Proposed Changes to Existing Measures for HEDIS®[1] MY 2020
Well-Child Visits in the First 15 Months of Life (W15)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Adolescent Well-Care Visits (AWC)

Proposed Retirement for HEDIS MY 2020
Children and Adolescents' Access to Primary Care Practitioners (CAP)

NCQA seeks comments on proposed modifications to three HEDIS health plan measures that assess whether children and adolescents receive well-care visits according to the American Academy of Pediatrics Bright Futures guidelines for Health Supervision of Infants, Children and Adolescents. The current measures are specified for reporting by commercial and Medicaid health plans.

- The current *Well-Child Visits in the First 15 Months of Life* (W15) measure assesses the percentage of members who turned 15 months old during the measurement year and who had well-child visits with a PCP (0, 1, 2, 3, 4, 5, or 6 or more visits).
- The current *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)* measure assesses the percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.
- The current *Adolescent Well-Care Visits (AWC)* measure assesses the percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

NCQA proposes to remove the hybrid reporting method from the measures. An examination of performance rates shows that, over time, medical record review has had less of an impact on rates. Given minimum impact on performance and reported difficulty clearly identifying well visits from medical record review, expert panels supported removing the hybrid option.

The current measures do not cover children 2 years old—a critical period for developmental and other screenings. The current measures also do not cover children 7–11 years old—a period that includes milestones for interpersonal development and may mark the beginning of puberty for some children. Panel members supported incorporating children not previously captured in the measures.

The current well-child measures require the visit be with a PCP (or OB/GYN for adolescents), to ensure the visits are focused on preventive care. Panels suggested this requirement was unnecessary and supported removing the provider requirement from these measures.

The current W15 measure includes separate rates for 0, 1, 2, 3, 4, 5 and 6 or more visits. Panel members supported collecting only the rate that assesses whether 6 or more visits occur.

For children and adolescents 3–21 years of age, panel members supported continuing to look for 1 or more visits during the measurement year, noting the importance of annual visits for this age group and in keeping in alignment with the Bright Futures recommendations.

NCQA proposes the following updates:

- *Well-Child Visits in the First 15 Months of Life (W15)*
  - Remove the hybrid specification.
  - Add a "15–30 months" age range.

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  - Remove performance rates for 0–5 visits.
  - Remove the provider type requirement.
  - Rename the measure *Well-Child Visits in the First 30 Months of Life.*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)*
  - Remove the hybrid specification.
  - Add a "7–11 years" age range.
  - Combine the measure with AWC and rename it *Child and Adolescent Well-Care Visits.*
- *Adolescent Well-Care Visits (AWC)*
  - Remove the hybrid specification.
  - Split the adolescent age range into two age ranges: 12–18 years and 19–21 years.
  - Combine the measure with W34 and rename it *Child and Adolescent Well-Care Visits.*

The Well-Care Value Set used in these measures includes ICD-10 diagnosis Z-codes. These codes would need to be used in conjunction with other encounter codes, so these codes alone do not indicate that a well-care visit occurred. NCQA proposes to remove these ICD-10 diagnosis codes from the Well-Care Value Set in the *Well-Child Visits in the First 30 Months of Life* and *Child and Adolescent Well-Care Visits* measures.

With revisions to the current well-child measures, *Children and Adolescents' Access to Primary Care Practitioners* may not continue to add useful information beyond the newly structured well-child measures. NCQA proposes to retire the *Children and Adolescents' Access to Primary Care Practitioners (CAP)* measure.

NCQA seeks feedback on the proposed changes.

Supporting documents for these measures include the current and draft measure specifications, evidence workup and performance data.

NCQA acknowledges the contributions of the Child & Adolescent Well-Care Measurement Advisory Panel and the Technical Measurement Advisory Panel.

Well-Child Visits in the First 15 Months of Life (W15)

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Added a rate for members 15–30 months of age and removed rates for 0–5 visits. The revised measure is described in the "Well-Child Visits in the First 30 Months of Life" draft measure specification.

Description

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits.
- One well-child visit.
- Two well-child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Six or more well-child visits.

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*
- *Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure for the Medicaid product line using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Age	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Day the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerators Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits (Well-Care Value Set) with a PCP, on different dates of service, on or before the child's 15-month birthday.

Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate for six or more visits, or the prior year's audited rate for six or more visits.

Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerators Seven separate numerators are calculated, corresponding to the number of members who had 0, 1, 2, 3, 4, 5, 6 or more complete well-child visits with a PCP, on different dates of service, on or before the child's 15-month birthday.

The well-child visit must occur with a PCP.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of *all* of the following:

- **A health history.** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history.** Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history.** Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam.**
- **Health education/anticipatory guidance.** Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Do not include services rendered via telehealth or during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***Health history***
    - *Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.*
  - ***Physical developmental history***
    - *notation of tanner stage/scale.*
    - *Notation of "appropriate for age" without specific mention of development.*
    - *Notation of "well-developed/nourished/appearing."*
  - ***Mental developmental history***
    - *Notation of "appropriately responsive for age."*
    - *Notation of "neurological exam."*
    - *Notation of "well-developed."*
  - ***Physical exam***
    - *Vital signs alone.*
  - ***Health education/anticipatory guidance***
    - *Information regarding medications or immunizations or their side effects.*
    - *"Handouts given" during the visit without evidence of a discussion.*
- *Refer to* Appendix 3 *for the definition of* PCP.
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more information about well-child visits.*

Data Elements for Reporting

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

Table W15-1/2: Data Elements for Well-Child Visits in the First 15 Months of Life

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 7 rates*
Current year's administrative rate (before exclusions)		*Each of the 7 rates*
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		*Each of the 7 rates*
Administrative rate on MRSS		*Each of the 7 rates*
Number of medical records excluded because of valid data errors		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 7 rates*	*Each of the 7 rates*
Numerator events by medical records		*Each of the 7 rates*
Numerator events by supplemental data	*Each of the 7 rates*	*Each of the 7 rates*
Reported rate	*Each of the 7 rates*	*Each of the 7 rates*

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Proposed to be combined with the AWC measure. The combined measure is described in the "Child and Adolescent Well-Care Visits" draft measure specification.

Description

The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*
- *Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure for the Medicaid product line using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Ages	3–6 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator The eligible population.

Numerator At least one well-child visit (Well-Care Value Set) with a PCP during the measurement year.

Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate.

Refer to *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerator At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of *all* of the following:

- **A health history.** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history.** Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- **A mental developmental history.** Mental developmental history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- **A physical exam.**
- **Health education/anticipatory guidance.** Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

Do not include services rendered via telehealth or during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***Health history***
    - *Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.*
  - ***Physical developmental history***
    - *Notation of Tanner Stage/Scale.*
    - *Notation of "appropriate for age" without specific mention of development.*
    - *Notation of "well-developed/nourished/appearing."*
  - ***Mental developmental history***
    - *Notation of "appropriately responsive for age."*
    - *Notation of "neurological exam."*
    - *Notation of "well-developed."*
  - ***Physical exam***
    - *Vital signs alone.*
  - ***Health education/anticipatory guidance***
    - *Information regarding medications or immunizations or their side effects.*
    - *"Handouts given" during the visit without evidence of a discussion.*
- *Refer to* Appendix 3 *for the definition of* PCP.
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more information about well-child visits.*

Data Elements for Reporting

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

Table W34-1/2: Data Elements for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

	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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical records excluded because of valid data errors		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Adolescent Well-Care Visits (AWC)

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Proposed to be combined with the W34 measure. The combined measure is described in the "Child and Adolescent Well-Care Visits" draft measure specification.

Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*
- *Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.*

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure for the Medicaid product line using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member.

Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate.

Refer to *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the member.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of *all* of the following:

- **A health history.** Health history is an assessment of the member's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- **A physical developmental history.** Physical developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- **A mental developmental history.** Mental developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- **A physical exam.**
- **Health education/anticipatory guidance.** Health education/anticipatory guidance is given by the health care provider to the member and/or parents or guardians in anticipation of emerging issues that a member and family may face.

Do not include services rendered via telehealth or during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to the assessment or treatment of an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***Health history***
    - *Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.*
  - ***Physical developmental history***
    - *Notation of "appropriate for age" without specific mention of development.*
    - *Notation of "well-developed/nourished/appearing."*

    Note: *Documentation of "Tanner Stage/Scale" meets criteria for Physical Developmental History for this measure.*
  - ***Mental developmental history***
    - *Notation of "appropriately responsive for age."*
    - *Notation of "neurological exam."*
    - *Notation of "well-developed."*
  - ***Physical exam***
    - *Vital signs alone.*
    - *Visits where care is limited to OB/GYN topics (e.g., prenatal or postpartum care). The purpose of including visits with OB/GYNs is to allow that practitioner type to perform the adolescent well-care visit requirements. It is not the measure's intent to allow care limited to OB/GYN topics to be a substitute for well-care.*
  - ***Health education/anticipatory guidance***
    - *Information regarding medications or immunizations or their side effects.*
    - *"Handouts given" during the visit without evidence of a discussion.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN *and* other prenatal care practitioners.
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more information about well-care visits.*

Data Elements for Reporting

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

Table AWC-1/2: Data Elements for Adolescent Well-Care Visits

	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)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of numerator events by administrative data in MRSS		✓
Administrative rate on MRSS		✓
Number of medical records excluded because of valid data errors		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Well-Child Visits in the First 30 Months of Life

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Revised the measure name to *Well-Child Visits in the First 30 Months of Life*.
- Added a rate for members 15–30 months.

Description

The percentage of members who had the following number of well-child visits during the last 15 months:

- Children who turned 15 months old during the measurement year: Six or more well-child visits.
- Children who turned 30 months old during the measurement year: Two or more well-child visits.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Age	• Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the first birthday plus 90 days. • Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.

Rate 1: Well Care Visits in the First 15 Months

Eligible population	
Age	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the first birthday plus 90 days.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.
Denominator	The eligible population.

Numerator	Six or more well-care visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Rate 2: Well Care Visits for Age 15 Months–30 Months

Eligible population	
Age	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.
Denominator	The eligible population.
Numerator	Two or more well-care visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Data Elements for Reporting

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

Table: Data Elements for Well-Child Visits in the First 30 Months of Life

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Child and Adolescent Well-Care Visits

SUMMARY OF CHANGES TO HEDIS MEASUREMENT YEAR 2020

- Proposed combination of existing measures W34 and AWC.
- Added a rate for members age 7–11 years.

Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit during the measurement year

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid (report each product line separately).
Age	3–21 years as of December 31 of the measurement year. Report four age stratifications: • 3–6 years. • 7–11 years. • 12–18 years. • 19–21 years.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
Denominator	The eligible population.
Numerator	One or more well-care visits (Well-Care Value Set) during the measurement year. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Data Elements for Reporting

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

Table: Data Elements for Child and Adolescent Well-Care Visits

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Well-Child Visits in the First 15 Months of Life (W15)
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Adolescent Well-Care Visits (AWC)
Measure Workup

Topic Overview

Importance and Prevalence

Health importance

Well-child visits aim to improve the quality of care through health promotion and disease prevention interventions (American Academy of Pediatrics, 2017). The visits are used to assess the physical health, development and behavior of infants, children and adolescents. They are foundational to preventive health care, such as evidence-based screenings and immunizations, because they promote better social, developmental and health outcomes (AAP, 2017). They provide an opportunity for primary care physicians and the care team to educate parents or deliver age-appropriate counseling (anticipatory guidance) (Magar et al., 2006) that can pertain to a wide range of issues such as behavioral, learning and emotional problems (AAP, 2017).

Well-child visits also incorporate other components, such as physical and mental health history and a physical examination (AAP, 2017). AAP Bright Futures Guidelines specify what should be covered during these visits; criteria vary by age. In addition to the Bright Futures Guidelines, the AAP publishes a recommended schedule of screenings and assessments (the periodicity schedule) for every visit from infancy to adolescence (AAP, 2019).

Infancy and childhood

Regular well-child visits promote better social, developmental and health outcomes, and are designed to meet the needs of infants, children and adolescents. In infancy and childhood, well-child visits provide the opportunity for clinicians to assess/screen for developmental delays. Early identification of developmental disorders is critical to the well-being of children and their families (AAP, 2017). It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals (AAP, 2017). A well-child visit is a critical opportunity to detect a possible developmental delay or disability and early treatment can lessen the future impact on both the child and family (AAP, 2002).

Fewer than half of children with developmental delays are identified before starting school (U.S. Department of Education, 2006). Research shows that early intervention treatment services can greatly improve a child's development. Early intervention services help children from birth through 3 years of age (36 months) learn important skills.

In addition, well-child visits allow physicians to promote behaviors conducive to healthy development and to give anticipatory guidance (Committee on Psychosocial Aspects of Child and Family Health, 2001). Anticipatory guidance given during a well-child visit can change parenting practices and increase knowledge of injury prevention practices and infant sleep patterns (Child Trends, 2004).

Adolescence For adolescents, routine well-care visits are an effective way for practitioners to dispense health promotion advice, intervene when an adolescent is engaged in health risk behaviors (e.g., tobacco or alcohol use) and identify patients who are at early stages of disease and illness (AAP, 2017). Guidelines addressing preventive services for adolescents recommend that all adolescents have annual, confidential, preventive services that include screening, educating and counseling adolescent patients on biomedical, emotional and socio-behavioral areas currently threatening adolescent health (AAP, 2017). Approximately 54% of adolescents visit a physician at least once a year and 35% have a preventive visit, indicating that a minority are screened for or educated about health risks that effect adolescents directly (Rand & Goldstein, 2018).

Guidelines/Evidence

The evidence presented below is based on the Bright Futures clinical guidelines (Table 1) for Health Supervision of Infants, Children and Adolescents developed by the American Academy of Pediatrics.

Table 1: Current Guidance

Society	Guideline
American Academy of Pediatrics [AAP]	• Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, 4th Edition • Recommendations for Preventive Pediatric Health Care 2019—Periodicity Schedule

Infancy and childhood The AAP/Bright Futures guidelines recommend eight well-care visits from the time the child is born to the time they reach 15 months old. They recommend that the well-child visits include an initial/interval medical history, measurements (length/height and weight, head circumference, weight for length), behavioral assessment, physical examination, immunization and anticipatory guidance.

The AAP/Bright Future guidelines recommend four well-care visits for children 3–6 years of age. They recommend that the well-care visits include a medical history, measurements (length/height and weight, BMI, blood pressure), sensory screening (vision and hearing), development surveillance, psychosocial/behavioral assessment, physical exam, immunization, oral health and anticipatory guidance.

Adolescence AAP/Bright Futures guidelines advise annual visits for adolescents (11–21 years). Given that the period of adolescence is marked by puberty and changes in physical appearance and psychological maturity, it is recommended that clinicians focus on concerns of the adolescent and the parent and address social determinants of health, physical growth and development, emotional well-being, risk reduction (pregnancy and sexually transmitted infections, tobacco, e-cigarettes, alcohol) and safety (seat belt and helmet use, sun protection, substance use, firearm safety) over the course of multiple visits.

Gaps in care A study of insured and uninsured children 0–6 years of age assessed gaps in well-child visits in primary care clinics serving low-income families. Of the 152,418 children included in the study, the most attended well-child visits were at 2 months, 4 months and 6 months. The 15-month,18-month and 4-year visits were the least frequently attended (Wolf et al., 2018).

Health care disparities

A study on children born between 2007 and 2009 examined the frequency of well-child visits in infants in relation to their demographics. It found that children with commercial insurance coverage had a 73.4% compliance rate for receiving well-child visits vs. children with Medicaid, who were 45% compliant. White children were more likely to be compliant than other ethnicities (68.1%; African American, 46.1%; Asian, 66.3%; Hawaiian/PI, 53.4%; Other, 52.4%). When the authors controlled for insurance status, African American children received 42% of well-child visits compared with White children, who received 58% of well-child visits (Dabney et al, 2012). A more recent study using data from 2009-2013 also found that "children in families with mixed insurance (child publicly insured and parent privately insured) were less likely to have a well-child visit than children in privately insured families" (King, 2016).

In 2014, the percentage of children and adolescents who had a well-child visit in the previous year (from birth to 17 years) from poor income families was 81%, low-income households was 80.5% and middle-income households was 83.2%, all of which were less likely to have well-child visits than those from high-income households which was 89.5%. White children had a higher probability of attending an annual well-child visit than Hispanic children (85.3% vs. 78.9%) (AHRQ, 2019). An older study from 2004 by Jhanjee et al. found that noncompliance for well-child visits was associated with transportation difficulties, parental depression and having private vs. public insurance.

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HEDIS Health Plan Performance Rates: Well-Child Visits in the First 15 Months of Life

Table 1. HEDIS W15 Measure Performance—Medicaid Plans (0 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	2.9	6.3	0.5	0.9	1.6	2.7	4.3
2017	275	201 (73.1)	2.3	2.5	0.5	1.0	1.5	2.7	4.5
2016	282	204 (72.3)	2.5	3.1	0.5	1.0	1.6	3.2	5.1

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 2. HEDIS W15 Measure Performance—Medicaid Plans (1 visit)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	2.4	2.6	0.6	1.2	1.9	2.7	3.6
2017	275	201 (73.1)	2.0	1.5	0.6	1.1	1.7	2.7	3.5
2016	282	204 (72.3)	2.0	1.3	0.6	1.0	1.7	2.6	3.7

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 3. HEDIS W15 Measure Performance—Medicaid Plans (2 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	3.4	2.0	1.5	2.2	3.2	4.0	5.4
2017	275	201 (73.1)	3.1	1.8	1.5	2.0	2.8	3.7	4.9
2016	282	204 (72.3)	3.2	1.4	1.5	2.2	3.1	4.0	5.1

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 4. HEDIS W15 Measure Performance—Medicaid Plans (3 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	5.0	2.1	2.9	3.6	4.6	5.8	7.5
2017	275	201 (73.1)	4.9	2.1	2.7	3.6	4.5	5.8	7.1
2016	282	204 (72.3)	5.1	2.1	3.1	3.9	4.9	6.3	7.5

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 5. HEDIS W15 Measure Performance—Medicaid Plans (4 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	8.6	3.0	5.6	7.0	8.3	9.7	11.5
2017	275	201 (73.1)	8.4	3.8	4.9	6.3	8.0	9.6	11.6
2016	282	204 (72.3)	9.1	2.9	5.6	7.2	9.2	10.6	12.3

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 6. HEDIS W15 Measure Performance—Medicaid Plans (5 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	15.0	4.6	9.9	12.4	14.4	17.3	20.7
2017	275	201 (73.1)	15.2	4.4	10.3	12.1	14.5	17.7	20.7
2016	282	204 (72.3)	16.4	4.2	11.1	13.9	16.4	18.5	22.0

*For 2018 the average denominator across plans was 1,281 with a standard deviation of 3,414.

Table 7. HEDIS W15 Measure Performance—Medicaid Plans (6 or more visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	197 (77.0)	62.8	12.7	49.9	59.0	65.8	69.8	73.2
2017	275	201 (73.1)	64.1	11.4	51.6	58.5	66.2	71.3	75.4
2016	282	204 (72.3)	61.7	10.2	50.0	56.1	62.1	68.7	72.5

*For 2018 the average denominator across plans was 1,281 individuals, with a standard deviation of 3,414.

Table 8. HEDIS W15 Measure Performance—Commercial Plans (0 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	1.9	3.7	0.2	0.6	1.2	2.0	3.4
2017	406	384 (94.6)	2.5	7.3	0.3	0.7	1.2	2.0	3.8
2016	420	398 (94.8)	2.0	4.4	0.2	0.6	1.2	2.0	3.5

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 9. HEDIS W15 Measure Performance—Commercial Plans (1 visit)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	1.1	2.0	0.0	0.4	0.8	1.3	2.0
2017	406	384 (94.6)	1.3	2.6	0.1	0.5	0.9	1.5	2.2
2016	420	398 (94.8)	1.2	1.9	0.0	0.4	0.8	1.4	2.2

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 10. HEDIS W15 Measure Performance—Commercial Plans (2 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	1.3	1.8	0.3	0.7	1.0	1.5	2.3
2017	406	384 (94.6)	1.3	1.7	0.0	0.5	1.0	1.5	2.2
2016	420	398 (94.8)	1.3	1.6	0.1	0.6	1.0	1.6	2.6

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 11. HEDIS W15 Measure Performance—Commercial Plans (3 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	1.9	1.5	0.5	1.1	1.6	2.2	3.3
2017	406	384 (94.6)	1.9	1.6	0.5	1.0	1.6	2.2	3.5
2016	420	398 (94.8)	2.0	1.6	0.5	1.0	1.7	2.5	3.6

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 12. HEDIS W15 Measure Performance—Commercial Plans (4 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	4.2	2.4	1.8	2.7	3.7	5.0	7.0
2017	406	384 (94.6)	4.1	2.2	2.0	2.7	3.7	5.1	6.9
2016	420	398 (94.8)	4.2	2.4	2.0	2.8	3.8	4.9	6.9

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 13. HEDIS W15 Measure Performance—Commercial Plans (5 visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	376 (92.8)	10.1	5.0	5.1	6.8	8.9	12.3	16.5
2017	406	384 (94.6)	10.6	5.3	5.3	7.4	9.5	12.8	16.7
2016	420	398 (94.8)	10.9	5.1	6.0	7.4	10.1	13.1	17.2

*For 2018 the average denominator across plans was 2,046 with a standard deviation of 3,710.

Table 14. HEDIS W15 Measure Performance—Commercial Plans (6 or more visits)

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	375 (92.6)	79.5	11.1	67.0	75.6	82.1	86.0	89.6
2017	406	384 (94.6)	78.3	13.1	67.1	74.6	80.8	85.7	88.9
2016	420	398 (94.8)	78.4	11.8	67.4	74.6	80.8	85.3	88.3

*For 2018 the average denominator across plans was 2,050 with a standard deviation of 3,714.

HEDIS Health Plan Performance Rates: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Table 1. HEDIS W34 Measure Performance—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	223 (87.1)	72.1	9.7	61.5	66.3	72.9	78.5	83.8
2017	275	242 (88.0)	73.0	8.7	61.1	67.2	73.9	79.3	83.7
2016	282	243 (86.2)	72.2	8.6	60.7	66.2	72.5	78.5	82.8

*For 2018 the average denominator across plans was 4,525 with a standard deviation of 14,677.

Table 2. HEDIS W34 Measure Performance—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	379 (93.6)	77.4	9.8	64.5	72.3	78.8	84.0	88.9
2017	406	385 (94.8)	75.9	10.9	62.9	70.8	77.3	82.9	87.5
2016	420	405 (96.4)	75.5	10.4	61.1	69.8	76.7	82.7	87.4

*For 2018 the average denominator across plans was 10,642 with a standard deviation of 19,033.

HEDIS Health Plan Performance Rates: Adolescent Well-Care Visits

Table 1. HEDIS AWC Measure Performance—Medicaid Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	256	211 (82.4)	53.2	12.8	36.5	44.3	54.3	62.8	68.1
2017	275	218 (79.3)	53.0	12.4	36.7	45.7	54.6	62.0	66.8
2016	282	227 (80.5)	50.6	13.2	33.8	43.1	50.1	59.7	68.1

*For 2018 the average denominator across plans was 8,172 with a standard deviation of 29,806.

Table 2. HEDIS AWC Measure Performance—Commercial Plans

Measurement Year	Total Number of Plans (N)	Number of Plans Reporting (N (%))	Performance Rates (%)						
			Mean	Standard Deviation	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile
2018*	405	385 (95.1)	48.5	12.3	33.2	40.6	47.4	55.9	64.9
2017	406	389 (95.8)	46.8	12.6	31.5	38.2	45.7	54.0	64.8
2016	420	409 (97.4)	46.2	12.5	30.4	37.9	45.2	53.6	64.7

*For 2018 the average denominator across plans was 35,181 with a standard deviation of 63,190.