



October 1, 2018

Dear Colleague:

NCQA is pleased to present the 2019 HEDIS^{®1} for the *Quality Rating System: Technical Update*. With this release, NCQA freezes the technical specifications for HEDIS for the Quality Rating System, with the exception of measures that require pharmacy data and the Risk Adjusted Utilization measures.

Measures that require pharmacy data and the Risk Adjusted Utilization measures will be final when the Medication List Directory of National Drug Codes (NDC) and the risk-adjustment tables are posted on November 1, 2018.

This memo contains the following information:

- Random Number (RAND) table for 2019 *HEDIS for the Quality Rating System*.
- Corrections, policy changes and clarifications to 2019 *HEDIS for the Quality Rating System*.
- An announcement and attachments for the following measure specification:
 - *Plan All-Cause Readmissions 2020 Version (PCR2020)*.

Following release of the draft PCR2020 measure in the 2019 *HEDIS for the Quality Rating System: Technical Specifications*, it was determined that additional revisions were required for the risk adjustment weighting for observation stays in the measure. The updated version of the measure specifications (Attachment A) replaces the version in the 2019 *HEDIS for the Quality Rating System: Technical Specifications*. The PCR2020 specification is a proposed version of the measure for 2020 HEDIS for QRS and will not be reported in 2019 HEDIS for QRS.

This memo does not contain changes to medications. Refer to the *Medication List Directory Technical Update* document posted with the Medication List Directory (NDC codes) in November for all medication changes.

This memo does not contain coding changes. Organizations must go to the NCQA Download Center (<https://downloads.ncqa.org/customer/Login.aspx>) and re-download the Value Set Directory (VSD) to obtain the October 1 version, which contains all coding changes. The NCQA Download Center does not list the VSD as “October 1 version” (in the Item Name column) but when organizations re-download the file, they will see the updated version date. Refer to the Summary of Changes spreadsheets in the VSD to identify codes and value sets that were added, deleted or revised.

Review all items in the table and attachment and incorporate them into your implementation processes. HEDIS Compliance Auditors will consider these documents to be part of the specifications. If you have questions about information included in the *Technical Update* or about other measure specifications, contact us through our Policy Clarification Support (PCS) system at <http://my.ncqa.org>. We wish everyone a successful HEDIS data collection season!

Sincerely,

Cindy Ottone, MHA
Director, Policy-Measures

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RAND Table for Measures Using the Hybrid Method

Measure	RAND
Adult BMI Assessment	.48
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	.35
Childhood Immunization Status	.42*
Immunizations for Adolescents	.08
Cervical Cancer Screening	.79
Colorectal Cancer Screening	.26
Controlling High Blood Pressure	.20
Comprehensive Diabetes Care	.31
Prenatal and Postpartum Care	.03

* The RANDs for these measures are the same. Organizations may choose to use the same sample for the two measures. If organizations chose to use different samples for these measures a different Minimum Required Sample Size (MRSS) is used in the sampling protocol.

Specification Updates

This document contains corrections, policy changes and clarifications to 2019 *HEDIS for the Quality Rating System*. NCQA has identified the appropriate page number, measure/guideline and head/subtitle for each item.

Page	Measure/Guideline	Head/Subtitle	Update		
22	The NCQA HEDIS Compliance Audit™	The NCQA HEDIS Compliance Audit™	Replace the last sentence in the second paragraph with the following text: Calculated measure results, based on unadjusted HEDIS specifications, may not be termed “Health Plan HEDIS rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Such results should be referred to as “Unaudited Health Plan HEDIS Rates.”		
23	General Guideline 6	Audit Preparation	Replace the “By April 17” task in the HEDIS Audit Timeline with the following text: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year’s specifications.</i></td> <td style="text-align: center; padding: 5px;">By April 17</td> </tr> </table>	Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year’s specifications.</i>	By April 17
Organization submits preliminary rates to the auditor for review. <i>Auditors should review preliminary rates based on the current year’s specifications.</i>	By April 17				
29	General Guideline 22	Supplemental data uses— Supplemental data may help determine	Remove the bullet that reads: <ul style="list-style-type: none"> • Observed Events in the Risk Adjusted Utilization measures. 		
30	General Guideline 22	Supplemental Data Definitions—Standard supplemental data	Replace the <i>Note</i> in this section with the following text: Note: <i>Prior year’s validated historic hybrid medical record result files are reviewed as part of the Data Preproduction Processing section of the HEDIS Roadmap. These data are loaded as administrative data.</i>		
31	General Guideline 22	Required Data Elements— Nonstandard supplemental data	In the fourth paragraph, replace the sentence “NPI or TIN along with date would also be acceptable.” with “Documentation of NPI/TIN is not required; however, documentation of NPI/TIN along with date, name and signature is preferred.”		
33	General Guideline 23	Obtaining Information for the Systematic Sample	In the third paragraph, remove the following two sentences, “All services must have evidence of accountability by the practitioner and at a minimum include date, name and signature). NPI or TIN along with date would also be acceptable.”		
36	General Guideline 31	Coding Systems Included in HEDIS Value Sets ⁴	Replace the language in the footnote (at the bottom of the page) with the following text: ⁴ <i>The updates to the International Classification of Diseases diagnosis and procedure codes that go into effect on October 1, 2018, have been incorporated into the HEDIS 2019 value sets.</i>		
37	General Guideline 31	Coding Systems Included in HEDIS Value Sets ⁴	Remove the bullet that reads: <ul style="list-style-type: none"> • Medicare Severity Diagnosis-Related Group (MS-DRG). 		
39	General Guideline 39	Mapping Proprietary or Other Codes	Replace the “SNOMED CT” and “RxNorm” bullets with the following text:		

Page	Measure/Guideline	Head/Subtitle	Update
			<ul style="list-style-type: none"> • <i>SNOMED CT</i>. Organizations can use the HEDIS Value Set Directory for Allowable Adjustments (“HEDIS Adjustments VSD”) as a resource. • <i>RxNorm</i>. Organizations can use the HEDIS Value Set Directory for Allowable Adjustments (“HEDIS Adjustments VSD”) as a resource.
45	Guidelines for Calculations and Sampling	Guidelines for the Hybrid Method-Table 1: Sample Size Information for Hybrid Measures	In the “Controlling High Blood Pressure” row, replace “Y” with “N” in the “Prior Year’s Rate May Be Used to Reduce MY 2018 Sample Size ⁵ ” column.
49	Guidelines for Calculations and Sampling	Systematic Sampling Methodology—Example 3	<p>Replace the steps following step 3 with the following text:</p> <ul style="list-style-type: none"> • Step 4 Because $411 < 436 \leq (411 + 42)$, skip to step 8. • Step 5 Skip this step. • Step 6 Skip this step. • Step 7 Skip this step. • Step 8 Sort the list and choose the first 411 as the primary list. The remaining 25 members become the oversample list*. <p><i>*Remember, members in the oversample are used only to replace members excluded from the sample.</i></p>
86	Appropriate Treatment for Children With Upper Respiratory Infection	Table URI-4: Data Elements for Appropriate Treatment for Children With Upper Respiratory Infection	Remove the “Numerator events by supplemental data” row.
92	Breast Cancer Screening	Eligible Population—Exclusions	<p>Replace the text in this section with the following text:</p> <p>Exclude members who meet any of the following criteria:</p> <p>Note: <i>Supplemental and medical record data may not be used for these exclusions.</i></p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits.

Page	Measure/Guideline	Head/Subtitle	Update
			<ul style="list-style-type: none"> At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). A dispensed dementia medication (<u>Dementia Medications List</u>).
93	Breast Cancer Screening	Administrative Specification—Exclusion (optional)	Replace all references of “ without a modifier” with “ without a right, left or bilateral modifier (<u>Right Modifier Value Set</u> , <u>Left Modifier Value Set</u> , <u>Bilateral Modifier Value Set</u>).”
100	Childhood Immunization Status	Administrative Specification—Numerators, MMR	<p>Replace the text in this section with the following text: Any of the following meet criteria:</p> <ul style="list-style-type: none"> At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set) on or between the child’s first and second birthdays. At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service. Only count vaccinations that are administered on or between the child’s first and second birthdays (e.g., “Vaccine Administered” value sets). History of illness (Mumps Value Set) can occur on or before the child’s second birthday. At least one measles vaccination or history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) and at least one rubella vaccination or history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service. Only count vaccinations that are administered on or between the child’s first and second birthdays (e.g., “Vaccine Administered” value sets). History of illness (Measles Value Set, Mumps Value Set, Rubella Value Set) can occur on or before the child’s second birthday. <p>Note: General Guideline 26 (i.e., the 14-day rule) does not apply to MMR.</p>
100	Childhood Immunization Status	Administrative Specification—Numerators, VZV	<p>Replace the text in this section with the following text: Either of the following meets criteria:</p> <ul style="list-style-type: none"> At least one VZV vaccination (<u>Varicella Zoster (VZV) Vaccine Administered Value Set</u>), with a date of service on or between the child’s first and second birthdays. History of varicella zoster (e.g., chicken pox) illness (<u>Varicella Zoster Value Set</u>) on or before the child’s second birthday.
102	Childhood Immunization Status	Hybrid Specification—Numerators, Medical Record	<p>Add the following text as a new paragraph after the fourth paragraph: Immunizations documented using a generic header (e.g., polio vaccine) or “IPV/OPV” can be counted as evidence of IPV. The burden on organizations to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.</p>
107	Colorectal Cancer Screening	Eligible Population—Exclusions	Replace the text in this section with the following text:

Page	Measure/Guideline	Head/Subtitle	Update
			<p>Exclude members who meet any of the following criteria: Note: <i>Supplemental and medical record data may not be used for these exclusions.</i></p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). – A dispensed dementia medication (<u>Dementia Medications List</u>).
113	Comprehensive Diabetes Care	Eligible Population—Exclusions	<p>Replace the text in this section with the following text: Exclude members who meet any of the following criteria: Note: <i>Supplemental and medical record data may not be used for these exclusions.</i></p> <ul style="list-style-type: none"> • Members 66 years of age and older as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). – A dispensed dementia medication (<u>Dementia Medications List</u>).
123	Controlling High Blood Pressure	Eligible Population—Exclusions	<p>Replace the text in this section with the following text: Exclude members who meet any of the following criteria: Note: <i>Supplemental and medical record data may not be used for these exclusions.</i></p>

Page	Measure/Guideline	Head/Subtitle	Update
			<ul style="list-style-type: none"> • Members 66–80 years of age as of December 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded: <ol style="list-style-type: none"> 1. At least one claim/encounter for frailty (<u>Frailty Value Set</u>) during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> – At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with an advanced illness diagnosis (<u>Advanced Illness Value Set</u>). – A dispensed dementia medication (<u>Dementia Medications List</u>). • Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (<u>Frailty Value Set</u>) during the measurement year.
131	Follow-Up After Hospitalization for Mental Illness	Event/diagnosis—Acute readmission or direct transfer	Replace the reference to “mental illness” with “mental health disorder.”
148	Initiation and Engagement of AOD Abuse or Dependence Treatment	Initiation of AOD Treatment	Replace the second paragraph with the following: <i>If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.</i>
182	Use of Imaging Studies for Low Back Pain	Table LBP-4: Data Elements for Use of Imaging Studies for Low Back Pain	Remove the “Numerator events by supplemental data” row.
3-1	Appendix 3	Plan All-Cause Readmissions 2020 Version	Remove this measure and its specification in its entirety from Volume 2 and replace it with the measure specification in Attachment A.

Plan All-Cause Readmissions 2020 Version (PCR2020)

This specification should not be used for 2019 HEDIS for QRS reporting. This is the proposed version of the measure for HEDIS 2020. Additional changes may be included when released for reporting.

SUMMARY OF CHANGES TO HEDIS 2020

- Added definitions of “outlier,” “nonoutlier” and “plan population.”
- Added observation stays to inpatient admissions.
- Revised direct transfers to include observation discharges.
- Added steps to remove hospitalizations for outlier members and report a count of outlier members.
- Added a step in the Risk Adjustment Weighting section for observation stay IHS.
- Removed the base weight variable from the risk adjustment weighting.
- Added instructions and data element tables to report plan population and outlier rate.
- Added instructions and data element tables to report the rate among index stays discharged or transferred to skilled nursing care.

HEDIS FOR QRS SPECIFIC GUIDANCE

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

Description

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

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of Observed 30-Day Readmissions (numerator).
3. Count of Expected 30-Day Readmissions.

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the <i>numerator</i> .
Plan population	Members who meet all of the following criteria: <ul style="list-style-type: none"> • 18 and older as of January 1 of the measurement year. • Enrolled on January 1 of the measurement year. • Continuously enrolled for at least 365 days at any point between January 1 of the year prior to the measurement year and December 1 of the measurement year with no more than one gap in enrollment of up to 45 days during the 365-day period.
Outlier	Members with three or more index hospital stays during the measurement year.
Nonoutlier	Members in the plan population who are not considered outliers.
Classification period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC-Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 3
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 4
PCR-Comm-OtherWeights	Commercial observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5

Note: The risk adjustment tables will be released on November 1, 2018, and posted to www.ncqa.org.

Eligible Population

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 10: Members in Hospice.

Ages	Ages 18–64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.

Administrative Specification

Denominator	The eligible population.
Step 1	<p>Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>) and observation stays (<u>Observation Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. <p>Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.</p> <p>The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).</p>
Step 2	<p>Direct transfers: For discharges with one or more direct transfers, use the last discharge.</p> <p>Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition below.</p>

A **direct transfer** is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less. For example:

- A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer.
- A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer.
- A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct stays.
- A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer.

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

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Exclude hospital stays for the following reasons:
Required exclusions

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

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

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Tables PCR-A-4.

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

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

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

Observation Stay	Determine if the IHS at discharge was an observation stay (<u>Observation Stay Value Set</u>). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the member underwent surgery during the stay. Download the list of codes from the NCQA website (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

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

Risk Adjustment Weighting

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

Note: The final weights table will be released on November 1, 2018. HEDIS for QRS uses the Commercial Risk Weights for risk adjustment.

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

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

OR

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

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

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

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

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

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

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

Note: *This variance is calculated at the IHS level. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables.*

Sample Table: PCR—Risk Adjustment Weighting

Member ID*	Admiss. Counter	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-10 Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Estimated Readmissions Risk	Variance
							Category	Weight	Category	Weight			
1250	1	67	Female	-2.619	-0.2753	T44992S	58	0.2990	18	0.1961	-2.1783	0.1017	0.0914
									55	0.2209			
4010	1	50	Male	-2.4722	NA	J439	111	0.4221	NA	NA	-2.0501	0.1140	0.1010
4010	2	50	Male	-2.4722	NA	B180	29	0.6090	87	0.141	-1.7222	0.1516	0.1286

*Each Member ID field with a value represents a unique IHS.

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

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

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

Inpatient stays and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient or observation stay must be used.

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

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition below.

A **direct transfer** is when the discharge date from the first stay precedes the admission date to a subsequent stay by one calendar day or less. For example:

- A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer.
- A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer.
- A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct stays.
- A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer.

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

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

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

Step 4 Remove hospital stays for outlier members.

Step 5 For each remaining IHS, determine if any of the acute inpatient and observation stays have an admission date within 30 days after the Index Discharge Date.

Reporting: Number of Members in Plan Population

Step 1 Determine member age as of January 1 of the measurement year.

Step 2 Report the count of members in the plan population for each age and gender group and the overall total. Enter these values in reporting Tables PCR-A-4.

Reporting: Number of Outliers

Step 1 Determine member age as of January 1 of the measurement year.

Step 2 Report the count of outlier members for each age and gender group and the overall total. Enter these values in reporting Tables PCR-A-4.

Calculated: Number of Nonoutliers

The number of members in the plan population minus the number of outliers for each age and gender group and the overall total calculated by IDSS.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, multiplied by 1,000, for each age and gender group and the overall total. Calculated by IDSS.

Reporting: Denominator

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

Reporting: Numerator

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

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

Step 1 Calculate the Count of Expected Readmissions among nonoutlier members for each age group and overall total.

Step 2 Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting tables.

Calculated: Expected Readmission Rate

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

Reporting: Variance

Step 1 Calculate the total (sum) variance for each age group.

Step 2 Round to four decimal places using the .5 rule and enter the variance into the reporting tables.

Calculated: O/E Ratio

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

Note

- *Supplemental data may not be used for this measure.*

Table PCR-A-4: Plan Population and Outlier Rate

Age	Sex	Members in Plan Population	Outlier Members	Nonoutlier Members	Outlier Rate
18-44	Male				
	Female				
	Total				
45-54	Male				
	Female				
	Total				
55-64	Male				
	Female				
	Total				
Total	Male				
	Female				
	Total				

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

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