Quality Incentive Pool (QIP) Program

Program Year 4 (PY4)

General Guidelines for QIP Data Collection and Reporting

RELEASED MAY 28, 2021

Applies to Measurement Period January 1, 2021 – December 31, 2021

DHCS has approved this QIP Reporting Manual for the sole purpose of facilitating the participation of qualified entities in the QIP program, pursuant to the applicable *Directed Payments QIP, Section 438.6(c) Preprint.* Note that guidelines in this Manual may change if required for CMS approvals applicable to this program. The continuation of this program is subject to, and contingent upon, CMS approval.

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VII. ABOUT THE GENERAL GUIDELINES FOR QIP DATA COLLECTION AND REPORTING SECTION

The General Guidelines for QIP Data Collection and Reporting is a user-friendly resource for QIP managers and reporting leads. The General Guidelines for QIP Data Collection and Reporting highlights key points of information necessary for reporting QIP performance measures. Citations from DHCS policy documents not included in the Guidelines are in quotes with the relevant policy document listed as the source. Texts not in quotations are a paraphrase of cited documents or are additional DHCS guidance.

VIII. MEASURE VALUE SETS, NDC LISTS AND LOCAL MAPPING

Specifications for QIP measures may refer to value sets, Medication List Directory (MLD), and/or National Drug Code (NDC) lists, which are maintained by the measure's steward. The source and instructions for obtaining these code sets is included in each applicable measure section below. Measures and/or measure types without external code sets are as follows:

A. HEDIS VALUE SETS

- HEDIS specifications and value sets can be obtained at the **NCQA Store** under "Technical Specifications for Health Plans." Please refer to the HEDIS MY2020 & MY2021 specifications and value sets (including the MY2021 Technical Update released March 2021) for the PY4 version of the QIP Reporting Manual. It is the QIP entities' responsibility to purchase the appropriate HEDIS value sets for each QIP PY.
    - Entities who have already purchased the current HEDIS Volume 2, must redownload the Value Set Directory file for MY2021 (released March 2021) via **https://my.ncqa.org/**.
- The most current HEDIS MLD list can be found on **NCQA's MY 2021 MLD website**.

Identifying HEDIS Code and Value Set Changes

Changes to HEDIS codes and Value Sets can be found in the in the HEDIS Value Set Directory file under the following tabs: Summary of Changes – **Value Sets** and Summary of Changes – **Codes**

The Summary of Changes – **Value Sets** tab lists the HEDIS value set changes and includes the elements in the table below.

Table 5. Value Set Summary of Changes Elements

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change.
Description	Describes the affected measure or, for renamed value sets, the new value set name.
Revised	October 1 release changes are identified by a revised date of 2020-10-01.

The Summary of Changes – **Codes** tab lists the HEDIS code changes by value set and includes the elements in the table below.

Table 6. Code Summary of Changes Elements

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.
Revised	October 1 release changes are identified by a revised date of 2020-10-01.

B. ECQM VALUE SETS

Value sets for eCQMs listed in this QIP Reporting Manual can be found at the **National Library of Medicine Value Set Authority Center (VSAC)**. To access the value sets, users must obtain a free **Unified Medical Language System® Metathesaurus License (UMLS)**.

To access the correct version of the value sets within the VSAC website:

- Click on the "Download" tab.
- Select the corresponding version of the value sets to the eCQM version being used in the QIP Manual. The PY4 version of the manual uses eCQM 2021, therefore select: "2021 Reporting/Performance Period of eCQM & Hybrid Measure Value Sets."
    - ***Note:*** *For Q-CMS 138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, use the "2020 Reporting/Performance Period eCQM Value Sets."*
- Then select the final version of value sets that align with eCQM 2021: "May 2020 Release eCQM & Hybrid Measure Value Sets Publication Date: May 07, 2020."
- A table of various value sets to download will show, and QIP entities can download the excel file listed under row: "eCQM Value Sets for Eligible Professionals and Eligible Clinicians Published May 07, 2020," and column: "Sorted by CMS ID" to view the value sets sorted by eCQM measure.

Identifying eCQM Value Set Changes

To find a list of eCQM value set updates, please follow the below instructions:

- Visit the **eCQI Resource Center website**.
- Locate the corresponding eCQM by clicking on the "EP / EC eCQMs" tab and then selecting 2021 from the drop down.
- After clicking on the corresponding measure name, scroll down to the "Value Set" section which will indicate the detailed value set updates to the latest version of the eCQM. These updates will also be noted in the Summary of Changes from PY3.5 Manual section at the top of most eCQM measures in the Manual.

C. CMS CORE SET VALUE SETS

Value sets for the CMS Child Core Set measures can be found **here** (email MACQualityTA@cms.hhs.gov for "2020 Child Core Set HEDIS Value Set Directory" and "2020 Child Core Set Non-HEDIS Value Set Directory", if the files are no longer available on the website).

Value sets for the CMS Adult Core Set measures can be found **here** (email MACQualityTA@cms.hhs.gov for "2020 Adult Core Set HEDIS Measures Value Set Directory" and "2020 Adult Core Set Non-HEDIS Measures Value Set Directory", if the files are no longer available on the website).

D. OPIOID NDC LISTS

The Opioid NDC lists for COB and OHD are publicly available via links included in the measure specifications.

E. LOCAL MAPPING

Local Mapping Not Allowed

- QIP entities are **not** permitted to map the following codes for QIP reporting: *Billable encounters codes*. For the purposes of QIP reporting, "billable encounters codes" are defined as encounter codes used to report traditional in-person, clinic-based, outpatient, primary and specialty encounters with a provider, as well as inpatient stays. QIP entities may not use local mapping for QIP measure-specified billable encounter codes. These codes must be recorded in the patient's medical record and associated billing system.
- *Standard or deleted codes*. Standard codes not used in a given measure (e.g., CPT, HCPCS, ICD-10-CM/PCS, LOINC, NDC, etc.) or deleted codes (those that have been removed from use in a measure) may not be mapped to standard codes used in the QIP Manual measures.

Allowable Local Mapping

QIP entities may locally map the following three categories for QIP reporting as per instructions specified below:

- Other health care services that may be represented by CPT (Current Procedural Terminology) or other alphanumeric codes.
- Performance codes that signify some kind of quality outcome/numerator fulfillment (e.g., G-Codes for Patient Health Questionnaire (PHQ) results, CPT-II code 3017F signifying "Colorectal cancer screening results documented and reviewed"). These are not used for billing, but are used for reporting performance.
- Clinical outcomes that do not have specific codes, e.g., A1c<8 evidence of which requires a combination of a lab code plus the lab result; or reporting of a point of service lab result.

If the QIP Manual measure-specified coding systems are not documented in the QIP entity medical record, entities must "map" the institution specific codes or workflows they use to determine compliance with the measures' numerator, denominator, and exclusions, to the codes specified for the relevant measures.

Institution-specific QIP entity codes may be mapped to codes in the QIP Manual used to determine compliance with measures' numerator, denominator, and exclusion criteria. Please note that if codes are mapped, they must be mapped consistently across all measures. When mapping codes, it is important to match the clinical specificity required for the measure.

QIP entities must have some form of auditable documentation of the mapping process in place. To support this auditable process, QIP entities should be prepared to submit, at a minimum, documentation that includes a crosswalk containing the relevant mapped codes, descriptions and clinical information, should this be requested by DHCS. It is also recommended that QIP entities document the policies and procedures and workflows used to map the institution specific codes to the codes specified in the measure.

QIP entities are strongly encouraged to review the August 8, 2018, DHCS document, Quality Measures for Encounter Data, in order fully understand what DHCS' expectations are for submission of encounter data.

IX. INCLUSION OF NON-CLINICIAN CARE TEAM MEMBER

Unless already delineated in the measure specifications, the QIP entity will determine the appropriate care team member(s) to conduct a given service measured by each QIP measure, including both in-person and virtual services. If the selected care team member(s) is/are not licensed to practice independently, the QIP entity will ensure that the care team member(s) has/have had the appropriate supervision and appropriate training to provide the service and maintain appropriate level of documentation of the services provided.

X. QIP TARGET POPULATIONS

QIP Target Population describes the payer criteria that is the starting point for each measure, prior to applying denominator criteria. Each measure includes the Target Population in the Measure Header, as well as in a separate section within the body of the measure. The following are the target populations used in QIP:

- Medi-Cal Managed Care (MCMC) beneficiaries assigned to the QIP Entity and meeting measure specific Continuous Assignment criteria: For a given contracted Medi-Cal Managed Care Plan, beneficiary meets the measure-specific continuous assignment criteria. For DMPHs with DHCS approved community partners only, this must also include patients meeting measure-specific continuous assignment criteria with community partners for allowable QIP community partner measures.
- Medi-Cal Managed Care beneficiaries as of the date of the denominator event: Beneficiary was assigned to a specific Medi-Cal Managed Care Plan on the date of

the measure specified event. For DMPHs with DHCS approved community partners only, this must also include MCMC beneficiaries as of the data of the denominator event(s) with community partners for allowable QIP community partner measures.

- Medi-Cal Managed Care beneficiaries with 12 months of continuous assignment to the QIP Entity during the program year OR Individuals enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of a primary care denominator encounter (Q-CMS130 *Colorectal Cancer Screening*, Q-CMS69 *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*, Q-CMS2 *Preventive Care and Screening: Screening for Depression and Follow-Up Plan* (CDF)).
- Medi-Cal Managed Care beneficiaries with 12 months of continuous assignment to the QIP Entity during the program year OR individuals enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of a Primary care or HIV specialty care denominator encounter (Q-HVL *HIV Viral Suppression* (HVL-AD)).
- Enrolled in Medi-Cal (Managed Care or Fee for Service) on the date of the denominator event: Beneficiary was enrolled in Medi-Cal Fee for Service or enrolled with a specific Managed Care Plan on the date of the measure specified event (e.g., encounter, procedure, ED visit).
- Payer Agnostic: On the date of the measure specified event (e.g., encounter, procedure) beneficiary was either enrolled in Medi-Cal Fee for Service, enrolled with a specific Medi-Cal Managed Care Plan, had coverage other than Medi-Cal or was uninsured.

Individuals that are enrolled in Medi-Cal and meet the measure criteria should be included in the measure, regardless of whether they are also enrolled in another type of insurance.

Type of Medi-Cal

The definitions for “enrolled in Medi-Cal Managed Care” and for “enrolled in Medi-Cal Fee for Service” are as follows:

- Enrolled in Medi-Cal Managed Care: Services provided to a patient for which the QIP entity receives payment from a Medi-Cal managed care plan. Those managed care plan payments can be in the form of fee for service payments or through capitation arrangements.
- Enrolled in Medi-Cal Fee for Service: Services provided to patients for which the QIP entity receives payment from the state or from the state’s fiscal intermediary.

XI. ELIGIBLE POPULATION EXCLUSIONS

Medi-Cal managed care beneficiaries who fit in any of these four categories below may be excluded prior to determining a measure’s QIP eligible population for all measures with continuous assignment criteria. QIP entities that apply these exclusions should do so consistently across all applicable measures.

1. Retroactive Eligibility

- Individuals for whom the retroactive eligibility period is greater than one month during the QIP PY should be excluded from measure denominators. The "retroactive eligibility period" is the elapsed time between the actual date when the eligibility organization became financially responsible for the Medi-Cal beneficiary and the date when it received notification of the new member.

2. Non-Certified Eligible Members

- Medi-Cal managed care beneficiaries for whom non-certified enrollment is greater than one month during the QIP PY should be excluded from measure denominators. Non-certified enrollment months are those months in which the beneficiary did not receive Medi-Cal benefit coverage (perhaps from unmet share of cost).

3. Deceased Patients

- Patients who have died during a measure's applicable continuous assignment period should be excluded if the QIP entity is aware of the patient's death prior to reporting. The QIP entity must also notify the patient's MCP of the patient's death and include in its data methodology narrative the number of patients who were removed from the measure denominator because of this reason.

XII. SAMPLING

Certain QIP measure specifications (e.g., Primary Care HEDIS and CMS Core Set measures) describe administrative, hybrid, and/or medical record review methods. If the QIP entity chooses to pursue the hybrid or medical record review method and if that specification includes guidelines on sampling, the QIP entity should follow the individual measure specification's guidelines on sampling. If the measure specification does not include guidelines on sampling, and if the QIP entity chooses to sample, the QIP entity should follow the sampling guidelines below.

For each measure, the QIP entity has the option to either report on the entire measure population or on a random sample, adhering closely to sampling criteria published and maintained in the **CMS Hospital Outpatient Quality Reporting Specifications** Manual. For each measure, participating QIP entities are required to indicate if sampling was used when reporting performance data.

Participating QIP entities are encouraged to submit as many cases as possible up to the entire population of cases if reasonably feasible. If the raw data can be easily extracted from an existing electronic database or the abstraction burden is manageable, the QIP entity should submit the entire population of cases that meet the initial selection criteria. Otherwise, a statistically valid sample can be selected.

If the QIP entity is not sampling, the entity should use all medical records identified in the population. If the QIP entity is sampling, the entity must use the medical records from the cases in the randomly identified sample.

When a measure population size is less than the minimum number of cases for the sample size, sampling cannot be used, as determined by DHCS.

Sampling must be done after the end of the PY.

A. SAMPLE SIZE

As a general rule, sample size requirements are based on commonly accepted sampling criteria:

- A 5% margin of error is recommended.
- The size of the population, also referred to as the universe population, is the volume of eligible records from which the sample is drawn. See the **Table 7: Sample Sizes** below for sample size requirements per population size.
- Given that the number of cases in the sample could further be reduced during the analysis phase due to missing data in the medical records and additional measure exclusion criteria, it is strongly advised to overestimate their sample size by 10 to 20 percent, or as much as possible.
- A quality check is recommended to ensure that sampling methodology was applied correctly. The participating QIP entity should run a basic comparative analysis of common demographic variables e.g., age, gender ratio, race/ethnicity between the sampled set, and the population of eligible patients. The relative frequency or distribution of theses common variables should be very close.
- The participating QIP entity may choose to use a larger sample size than is required.

B. RANDOM SAMPLING

To obtain statistically valid sample data, the sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected thus representing the whole population.

The participating QIP entity has the option of using either simple random sampling or systematic random sampling:

- Simple random sampling is selecting a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- Systematic random sampling is selecting every kth record from a population size (N) in such a way that sample size (n) is obtained, where k=N/n rounded to the lower digit. Before taking the kth record, the first sample record or starting point must be randomly selected by choosing a number between one and k using a table of random numbers or a computer-generated random number.

Table 7: Sample Sizes

Annual Population Size (N)	Annual Sample Size (n)
≤ 80	Use all cases

Annual Population Size (N)	Annual Sample Size (n)
81-100	80
101-125	95
126-150	109
151-175	121
176-200	132
201-225	143
226-250	152
251-275	161
276-300	169
301-325	177
326-350	184
351-375	191
376-400	197
401-425	203
426-450	208
451-500	218
501-600	235
601-700	249
701-800	260
801-900	270
901-1,000	278
1,001-2,000	323
2,001-3,000	341
3,001-4,000	351
4,001-5,000	357
5,001-10,000	370
≥ 10,001	377

C. PROPORTIONATE SAMPLING

If a QIP entity chooses to sample and the data is available electronically for one part of the entity and only available by paper charts in another, the QIP entity may choose to sample using proportionate sampling. The sample should be based on the total population of qualifying cases from both electronic and paper sources across the entire QIP entity. The proportion of cases to be sampled electronically is equal to the proportion of electronic cases of the total population. The same applies for paper charts. For example: 8,000 cases have an electronic data source. 2,000 cases have paper charts only as the data source. The total population is 10,000. Per sample size table, the sample size should be at least 377. If the QIP entity oversamples for a sample of 450 patients, the entity can sample 360 cases from the electronic data source and 90 cases from the paper charts. Sampling should adhere to the random sampling principles above.

XIII. QIP REPORTING MECHANISM

A. REPORTING MECHANISM

QIP entities will report data as specified by DHCS. The reporting mechanism and instructions for the reporting mechanism will be released closer to the reporting deadline for PY4. QIP entities are expected to report data stratified by Medi-Cal managed care Plans as specified in **Section XIII. C. Stratification of Reported Data by Medi-Cal Health Plan**.

B. STRATIFICATION OF REPORTED DATA BY RACE AND ETHNICITY

DHCS will require race and ethnicity stratification for Diabetes Poor Control under Q-IHE1 for PY4. Please refer to Q-IHE-1 for those details.

DHCS will require informational reporting of race and ethnicity stratifications of the QIP entity's Total Medi-Cal managed care assigned lives population, as well as for five measures in PY4. The required stratifications will be outlined in a forthcoming QIP Policy Letter. The specific measures to be stratified are:

- Q-BCS: Breast Cancer Screening.
- Q-CMS130: Colorectal Cancer Screening.
- Q-CBP: Controlling High Blood Pressure.
- Q-CMS147: Preventive Care and Screening: Influenza Immunization
- Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan.

C. STRATIFICATION OF REPORTED DATA BY MEDI-CAL HEALTH PLAN

All QIP measures are to be reported as a single QIP entity rate. All QIP entities will also report all measures, with the exceptions of Q-CDI: Reduction in Hospital Acquired C Difficile Infections and Q-SSI: SSI, stratified by enrollment with Medi-Cal MCP and by enrollment in Medi-Cal Fee for Service, according to the type of Medi-Cal with which each measures' denominator patients are enrolled within the QIP PY.

Refer to **Section X. QIP Target Populations** for definitions of "Type of Medi-Cal".

When reporting each measure's Medi-Cal stratified denominator data, QIP entities should only include those patients that meet each measure's payer population. Refer to **Section X. QIP Target Populations** for definitions.

If a beneficiary was continuously assigned to the QIP entity through Medi-Cal managed care for the entire measure specified continuous assignment period, but switched MCP mid-year, and thus did not meet the continuous enrollment criteria for any contracted MCP, the QIP entity must include the data for these beneficiaries in the "Beneficiaries continuously assigned to the QIP Entity but not meeting continuous enrollment criteria for any MCP plan above" row.

XIV. MEASURE QUESTIONS PROCESS

For questions regarding **QIP measure specifications** as well as questions regarding **QIP reporting**, QIP entities should first review previously asked and answered QIP measure specification and reporting questions by accessing the QIP Policy Clarification Support (PCS) report, located on the DHCS QIP SharePoint site, **eQIP** and for DPHs at **SNI Link/QIP**.

For **measure** questions that are not answered in the QIP PCS report, QIP entities should submit questions directly to PCS (see Appendix 2 in the QIP PY4 Reporting Manual for instructions on PCS use). Responses to measure questions are posted in **eQIP** (NCQA Measure Policy Guidance).

For **non-measure** questions related to QIP, DPH participating entities may contact SNI (Dana Pong, **dpong@caph.org**) and DMPH participating entities may contact DHLF (Charity Bracy, **cbracy@umich.edu**). All QIP entities may also contact their QIP Liaison at **DHCS**.

XV. STANDARD QIP SUMMARY OF CHANGES FROM PY3.5 MANUAL

A. ALL SPECIFICATIONS

- Updated all dates to align with the QIP PY4 reporting period and native specifications.
- Updated references to “Measurement Period” and “Measurement Year” to align with language used in native specifications.
- Removed references to PY3.5 reporting.
- Removed references to PRIME Target Population.
- Removed references to QIP Specialty Care Population.
- Changed all references from DPH to QIP Entity.

B. HEDIS SPECIFICATIONS

- Updated Hospice exclusion to align with HEDIS General Guideline 17.

C. QIP PRIORITY MEASURE SPECIFICATIONS

Priority Measures are noted by the presence of an asterisk in front of the title. Please refer to QIP Program Policies Section, Section V.C. Priority Measure Reporting, for directions on reporting Priority Measures by QIP entity characteristics.

XVI. STANDARD QIP MODIFICATIONS FROM NATIVE SPECIFICATIONS

A. ALL SPECIFICATIONS

- Removed all references to Commercial and/or Medicare product lines, except the Medicare Special Needs Plan (SNP) and "living long-term in an institution" exclusion.
- Removed copyright language, as it is included in **Section XVII. QIP Measure Copyright Table** of the General Guidelines for QIP Data Collection and Reporting.
- Changed references of "Continuous Enrollment" to "Continuous Assignment to QIP Entity" (HEDIS & Core Set).
- Added QIP target population language for all measures (see **X. QIP Target Populations** for target population details).

B. HEDIS SPECIFICATIONS

- Changed all references of "member" to "individual".
- Removed section "Data Elements for Reporting" describing requirements for plans reporting to NCQA, as it is not applicable to QIP.
- Removed section "Rules for Allowable Adjustments" describing rules for permissible modifications to the HEDIS measure.
- Added the full Hospice exclusion language from the HEDIS General Guideline 17 into the specification, except for the following portion as it does not apply to QIP reporting, "If organizations use the Monthly Membership Detail Data File to identify these members, use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year."

C. MIPS ECQM SPECIFICATIONS

- Throughout, removed references to "Payer", "Race", "Ethnicity" and "Sex", as these are supplemental data elements not used for reporting in QIP.
- Removed "References" section from specification and noted to see native specification for full list of references.
- Removed row for Supplemental Data Elements in the header section of the measure, as these are not used for reporting in QIP.
- Removed the following statement from the 'Measure Reporting' section, as it is not applicable to QIP, "Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries… The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website."

D. MIPS CQM SPECIFICATIONS

- Use "reporting/reported" instead of "submitted/submitting" throughout measure.
- Removed the following statements from the 'Measure Reporting' section, as it is not applicable to QIP, "Measure data may be submitted by individual MIPS

eligible clinicians, groups, or third party intermediaries."; "The quality-data codes listed do not need to be reported by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be reported for those registries that utilize claims data."; " For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website."

E. CMS ADULT AND CHILD CORE SET SPECIFICATIONS

- None.

F. OTHER SPECIFICATIONS

- None.

XVII. QIP MEASURE COPYRIGHT TABLE

See list of measures and associated Measure ID in the document's Navigation Pane and Table of Contents.

Current Procedural Terminology (CPT®)

The five-character codes included in the "QIP Reporting Manual PY4" are obtained from Current Procedural Terminology (CPT®), copyright 2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures.

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CPT is a registered trademark of the American Medical Association.

Table 8. QIP Measure Copyright

Measure ID (Version)	Copyright Language
Q-BCS, Q-CCS, Q-WCV, Q-CIS10, Q-CHL, Q-CMS130, Q-IMA, Q-LSC, Q-CMS138, Q-WCC, Q-W30 Q-DRR, Q-FUA Q-CBP Q-CDC-H9, Q-CDC-EDM2, Q-CDC-N	HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications were developed by and are owned by NCQA. NCQA holds a copyright in the HEDIS measures and specifications and may rescind or alter these measures and specifications at any time. Users of the HEDIS measures and specifications shall not have the right to alter, enhance or otherwise modify the HEDIS measures and specifications, and

Measure ID (Version)	Copyright Language
Q-AMR, Q-PCE Q-TRC, Q-PCR Q-PPC-Pre, Q-PPC-Pst Q-URI, Q-AAB, Q-LBP (HEDIS)	shall not disassemble, recompile or reverse engineer the HEDIS measures and specifications. Use of the *Rules for Allowable Adjustments of HEDIS* to make permitted adjustments of the materials does not constitute a modification. No license is required for noncommercial use of the measures solely to report quality data for the Quality Incentive Pool (QIP) Program or for noncommercial, internal quality improvement activities. All other uses, including a commercial use, or any external reproduction, distribution and publication must be approved by NCQA and are subject to a license at the discretion of NCQA. HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications. ©2020 National Committee for Quality Assurance, all rights reserved. **A rate from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called an "Adjusted HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS Rates".** Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association holds a copyright to the CPT® codes contained in the measure specifications. The American Hospital Association holds a copyright to the Uniform Billing Codes ("UB") contained in the measure

Measure ID (Version)	Copyright Language
	specifications. The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS measure results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org. Some measure specifications contain coding from LOINC® (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright © 1995–2020, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and is available at no cost under the license at **http://loinc.org/terms-of-use.** "SNOMED" and "SNOMED CT" are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO). "HL7" is the registered trademark of Health Level Seven International.
Q-CCS, Q-CMS147 Q-CMS347 (MIPS eCQM)	Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. PCPI disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT[R]) or other coding contained in the specifications. CPT(R) contained in the Measure specifications is copyright 2004-2020 American Medical Association. LOINC(R) is copyright 2004-2020 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2020 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2020 World Health Organization. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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