discharge (31 days total). * Added value sets to identify acute and nonacute inpatient discharges, readmissions and transfer setting for the event/diagnosis. * Clarified medical record documentation requirements for medication reconciliation. * 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. | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females | ✓ | ✓ |  | * Added a requirement to not include denied claims 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. | |
| Non-Recommended PSA-Based Screening in Older Men |  |  | ✓ | * Added a requirement to not include denied claims 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. | |
| Appropriate Treatment for Children With Upper Respiratory Infection | ✓ | ✓ |  | * 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. | |
| Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis | ✓ | ✓ |  | * 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. | |
| Use of Imaging Studies for Low Back Pain | ✓ | ✓ |  | * 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. | |
| Use of Multiple Concurrent Antipsychotics in Children and Adolescents | ✓ | ✓ |  | * 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. | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare | |
| **EFFECTIVENESS OF CARE** | | | | | |
| Potentially Harmful Drug-Disease Interactions in the Elderly |  |  | ✓ | * Revised the method and value sets to identify acute and nonacute inpatient discharges for step 1 of the Rate 1 additional eligible population criteria. * Added Other Bipolar Disorder Value Set to step 2: required exclusions for Rate 1 and Rate 2. * 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. | |
| Use of High-Risk Medications in the Elderly |  |  | ✓ | * 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. | |
| Medicare Health Outcomes Survey |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 6: Specifications for the Medicare Health Outcomes Survey*. | |
| Fall Risk Management |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 6: Specifications for the Medicare Health Outcomes Survey.* | |
| Management of Urinary Incontinence in Older Adults |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 6: Specifications for the Medicare Health Outcomes Survey.* | |
| Osteoporosis Testing in Older Women |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 6: Specifications for the Medicare Health Outcomes Survey.* | |
| Physical Activity in Older Adults |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 6: Specifications for the Medicare Health Outcomes Survey.* | |
| Aspirin Use and Discussion | ✓ | ✓ |  | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* | |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **EFFECTIVENESS OF CARE** | | | | |
| Flu Vaccinations for Adults Ages 18-64 | ✓ | ✓ |  | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| Flu Vaccinations for Adults Ages 65 and Older |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| Medical Assistance With Smoking and Tobacco Use Cessation | ✓ | ✓ | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| Pneumococcal Vaccination Status for Older Adults |  |  | ✓ | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| **ACCESS/AVAILABILITY OF CARE** | | | | |
| Adults’ Access to Preventive/ Ambulatory Health Services | ✓ | ✓ | ✓ | * No changes to this measure. |
| Children’s and Adolescents’ Access to Primary Care Practitioners | ✓ | ✓ |  | * No changes to this measure. |
| Annual Dental Visit |  | ✓ |  | * Revised the upper age limit to 20 years of age to align with the EPSDT services guidelines, which include dental coverage for children under 21 who are enrolled in Medicaid. |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | ✓ | ✓ | ✓ | * Added value sets to identify acute and nonacute inpatient discharges for step 1 of the event/diagnosis and for both numerators. |
| Prenatal and Postpartum Care | ✓ | ✓ |  | * Deleted the use of infant claims to identify deliveries. * Clarified the tests that must be included to meet criteria for an obstetric panel in the hybrid specification. |
| Call Answer Timeliness | ✓ | ✓ | ✓ | * No changes to this measure. |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics | ✓ | ✓ |  | * No changes to this measure. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | | Medicare | |
| **EXPERIENCE OF CARE** | | | | | | |
| CAHPS Health Plan Survey 5.0H, Adult Version | ✓ | ✓ | |  | | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| CAHPS Health Plan Survey 5.0H, Child Version | ✓ | ✓ | |  | | * This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| Children With Chronic Conditions | ✓ | ✓ | |  | | * This measure is collected using survey methodology. Detailed specifications and summary of changes for the measure are contained in *HEDIS 2016, Volume 3: Specifications for Survey Measures.* |
| **UTILIZATION AND RISK ADJUSTED UTILIZATION** | | | | | | |
| **Guidelines for Utilization and Risk Adjusted Utilization Measures** | ✓ | ✓ | | ✓ | | * “Guidelines for Utilization Measures” have been renamed, “Guidelines for Utilization and Risk Adjusted Utilization Measures.” |
| Frequency of Ongoing Prenatal Care |  | ✓ | |  | | * Deleted the use of infant claims to identify deliveries. * 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. |
| Well-Child Visits in the First 15 Months of Life | ✓ | ✓ | |  | | * 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. |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life | ✓ | ✓ | |  | | * 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. |
| Adolescent Well-Care Visits | ✓ | ✓ | |  | | * 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. |
| Frequency of Selected Procedures | ✓ | ✓ | | ✓ | | * Added new value sets to identify unilateral mastectomy. |
| Ambulatory Care | ✓ | ✓ | | ✓ | | * No changes to this measure. |
| Inpatient Utilization—General Hospital/Acute Care | ✓ | ✓ | ✓ | | * Added a method and value sets to identify acute inpatient discharges in step 1. | |
| Identification of Alcohol and Other Drug Services | ✓ | ✓ | ✓ | | * Added a method and value sets to identify inpatient discharges. | |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **UTILIZATION AND RISK ADJUSTED UTILIZATION** | | | | |
| Mental Health Utilization | ✓ | ✓ | ✓ | * Added a method and value sets to identify inpatient discharges. |
| Antibiotic Utilization | ✓ | ✓ | ✓ | * No changes to this measure. |
| Plan All-Cause Readmissions | ✓ |  | ✓ | * Added a method and value sets to identify acute inpatient discharges in step 1 of the event/diagnosis. * Added instructions for identifying the transfer setting in step 2 of the event/diagnosis. * Added a *Note* to steps 4 and 5 of the event/diagnosis. * Added a method and value sets to identify acute inpatient admissions in step 1 of the numerator. |
| Inpatient Hospital Utilization | ✓ |  | ✓ | * First-year measure. |
| Emergency Department Utilization | ✓ |  | ✓ | * First-year measure. |
| Hospitalization for Potentially Preventable Complications |  |  | ✓ | * First-year measure. |
| **RELATIVE RESOURCE USE** | | | | |
| **Guidelines for Relative Resource Use Measures** | ✓ | ✓ | ✓ | * Removed ASM as a related quality EOC measure that must be reported with RAS in *Guideline 1*. * Removed reference to “regional” in the “expected amount” definition; regional peer groups (regional versions of the O/E) were eliminated in the RRU calculations. * Removed references to “index ratio” and “index score” in the *Relative Resource Use Results* section; indexing of the O/E ratio was eliminated. |
| Relative Resource Use for People With Diabetes | ✓ | ✓ | ✓ | * Removed the optional exclusion for polycystic ovaries. |
| Relative Resource Use for People With Cardiovascular Conditions | ✓ | ✓ | ✓ | * Added a method and value sets to identify discharges for the event/diagnosis. |
| Relative Resource Use for People With Hypertension | ✓ | ✓ | ✓ | * No changes to this measure. |
| Relative Resource Use for People With COPD | ✓ | ✓ | ✓ | * No changes to this measure. |
| Relative Resource Use for People With Asthma | ✓ | ✓ |  | * Expanded age range up to 85 years for the commercial product line. * Added the Medicare product line. * Removed the reference to the retired ASM measure in the eligible population Note. * Replaced all references of Table ASM-C with “Table MMA-A" in step 1. * Revised and renamed the reporting tables. |

HEDIS 2016 Summary Table of Measures, Product Lines and Changes *(continued)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HEDIS 2016 Measures | Applicable to: | | | Changes to HEDIS 2016 |
| Commercial | Medicaid | Medicare |
| **HEALTH PLAN DESCRIPTIVE INFORMATION** | | | | |
| Board Certification | ✓ | ✓ | ✓ | * No changes to this measure. |
| Enrollment by Product Line | ✓ | ✓ | ✓ | * No changes to this measure. |
| Enrollment by State | ✓ | ✓ | ✓ | * No changes to this measure. |
| Language Diversity of Membership | ✓ | ✓ | ✓ | * No changes to this measure. |
| Race/Ethnicity Diversity of Membership | ✓ | ✓ | ✓ | * No changes to this measure. |
| Weeks of Pregnancy at Time of Enrollment |  | ✓ |  | * Deleted the use of infant claims to identify deliveries. |
| Total Membership | ✓ | ✓ | ✓ | * Added the EPO product. * Added the Marketplace product line. * Clarified that Medicare-Medicaid Plans (MMP) are included in the Medicare count. * Clarified that this measure is reported for an organization in its entirely. |
| **MEASURES COLLECTED USING ELECTRONIC CLINICAL DATA SYSTEMS** | | | | |
| Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults | ✓ | ✓ | ✓ | * First-year measure. |

**Appendix 2**

**Technical Considerations**

**for New Measures**

**APPENDIX 2**

**TECHNICAL CONSIDERATIONS FOR NEW MEASURES**

The NCQA Committee on Performance Measurement (CPM) approved six new measures for HEDIS 2016. These measures provide feasible assessment strategies that are meaningful to consumers, purchasers, organizations and clinicians.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| New HEDIS 2016 Measures | PRODUCT LINE | | | DATA SOURCE | | | |
| Commercial | Medicaid | Medicare | Admin | Hybrid | Survey | ECDS |
| **Effectiveness of Care** | | | | | | |  |
| Statin Therapy for Patients With Cardiovascular Disease |  |  |  |  |  |  |  |
| Statin Therapy for Patients With Diabetes |  |  |  |  |  |  |  |
| **Utilization and Risk Adjusted Utilization** | | | | | | |  |
| Inpatient Hospital Utilization |  |  |  |  |  |  |  |
| Emergency Department Utilization |  |  |  |  |  |  |  |
| Hospitalization for Potentially Preventable Complications |  |  |  |  |  |  |  |
| **Measures Collected using Electronic Clinical Data Systems** | | | | | | | |
| Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults\* |  |  |  |  |  |  |  |

\*This measure is part of a pilot implementation. It is not part of NCQA’s Measure Certification or Audit programs for HEDIS 2016.

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

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.

Background

Cardiovascular disease is the leading cause of death in the United States. Although the death rate due to cardiovascular disease fell by 39 percent between 2001 and 2011, the public health burden remains significant. More than 85 million American adults have one or more types of cardiovascular disease (Mozaffarian et al., 2015). It is estimated that by 2030, more than 43 percent of Americans will have a form of cardiovascular disease (Heidenreich et al., 2011).

Atherosclerosis is a systemic disease process that occurs when plaque builds up within the walls of arteries. Plaque consists of fat, cholesterol, calcium, inflammatory cells and scar tissue that can harden over time and narrow arteries, which reduces the flow of oxygen to organs and throughout the body and results in most cardiovascular events, including heart attack and stroke (NHLBI, 2014).

Research shows that adherence to statin medications is poor in the United States. In a randomized trial of medication coverage, 50 percent of patients in the control group (usual coverage) stopped using statin medications within one year of starting treatment (Choudhry, 2011). NCQA seeks to improve statin adherence in patients with cardiovascular disease and thereby reduce the risk for cardiovascular related mortality.

Relevance

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| --- | --- |
| Health importance | Statins (HMG CoA reductase inhibitors) are a class of drugs that lower blood cholesterol. Statins work in the liver by preventing the formation of cholesterol, thus lowering the amount of cholesterol in the blood (AHA, 2014). Statins are most effective in lowering low-density lipoprotein cholesterol (LDL-C). The amount of cholesterol lowering effect is based on statin intensity, which is classified as either high, moderate or low intensity.  Statins are among the most commonly prescribed medications in the United States, accumulating $17 billion in sales in 2012 (Consumer Reports, 2014). According to recent blood cholesterol treatment guidelines from the American College of Cardiology and American Heart Association (ACC/AHA), statins of moderate or high intensity are recommended for adults with established clinical ASCVD. Many studies support the use of statins to reduce ASCVD events in primary and secondary prevention.  One meta-analysis of data from 170,000 patients in 26 randomized controlled trials found that intensive statin therapy reduces major vascular events by 15 percent (CTT, 2010). The study also found a 13 percent reduction in coronary death or nonfatal myocardial infarction, a 19 percent reduction in coronary revascularization and a 16 percent reduction in ischemic stroke (CTT, 2010).  Another systematic review and meta-analysis estimates that long-term statin therapy reduces the risk for ASCVD events by 25 percent–45 percent (Law, 2003). |

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| Financial importance | In 2011, the total cost of cardiovascular disease and stroke in the United States was estimated to be $320 billion. This total includes direct costs, such as the cost of physicians and other health professionals, hospital services, prescribed medications and home health care, as well as indirect costs due to loss of productivity from premature mortality.  Interventions to address cardiovascular disease are increasing: since 2000, the number of inpatient cardiovascular operations and procedures increased by 28 percent, from 5,939,000 to 7,588,000 (Mozaffarian et al., 2015). By 2030, direct medical costs for cardiovascular disease are projected to increase to nearly $918 billion (Heidenreich, 2011). |
| Potential for improvement | The ACC/AHA guidelines state “adherence to both medication and lifestyle regimens are required for ASCVD risk reduction” (Stone et al., 2013). This measure uses the proportion of days covered (PDC) to assess adherence. According to the Pharmacy Quality Alliance, a PDC threshold of 80 percent is considered highly adherent for most classes of chronic medications (Nau, 2012).  The impact of adherence on statin efficacy has been shown: each 25 percent increase in statin adherence is associated with a ~3.8 mg/dL reduction in low-density lipoprotein cholesterol (Ho, 2009). Nonadherence to statin therapy can result in an increased risk for mortality. One study found a 12 percent–25 percent increase in the risk for mortality with nonadherence to statins after an acute myocardial infarction (Rasmussen, 2007). |

Scientific Soundness

|  |  |
| --- | --- |
| Clinical importance  and evidence |  |
| *Guideline recommendations* | **ACA/AHA.** For men and women 21–75 years of age with a diagnosis of clinical ASCVD, high-intensity statin therapy is recommended. If high-intensity therapy is contraindicated, or when adverse effects are present, moderate-intensity statin therapy should be used. |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

|  |  |
| --- | --- |
| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure. In general, claims and encounter data required for this measure should be available to health plans. |
| Auditable | This measure has been reviewed by NCQA’s internal HEDIS Audit and Measure certification staff and found to be auditable. |

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***Statin Therapy for Patients With Diabetes (SPD)***

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

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

Background

Diabetes is a complex group of diseases marked by high blood sugar due to the body’s inability to make or use insulin. Diabetes can lead to serious complications (CDC, 2014). Twenty nine million (9.3 percent) of Americans had diabetes in 2012 and 1.7 million adults were newly diagnosed with diabetes (ADA, 2014). Patients with diabetes have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places patients at a significant risk for developing atherosclerotic cardiovascular disease (ASCVD) (ADA, 2015).

Primary prevention for cardiovascular disease is an important aspect of diabetes management. The risk of an adult with diabetes developing cardiovascular disease is two to four times higher than that of an adult without diabetes (AHA, 2012). In addition to being at a higher risk for developing cardiovascular disease, patients with diabetes tend to have worse survival after the onset of cardiovascular disease (Stone et al., 2013). The Centers for Disease Control and Prevention estimates that adults with diabetes are 1.7 times more likely to die from cardiovascular disease than adults without diabetes (CDC, 2014).

Numerous studies have demonstrated the efficacy of statins in reducing cardiovascular risk. The use of statins for primary prevention of cardiovascular disease in patients with diabetes, based on their age and other risk factors, is recommended by guidelines from the American Diabetes Association (ADA) and the American College of Cardiology/American Heart Association (ACC/AHA).

Relevance

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| Health importance | Statins (3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors) are a class of drugs that decrease low-density lipoprotein cholesterol (LDL-C) levels. Statins can decrease LDL-C levels by as much as 50% and could have additional benefit on high-density lipoprotein cholesterol (HDL-C) and triglyceride levels (Spratt, 2009). The amount of cholesterol lowering effect is based on statin intensity, which is classified as either high, moderate or low intensity.  Cholesterol lowering medications, such as statins, are among the most commonly prescribed drugs in America, accumulating $17 billion in sales in 2012. In the United States, 22 percent of adults (45 and older) take statins (Consumer Reports, 2014). Evidence shows statin use decreases cardiovascular mortality in patients with established cardiovascular disease, and total mortality rates. Primary and secondary prevention trial data strongly support starting lipid-lowering therapy with a statin in most patients with type 2 diabetes (Spratt, 2009).  In a systematic review and meta-analysis of 12 studies conducted to evaluate the clinical benefit of lipid-lowering drug treatment in primary and secondary prevention, researchers found statins were equally effective in patients with and without diabetes (Costa et al, 2006). However, after adjusting for baseline risk, patients with diabetes had greater benefit in both the primary and secondary prevention of death due to coronary artery disease, nonfatal myocardial infarction, revascularization and stroke. Another meta-analysis by the American College of Physicians on lipid-lowering therapy for type 2 diabetes patients found a 22 percent reduction of cardiovascular events with primary prevention and a 24 percent reduction for secondary prevention (Spratt, 2009). |
| Financial importance | The total cost of diabetes care in the United States was $245 billion in 2012—a 41 percent increase from $175 billion in 2007. The cost of care to treat patients with diabetes includes direct costs ($176 billion) from office visits, hospital care and medications. Indirect costs to treat patients with diabetes are estimated to be $69 billion and includes costs for absenteeism, reduced productivity, unemployment due to disability and loss of productivity due to premature mortality. Research also shows that more than 1 in 10 dollars spent on health care in the United States are spent on the care of patients with diabetes and its complications. (ADA, 2013) |
| Potential for improvement | The ACC/AHA guidelines state, “adherence to both medication and lifestyle regimens are required for ASCVD risk reduction” (Stone et al., 2013). This measure uses the proportion of days covered (PDC) to assess adherence. According to the Pharmacy Quality Alliance, a PDC threshold of 80 percent is considered highly adherent for most classes of chronic medications (Nau, 2012).  The impact of adherence on statin efficacy has been shown: each 25 percent increase in statin adherence is associated with a ~3.8 mg/dL reduction in low-density lipoprotein cholesterol (Ho, 2009). Nonadherence to statin therapy can result in an increased risk for morbidity and mortality. One study found a 12 percent–25 percent increase in the risk for mortality with non-adherence to statins after an acute myocardial infarction (Rasmussen, 2007). |

Scientific Soundness

|  |  |
| --- | --- |
| Clinical importance  and evidence |  |
| *Guideline recommendations* | **ACA/AHA.** For men and women 40–75 years of age with a diagnosis of diabetes, moderate-intensity statin therapy is recommended. For men and women age 40–75 years of age with diabetes and an estimated 10-year ASCVD risk, high-intensity statin therapy should be used unless contraindicated. For men and women under 40 years of age or over 75 years of age with a diagnosis of diabetes, it is reasonable to initiate or continue statin therapy for those who are tolerating it, provided that benefits, potential risks, drug interactions and patient preferences are taken into consideration.  **ADA.** For men and women 40-75 years of age with a diagnosis of diabetes but without any CVD risk factors, consider using moderate-intensity stain and lifestyle therapy. For men and women of all ages with a diagnosis of diabetes and CVD risk factors, moderate or high-intensity statin therapy is recommended. |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

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| --- | --- |
| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure. In general, claims and encounter data required for this measure should be available to health plans. |
| Auditable | This measure has been reviewed by NCQA’s internal HEDIS Audit and Measure certification staff and found to be auditable. |

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## Inpatient Hospital Utilization (IHU)

Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year reported by Surgery, Medicine and Total.

Background

NCQA investigated the appropriateness of developing this risk adjusted HEDIS measure by building on the existing unadjusted measure: *Inpatient Utilization—General Hospital/Acute Care (IPU)*. Since 1993, the IPU measure has reported the unadjusted total discharges per member month/year from acute inpatient care.

Relevance

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| --- | --- | --- |
| Health importance | | Risk modeling and testing were undertaken to assess whether risk adjustment might improve the measure’s ability to highlight quality differences, such as the impact of effective care coordination and other system interventions, in reducing inpatient admissions and ED overutilization. The proposed risk adjusted specifications are intended to enhance our understanding of variation in utilization and comparability of inpatient and ED utilization among plans.  NCQA used a comprehensive approach when assessing appropriate strategies for reporting adjusted utilization in HEDIS. We conducted a number of stakeholder interviews with health plans and risk adjustment experts, most of whom support application of a risk adjustment strategy to HEDIS utilization measures. We then employed a large research database of Medicare Advantage and commercial plan members to model several variations of risk adjustment.  Test results reveal that risk adjustment is a desirable refinement and demonstrate that the proposed risk adjustment strategy is both accurate and reliable. NCQA’s advisory panels agree that the results support the reliability of the risk adjustment model and that the measures can help identify opportunities for quality improvement. |
| Potential for improvement | The aim of applying a risk adjustment strategy to this utilization measures is to allow better comparison of inpatient use across health plans and to create an “even playing field” by removing the effect of select patient characteristics and health status differences on the reported results. | |

Scientific Soundness

|  |  |
| --- | --- |
| Clinical importance  and evidence |  |
| *Guideline recommendations* | It is NCQA policy to use guidelines which are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency. This measure of utilization is not based on clinical guidelines. The results should be used by plans in conjunction with other use of service data and clinical quality of care data to evaluate trends in patient care settings. Year to year trends and risk-adjusted comparisons between plans should be evaluated rather than a cross-sectional observed rate. |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

|  |  |
| --- | --- |
| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure. In general, claims and encounter data required for this measure should be available to health plans. |
| Auditable | This measure has been reviewed by NCQA’s internal HEDIS Measure Validation staff and found to be auditable. |

***Emergency Department Utilization (EDU)***

Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

Background

NCQA investigated the appropriateness of developing this risk adjusted HEDIS measure by building on the existing, unadjusted measure: *Ambulatory Care (AMB).* Since 1993, the AMB measure has reported the unadjusted ED and outpatient services across health plan members of all ages.

***Note:*** *The new EDU measure assesses ED visits only.*

Relevance

|  |  |  |
| --- | --- | --- |
| Health importance | | Risk modeling and testing were undertaken to assess whether risk adjustment might improve the measure’s ability to highlight quality differences, such as the impact of effective care coordination and other system interventions, in reducing inpatient admissions and ED overutilization. The proposed risk adjusted specifications are intended to enhance our understanding of variation in utilization and comparability of inpatient and ED utilization among plans.  NCQA used a comprehensive approach when assessing appropriate strategies for reporting adjusted utilization in HEDIS. We conducted a number of stakeholder interviews with health plans and risk adjustment experts, most of whom support application of a risk adjustment strategy to HEDIS utilization measures. We then employed a large research database of Medicare Advantage and commercial plan members to model several variations of risk adjustment.  Test results reveal that risk adjustment is a desirable refinement and demonstrate that the proposed risk adjustment strategy is both accurate and reliable. NCQA’s advisory panels agree that the results support the reliability of the risk adjustment model and that the measures can help identify opportunities for quality improvement. |
| Potential for improvement | The aim of applying a risk adjustment strategy to this utilization measure is to allow better comparison of ED use across health plans and to create an “even playing field” by removing the effect of select patient characteristics and health status differences on the reported results. | |

Scientific Soundness

|  |  |
| --- | --- |
| Clinical importance  and evidence |  |
| *Guideline recommendations* | It is NCQA policy to use guidelines which are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency. This measure of utilization is not based on clinical guidelines. The results should be used by plans in conjunction with other use of service data and clinical quality of care data to evaluate trends in patient care settings. Year to year trends and risk-adjusted comparisons between plans should be evaluated rather than a cross-sectional observed rate. |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

|  |  |
| --- | --- |
| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure. In general, claims and encounter data required for this measure should be available to health plans. |
| Auditable | This measure has been reviewed by NCQA’s internal HEDIS Measure Validation staff and found to be auditable. |

## Hospitalization for Potentially Preventable Complications (HPC)

Description

For members 67 years of age and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.

Background

Development of Ambulatory Care Sensitive Conditions

ACSC were originally designed to evaluate the potential impact of differences in socioeconomic status and resources on hospitalization rates. An early study by Billings et al. (1993) aimed to improve understanding of the causes of any variation in hospital use and evaluating the effectiveness of programs designed to improve access to care. The team used a modified Delphi approach to define three basic categories for grouping all causes of hospital admission:

1. Conditions for which the provision of timely and effective outpatient care is likely to have *little* impact on the need for hospital admission.
2. Conditions for which timely and effective outpatient care can help to reduce the risks of hospitalization by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease or condition.
3. Referral-sensitive surgeries, defined as high-cost/high-technology surgical procedures for which impediments to access or referral to specialty care may reduce the chances of having the surgery.

Analysis focused on the rates of hospitalization among adults under 65 years of age for conditions the panel identified as being potentially responsive to timely and effective outpatient management.They found adults in low-income areas had substantially higher admission rates for ACSC than those in high-income areas. The authors suggested that adults in low income areas are more likely to be affected by access problems, given higher rates of the uninsured and less experience in navigating the complexities of the fragmented health care delivery system. This lack of adequate access to ambulatory care and potentially low performance of outpatient care delivery systems was partially responsible for the higher rates of hospitalization for ACSC.

Other factors contributing to hospitalization included disease prevalence, patient lifestyle (alcohol/substance abuse), and possible differences in physician decision making (Billings 1993). Since this early study, many more studies have examined the effect of income, insurance and access on ACSC hospitalization and many more diagnoses have been classified in various research studies as potentially ACSC hospitalizations.Across studies the list of potentially ACSC now includes more than 100 conditions.

Research on ACSC in Medicare Populations:

We identified two studies that looked at hospitalization for ACSC in the Medicare population.In 2001 McCall et al. evaluated the feasibility of measuring hospitalization for ACSC for Medicare + Choice programs (now called Medicare Advantage). The authors suggested information about ACSC hospitalization could be used by health plans to evaluate their providers’ processes of care, and to develop case management strategies to reduce rates of ACSC hospitalizations. ACSCs can also be used as identifying events to improve the adequacy of primary care for potentially vulnerable populations. To meet this focus, Health Care Financing Administration (HCFA) had each condition reviewed by two clinical consultants to ensure that selected ACSCs were appropriate for the elderly population, because the original set had been developed as a measure of access to care for the nonelderly population.

ACSCs selected for the study included chronic asthma/chronic obstructive pulmonary disease (COPD), congestive heart failure, seizure disorder, diabetes and hypertension; acute hypoglycemia, urinary tract infections, cellulitis, dehydration, hypokalemia, gastric and duodenal ulcer, bacterial pneumonia and severe ear/nose/throat infections; and preventable influenza and malnutrition.The study found that the oldest population (85 and older) experience statistically significant higher rates of ACSC admissions and are more likely to die during an ACSC admission than younger Medicare beneficiaries.

The study also found lower overall rates of hospitalization in the MC population than in the Medicare FFS population. On average, MC adjusted hospitalization rates were about one-third lower than comparable FFS rates. The rates of hospital discharges for MC in comparison to FFS may be explained by better management of patient conditions, utilization controls or healthier MA enrollees. Ultimately, the study found the measurement of ACSC in the MC population to be feasible, however they suggested further studies may want to limit the scope of conditions to the most frequently occurring in the Medicare population, e.g., congestive heart failure, pneumonia, and asthma/COPD as many of the other conditions evaluated in this study did not occur with enough frequency to produce statistically reliable estimates at the MA organization level for the majority of MA organizations (McCall 2001).

In 2004, CMS contracted with RTI to explored trends in hospitalization for ACSC among a sample of Medicare FFS beneficiaries.Specifically they were interested in a set of ACSC that had previously been shown to be increasing in the Medicare population. Using a comprehensive literature review and expert review process they narrowed a list of 48 possible acute and chronic ACSC down to eleven conditions selected for inclusion in analysis (cellulitis, asthma, COPD, CHF, dehydration, pneumonia, septicemia, stroke, UTI, acute diabetic events, lower limb PVD).During the study period (1998–2001), all-cause hospitalization rates increased by 6 percent in the Medicare FFS population.

Multivariate modeling of the trend in ACSC hospitalizations from 1993–2000 showed that changes in socio-demographic characteristics and health status among elderly Medicare FFS beneficiaries explained a substantial proportion of the observed positive trend in ACSC hospitalization rates for CHF, COPD and PVD among Medicare beneficiaries. Although having a usual source of care or having supplemental health insurance, including prescription drug coverage, did not appreciably reduce the likelihood of an ACSC hospitalization in the Medicare population, poverty appeared to have the strongest relationship to the rate of ACSC hospitalization (McCall 2004).

The authors concluded that because rates of ACSC hospitalization are strongly influenced by the health status of the Medicare population, interventions employed to reduce hospitalization for ACSCs may have to be tailored to the specific underlying condition to be effective. Prior-year hospitalization for ACSCs appeared to be a strong proxy for severity of disease; therefore, the authors suggested that targeting hospitalized Medicare beneficiaries, or those who have been hospitalized in the prior year, for disease management programs may be a reasonable strategy to reduce future hospitalizations.

The authors concluded that further exploration is necessary to understand contributing factors to ACSC hospitalization that may be beyond the control of the health plan or provider, such as population aging or onset of new comorbid conditions (McCall 2004).

Development of Prevention Quality Indicators:

In 2001, AHRQ’s Evidence-Based Practice Center (EPC) at the University of California San Francisco (UCSF) and Stanford University developed the Prevention Quality Indicators (PQI) based on the original Healthcare Cost and Utilization Project (HCUP) quality indicators developed in the early 1990s (Davies 2001). They reviewed evidence on ACSC and used a multi-stakeholder review process of three questions to assess face validity of the indicators:

1. Have clinical trials demonstrated that specific outpatient therapies can reduce the risk of hospitalization?
2. Have observational studies shown associations between specific outpatient therapies and the risk of hospitalization?
3. Is there general consensus that hospitalizations for these conditions are often avoidable or preventable, if the patient has timely access to high-quality outpatient care?

They selected 16 ASCSs to be used as area-level quality indicators (dehydration, bacterial pneumonia, UTI, perforated appendix, angina, asthma, COPD, CHF, diabetes short-term complications, uncontrolled diabetes, diabetes long-term complications, lower extremity amputation in diabetics, hypertension, low birth weight, pediatric asthma, pediatric gastroenteritis).

In general, the AHRQ, UCSF and Stanford research team (“the AHRQ team”) found little published evidence for individual indicators, presumably due to the common usage of indicators within sets.Most studies examined sets of ACSC conditions without providing data stratified by indicator. The AHRQ team found that condition prevalence, race and socioeconomic status were independent predictors of the rate of hospitalization for ACSC in the general population. At the individual condition level, self-reported health status, functional limitations, several chronic diseases and a chronic disease risk score are associated with preventable hospitalizations among Medicare beneficiaries. Income was found to be a much less powerful predictor of hospitalization for chronic ACSC among Medicare beneficiaries, after adjusting for health factors (Davies 2001).

Although many studies have been published about the association between access to care and ACSC hospitalization, AHRQ found few that tested true measures of access to care as opposed to socioeconomic status. One study that used survey day from the Medicare Current Beneficiaries Survey (MCBS) is described above (McCall 2004). Bindman and colleagues found that patient-reported “difficulty in receiving medical care when needed” explained 50 percent of the variability in hospitalization rates for five chronic medical conditions. Having a regular source of care, and a higher primary care physician/population ratio, were also independently associated with avoidable hospitalization rates (Bindman 1995).

Other studies have shown that the physician-to-population ratio for family and general physicians is more associated with avoidable hospitalization rates than measures that include internists, pediatricians or all physicians. Beneficiaries in fair or poor health are at increased risk if they live in an area with a shortage of primary care. Relationships between access indicators (e.g., patient-reported access, having a regular source of care and the primary care physician-to-population ratio) and hospitalization for ACSC did not hold in two separate studies of rural zip codes, suggesting that avoidable hospitalization rates are invalid indicators of access in rural areas.

Almost all of the chronic ACSCs have practice guidelines associated with them, and several of the acute conditions have guidelines. Studies have shown that access to ambulatory care and adherence to evidence-based treatment guidelines can reduce patient complication rates of existing disease, many of which result in hospitalization.Since many hospital admission rates for ACSC are correlated, it is likely there is a common underlying factor influencing many of these rates (AHRQ 2007). For specific evidence on each PQI, refer to the AHRQ Guide to Prevention Quality Indicators: <http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V31/pqi_guide_v31.pdf>

Expanding the Use of PQI for Performance Measurement:

Recently, AHRQ convened a multi-stakeholder panel of experts to review the evidence for all AHRQ PQIs and to assess the appropriateness of using the PQI for quality improvement, public reporting and pay-for-performance (Davies 2009). This group used a Delphi and Nominal Panel method for soliciting feedback from panel members on the face validity of the PQI for different settings and uses. Overall, the panelists rated most indicators as appropriate for many settings and use.

The table below summarizes the panel recommendations regarding the use of the indicators for comparative reporting and pay-for-performance at the payer level. The panel also made recommendations for the provider, area and long-term care settings, which are not listed below. The lowest rated indicators were perforated appendix, dehydration, bacterial pneumonia, UTI and angina. Panel members had “major concerns regarding use” for these measures in either pay-for-performance or comparative reporting at the payer level.

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| **Indicators** | **Comparative Reporting** | **Pay for Performance** |
| COPD | ⧫⧫ | ⧫⧫+ |
| Asthma (<39) | ⧫⧫+ | ⧫⧫+ |
| Hypertension | ⧫⧫+ | ⧫⧫ |
| Angina | ⧫⧫ | ⧫+ |
| CHF | ⧫⧫+ | ⧫⧫ |
| Perforated Appendix | ⧫+ | ⧫+ |
| Diabetes Short-Term Complications | ⧫⧫+ | ⧫⧫ |
| Diabetes Long-Term Complications | ⧫⧫ | ⧫⧫ |
| Lower Extremity Amputation in Diabetes | ⧫⧫+ | ⧫⧫ |
| Bacterial Pneumonia | ⧫⧫ | ⧫ |
| UTI | ⧫⧫ | ⧫+ |
| Dehydration | ⧫+ | ⧫ |

⧫ Major concern regarding use

⧫⧫ Some concern

+One of the two panels reported a higher level of support for the measure than shown

Below we summarize the qualitative recommendations of the panelists regarding each conditions and pathway for payers and providers to influence hospitalization (Davies 2009).

* **Diabetes Related Indicators:** Payer and provider organizations may be able to reduce hospitalization for diabetes (short-term complications, long-term complications and uncontrolled diabetes) by enhancing coverage for medication supplied for blood glucose monitoring and care coordination for diabetes patients. Ongoing patient education and promotion of self-management might also reduce rates of hospitalization for diabetes.
* **Perforated Appendix:** Panelists did not feel this indicator reflected high-quality outpatient care because most appendicitis patients present directly to the ER. The panelists felt that time to presentation, the highest predictor of appendicitis, was not in the health system’s control. They also expressed concerns that older adults tend to present atypical symptoms of appendicitis and therefore may be more difficult to diagnosis.
* **COPD and Asthma:** Panelists cited several mechanisms health systems could use to reduce hospitalization for COPD and asthma, including increase reimbursement for smoking cessation programs, medication, access to pulmonary rehabilitation and oxygen therapy, patient education and improved care coordination. Panelists also expressed concern that this rate may reflect a level of “social hospitalization” for situations where the provider feels the support in the home environment is insufficient for recovery.
* **Hypertension:** Payer and provider organizations may be able to reduce hypertension-related hospitalizations through enhanced coverage of preventive primary care visits, patient education and antihypertensive medication. Improved rates of blood pressure screening may also reduce rates of hospitalization.
* **Congestive Heart Failure:** Similar to the other chronic conditions, panelists cited enhanced coverage of medications, access to primary care and patient education as the main mechanisms for plans to use to mitigate hospitalization for CHF. They also suggested outreach to at-risk patients through teleconferencing and home visits had the potential to significantly reduce hospitalization.
* **Dehydration:** In general panelists expressed concern about the state of evidence linking payer and provider organization intervention to reduction of admission for dehydration. They cited that many older adults do not present in a timely manner to the outpatient setting and patients are rarely sent home from ambulatory care with hypovolemia.
* **Bacterial Pneumonia:** Panelists agreed that payers could influence hospitalization for bacterial pneumonia by ensuring access to immunizations and antibiotics, although they were uncertain about the degree to which increased access could reduce hospitalization in particularly high-risk populations.
* **Urinary Tract Infection:** Some panelists expressed concern about the lack of evidence directly linking care in the outpatient setting to hospitalization for UTI. Others suggested that enhanced coverage of antibiotics and careful attention to inappropriate use of Foley/suprapubic catheters could impact rates of hospitalization.
* **Angina Without Cardiac Procedure:** Panelists were divided about how much payers and providers could influence hospitalization for angina. Payers may promote education and lifestyle change (smoking cessation, self-care, regular primary care visits), but panelists did not express confidence that such interventions would reduce the rate of hospitalization. Panelists expressed concern that many individuals with angina are directed to the ER, where thresholds for admission for chest pain are low due to the fear of possible legal action.
* **Lower Extremity Amputation:** Minor problems in the lower extremities can be treated in outpatient care, limiting the progression of the disease. Payer organizations may be able to enhance coverage of medication and supplies for diabetes self-management, and promote care coordination.There was a concern that patient factors such as diet, income and geographic limitations may limit the health care system’s control on admission rates.

Relevance

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| Health importance | | In 2011, approximately 3 out of every 10 Medicare beneficiaries were admitted to the hospital (DHHS 2013). Hospitalization also poses several risks for older adults, who frequently develop serious conditions as a result of hospitalization such as delirium, infection and decline in functional ability (Gillick 1982; Covinsky 2011). Reducing the rate of hospitalization for older adults will improve patient health, reduce costs and improve quality of life. A number of studies have suggested that certain hospitalizations can be prevented by optimal outpatient care for certain conditions, called “ambulatory care sensitive conditions” (ACSC). |
| Financial importance | | Hospital and inpatient care is the largest component of total health care costs for older adults (26 percent of Medicare spending, approximately $140 billion dollars annually) (KFF 2012). |
| Potential for improvement | Composites were designed to assess quality of care for ACSCs. Not all complications that result in hospitalizations are preventable; therefore, the goal of this measure is not to obtain a rate of no (zero) hospitalizations; rather, the measures reflect on the community health care system’s success at chronic disease management and outpatient care for acute conditions. Composites can act as “indicators” to help flag potential health care quality problems in chronic disease management and acute care. | |

Scientific Soundness

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| Clinical importance  and evidence |  |
| *Guideline recommendations* | It is NCQA policy to use guidelines that are evidence based, that apply to physicians and other health care providers and that are developed by a national specialty organization or government agency. This measure of utilization is not based on clinical guidelines; however, appropriate treatment plans for these conditions are supported by clinical guidelines. Results should be used by plans in conjunction with other use-of-services data and clinical quality-of-care data to evaluate trends in patient care settings. Year-to-year trends and risk-adjusted comparison among plans should be evaluated, rather than a cross-sectional observed rate of hospitalization. |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

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| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure. In general, claims and encounter data required for this measure should be available to health plans. |
| Auditable | This measure has been reviewed by NCQA’s internal HEDIS Audit and Measure certification staff and found to be auditable. |

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***Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)***

Description

The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who have a PHQ-9 or PHQ-A tool administered at least once during a four-month period. Two rates are reported.

1. **Inclusion in ECDS Rate.** The percentage of members 12 and older with a diagnosis of major depression or dysthymia, who are included in an electronic clinical data system (ECDS).
2. **Utilization of PHQ-9 Rate.** The percentage of PHQ utilization. Members with a diagnosis of major depression or dysthymia who are covered by an ECDS and, if they had an outpatient encounter, have *either* a PHQ-9 or a PHQ-A score present in their record.

Background

Depression—an overwhelming feeling of sadness and hopelessness that can last for months or years—can make people feel that life is no longer worth living. People affected by depression lose interest in activities they used to enjoy and can also be affected by physical symptoms that interfere with their ability to participate in normal daily activities. For adolescents, depression can also have a major impact, disrupting daily life at home, school or in the community.

Depressive disorders are common mental disorders that occur in people of all ages. Major depressive disorder (MDD) is a leading cause of disability worldwide, affecting an estimated 120 million people (Murray et al., 2013). The lifelong prevalence is estimated to range from 10 percent–15 percent (Lepine and Briley, 2011). In the United States, 15.7 percent of people report that at some point in their lifetime they were told by a health care professional that they had depression (CDC, 2009).

Depression has long been recognized as a major contributor to disease burden (Murray et al., 1997; Üstün et al., 2004). The Global Burden of Disease study of 2010 identified depression as a leading cause of disease burden in the world. Depressive disorders were the second largest contributor to years lived with disability, an indicator of the impact of disease burden (Ferrari et al., 2013). This accounts for an estimated 10 percent of Years Lived with Disability worldwide, which is three times the impact of diabetes, eight times the impact of heart disease, and forty times the impact of cancer (Murray et al., 2013). These findings underscore the need for attention to depressive disorders and the implementation of effective interventions to reduce their disease burden.

Relevance

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| Health importance | Depression is associated with other chronic medical conditions and increased morbidity and mortality. The mortality risk for suicide in depressed patients is more than 20-fold greater than in the general population (Bostwick and Pankratz, 2000). In terms of other chronic conditions, depression is associated with a 60 percent increased risk of type 2 diabetes (Mezuk et al., 2008), and has been identified as a risk factor for development of cardiovascular disease (Van de Kooy et al., 2007). In addition, depression adversely affects the course, complications and management of other chronic medical illnesses (Katon, 2011). In adolescents, depression can also result in serious long-term morbidities such as generalized anxiety disorder and panic disorder or lead to engagement in risky behaviors such as substance use (Taylor et al., 1996; Foley et al., 1996; Friedman et al., 1996; National Research Council and Institute of Medicine., 2009). Adolescent-onset depression increases the risk of attempted suicide by five-fold in comparison to non-depressed adolescents (Garber, 2009). Most adolescents who commit suicide, the third leading cause of death among 15–24 year olds, have a previous history of depression (Williams et al., 2009; National Research Council and Institute of Medicine, 2009). |

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| Financial importance | Depression has large effects on both health care costs and lost productivity. Adolescents with depression have higher medical expenditures, including those related to general and mental health care, than adolescents without a depression diagnosis (O’Connor et al., 2009). Older adults with depression or depressive symptoms have significantly higher health care costs even after adjusting for chronic medical conditions (Katon et al., 2003).  For working-age adults, a recent study showed a relationship between the severity of depression symptoms and work function and found that for every 1-point increase in PHQ-9 score (a measure of depression severity), patients experienced an additional mean productivity loss of 1.65 percent. Even minor levels of depression symptoms were associated with decreases in work function (Beck et al., 2011). In a survey study, Birnbaum et al. (2011) found that major depressive disorder severity is significantly associated with increased treatment usage and costs, unemployment, disability and reduced work performance. When the results of the study were projected to the U.S. workforce, it was estimated that monthly depression-related worker productivity losses had human capital costs of nearly $2 billion. |
| Potential for improvement | There are significant quality concerns along the continuum of depression care (Katon and Guico-Pabia, 2011): under-treatment (Kessler et al., 2003), inappropriate treatment (Mojtabai and Olfson, 2011), and lack of follow-up and monitoring (Katon and Seelig, 2008).  Quality gaps are more pronounced among ethnic and racial minorities (Gonzalez et al., 2010) and individuals with multiple chronic conditions (Katon et al., 2004). In a large representative survey study, only one-third of those with depression reported receiving mental health services in a given year and only about half had any type of health service use (Wang et al., 2005).  Numerous studies have demonstrated the effectiveness of screening and treatment for depression. Recent literature has focused on the care processes needed to treat and manage depression in primary care settings, where the majority of depression cases first present. Studies have found that patient outcomes improve when there is collaboration between a primary care doctor, case manager and a mental health specialist to screen for depression, monitor symptoms, provide treatment and refer to specialty care as needed (Von Korff and Goldberg, 2001; Gilbody et al., 2006; Thota et al., 2012). |

Scientific Soundness

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| Clinical importance  and evidence |  |
| *Guideline recommendations* | Screening and follow-up: Screening for depression in adults when staff-assisted depression care supports are in place received a Grade B recommendation from the U.S. Preventive Services Task Force (USPSTF, 2009). The National Institute for Health and Clinical Excellence (NICE) guidelines recommend universal screening of adolescents 12–18 for depression in primary care settings (NICE, 2005).  Limited available data suggest that screening tools, feasible for use in the primary care setting, can accurately identify depressed individuals and treatment can improve depression outcomes (O’Connor et al., 2009; Williams et al., 2009). The use of a standardized screening tool may help to reduce misdiagnosis, which one study suggests occurs in up to 60 percent of patients diagnosed with major depressive disorder (Mojtabai, 2013).  In its review, the USPSTF found little evidence to support recommending one screening tool over another to identify depressed individuals accurately. Research has demonstrated that many brief self-administered tools are valid and reliable for identifying possible depression cases (Martin et al., 2006; Williams et al., 2002). Once a positive screen is identified, follow-up is necessary and may include further evaluation to determine or rule out a diagnosis, provide education or interventions or refer treatment with another provider.  Monitoring depressive symptoms: The use of standardized tools is essential for tracking depressive symptoms and monitoring patient response to treatment. Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines recommend that providers establish and maintain regular follow‐up with patients diagnosed with depression and use a standardized tool to track symptoms (Mitchel et al., 2013).  Meta-analyses of studies in adults indicate that formally monitoring patient progress improves patient outcomes (Lambert et al., 2003; Shimokawa et al., 2010; Knaup., 2009). For adolescents, the Guideline for Adolescent Depression in Primary Care (GLAD-PC) recommends systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms and function, monitoring for adverse events during antidepressant treatment and reassessing diagnosis and treatment if no improvement is noted after 6–8 weeks (Cheung et al., 2007). One study found that youths with a range of symptoms improve more quickly when clinicians receive feedback from assessments every other week instead of every 3 months (Bickman et al., 2011).  Existing “gold standard” instruments, such as the Hamilton Depression Rating Scale, can be time consuming and require a specially trained interviewer. The brief PHQ-9 questionnaire (© 2005 Pfizer) can be self-administered by the patient and has been validated for measuring depression severity and treatment response (Kroenke et al., 2001).  The tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criterion symptoms and effects on functioning, and has been shown to be highly accurate in discriminating patients with persistent major depression, partial remission and full remission (Gilbody et al., 2007; Lowe et al., 2004; Martin et al., 2006).  Benefits of the PHQ-9 tool are numerous: it is non-proprietary and widely accepted by primary care providers and in general medical settings, it can be completed by the patient in-person or over the telephone, it is translated into many languages and it is easy for the patient to complete and the provider to score. Widespread use of the PHQ-9, within a collaborative care model, would allow organizations to systematically assess their effectiveness in helping individuals to experience remission of depressive symptoms with appropriate treatment.  Interventions and treatment models to improve depression outcomes: There are a number of effective treatment options available for depressive disorders, including antidepressant medications and psychotherapies. Guidelines recommend cognitive behavioral therapy and interpersonal therapy as first-line psychotherapy treatments for depression and selective serotonin reuptake inhibitors (SSRI) as first-line pharmacotherapy (APA, 2010; National Collaborating Centre for Mental Health, 2009).  Clinical guidelines also recommend a stepped-care approach to depression treatment, beginning with the least-intrusive intervention and stepping up to more intensive care if the patient does not respond to or benefit from the first intervention (National Collaborating Centre for Mental Health, 2009; Mitchell et al., 2013).  For mild and moderate depression, psychotherapy alone may be the preferred initial treatment, to be followed by the use of medication if symptoms persist (APA, 2010). This stepped-care approach includes providing assessment, support, psycho-education and monitoring of symptoms as a first step, followed by psychosocial, psychological and pharmacologic interventions, and then combined treatments for those with inadequate response. High-intensity interventions, crisis and inpatient care are only used in severe cases.  For adolescents, the USPSTF found adequate evidence that treatment with SSRIs, psychotherapy and combined therapy (SSRIs and psychotherapy) results in decreases of major depressive disorder symptoms. This conclusion was based on a systematic review that revealed several fair- or good-quality randomized controlled trials (RCT) (USPSTF, 2009).  There are challenges to delivering guideline-recommended care in nonmental health settings such as primary care, where providers may not be as knowledgeable about depression management and there are competing demands of other medical issues (Nutting et al., 2002; Rost et al., 2000). Numerous studies have shown that a collaborative care model can address these challenges and demonstrate effectiveness for managing depression in primary care settings (Gilbody et al., 2006; Katon et al., 2008; Katon and Guico-Pabia, 2011).  A recent RCT demonstrated effectiveness of the collaborative care model for adolescent depression, as well (Richardson et al., 2014). The model includes primary care providers using evidence-based approaches to depression care and a standardized tool for measuring severity of symptoms, response to treatment plan and remission. Key concepts of this approach are:   * Care management by a nonphysician working with the primary care physician. * Planned collaborative care between physicians and mental health clinicians. * Education and support of patients for self-management. * Attention to patient preferences.   Patients are tracked and reminded of visits with their primary care physician and monitored for treatment adherence and effectiveness. A care manager is typically used to make frequent contacts with patients, often by telephone, to provide education and self-management support and to monitor for response to treatment. If the patient does not respond to a treatment, other treatment options are explored and delivered (Solberg, 2005).  This model has demonstrated improvement in treatment adherence, patient quality of life and depression outcomes. Preliminary evidence suggests the collaborative care model is also effective for depression during pregnancy and postpartum (Gjerdingen et al., 2008) and in treating late-life depression (Unutzer et al., 2002; Hunkeler et al., 2006). |
| Validity | This measure has detailed, precise specifications that clearly define the numerator, denominator, data sources, allowable values, methods of measurement and method of reporting. |

Feasibility

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| Logistically feasible | Feedback from plans and NCQA panels support the logistic feasibility of this measure for some health plans. In general, claims and encounter data required for this measure should be available to health plans. Clinical data required for this measure will be available to some plans who have systems in place to receive or generate electronic clinical data for their members. |
| Auditable | This measure is not part of NCQA’s Measure Certification or Audit programs for HEDIS 2016. |

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Appendix 3

Practitioner Types

**APPENDIX 3**

**PRACTITIONER TYPES**

|  |  |
| --- | --- |
| clinical pharmacist | A pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications.  Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority. |
| dental practitioner | A practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.  Certified and licensed dental hygienists are considered dental practitioners. |
| mental health practitioner | A practitioner who provides mental health services and meets any of the following criteria:   * An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. * An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. * An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker’s Clinical Register; or who has a master’s degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. * A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master’s degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. * An individual (normally with a master’s or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy. |

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

Appendix 4

Data Element Definitions

**APPENDIX 4**

**DATA ELEMENT DEFINITIONS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Admin | Hybrid | Research | Meaning |
| Measurement year | ✓ | ✓ |  | Data year (i.e., year prior to reporting year). For HEDIS 2016, the measurement year is 2015. |
| Data collection methodology (Administrative or Hybrid) | ✓ | ✓ |  | Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample. |
| Eligible population | ✓ | ✓ |  | * Members who meet all criteria for the population. This is the universe of members for each measure. * For administrativemeasures, the eligible population is reported after evaluation for optional exclusion criteria and after required exclusions are applied. * For hybrid measures, the eligible population of members is reported prior to optional exclusions and after required exclusions are applied (see *Guidelines for Calculations and Sampling* for the three approaches to conducting the Hybrid Method). |
| Number of optional exclusions | ✓ |  |  | Number of members excluded from the eligible population because they did not meet the numerator criteria and did meet the optional exclusion criteria. |
| Number of required exclusions | ✓ |  |  | Number of members excluded from the eligible population because they did meet the required exclusion criteria. |
| Number of numerator events by administrative data in eligible population (before exclusions) |  | ✓ |  | The number of members in the eligible population who met the numerator criteria. |
| Current year’s administrative rate (before exclusions) |  | ✓ |  | This is a calculated field in IDSS.  Numerator events by administrative data in eligible population ÷ eligible population. |
| Minimum required sample size (MRSS) or other sample size |  | ✓ |  | When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines. |
| Oversampling rate |  | ✓ |  | The percentage of additional records needed to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA. |
| Final sample size (FSS) |  | ✓ |  | Minimum required sample size + oversample. |
| Number of numerator events by administrative data in FSS |  | ✓ |  | Number of members in the final sample size who meet numerator criteria through system/ transactional data. |
| Administrative rate on FSS |  | ✓ |  | This is a calculated field in IDSS.  Numerator events by administrative data in the FSS ÷ FSS. |
| Number of original sample records excluded because of valid data errors |  | ✓ |  | If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error. |

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

**\***Data element is optional.

Standard Administrative Data Element Table

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

Standard Hybrid Data Element Table

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

Appendix 5

Contributors

**APPENDIX 5**

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Appendix 6

Alphabetized List of   
HEDIS Measures

**APPENDIX 6**

**ALPHABETIZED LIST OF HEDIS MEASURES**

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Appendix 7

Logical Measure Groups

APPENDIX 7

LOGICAL MEASURE GROUPS

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EFFECTIVENESS OF CARE MEASURES | | | | | | | | | | | | | | | | | |
| Logical Group | ABA | WCC | CIS | IMA | HPV | LSC | BCS | CCS | COL | CHL | COA | CWP | SPR | PCE | MMA | AMR | CBP |
| Commercial | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare1 | ✓ |  |  |  |  |  | ✓ |  | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicaid | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Claims-based denominator | ✓ | ✓ |  |  |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Membership-based denominator |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |  |  |  |  |  |
| Pharmacy benefit |  |  |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  |
| MH or CD benefit |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Live birth methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Practitioner type requirement |  | ✓ |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |
| Risk adjustment methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lab data |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  | ✓ |  |  |  |  |  |
| Radiology data |  |  |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |
| MH or CD data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pharmacy data |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ |
| Vision data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Optional exclusions | ✓ | ✓ | ✓ | ✓ | ✓ | ✓2 | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  |  | ✓ |
| Required exclusions |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ |  |
| CE pre-MY | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ |  | ✓ | ✓ |  |
| Anchor date | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| MY + 1 year claims data | ✓ |  | ✓ |  |  | ✓ | ✓ |  |  |  |  | ✓ |  |  | ✓ | ✓ | ✓ |
| At least MY + 2 years claims data |  |  |  | ✓ | ✓ |  |  | ✓ | ✓ |  |  |  | ✓ |  |  |  | ✓3 |
| Hybrid | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |  | ✓ |  |  |  |  |  | ✓ |
| Inpatient claims data |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |

1For the required measures list, refer to the annual CMS Reporting Requirements memo.

2 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.

3 Applies to the Optional Exclusion criteria.

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| EFFECTIVENESS OF CARE MEASURES | | | | | | | | | | | | | | | | | |
| Logical Group | ABA | WCC | CIS | IMA | HPV | LSC | BCS | CCS | COL | CHL | COA | CWP | SPR | PCE | **MMA** | **AMR** | **CBP** |
| V codes | ✓ | ✓ | ✓ |  |  |  |  | ✓ | ✓ | ✓ |  |  |  |  |  |  | ✓ |
| Rev codes | ✓ | ✓ |  |  |  |  | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| POS codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| TOB codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| DRGs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HCPCS codes | ✓ | ✓ | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| J codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LOINC codes |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  | ✓ |  |  |  |  |  |
| CPT II codes |  |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |
| SNOMED CT codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Principal diagnosis |  |  |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  |
| Survey measure |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| EFFECTIVENESS OF CARE MEASURES | | | | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | PBH | SPC | CDC | SPD | ART | OMW | AMM | ADD | FUH | SSD | SMD | SMC | SAA | APM | MPM | MRP | NCS | PSA | URI | AABV | LBP | APC | DDE | DAE |
| Commercial | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |  |  | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ |  |  |
| Medicare1 | ✓ | ✓ | ✓2 | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |  |  |  |  | ✓ | ✓ |  | ✓ |  |  |  |  | ✓ | ✓ |
| Medicaid | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ |  |  |
| Claims-based denominator | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |
| Membership-based denominator |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| Pharmacy benefit | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |  | ✓ | ✓ | ✓ |  |  |  | ✓ | ✓ |  | ✓ | ✓ | ✓ |
| MH or CD benefit |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Live birth methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Practitioner type requirement |  |  | ✓ |  |  |  |  | ✓ | ✓ |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |
| Risk adjustment methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lab data |  |  | ✓ |  |  |  |  |  |  | ✓ | ✓ | ✓ |  | ✓ | ✓ |  | ✓ | ✓ |  |  |  |  |  |  |
| Radiology data |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |
| MH or CD data |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |
| Pharmacy data | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |
| Vision data |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Optional exclusions | ✓ |  | ✓ |  | ✓ |  |  | ✓ |  |  | ✓ |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |
| Required exclusions |  | ✓ | ✓ | ✓ |  | ✓ | ✓ |  |  | ✓ |  |  | ✓ |  |  |  | ✓ | ✓ |  |  | ✓ |  | ✓ |  |

1For the required measures list, refer to the annual CMS Reporting Requirements memo.

2The HbA1c control (<7.0%) for a selected population indicator is only reported for the commercial and Medicaid product lines.

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| EFFECTIVENESS OF CARE MEASURES | | | | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | PBH | SPC | CDC | SPD | ART | OMW | AMM | ADD | FUH | SSD | SMD | SMC | SAA | APM | MPM | MRP | NCS | PSA | URI | AAB | LBP | APC | DDE | DAE |
| CE pre-MY | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ |  |  |  | ✓ |  |  |  |  |  |  | ✓ | ✓ | ✓ |  | ✓ |  |
| Anchor date | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| MY + 1 year claims data | ✓ | ✓ |  | ✓ |  |  | ✓ |  |  | ✓ | ✓1 | ✓ |  |  |  |  |  |  | ✓ | ✓ | ✓ |  | ✓ |  |
| At least MY + 2 years claims data |  |  | ✓ |  |  | ✓ |  | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |
| Hybrid |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |
| Inpatient claims data | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ |  |  |  |  |  |  | ✓ |  |
| V codes |  |  | ✓ |  | ✓ |  |  |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  | ✓ |  |
| Rev codes |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  | ✓ |  |
| POS codes |  | ✓ | ✓ | ✓ |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |
| TOB codes |  | ✓ | ✓ | ✓ |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  |
| DRGs |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HCPCS codes |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  |
| J codes |  |  |  |  | ✓ | ✓ |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |
| LOINC codes |  |  | ✓ |  |  |  |  |  |  | ✓ | ✓ | ✓ |  | ✓ | ✓ |  | ✓ | ✓ |  |  |  |  |  |  |
| CPT II codes |  |  | ✓ |  |  |  |  |  |  |  | ✓ | ✓ |  | ✓ |  | ✓ |  |  |  |  |  |  |  |  |
| SNOMED CT codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Principal diagnosis |  |  |  |  |  |  |  | ✓ | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ |  |  |  |
| Survey measure |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1Applies to the Optional Exclusion criteria.

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| ACCESS/AVAILABILITY OF CARE, UTILIZATION AND RISK ADJUSTED UTILIZATION, AND RELATIVE RESOURCE USE MEASURES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | AAP | CAP | ADV | IET | PPC | CAT | APP | FPC | W15 | W34 | AWC | FSP | AMB | IPU | IAD | MPT | ABX | PCR | IHU | EDU | HPC | RDI | RAS | RCA | RHY | RCO |
| Commercial | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare1 | ✓ |  |  | ✓ |  | ✓ |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |
| Medicaid | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Claims based denominator |  |  |  | ✓ | ✓ |  | ✓ | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Membership-based denominator | ✓ | ✓ | ✓ |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |  |  |  |
| Pharmacy benefit |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  |  | ✓ |  |  |  |
| MH or CD benefit |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  | ✓ | ✓ |  |  |  |  |  |  |  |  |  |  |
| Live birth methodology |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Practitioner type requirement |  | ✓ | ✓ |  | ✓ |  |  | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Risk adjustment methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Lab data |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Radiology data |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| MH or CD data |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ |  |  |  |  |  |  |
| Pharmacy data |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Vision data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Optional exclusions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  |  | ✓ |  |

1For the required measures list, refer to the annual CMS Reporting Requirements memo.

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| ACCESS/AVAILABILITY OF CARE, UTILIZATION AND RISK ADJUSTED UTILIZATION, AND RELATIVE RESOURCE USE MEASURES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | AAP | CAP | ADV | IET | PPC | CAT | APP | FPC | W15 | W34 | AWC | FSP | AMB | IPU | IAD | MPT | ABX | PCR | IHU | EDU | HPC | RDI | RAS | RCA | RHY | RCO |
| Required exclusions |  |  |  |  |  |  | ✓ |  |  |  |  |  | ✓ |  |  |  |  | ✓ |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| CE pre-MY | ✓ | ✓ |  | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |  |  |
| Anchor date | ✓ | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| MY + 1 year claims data |  | ✓ |  | ✓ | ✓ |  | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ |  | ✓ |
| At least MY + 2 years claims data | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ |  |
| Hybrid |  |  |  |  | ✓ |  |  | ✓ | ✓1 | ✓1 | ✓1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Inpatient claims data |  |  |  | ✓ | ✓ |  | ✓ | ✓ |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| V codes | ✓ | ✓ |  |  | ✓ |  |  | ✓ | ✓ | ✓ | ✓ |  |  | ✓ |  |  |  | ✓ |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| Rev codes | ✓ |  |  | ✓ | ✓ |  |  | ✓ |  |  |  |  | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

1Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.

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| ACCESS/AVAILABILITY OF CARE, UTILIZATION AND RISK ADJUSTED UTILIZATION, AND RELATIVE RESOURCE USE MEASURES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | AAP | CAP | ADV | IET | PPC | CAT | APP | FPC | W15 | W34 | AWC | FSP | AMB | IPU | IAD | MPT | ABX | PCR | IHU | EDU | HPC | RDI | RAS | RCA | RHY | RCO |
| POS codes |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  | ✓ |  | ✓ | ✓ |  |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ |
| TOB codes |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| DRGs |  |  |  |  |  |  |  |  |  |  |  | ✓ |  | ✓ | ✓ | ✓ |  |  | ✓ |  |  |  |  |  |  |  |
| HCPCS codes | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| J codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LOINC codes |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CPT II codes |  |  |  |  | ✓ |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SNOMED CT codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Principal diagnosis |  |  |  |  |  |  |  |  |  |  |  |  | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ |  |  | ✓ |  |  |  |
| Survey measure |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **HEALTH PLAN DESCRIPTIVE INFORMATION, MEASURES COLLECTED USING ELECTRONIC CLINICAL DATA SYSTEMS  AND SURVEY MEASURES** | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | BCR | ENP | EBS | LDM | RDM | WOP | TLM | DMS | HOS | FRM | MUI | OTO | PAO | ASP | FVA | FVO | MSC | PNU | CPA | CPC | CCC |
| Commercial | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |  |  |  |  |  | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ |
| Medicare1 | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  | ✓ | ✓ | ✓ |  |  |  |
| Medicaid | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |  |  |  |  | ✓ |  |  | ✓ |  | ✓ | ✓ | ✓ |
| Claims-based denominator |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Membership-based denominator |  | ✓ | ✓ | ✓ | ✓ |  | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pharmacy benefit |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MH or CD benefit |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Live birth methodology |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Practitioner type requirement | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Risk adjustment methodology |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lab data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Radiology data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MH or CD data |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pharmacy data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Vision data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Optional exclusions |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Required exclusions |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CE pre-MY |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Anchor date |  |  | ✓ |  |  | ✓ | ✓ | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MY + 1 year claims data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |

1For the required measures list, refer to the annual CMS Reporting Requirements memo.

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| **HEALTH PLAN DESCRIPTIVE INFORMATION, HEALTH PLAN STABILITY AND SURVEY MEASURES** | | | | | | | | | | | | | | | | | | | | | |
| Logical Group | BCR | ENP | EBS | LDM | RDM | WOP | TLM | DMS | HOS | FRM | MUI | OTO | PAO | ASP | FVA | FVO | MSC | PNU | CPA | CPC | CCC |
| At least MY + 2 years claims data |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hybrid |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Electronic Clinical Data Systems |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Inpatient claims data |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| V codes |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Rev codes |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| POS codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| TOB codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DRGs |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HCPCS codes |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  | ✓ |
| J codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LOINC codes |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CPT II codes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SNOMED CT codes |  |  |  |  |  |  |  | ✓ |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Principal diagnosis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Survey measure |  |  |  |  |  |  |  |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

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