Glossary of Terms

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Measurement year

In most cases, the 12-month time frame between which a service was rendered – generally Jan.1 – Dec. 31. Data collected from this time frame is reported during the reporting year.

Reporting year

The time frame when data is collected and reported. The service dates are from the measurement year, which is usually the year prior. In some cases, the service dates may go back more than one year.

Example: The 2026 reporting year would include data from services rendered during the measurement year, which would be 2025 and/or any time prior. Results from the 2026 reporting year would likely be released in June 2026, depending on the quality program.

Denominator

The number of members who qualify for the measure criteria, based on NCQA technical specifications.

Numerator

The number of members who meet compliance criteria based on NCQA technical specifications for appropriate care, treatment or service.

Medical record data

The information taken directly from a member's medical record to validate services rendered that weren't captured through medical or pharmacy claims, encounters or supplemental data.

Collection and reporting method

- Administrative – Measures reported as administrative use the total eligible population for the denominator. Medical, pharmacy and encounter claims count toward the numerator. In some instances, health plans use approved supplemental data for the numerator.
- Hybrid – Measures reported as hybrid use a random sample of 411 members from a health plan's total eligible population for the denominator. The numerator includes medical and pharmacy claims, encounters and medical record data. In some cases, health plans use auditor-approved supplemental data for the numerator.
- Supplemental data – Standardized process in which clinical data is collected by health plans for purposes of HEDIS improvement. Supplemental clinical data is additional data beyond claims data.
- Electronic Clinical Data Systems (ECDS) - Organizations may use several data sources to provide complete information about the quality of health services delivered to its members. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to:
  - Administrative claims
  - Member eligibility files
  - Electronic health records
  - Clinical registries
  - Health information exchanges
  - Administrative claims systems
  - Disease/case management registries

Glossary of Terms (cont.)

Required exclusion

Members are excluded from a measure denominator based on a diagnosis and/or procedure captured in their Claim/encounter/ Pharmacy data. If applicable, the required exclusion is applied after the claims data is processed within certified HEDIS software while the measure denominator is being created.

For example: Members with end-stage renal disease (ESRD) during the measurement year or year prior will be excluded from the statin therapy for patients with cardiovascular disease (SPC) measure denominator.

- Members with a claim for hospice services during the measurement year will be excluded from all applicable measures.

Proportion of days covered (PDC)

According to the Pharmacy Quality Alliance (PQA), the PDC is the percent of days in the measurement period covered by prescription claims for the same medication or another in its therapeutic category.