Connecticut Quality Council
Annual Review of the Core Measure Set
Measure Specifications

Appendix A. Items in the PCMH Item Set

The table below lists the individual questions in the PCMH Item Set, the measures that can be calculated, and the PCMH topics that the items address.

To download a version of the Clinician & Group Survey that combines the 12-Month Survey with the complete set of formatted PCMH items, go to https://cahps.ahrq.gov/surveys-guidance/cg/instructions/index.html. Both the Adult and Child versions are available.

Additional information on using other supplemental items with the PCMH Item Set, including placement instructions, is available in ***CAHPS Clinician & Group Surveys: Supplemental Items for the Adult Surveys*** and ***CAHPS Clinician & Group Surveys: Supplemental Items for the Child Surveys.***

Number in the Adult PCMH Item Set	Number in the Child PCMH Item Set	Short Item Title	PCMH Item Set Measure	PCMH Topic Addressed
PCMH1	PCMH1	Number of days wait for urgent care appointment	Individual item	Access
PCMH2	PCMH2	Patient got information about what to do if care is needed on evenings, weekends, or holidays	Individual item	Access
PCMH3	PCMH3	Patient needed care during evenings, weekends, or holidays	(Screening item)	Access
PCMH4	PCMH4	Patient able to get needed care on evenings, weekends, or holidays	Individual item	Access
PCMH5	PCMH5	Patient got reminders from provider's office between visits	Individual item	Access
PCMH6		Patient started or stopped a medicine	(Screening item)	
PCMH7		Provider talked to patient about reasons patient might want to take a medicine	Talking with you about medication decisions (composite)	Shared decisionmaking
PCMH8		Provider talked to patient about reasons patient might not want to take a medicine		Shared decisionmaking
PCMH9		Provider asked what patient thought was best		Shared decisionmaking
PCMH10	PCMH6	Patient saw a specialist for a particular health problem	(Screening item)	
PCMH11	PCMH7	Provider seemed informed and up-to-date about care from specialists	Individual item	Coordination

Number in the Adult PCMH Item Set	Number in the Child PCMH Item Set	Short Item Title	PCMH Item Set Measure	PCMH Topic Addressed
PCMH12	PCMH8	Anyone in provider's office talked with patient about specific health goals	Talking with you about taking care of your own health (composite)	Self-management support
PCMH13	PCMH9	Anyone in provider's office asked if there were things that made it hard for patient to take care of health		Self-management support
PCMH14	PCMH10	Patient took prescription medicine	(Screening item)	
PCMH15	PCMH11	Anyone in provider's office talked with patient about all prescriptions	Individual item	Coordination
PCMH16		Anyone in provider's office asked if patient had felt sad, empty, or depressed	Attention to your mental and emotional health (composite)	Comprehensive-ness
PCMH17		Anyone in provider's office talked about worrying/stressful aspects of patient's life		Comprehensive-ness
PCMH18		Anyone in provider's office talked with patient about personal problem, family problem, alcohol use, drug use, or a mental or emotional illness		Comprehensive-ness

CAHPS® Clinician & Group Survey

Version: 3.0

Population: Adult

Language: English

Notes

- **References to "this provider" rather than "this doctor:"** This survey uses "this provider" to refer to the individual specifically named in Question 1. A "provider" could be a doctor, nurse practitioner, physician assistant, or other individual who provides clinical care. Survey users may change "provider" to "doctor" throughout the questionnaire. For guidance, please see **Preparing a Questionnaire Using the CAHPS Clinician & Group Survey**.
- **Supplemental items:** Survey users may add questions to this survey. Please visit the CAHPS Web site to review supplemental items developed by the CAHPS Consortium and descriptions of major item sets.

For assistance with this survey, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

File name: adult-eng-cg30-2351a.docx
Last updated: July 1, 2015

Your Provider

1. Our records show that you got care from the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #23 on page 4**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?

[1] ☐ Yes
[2] ☐ No

3. How long have you been going to this provider?

[1] ☐ Less than 6 months
[2] ☐ At least 6 months but less than 1 year
[3] ☐ At least 1 year but less than 3 years
[4] ☐ At least 3 years but less than 5 years
[5] ☐ 5 years or more

Your Care From This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

4. In the last 6 months, how many times did you visit this provider to get care for yourself?

☐ None → **If None, go to #23 on page 4**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

5. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7**

6. In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

1 ☐ Yes
2 ☐ No → **If No, go to #9**

8. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

9. In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

1 ☐ Yes
2 ☐ No → **If No, go to #11**

10. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

11. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

12. In the last 6 months, how often did this provider listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

13. In the last 6 months, how often did this provider seem to know the important information about your medical history?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. In the last 6 months, how often did this provider show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

15. In the last 6 months, how often did this provider spend enough time with you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

16. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

1 ☐ Yes
2 ☐ No → **If No, go to #18**

17. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

18. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

☐ 0 Worst provider possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best provider possible

19. In the last 6 months, did you take any prescription medicine?

1 ☐ Yes
2 ☐ No → **If No, go to #21**

20. In the last 6 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

Clerks and Receptionists at This Provider's Office

21. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

22. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

About You

23. In general, how would you rate your overall health?

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

24. In general, how would you rate your overall **mental or emotional** health?

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

25. What is your age?

- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

26. Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

27. What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

28. Are you of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

29. What is your race? Mark one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or Other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other

30. Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No → **Thank you.**
  Please return the completed survey in the postage-paid envelope.

31. How did that person help you? Mark one or more.

- [1] ☐ Read the questions to me
- [2] ☐ Wrote down the answers I gave
- [3] ☐ Answered the questions for me
- [4] ☐ Translated the questions into my language
- [5] ☐ Helped in some other way

Thank you.

Please return the completed survey in the postage-paid envelope.

CAHPS® Clinician & Group Survey

Version: 3.0

Population: Child

Language: English

Notes

- **References to "this provider" rather than "this doctor:"** This survey uses "this provider" to refer to the individual specifically named in Question 1. A "provider" could be a doctor, nurse practitioner, physician assistant, or other individual who provides clinical care. Survey users may change "provider" to "doctor" throughout the questionnaire. For guidance, please see **Preparing a Questionnaire Using the CAHPS Clinician & Group Survey**.
- **Supplemental items:** Survey users may add questions to this survey. Please visit the CAHPS Web site to review supplemental items developed by the CAHPS Consortium and descriptions of major item sets.

For assistance with this survey, please contact the CAHPS Help Line at 800-492-9261 or cahps1@westat.com.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

Your Child's Provider

1. Our records show that your child got care from the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #28 on page 5**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if your child needs a check-up, has a health problem, or gets sick or hurt?

[1] ☐ Yes
[2] ☐ No

3. How long has your child been going to this provider?

[1] ☐ Less than 6 months
[2] ☐ At least 6 months but less than 1 year
[3] ☐ At least 1 year but less than 3 years
[4] ☐ At least 3 years but less than 5 years
[5] ☐ 5 years or more

Your Child's Care From This Provider in the Last 6 Months

These questions ask about **your child's** health care. Do **not** include care your child got when he or she stayed overnight in a hospital. Do **not** include the times your child went for dental care visits.

4. In the last 6 months, how many times did your child visit this provider for care?

☐ None → **If None, go to #28 on page 5**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

5. In the last 6 months, did you ever stay in the exam room with your child during a visit to this provider?

[1] ☐ Yes → **If Yes, go to #7**
[2] ☐ No

6. Did this provider give you enough information about what was discussed during the visit when you were not there?

[1] ☐ Yes → **If Yes, go to #10**
[2] ☐ No → **If No, go to #10**

7. Is your child able to talk with providers about his or her health care?

[1] ☐ Yes
[2] ☐ No → **If No, go to #10**

8. In the last 6 months, how often did this provider explain things in a way that was easy for **your child** to understand?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

9. In the last 6 months, how often did this provider listen carefully to **your child**?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

10. Did this provider tell you that you needed to do anything to follow up on the care your child got during the visit?

[1] ☐ Yes
[2] ☐ No → **If No, go to #12**

11. Did this provider give you enough information about what you needed to do to follow up on your child's care?

[1] ☐ Yes
[2] ☐ No

12. In the last 6 months, did you contact this provider's office to get an appointment for your child for an illness, injury, or condition that **needed care right away**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #14**

13. In the last 6 months, when you contacted this provider's office to get an appointment for **care your child needed right away**, how often did you get an appointment as soon as your child needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

14. In the last 6 months, did you make any appointments for a **check-up or routine care** for your child with this provider?

[1] ☐ Yes
[2] ☐ No → **If No, go to #16**

15. In the last 6 months, when you made an appointment for a **check-up or routine care** for your child with this provider, how often did you get an appointment as soon as your child needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

16. In the last 6 months, did you contact this provider's office with a medical question about your child during regular office hours?

[1] ☐ Yes
[2] ☐ No → **If No, go to #18**

17. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

18. In the last 6 months, how often did this provider explain things about your child's health in a way that was easy to understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. In the last 6 months, how often did this provider listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

20. In the last 6 months, how often did this provider seem to know the important information about your child's medical history?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

21. In the last 6 months, how often did this provider show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

22. In the last 6 months, how often did this provider spend enough time with your child?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

23. In the last 6 months, did this provider order a blood test, x-ray, or other test for your child?

1 ☐ Yes
2 ☐ No → **If No, go to #25**

24. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for your child, how often did someone from this provider's office follow up to give you those results?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

25. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ☐ 0 Worst provider possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best provider possible

Clerks and Receptionists at This Provider's Office

26. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

27. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

About Your Child and You

28. In general, how would you rate your child's overall health?

- [1] ☐ Excellent
- [2] ☐ Very Good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

29. In general, how would you rate your child's overall **mental or emotional** health?

- [1] ☐ Excellent
- [2] ☐ Very Good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

30. What is **your child's** age?

☐ Less than 1 year old

_____ YEARS OLD *(write in)*

31. Is your child male or female?

- [1] ☐ Male
- [2] ☐ Female

32. Is your child of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

33. What is your child's race? Mark one or more.

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or Other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other

34. What is **your** age?

- [0] ☐ Under 18
- [1] ☐ 18 to 24
- [2] ☐ 25 to 34
- [3] ☐ 35 to 44
- [4] ☐ 45 to 54
- [5] ☐ 55 to 64
- [6] ☐ 65 to 74
- [7] ☐ 75 or older

35. Are you male or female?

- [1] ☐ Male
- [2] ☐ Female

36. What is the highest grade or level of school that you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

37. How are you related to the child?

- [1] ☐ Mother or father
- [2] ☐ Grandparent
- [3] ☐ Aunt or uncle
- [4] ☐ Older brother or sister
- [5] ☐ Other relative
- [6] ☐ Legal guardian
- [7] ☐ Someone else

38. Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No → **Thank you.**
  Please return the completed survey in the postage-paid envelope.

39. How did that person help you? Mark one or more

- [1] ☐ Read the questions to me
- [2] ☐ Wrote down the answers I gave
- [3] ☐ Answered the questions for me
- [4] ☐ Translated the questions into my language
- [5] ☐ Helped in some other way

Thank you.

Please return the completed survey in the postage-paid envelope.

PERSON-CENTERED PRIMARY CARE MEASURE

v 2.1-ENG

HOW WOULD YOU ASSESS YOUR PRIMARY CARE EXPERIENCE?	
My practice makes it easy for me to get care.	Definitely Mostly Somewhat Not at all
My practice is able to provide most of my care.	Definitely Mostly Somewhat Not at all
In caring for me, my doctor considers all factors that affect my health.	Definitely Mostly Somewhat Not at all
My practice coordinates the care I get from multiple places.	Definitely Mostly Somewhat Not at all
My doctor or practice knows me as a person.	Definitely Mostly Somewhat Not at all
My doctor and I have been through a lot together.	Definitely Mostly Somewhat Not at all
My doctor or practice stands up for me.	Definitely Mostly Somewhat Not at all
The care I get takes into account knowledge of my family.	Definitely Mostly Somewhat Not at all
The care I get in this practice is informed by knowledge of my community.	Definitely Mostly Somewhat Not at all
Over time, my practice helps me to stay healthy.	Definitely Mostly Somewhat Not at all
Over time, my practice helps me to meet my goals.	Definitely Mostly Somewhat Not at all

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the measure description.
- Added a *Note* to the definition of "plan population" to clarify that it should be used as a denominator for the outlier rate.
- Removed "Risk Adjustment Tables" from the Definitions.
- Replaced references to "Table HCC-Surg" with references to the "Surgery Procedure Value Set" in the *Risk Adjustment Determination* section.
- Replaced references to "Table PCR-DischCC" with "Table CC_Mapping" in the *Risk Adjustment Determination* section.
- Updated the *Note* in the *Risk Adjustment Weighting* section for IHS that are discharged or transferred to skilled nursing care.
- Removed references to specific risk weight tables in the *Risk Adjustment Weighting* section.
- Clarified rounding rules in step 8 of the *Risk Adjustment Weighting* section.
- Revised the data element tables to separate the Medicaid and commercial product lines from the Medicare product line.

Description

For members 18 years of age and older, 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.

Note: *For commercial and Medicaid, report only members 18–64 years of age.*

Definitions

HIS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
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 numerator.

Plan population

Members who meet all of the following criteria:

- 18 and older as of January 1 of the measurement year.
- Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year.

Assign members to the product and product line at the start of this defined continuous enrollment period.

Note: *The plan population is only used as a denominator for the Outlier Rate.*

Outlier

Medicaid and Medicare members in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year.

Commercial members in the eligible population with three or more index hospital stays between January 1 and December 1 of the measurement year.

Assign members who transition between product lines during the measurement year to the product they were enrolled in on January 1 of the measurement year. If the member is an outlier and has a gap on January 1 of the measurement year, the member is assigned to the product line based on their last enrollment segment prior to January 1.

Nonoutlier

Members in the plan population who are not considered outliers.

Classification period

365 days prior to and including an Index Discharge Date.

Eligible Population

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

Refer to General Guideline 10: Reporting for small denominator limits.

Product line stratification

Commercial, Medicare, Medicaid (report each product line separately).

For only Medicare IHS, report the following SES stratifications and total:

- Non-LIS/DE, Nondisability.
- LIS/DE.
- Disability.
- LIS/DE and Disability.
- Other.
- Unknown.
- Total Medicare.

Note: *The stratifications are mutually exclusive and the sum of all six stratifications is the Total population.*

Ages	*For commercial,* ages 18–64 as of the Index Discharge Date. *For Medicare,* ages 18 and older as of the Index Discharge Date. *For Medicaid,* 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 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:

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 discharge date for the stay.

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.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

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 found in the *Guidelines for Risk Adjusted Utilization Measures.*

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:

- The member died during the stay.
- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- 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 Table PCR-1/2/3.

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 (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries Determine if the member underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code 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 CC_Mapping. For direct transfers, use the primary discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC_Mapping.

Comorbidities Refer to the *Risk Adjustment Comorbidity Category Determination* in the *Guidelines for Risk Adjusted Utilization Measures.*

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. Weights are specific to product line (Medicare Under 65, Medicare 65+, commercial, Medicaid). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Note: *For Medicare product lines, IHS that are discharged or transferred to skilled nursing care should be assigned two sets of risk adjustment weights; the skilled nursing care risk weights for reporting in Table PCR-E-3 and the standard set of risk weights for reporting in Table PCR-C-3 and Table PCR-D-3. For reporting IHS that are discharged or transferred to skilled nursing care, do not assign the skilled nursing care risk weights for the stays when reporting in Table PCR-C-3 and Table PCR-D-3 and do not assign the standard set or risk weights for the stays when reporting in Table PCR-E-3.*

Step 1 For each IHS discharge that is an observation stay, link the observation stay IHS weight.

Step 2 For each IHS with a surgery, link the surgery weight.

Step 3 For each IHS with a discharge CC Category, link the primary discharge weights.

Step 4 For each IHS with a comorbidity HCC Category, link the comorbidity weights.

Step 5 Link the age and gender weights for each IHS.

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

Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (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.

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

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 x 0.8481549259 = 0.1287881476.

Note: *When calculating variance at the IHS level, do not round. Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

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.

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 found in the *Guidelines for Risk Adjusted Utilization Measures.*

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 Encounter 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 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: *Count each acute hospitalization only once toward the numerator for the last denominator event.*

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- *Acute inpatient stay 1: May 1–10.*
- *Acute inpatient stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute inpatient stay 3: May 30–June 5.*

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15–25).

Reporting: Number of Members in Plan Population

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

Step 2 Report the count of members in the plan population for each age group and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

Reporting: Number of Outliers

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

Step 2 Report the count of outlier members for each age group and the overall total. Enter these values in reporting Tables PCR-1/2 and PCR-A-3.

Calculated: Outlier Rate

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall totals 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: SES Stratification (Medicare only)

Step 1 Determine the member's SES stratifications as of the end of the continuous enrollment period for each Medicare discharge:

- *Non-LIS/DE, Nondisability:* Member is eligible for Medicare due to age only (does not receive LIS, is not DE for Medicaid, does not have disability status).
- *LIS/DE:* Member is eligible for Medicare due to age and receives LIS (includes members eligible for Medicare due to DE), does not have disability status.
- *Disability*: Member is eligible for Medicare due to disability status only.
- *LIS/DE and Disability:* Member is eligible for Medicare, receives LIS and has disability status.
- *Other:* Member has ESRD-only status or is assigned "9—none of the above."
- *Unknown:* Member's SES is unknown.
- *Total Medicare:* Total of all categories.

Step 2 Report Medicare discharges based on the SES stratification assigned for each Medicare index stay in Table PCR-D-3.

Reporting: Skilled Nursing Care Stratification (Medicare only)

Step 1 For Medicare nonoutlier members, determine if the IHS was discharged or transferred to skilled nursing care (Skilled Nursing Stay Value Set).

An index stay is discharged or transferred to skilled nursing care when the discharge date from the acute inpatient or observation stay precedes the admission date for skilled nursing care by one calendar day or less. For example:

- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 1, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 2, is an IHS discharged or transferred to skilled nursing care.
- An index stay discharge on June 1, followed by an admission to a skilled nursing setting on June 3, is not an IHS discharged or transferred to skilled nursing care.

Step 2 Report Medicare discharges for each IHS discharged or transferred to skilled nursing care to an age group in Table PCR-E-3.

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 SES stratification (Medicare only), skilled nursing stratification (Medicare only) and 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-1/2: Plan Population and Outlier Rate (Medicaid, Commercial, 18-64)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
18-64 Total			

Table PCR-A-3: Plan Population and Outlier Rate (Medicare, 18+)

Age	Members in Plan Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
65-74			
75-84			
85+			
18-64 Total			
65+ Total			

Table PCR-B-1/2: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicaid, Commercial, 18–64)

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							
18-64 Total							

Table PCR-C-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by Age (Medicare, 18+)

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							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Table PCR-D-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members by SES Stratification (Medicare, 18+)

SES Stratification	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
Non-LIS/ DE, Non-disability	18-64							
	65+							
LIS/DE	18-64							
	65+							
Disability	18-64							
	65+							
LIS/DE and Disability	18-64							
	65+							
Other	18-64							
	65+							
Unknown	18-64							
	65+							

Table PCR-E-3: Plan All-Cause Readmissions Rates Among Nonoutlier Members Discharged or Transferred to Skilled Nursing Care by Age (Medicare, 18+)

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							
65-74							
75-84							
85+							
18-64 Total							
65+ Total							

Annual Monitoring for Patients on Persistent Medications (MPM)

SUMMARY OF CHANGES TO HEDIS 2019

- Removed "Lower 95% confidence interval" and "Upper 95% confidence interval" data elements from the Data Elements for Reporting tables.

Description

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on diuretics.
- Total rate (the sum of the two numerators divided by the sum of the two denominators).

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).
Ages	18 years and older 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 measurement year. To determine continuous enrollment for a Medicaid beneficiary 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.
Benefits	Medical and pharmacy.
Event/ diagnosis	Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to *Additional Eligible Population Criteria* for each rate. Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year. ***Note:*** *Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.*

Administrative Specification

For each product line, report each of the two rates separately and as a combined rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year (ACE Inhibitor/ARB Medications List).

ACE Inhibitor/ARB Medications

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan	• Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

Note: *Members may switch therapy with any medication on the ACE Inhibitor/ARB Medications List during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

Numerator

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set) on the same date of service or on different dates of service.

Rate 3: Annual Monitoring for Members on Diuretics

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Diuretic Medications List) during the measurement year.

Note: *Members may switch therapy with any medication on the Diuretic Medications List during the measurement year and have the days supply for those medications count toward the total 180 treatment days.*

Diuretic Medications

Description	Prescription
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan
Loop diuretics	• Bumetanide • Ethacrynic acid • Furosemide • Torsemide
Potassium-sparing diuretics	• Amiloride • Eplerenone • Spironolactone • Triamterene
Thiazide diuretics	• Chlorothiazide • Chlorthalidone • Hydrochlorothiazide • Indapamide • Methyclothiazide • Metolazone

Numerator

At least one serum potassium *and* a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***and*** a serum creatinine test (Serum Creatinine Value Set) on the same date of service or on different dates of service.

Exclusion *(optional)*

Exclude members from each eligible population who had an acute inpatient encounter (Acute Inpatient Value Set) or nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

Data Elements for Reporting

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

Table MPM-1/2/3: Data Elements for Annual Monitoring for Patients on Persistent Medications

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each of the 2 rates and total*
Number of optional exclusions	*For each of the 2 rates and total*
Numerator events by administrative data	*For each of the 2 rates and total*
Numerator events by supplemental data	*For each of the 2 rates and total*
Reported rate	*For each of the 2 rates and total*

Breast Cancer Screening (BCS)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added the "Number of required exclusions" data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

Description

The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Eligible Population

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

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratification	For only Medicare, report the following SES stratifications and total: • Non-LIS/DE, Nondisability. • LIS/DE. • Disability. • LIS/DE and Disability. • Other. • Unknown. • Total Medicare. ***Note:*** *The stratifications are mutually exclusive, and the sum of all six stratifications is the Total population.*
Ages	Women 52–74 years as of December 31 of the measurement year.
Continuous enrollment	October 1 two years prior to the measurement year through December 31 of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to the measurement year). To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.

No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Required exclusion Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- 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:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

- At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerator One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion *(optional)*

Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set).
- Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set).
  Note: *The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.*
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes from the table below that indicate a mastectomy on ***both*** the left ***and*** right side on the same or different dates of service.

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Left Modifier Value Set) (same procedure)	• Unilateral mastectomy (Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Right Modifier Value Set) (same procedure)
• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a left-side modifier (Clinical Left Modifier Value Set) (same procedure)	• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) ***with*** a right-side modifier (Clinical Right Modifier Value Set) (same procedure)
• Absence of the left breast (Absence of Left Breast Value Set)	• Absence of the right breast (Absence of Right Breast Value Set)
• Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)	• Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)

Note

- *This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) qualify for numerator compliance. Do not count MRIs, ultrasounds or biopsies towards the numerator: although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.*

Data Elements for Reporting

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

Table BCS-1/2: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Eligible population	✓
Number of optional exclusions	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓

Table BCS-3: Data Elements for Breast Cancer Screening

	Administrative
Measurement year	✓
Eligible population	*Each of the 6 stratifications and total*
Number of optional exclusions	*Each of the 6 stratifications and total*
Number of required exclusions	*Each of the 6 stratifications and total*
Numerator events by administrative data	*Each of the 6 stratifications and total*
Numerator events by supplemental data	*Each of the 6 stratifications and total*
Reported rate	*Each of the 6 stratifications and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Breast Cancer Screening

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age range may be expanded to 40-74 years of age.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Mammogram	No	Value sets and logic may not be changed.

Cervical Cancer Screening (CCS)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added palliative care as a required exclusion.
- Updated the Hybrid Specification to indicate that sample size reduction is allowed.
- Clarified that documentation of "vaginal hysterectomy" meets criteria for documentation of hysterectomy with no residual cervix (optional exclusion).
- Added the "Number of required exclusions" data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	*Commercial:* The measurement year and the two years prior to the measurement year. *Medicaid:* The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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.
Required exclusion	Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator The number of women who were screened for cervical cancer. Either of the following meets criteria:

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of the test.

  Note: *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore additional methods to identify cotesting are not necessary.*

Exclusion *(optional)*

Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual Cervix Value Set) any time during the member's history through December 31 of the measurement year.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

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

Medical record Appropriate screenings are defined by any of the following:

- Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the cervical cytology was performed.
    - The result or finding.
  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

  Note: *Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.*

- Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older as of the date of testing.
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test.
    - The results or findings.
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

  Note: *Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.*

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year. The following examples meet criteria for documentation of hysterectomy with no residual cervix:

- Documentation of "complete," "total" or "radical" hysterectomy (abdominal, vaginal or unspecified).
- Documentation of "vaginal hysterectomy."
- Documentation of "vaginal pap smear" in conjunction with documentation of "hysterectomy."
- Documentation of "hysterectomy" in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.
  - Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.

Data Elements for Reporting

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

Table CCS-1/2: Data Elements for Cervical Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
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 medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Cervical Cancer Screening

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Cervical cancer screening	No	Value sets and logic may not be changed.

Chlamydia Screening in Women (CHL)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- No changes to this measure.

Description

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia 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).

Ages Women 16–24 years as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 16–20 years.
- 21–24 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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 *Sexually active*. Two methods identify sexually active women: pharmacy data and claim/encounter data. The organization must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:

- Pregnancy Value Set.
- Sexual Activity Value Set.
- Pregnancy Tests Value Set.

Pharmacy data. Members who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List).

Contraceptive Medications

Description	Prescription	
Contraceptives	• Desogestrel-ethinyl estradiol • Dienogest-estradiol (multiphasic) • Drospirenone-ethinyl estradiol • Drospirenone-ethinyl estradiol-levomefolate (biphasic) • Ethinyl estradiol-ethynodiol • Ethinyl estradiol-etonogestrel • Ethinyl estradiol-levonorgestrel • Ethinyl estradiol-norelgestromin	• Ethinyl estradiol-norethindrone • Ethinyl estradiol-norgestimate • Ethinyl estradiol-norgestrel • Etonogestrel • Levonorgestrel • Medroxyprogesterone • Mestranol-norethindrone • Norethindrone
Diaphragm	• Diaphragm	
Spermicide	• Nonoxynol 9	

Administrative Specification

Denominator The eligible population.

Numerator At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Exclusion (optional)

Exclude members who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone ***and*** who meet either of the following:

- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List) on the date of the pregnancy test or the six days after the pregnancy test.
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or the six days after the pregnancy test.

Retinoid Medications

Description	Prescription
Retinoid	• Isotretinoin

Data Elements for Reporting

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

Table CHL-1/2: Data Elements for Chlamydia Screening in Women

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Number of optional exclusions	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Numerator events by supplemental data	*For each age stratification and total*
Reported rate	*For each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Chlamydia Screening in Women

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are acceptable.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are acceptable.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in medication lists and value sets may be used to identify sexual activity. Medication lists, value sets and logic may not be changed. Claims/encounter data or pharmacy data may be used to identify sexual activity.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Medication lists, and value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Chlamydia test	No	Value sets and logic may not be changed.

Colorectal Cancer Screening (COL)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added the "Number of required exclusions" data element to the Data Elements for Reporting table.
- Added guidance adjusting required exclusions criteria in the *Rules for Allowable Adjustments* section.

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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, Medicare (report each product line separately).
Stratification	For only Medicare, report the following SES stratifications and total: • Non-LIS/DE, Nondisability. • LIS/DE. • Disability. • LIS/DE and Disability. • Other. • Unknown. • Total Medicare. ***Note:*** *The stratifications are mutually exclusive, and the sum of all six stratifications is the Total population.*
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/diagnosis None.

Required exclusion

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- 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:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
       3. Identify the discharge date for the stay.
     - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
     - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
       2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

– A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerator One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT DNA Lab Test Value Set; FIT DNA Test Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

Exclusion *(optional)*

Either of the following any time during the member's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set).
- Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

For Medicare reporting, the denominator (MRSS) for the Total category is the entire systematic sample. Do not pull samples for each stratification. The individual stratifications for the denominators and all numerators must sum to the totals.

Numerator

One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following:

- FOBT during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA during the measurement year or the two years prior to the measurement year.

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 the date when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the member's "medical history"; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures:

- Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.
- Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.

- FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
  - *If the medical record does not indicate the number of returned samples,* assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that three or more samples were returned,* the member meets the screening criteria for inclusion in the numerator.
  - *If the medical record indicates that fewer than three samples were returned,* the member does not meet the screening criteria.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.

Exclusion *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the member's history through December 31 of the measurement year.

Data Elements for Reporting

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

Table COL-2: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
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 medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Table COL-3: Data Elements for Colorectal Cancer Screening

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	*Each of the 6 stratifications and total*	*Each of the 6 stratifications and total*
Number of required exclusions	*Each of the 6 stratifications and total*	*Each of the 6 stratifications and total*
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 oversampling records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		*Each of the 6 stratifications and total*
Numerator events by administrative data	*Each of the 6 stratifications and total*	*Each of the 6 stratifications and total*
Numerator events by medical records		*Each of the 6 stratifications and total*
Numerator events by supplemental data	*Each of the 6 stratifications and total*	*Each of the 6 stratifications and total*
Reported rate	*Each of the 6 stratifications and total*	*Each of the 6 stratifications and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Colorectal Cancer Screening

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Colorectal Cancer Screening	No	The value sets and the logic may not be changed.

Immunizations for Adolescents (IMA)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- No changes to this measure.

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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	Adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the member's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	For meningococcal, Tdap and HPV count *only* evidence of the antigen or combination vaccine.
Meningococcal serogroups A, C, W, Y	At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the member's 11th and 13th birthdays.

Tdap At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Immunization Value Set; Tdap Vaccine Procedure Value Set), with a date of service on or between the member's 10th and 13th birthdays.

HPV

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with dates of service at least 146 days apart on or between the member's 9th and 13th birthdays. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

OR

- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays.

Combination 1 (Meningococcal, Tdap) Adolescents who are numerator compliant for both the meningococcal and Tdap indicators.

Combination 2 (Meningococcal, Tdap, HPV) Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Exclusion *(optional)*

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Any of the following meet optional exclusion criteria:

Any particular vaccine

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Tdap

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set) anytime on or before the member's 13th birthday.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using current year's administrative rate or prior year's audited, product line-specific rate for the lowest rate across all antigens and combinations. For information on reducing the sample size, refer to the *Guidelines for Calculations and Sampling.*

Numerators For meningococcal, Tdap and HPV, count *only* the evidence of the antigen or combination vaccine.

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

Medical record For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal, *do not count* meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of "meningococcal" and generic documentation that "meningococcal vaccine," "meningococcal conjugate vaccine" or "meningococcal polysaccharide vaccine" were administered meet criteria.

Immunizations documented using a generic header of "Tdap/Td" can be counted as evidence of Tdap. The burden on organizations to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member's 13th birthday.

Note

- *To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure.*
- *To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).*

Data Elements for Reporting

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

Table IMA-1/2: Data Elements for Immunizations for Adolescents

	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 5 rates*
Current year's administrative rate (before exclusions)		*Each of the 5 rates*
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 5 rates*	*Each of the 5 rates*
Numerator events by medical records		*Each of the 5 rates*
Numerator events by supplemental data	*Each of the 5 rates*	*Each of the 5 rates*
Reported rate	*Each of the 5 rates*	*Each of the 5 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Immunizations for Adolescents

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age 13 as of June 30"). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Meningococcal • Tdap • HPV	No	Value sets and logic may not be changed. Vaccine dose requirements may not be changed.
• Combination Rates	Yes, with limits	Organizations are not required to calculate combination rates; alternate combinations of specified immunizations are allowed.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Removed the exclusion of member-reported biometric values (body mass index, height and weight).
- Added a *Note* to clarify that services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators.

Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Definitions

BMI percentile The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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 3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators:

- 3–11 years.
- 12–17 years.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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 An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

BMI Percentile BMI percentile (BMI Percentile Value Set) during the measurement year.

Counseling for Nutrition Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.

Counseling for Physical Activity Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Exclusions *(optional)*

Female members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these members must do so for all rates.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.

Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

BMI Percentile BMI percentile during the measurement year as identified by administrative data or medical record review.

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

Medical record

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile).
- BMI percentile plotted on an age-growth chart.

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Member-collected biometric values (height, weight, BMI percentile) that meet the requirements of *General Guideline 39: Member-Reported Services and Biometric Values* are eligible for use in reporting.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Counseling for Nutrition

Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical record

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

Counseling for Physical Activity

Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical record

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.

- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child's physical activity.
- Weight or obesity counseling.

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - ***BMI***
    - *No BMI percentile documented in medical record or plotted on age-growth chart.*
    - *Notation of BMI value only.*
    - *Notation of height and weight only.*
  - ***Nutrition***
    - *No counseling/education on nutrition and diet.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of nutrition.*
    - *A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.*
    - *Documentation related to a member's "appetite" does not meet criteria.*
  - ***Physical Activity***
    - *No counseling/education on physical activity.*
    - *Notation of "cleared for gym class" alone without documentation of a discussion.*
    - *Counseling/education before or after the measurement year.*
    - *Notation of "health education" or "anticipatory guidance" without specific mention of physical activity.*
    - *Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations.*
    - *Notation solely related to screen time (computer or television) without specific mention of physical activity.*
- *Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.*

  For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - *Notation that a member with chronic knee pain is able to run without limping.*
  - *Notation that a member has exercise-induced asthma.*
  - *Notation that a member with diarrhea is following the BRAT diet.*
  - *Notation that a member has decreased appetite as a result of an acute or chronic condition.*
- *Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.*

- *Referral to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.*
- *The Counseling for Nutrition and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephone visit, e-visit or virtual check-in meet criteria.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN practitioner.

Data Elements for Reporting

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

Table WCC-1/2: Data Elements for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*Each of the 3 rates*	*Each of the 3 rates*
Eligible population	*For each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 3 rates, for each age stratification and total*
Current year's administrative rate (before exclusions)		*Each of the 3 rates, for each age stratification and total*
Minimum required sample size (MRSS)		*Each of the 3 rates*
Oversampling rate		*Each of the 3 rates*
Number of oversample records		*Each of the 3 rates*
Number of medical records excluded because of valid data errors		*Each of the 3 rates*
Number of administrative data records excluded		*Each of the 3 rates*
Number of medical records excluded		*Each of the 3 rates*
Number of employee/dependent medical records excluded		*Each of the 3 rates*
Records added from the oversample list		*Each of the 3 rates*
Denominator		*Each of the 3 rates, for each age stratification and total*
Numerator events by administrative data	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Numerator events by medical records		*Each of the 3 rates, for each age stratification and total*
Numerator events by supplemental data	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*
Reported rate	*Each of the 3 rates, for each age stratification and total*	*Each of the 3 rates, for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (3–17 years). Organizations must consult UPSTSF guidelines when considering whether to expand the age ranges outside of the current thresholds.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• BMI Percentile • Counseling for Nutrition • Counseling for Physical Activity	No	Value sets and logic may not be changed.

Quality ID #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Preventive Care

2020 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2

INSTRUCTIONS:
There is no diagnosis associated with this measure. This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters" (See Definitions for examples of follow-up plan treatments). *If more than one BMI is submitted during the measurement period, the most recent BMI will be used to determine if the performance has been met. Review the exclusions and exceptions criteria to determine those patients that BMI measurement may not be appropriate or necessary.*

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

DENOMINATOR:
All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

Denominator Criteria (Eligible Cases):
Patients aged ≥18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 99201, 99202,

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99203, 99204, 99205, 99212, 99213, 99214, 99215, 99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, D7111, D7140, D7210, D7220, D7230, D7240,D7241, D7250, D7251,G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

NUMERATOR:

Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter

Definitions:

BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI outside of normal parameters. A follow-up plan may include, but is not limited to:

- Documentation of education
- Referral (for example a Registered Dietitian Nutritionist (RDN), occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), for lifestyle/behavioral therapy
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- Nutrition counseling

Not Eligible for BMI Calculation or Follow-Up Plan (Denominator Exclusion) – A patient is not eligible if one or more of the following reasons are documented:

- Patients receiving palliative or hospice care on the date of the current encounter or any time prior to the current encounter
- Patients who are pregnant on the date of the current encounter or any time during the measurement period prior to the current encounter
- Patients who refuse measurement of height and/or weight on the date of the current encounter or any time during the measurement period prior to the current encounter

Patients with a documented BMI outside normal limits and a documented reason for not completing BMI follow-up plan during the current encounter or within the previous 12 months of the current encounter (Denominator Exception):

- Patients with a documented Medical Reason. The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider
- Elderly patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
    - Illness or physical disability
    - Mental illness, dementia, confusion
    - Nutritional deficiency, such as vitamin/mineral deficiency

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- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

Numerator Instructions:

- Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within twelve months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- Follow-Up Plan – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above or below normal parameters". (See Definitions for examples of follow-up plan treatments).
- Performance Met for **G8417** & **G8418**
    - If the provider documents a BMI and a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous twelve months of the current encounter, the provider documents a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous twelve months of the current encounter **AND** the patient has a documented follow-up plan for a BMI outside normal parameters within the previous twelve months of the current visit

Numerator Quality-Data Coding Options:

BMI not Documented, Patient not Eligible
Denominator Exclusion: **G8422:** BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible
Denominator Exclusion: **G8938:** BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI Documented as Normal, No Follow-Up Plan Required
Performance Met: **G8420:** BMI is documented within normal parameters and no follow-up plan is required

OR

BMI Documented as Above Normal Parameters, AND Follow-Up Documented
Performance Met: **G8417:** BMI is documented above normal parameters and a follow-up plan is documented

OR

BMI Documented as Below Normal Parameters, AND Follow-Up Documented
Performance Met: **G8418:** BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI Documented Outside of Normal Limits, Follow-Up Plan not Completed for Documented Reason
Denominator Exception: **G9716:** BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason

OR

BMI not Documented, Reason not Given
Performance Not Met: **G8421:** BMI not documented and no reason is given

OR

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BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given

***Performance Not Met:* G8419:** BMI documented outside normal parameters, no follow-up plan documented, no reason given

RATIONALE:

BMI Above Normal Parameters

Obesity is a chronic, multifactorial disease with complex psychological, environmental (social and cultural), genetic, physiologic, metabolic and behavioral causes and consequences. The prevalence of overweight and obese people is increasing worldwide at an alarming rate in both developing and developed countries. Environmental and behavioral changes brought about by economic development, modernization and urbanization have been linked to the rise in global obesity. The health consequences are becoming apparent (Fitch, 2013. p.6).

Hales et al (2017), report that the prevalence of obesity among adults and youth in the United States was 39.8% and 18.5% respectively, from 2015–2016. They note that obesity prevalence was higher among adults in the 40–59 age bracket than those in the 20–39 age bracket, for both men and women. Hales et al. (2017) also disaggregated the data according to ethnicity and noted that obesity prevalence was higher among non-Hispanic black and Hispanic adults and youth when compared with other races ethnicities. While obesity prevalence was lower among non-Hispanic Asian men and women, obesity prevalence among men, was comparable between non-Hispanic black and non-Hispanic white men. Obesity prevalence was higher among Hispanic men compared with non-Hispanic black men. While the prevalence among non-Hispanic black and Hispanic women was comparable, the prevalence for both groups was higher than that of non-Hispanic white women. Most notably, Hales et al. (2017), report that the prevalence of obesity in the United States remains higher than the Healthy People 2020 goals of 14.5% among youth and 30.5% among adults.

More than a third of U.S. adults have a body mass index [BMI] ≥ 30 kg/m2; substantially at increased risk for diabetes and cardiovascular disease (CVD) (Flegal et al., 2012; Ogden et al., 2014). Behavioral weight management treatment has been identified as an effective first-line treatment for obesity with an average initial weight loss of eight to ten percent. This percentage weight loss is associated with a significant risk reduction for diabetes and CVD (Wadden, Butryn & Wilson, 2007). Despite the availability of effective interventions, two-thirds of obese U.S. patients were not offered or referred to weight management treatment during their primary care visit between 2005 and 2006 (Ma et al., 2009). In addition, the rate of weight management counseling in primary care significantly decreased by ten percent (40% to 30%) between 1995–1996 and 2007–2008 (Kraschnewski et al., 2013). This suggests that the availability of evidence based clinical guidelines since 2008 obesity management in primary care remains suboptimal (Fitzpatrick & Stevens, 2017).

BMI continues to be a common and reasonably reliable measurement to identify overweight and obese adults who may be at an increased risk for future morbidity. Although good quality evidence supports obtaining a BMI, it is important to recognize it is not a perfect measurement. BMI is not a direct measure of adiposity and as a consequence it can over- or underestimate adiposity. BMI is a derived value that correlates well with total body fat and markers of secondary complications, e.g., hypertension and dyslipidemia (Barlow & the Expert Committee, 2007).

In contrast with waist circumference, BMI and its associated disease and mortality risk appear to vary among ethnic subgroups. Female African American populations appear to have the lowest mortality risk at a BMI of 26.2-28.5 kg/m2 and 27.1-30.2 kg/m2 for women and men, respectively. In contrast, Asian populations may experience lowest mortality rates starting at a BMI of 23 to 24 kg/m2. The correlation between BMI and diabetes risk also varies by ethnicity (LeBlanc et al., 2011. p.2-3).

Screening for BMI and follow-up therefore is critical to closing this gap and contributes to quality goals of population health and cost reduction. However, due to concerns for other underlying conditions (such as bone health) or nutrition related deficiencies providers are cautioned to use clinical judgment and take these into account when

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considering weight management programs for overweight patients, especially the elderly (National Heart, Lung, and Blood Institute [NHLBI] Obesity Education Initiative, 1998, p. 91).
It is important to enhance beneficiary access to all existing providers of Intensive Behavioral Therapy for obesity (IBT) which would result in decreased healthcare costs and lower obesity rates. Dietary counseling performed by a Registered Dietitian Nutritionist (RDN) is more effective than by a primary care clinician. IBT provided by RDNs for 6-12 months shows significant mean weight loss of up to 10% of body weight, maintained over one year's time (Raynor & Champagne, 2016).

BMI below Normal Parameters
On the other end of the body weight spectrum is underweight (BMI <18.5 kg/m2), which is equally detrimental to population health. When compared to normal weight individuals (BMI 18.5-25 kg/m2), underweight individuals have significantly higher death rates with a Hazard Ratio of 2.27 and 95% confidence intervals (CI) = 1.78, 2.90 (Borrell & Lalitha, 2014).

Poor nutrition or underlying health conditions can result in underweight (Fryer & Ogden, 2012). The National Health and Nutrition Examination Survey (NHANES) results from the 2007-2010 indicate that women are more likely to be underweight than men. Therefore patients should be equally screened for underweight and followed up with nutritional counselling to reduce mortality and morbidity associated with underweight.

CLINICAL RECOMMENDATION STATEMENTS:
All adults should be screened annually using a BMI measurement. BMI measurements ≥ 25kg/m2 should be used to initiate further evaluation of overweight or obesity after taking into account age, gender, ethnicity, fluid status, and muscularity; therefore, clinical evaluation and judgment must be used when BMI is employed as the anthropometric indicator of excess adiposity, particularly in athletes and those with sarcopenia (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. pp. 12-13) (Grade A).

Overweight and Underweight Categories:

Underweight <18.5; Normal weight 18.5-24.9; Overweight 25-29.9; Obese class I 30-34.9; Obese class II 35-39.9; Obese class III ≥40 (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 15).

When evaluating patients for adiposity related disease risk, waist circumference should be measured in all patients with BMI <35 kg/m2 (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 13) (Grade A).

BMI cutoff point value of ≥23 kg/m2 should be used in the screening and confirmation of excess adiposity in Asian adults (Garvey, et al., 2016 AACE/ACE Guidelines, 2016,. p. 13) (Grade B).

In the United States the waist circumference cutoff points that can be used to indicate increased risk are ≥102 cm (>40 inches) for men and ≥88 cm (>35 inches) for women (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 13) (Grade A).

Lifestyle/Behavioral Therapy for Overweight and Obesity should include behavioral interventions that enhance adherence to prescriptions for a reduced-calorie meal plan and increased physical activity (behavioral interventions can include: self-monitoring of weight, food intake, and physical activity; clear and reasonable goal-setting; education pertaining to obesity, nutrition, and physical activity; face-to-face and group meetings; stimulus control; systematic approaches for problem solving; stress reduction; cognitive restructuring [i.e., cognitive behavioral therapy], motivational interviewing; behavioral contracting; psychological counseling; and mobilization of social support structures) (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 22) (Grade A).

Behavioral lifestyle intervention should be tailored to a patient's ethnic, cultural, socioeconomic, and educational background (Garvey, et al., 2016 AACE/ACE Guidelines, 2016. p. 22) (Grade B).

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USPSTF Clinical Guideline (Grade B Recommendation)
The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.
Interventions:

- Effective intensive behavioral interventions were designed to help participants achieve or maintain a ≥5% weight loss through a combination of dietary changes and increased physical activity
- Most interventions lasted for 1 to 2 years, and the majority had ≥12 sessions in the first year
- Most behavioral interventions focused on problem solving to identify barriers, self-monitoring of weight, peer support, and relapse prevention
- Interventions also provided tools to support weight loss or weight loss maintenance (e.g., pedometers, food scales, or exercise videos) (USPSTF, 2018).

The USPSTF recommends screening for abnormal blood glucose levels as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or have obesity. Patients with certain risk factors (family history of diabetes, personal history of gestational diabetes or polycystic ovarian syndrome, or being a member of certain racial/ethnic groups [African American, American Indian or Alaskan Native, Asian American, Hispanic or Latino, or Native Hawaiian or Pacific Islander]) may also be at increased risk of diabetes at a younger age or at a lower BMI and should be considered for screening (USPSTF, 2018).

Nutritional safety for the elderly should be considered when recommending weight reduction. “A clinical decision to forego obesity treatment in older adults should be guided by an evaluation of the potential benefits of weight reduction for day-to-day functioning and reduction of the risk of future cardiovascular events, as well as the patient’s motivation for weight reduction. Care must be taken to ensure that any weight reduction program minimizes the likelihood of adverse effects on bone health or other aspects of nutritional status” (NHLBI Obesity Education Initiative, 1998, p. 91) (Evidence Category D). In addition, weight reduction prescriptions in older persons should be accompanied by proper nutritional counseling and regular body weight monitoring (NHLBI Obesity Education Initiative, 1998, p. 91).

The possibility that a standard approach to weight loss will work differently in diverse patient populations must be considered when setting expectations about treatment outcomes (NHLBI Obesity Education Initiative, 1998, p. 97) (Evidence Category B).

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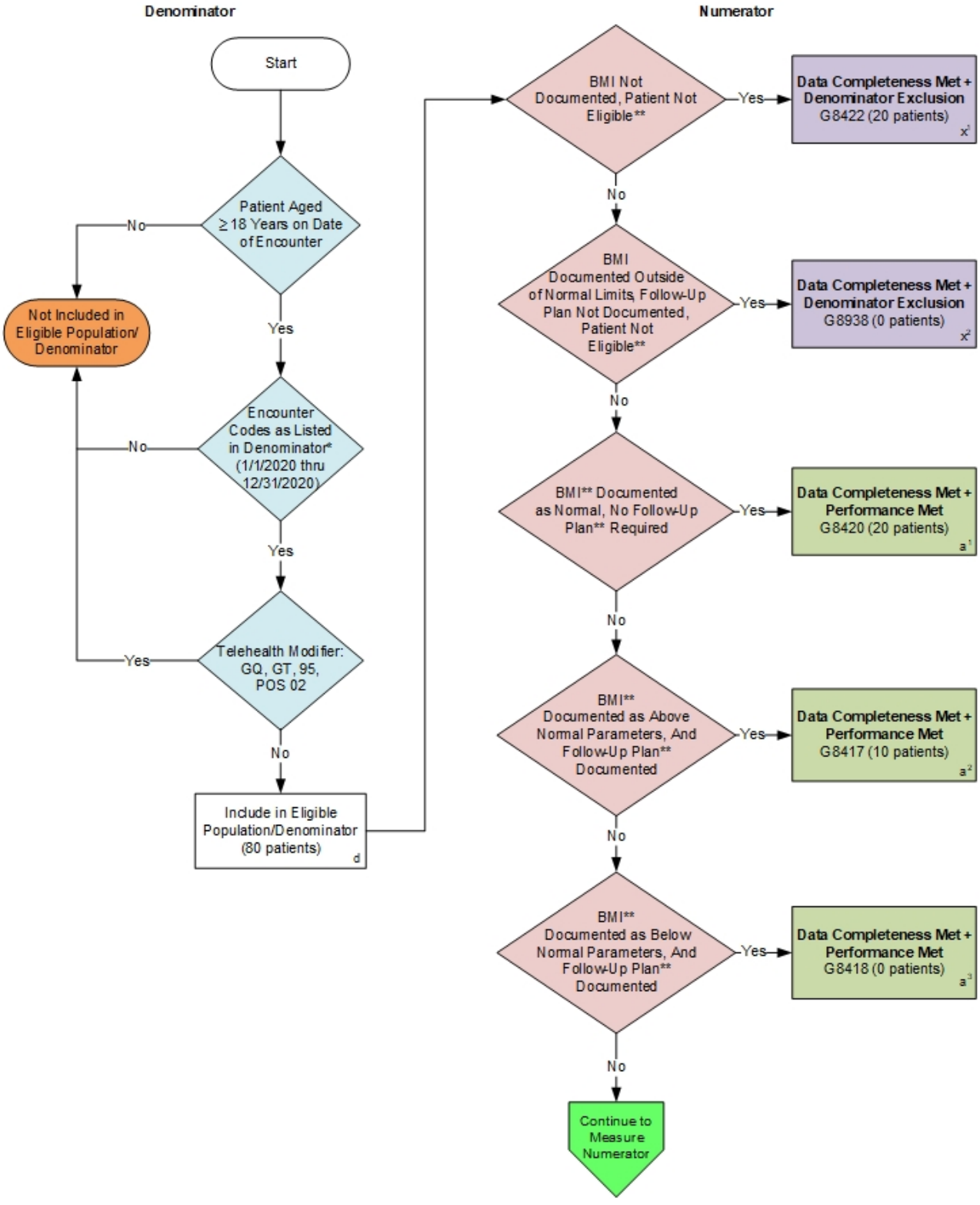
2020 Medicare Part B Claims Flow for Quality ID #128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



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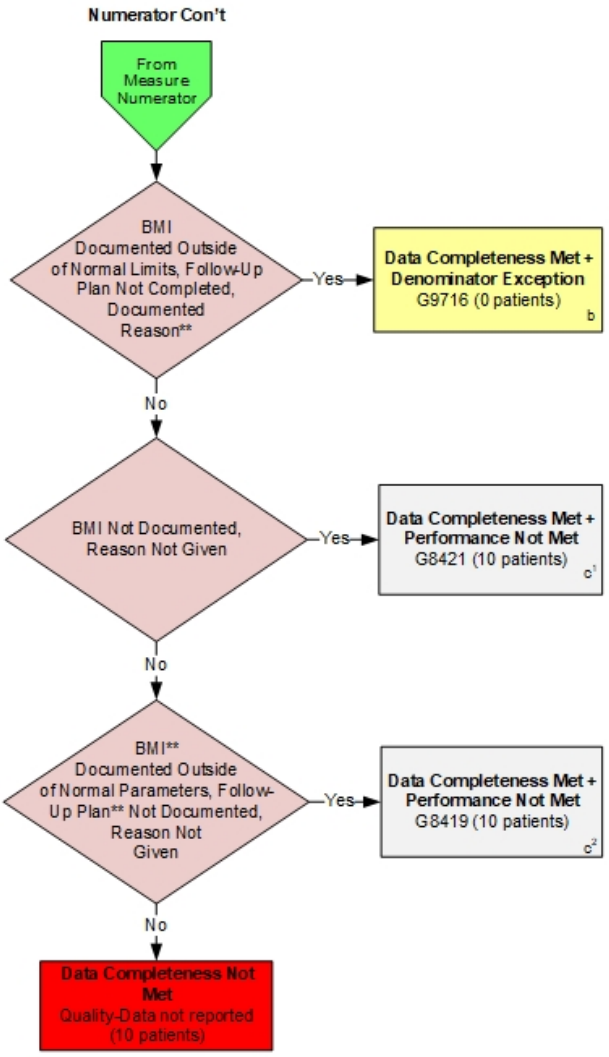

SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Denominator Exclusion}(x^1+x^2=20 \text{ patients}) + \text{Performance Met}(a^1+a^2+a^3=30 \text{ patients}) + \text{Denominator Exception}(b=0 \text{ patients}) + \text{Performance Not Met}(c^1+c^2=20 \text{ patients})}{\text{Eligible Population / Denominator (d=80 patients)}} = \frac{70 \text{ patients}}{80 \text{ patients}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met}(a^1+a^2+a^3=30 \text{ patients})}{\text{Data Completeness Numerator (70 patients)} - \text{Denominator Exclusion}(x^1+x^2=20 \text{ patients}) - \text{Denominator Exception}(b=0 \text{ patients})} = \frac{30 \text{ patients}}{50 \text{ patients}} = \mathbf{60.00\%}$$

* See the posted measure specification for specific coding and instructions to submit this measure.
** See the posted measure specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.
NOTE : Submission Frequency: Patient-Intermediate

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2020 Medicare Part B Claims Flow Narrative For Quality ID #128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check Patient Age:
    a. If the Patient Age is greater than or equal to 18 years on Date of Encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing.
    b. If the Patient Age is greater than or equal to 18 years on Date of Encounter equals Yes during the measurement period, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in the Denominator equals Yes, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier as Listed in the Denominator equals No, include in Eligible Population.
    b. If Telehealth Modifier as Listed in the Denominator equals Yes, do not include in Eligible Population. Stop Processing.
5. Denominator Population
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
6. Start Numerator
7. Check BMI Not Documented, Patient Not Eligible**:
    a. If BMI Not Documented, Patient Not Eligible** equals Yes, include in Data Completeness Met and Denominator Exclusion.
    b. Data Completeness Met and Denominator Exclusion is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter x^1 equals 20 patients in Sample Calculation.
    c. If BMI Not Documented, Patient Not Eligible equals No, proceed to check BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible**.
8. Check BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible**:
    a. If BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible** equals Yes, include in Data Completeness Met and Denominator Exclusion.

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b. Data Completeness Met and Denominator Exclusion letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter x^2 equals 0 patients in Sample Calculation.

c. If BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible** equals No, proceed to check BMI** Documented as Normal, No Follow-Up Plan** Required.

9. Check BMI** Documented as Normal, No Follow-Up Plan** Required:

   a. If BMI** Documented as Normal, No Follow-Up Plan** Required equals Yes, include in Data Completeness Met and Performance Met.

   b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 10 patients in Sample Calculation.

   c. If BMI** Documented as Normal, No Follow-Up Plan** Required equals No, proceed to check BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented.

10. Check BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented:

    a. If BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented equals Yes, include in Data Completeness Met and Performance Met.

    b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 10 patients in Sample Calculation.

    c. If BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented equals No, proceed to check BMI** Documented as Below Normal Parameters, And Follow-Up Plan** Documented

11. Check BMI** Documented as Below Normal Parameters, And Follow-Up Plan** Documented:

    a. If BMI** Documented as Below Normal Parameters, And Follow-up Plan** Documented equals Yes, include in Data Completeness Met and Performance Met.

    b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 10 patients in Sample Calculation.

    c. If BMI** Documented as Below Normal Parameters, And Follow-Up Plan** Documented equals No, proceed to check BMI Documented Outside of Normal Limits, Follow-Up Plan Not Completed, Documented Reason.**

12. Check BMI Documented Outside of Normal Limits, Follow-Up Plan Not Completed, Documented Reason**:

    a. If BMI Documented Outside of Normal Limits, Follow-Up Plan Not Completed, Documented Reason** equals Yes, include in Data Completeness Met and Denominator Exception.

    b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 0 patients in Sample Calculation.

    c. If BMI Documented Outside of Normal Limits, Follow-Up Plan Not Completed, Documented Reason** equals No, proceed to check BMI Not Documented, Reason Not Given.

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13. Check BMI Not Documented, Reason Not Given:

    a. If BMI Not Documented, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    c. If BMI Not Documented, Reason Not Given equals No, proceed to check BMI** Documented Outside of Normal Parameters, Follow-Up Plan** Not Documented, Reason Not Given.

14. Check BMI** Documented Outside of Normal Parameters, Follow-Up Plan** Not Documented, Reason Not Given:

    a. If BMI** Documented Outside of Normal Parameters, Follow-up Plan** Not Documented, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    c. If BMI** Documented Outside of Normal Parameters, Follow-up Plan** Not Documented, Reason Not Given equals No, proceed to check Data Completeness Not Met

15. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality Data Code was not reported. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation

SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Denominator Exclusion } (x^1+x^2=20 \text{ patients}) + \text{Performance Met } (a^1+a^2+a^3=30 \text{ patients}) + \text{Denominator Exception } (b=0 \text{ patients}) + \text{Performance Not Met } (c^1+c^2=20 \text{ patients})}{\text{Eligible Population / Denominator } (d=80 \text{ patients})} = \frac{70 \text{ patients}}{80 \text{ patients}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2+a^3=30 \text{ patients})}{\text{Data Completeness Numerator } (70 \text{ patients}) - \text{Denominator Exclusion } (x^1+x^2=20 \text{ patients}) - \text{Denominator Exception } (b=0 \text{ patients})} = \frac{30 \text{ patients}}{50 \text{ patients}} = \mathbf{60.00\%}$$

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MEASURE DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

Oregon Health and Sciences University

A. DESCRIPTION

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported. The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C).
- The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts. For example, a state could do a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening. Another example, is that states may encourage use of a Z code or other modifiers to distinguish amongst tools (https://www.aap.org/en-us/documents/coding_preventive_care.pdf).
- To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
- Only those tools cited in the specifications for this measure meet the criteria for the numerator. During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays. States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.

The following coding system is used in this measure: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

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B. ELIGIBLE POPULATION

Age	Children age 1, 2, or 3 between January 1 and December 31 of the measurement year.
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
Anchor date	Enrolled on the child's first, second, or third birthday.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

The children in the eligible population who turned 1 during the measurement year.

Denominator 2

The children in the eligible population who turned 2 during the measurement year.

Denominator 3

The children in the eligible population who turned 3 during the measurement year.

Denominator 4

All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. This measure is based on three, age-specific indicators.

Numerator 1

Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2

Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

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Numerator 3

Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4

Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data

CPT code 96110 (Developmental testing, with interpretation and report)

Important note about appropriate use of claims data

This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with “Tools must meet the following criteria.” States that have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

Claims NOT included in this measure

It is important to note that modified 96110 claims (for example, where modifiers are added to claims indicating standardized screening for a specific domain of development such as social emotional screening via the ASQ-SE, autism screening) should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

Exclusions

None.

D. MEDICAL RECORD SPECIFICATION

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1

137 children from the sample who turned 1 during the measurement year.

Denominator 2

137 children from the sample who turned 2 during the measurement year.

Denominator 3

137 children from the sample who turned 3 during the measurement year.

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented before or on their first birthday.

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Numerator 2

Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday.

Numerator 3

Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday.

Numerator 4

Children in Denominator 4 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented in the 12 months preceding or on their first, second or third birthday (the sum of numerators 1, 2 and 3).

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The following tools included in the Bright Futures Recommendations for Preventive Care which reference the updated January 2020 American Academy of Pediatrics Statement: Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening and meet the above criteria**:**

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

Note: The 2020 AAP statement provides descriptive information about the screening tool properties that may be useful for states to consider in designing their policies.

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Tools that meet the criteria, were included in the 2006 statement, and not listed in 2020 Statement as they often are not used by primary care providers in the context of routine well-child care include the following:

- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months

Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Tools listed above: The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that have met the above criteria. Bright Futures cites the 2020 American Academy of Pediatrics Statement: Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening..

Exclusions

None.

E. CALCULATION ALGORITHM

Step 1

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned age one, two or three between January 1 and December 31 of the measurement year.

Step 2

Determine the numerators.

For each age cohort, and for the total, identify children who had a screening for developmental, behavioral, and social delays performed before or on their birthday as found through claims data or documented in the medical chart.

Administrative Data: Children for whom a claim of 96110 was submitted for services in the 12 months preceding or on their birthday.

Medical Record Review: Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding or on their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

Step 3

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Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4

Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a statewide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children sampled in the age-specific and total rates reported to CMS.

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

SUMMARY OF CHANGES TO HEDIS 2020

- Added instructions to not count services provided via telehealth when reporting this measure.
- Added a *Note* to clarify that handouts given during a visit without evidence of a discussion does not meet criteria for Health Education/Anticipatory Guidance.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

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 First 30 Months of Life (W30)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the measure name to *Well-Child Visits in the First 30 Months of Life*.
- Retired the 0, 1, 2, 3, 4 and 5 well-child visit rates.
- Added Rate 2 for children who turned 30 months old during the measurement year and had two or more well-child visits in the last 15 months.
- Removed the Hybrid Data Collection Method.
- Removed the telehealth exclusion.
- Revised the Data Elements for Reporting table.
- Revised the Ages criteria in the *Rules for Allowable Adjustments* section to only allow ranges within the specified age range of the measure.

Description

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. *Well-Child Visits in the First 15 Months*. Children who turned 15 months old during the measurement year: Six or more well-child visits.
2. *Well-Child Visits for Age 15 Months–30 Months*. Children who turned 30 months old during the measurement year: Two 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.*

Eligible Population: *Rate 1*—Well-Child Visits in the First 15 Months

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).
Ages	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 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 (e.g., 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.

Administrative Specification: *Rate 1*—Well-Child Visits in the First 15 Months

Denominator	The Rate 1 eligible population.
Numerator	Six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Eligible Population: *Rate 2*—Well-Child Visits for Age 15 Months–30 Months

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).
Ages	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 (e.g., 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.

Administrative Specification: *Rate 2*—Well-Child Visits for Age 15 Months–30 Months

Denominator	The Rate 2 eligible population.
Numerator	Two or more well-child 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. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

- *Refer to Appendix 3 for the definition of PCP.*
- *This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).*

Data Elements for Reporting

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

Table W30-1/2: Data Elements for Well-Child Visits in the First 30 Months of Life

	Administrative
Measurement year	✓
Eligible population	*Each of the 2 rates*
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Well-Child Visits in the First 30 Months of Life

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 15 months as of June 30"). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Well Care Visits in the First 15 Months • Well Care Visits for Age 15 Months–30 Months	No	Value sets and logic may not be changed.

Adolescent Well-Care Visits (AWC)

SUMMARY OF CHANGES TO HEDIS 2020

- Added instructions to not count services provided via telehealth when reporting this measure.
- Added a *Note* to clarify that handouts given during a visit without evidence of a discussion does not meet criteria for Health Education/Anticipatory Guidance.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

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	✓	✓

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- This measure is a combination measure that replaces the former "Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life" and "Adolescent Well-Care Visits" HEDIS measures.
- Added members age 7–11 years.
- Added age stratifications.
- Removed the Hybrid Data Collection Method.
- Removed the telehealth exclusion.
- Revised the Data Elements for Reporting table.
- Revised the Ages criteria in the *Rules for Allowable Adjustments* section to only allow ranges within the specified age range.

Description

The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

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).
Ages	3–21 years as of December 31 of the measurement year. Report three age stratifications and total rate: • 3–11 years. • 12–17 years. • 18–21 years. • Total. The total is the sum of the age stratifications for each product line.
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 (e.g., 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 One or more well-care visits (Well-Care Value Set) during the measurement year.

The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Note

- *Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal care practitioners.*
- *This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).*

Data Elements for Reporting

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

Table WCV-1/2: Data Elements for Child and Adolescent Well-Care Visits

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Numerator events by supplemental data	*For each age stratification and total*
Reported rate	*For each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Child and Adolescent Well-Care Visits

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (3–21 years). Organizations must consult American Academy of Pediatrics guidelines when considering whether to expand the age ranges outside of the current thresholds.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	NA	There is no event/diagnosis for this measure.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Well-Child Visit(s)	No	Value sets and logic may not be changed.

Quality ID #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2020 COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. For this implementation of the measure, the denominator eligible encounter should be used to determine if the numerator action for each of the submission criteria was performed within the 24 month look back period from the date of the denominator eligible encounter. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who provided the measure-specific denominator coding.

This measure will be calculated with 3 performance rates:

1) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
2) Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
3) Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients, submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1) All patients who were screened for tobacco use

AND

2) All patients who were identified as a tobacco user and who received tobacco cessation intervention

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AND

3) All patients who were screened for tobacco use and, if identified as a tobacco user received tobacco cessation intervention, or identified as a tobacco non-user

This measure contains three submission criteria which aim to identify patients who were screened for tobacco use (submission criteria 1), patients who were identified as tobacco users and who received tobacco cessation intervention (submission criteria 2), and a comprehensive look at the overall performance on tobacco screening and cessation intervention (submission criteria 3). By separating this measure into various submission criteria, the MIPS eligible professional or MIPS eligible clinician will be able to better ascertain where gaps in performance exist, and identify opportunities for improvement. The overall rate (submission criteria 3) can be utilized to compare performance to published versions of this measure prior to the 2018 performance year, when the measure had a single performance rate. For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE

DENOMINATOR (SUBMISSION CRITERIA 1):
All patients aged 18 years and older

DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 9951349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439
WITHOUT
Telehealth Modifier: GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 1):
Patients who were screened for tobacco use at least once within 24 months

Definitions:
Tobacco Use – Includes any type of tobacco.

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and tobacco status is unknown, submit G9905.

Denominator Exception(s) are determined on the date of the denominator eligible encounter for all submission criteria.

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Numerator Quality-Data Coding Options:

Patient Screened for Tobacco Use, Identified as a Tobacco User or Tobacco Non-User

***Performance Met:* G9902:** Patient screened for tobacco use AND identified as a tobacco user

OR

***Performance Met:* G9903:** Patient screened for tobacco use AND identified as a tobacco non-user

OR

Tobacco Use Screening not Performed for Medical Reasons

(One G-code [G9904] is required on the claim form to submit documented circumstances when the action described in the numerator is not performed for medical reasons.)

***Denominator Exception:* G9904:** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

OR

Tobacco Use Screening not Performed, Reason Not Given

(One G-code [G9905] is required on the claim form to submit circumstances when the action described in the numerator is not performed and the reason is not given.)

***Performance Not Met:* G9905:** Patient not screened for tobacco use, reason not given

SUBMISSION CRITERIA 2: ALL PATIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

DENOMINATOR (SUBMISSION CRITERIA 2):

All patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user

***DENOMINATOR NOTE:** *Signifies that this CPT Category I code is a non-covered service under the PFS. These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

All eligible instances when **G9902** is submitted for Performance Met (patient screened for tobacco use AND identified as a tobacco user) in the numerator of Submission Criteria 1

AND

Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 2):

Patients who received tobacco cessation intervention

Definitions:

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

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Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

NUMERATOR NOTE: *If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.*

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.

Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter for all submission criteria.

Numerator Quality-Data Coding Options:

Patient Identified as Tobacco User Received Tobacco Cessation Intervention

(Two G-codes [G9902 & G9906] are required on the claim form to submit when the action described in the numerator is performed.)

Performance Met: **G9906:**	Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)

OR

Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention for Medical Reason(s)

(Two G-codes [G9902 & G9907] are required on the claim form to submit documented circumstances when the action described in the numerator is not performed for medical reason(s).)

Denominator Exception: **G9907:**	Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

OR

Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention, Reason Not Given

(Two G-codes [G9902 & G9908] are required on the claim form to submit circumstances when the action described in the numerator is not performed and the reason is not given.)

Performance Not Met: **G9908:**	Patient identified as tobacco user did not receive tobacco cessation intervention (counseling and/or pharmacotherapy), reason not given

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER RECEIVED TOBACCO CESSATION INTERVENTION, OR IDENTIFIED AS A TOBACCO NON-USER

DENOMINATOR (SUBMISSION CRITERIA 3):

All patients aged 18 years and older

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DENOMINATOR NOTE: **Signifies that this CPT Category I code is a non-covered service under the PFS (Physician Fee Schedule). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439
WITHOUT
Telehealth Modifier: GQ, GT, 95, POS 02

NUMERATOR (SUBMISSION CRITERIA 3):
Patients who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user

Definitions:
Tobacco Use – Includes any type of tobacco.
Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy. Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates. (U.S. Preventive Services Task Force, 2015)

NUMERATOR NOTE: *To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention, or if tobacco status is unknown, submit 4004F with 8P.

If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit CPT II 4004F.

Denominator Exception(s) are determined on the date of the denominator eligible encounter for all submission criteria.

Numerator Quality-Data Coding Options:
Patient Screened for Tobacco Use, Identified as a Tobacco User and Received Tobacco Cessation Intervention
Performance Met: **CPT II 4004F:** Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or

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both), if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Tobacco Non-User

***Performance Met:* CPT II 1036F:** Current tobacco non-user

OR

Tobacco Screening not Performed OR Tobacco Cessation Intervention not Provided for Medical Reasons

Append a modifier (1P) to CPT Category II code 4004F OR submit a G-code (G9909) to submit documented circumstances that appropriately exclude patients from the denominator.

***Denominator Exception:* 4004F *with* 1P:** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

OR

***Denominator Exception:* G9909** Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other medical reason)

OR

Tobacco Screening not Performed OR Tobacco Cessation Intervention not Provided, Reason Not Otherwise Specified

Append a submission modifier (8P) to CPT Category II code 4004F to submit circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Not Met:* 4004F *with* 8P:** Tobacco screening not performed OR tobacco cessation intervention not provided, reason not otherwise specified

RATIONALE:

This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop using tobacco lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco (Grade A Recommendation) (U.S. Preventive Services Task Force, 2015).

The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety (previously stated) (Grade I Statement) (U.S. Preventive Services Task Force, 2015).

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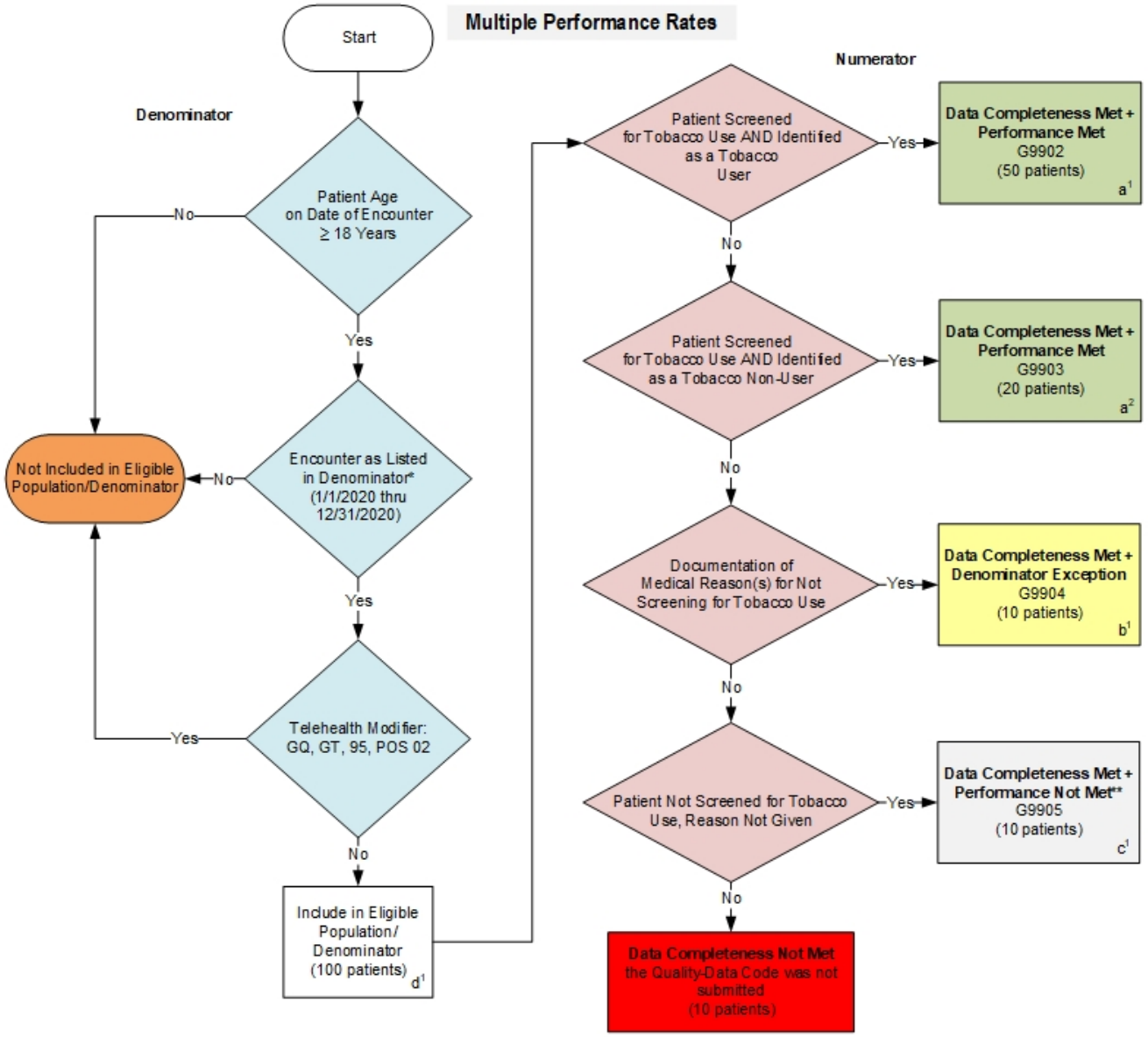
2020 Medicare Part B Claims Flow for Quality ID #226 NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Submission Criteria One

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS SUBMISSION CRITERIA ONE:

Data Completeness=

$$\frac{\text{Performance Met } (a^1+a^2=70 \text{ patients}) + \text{Denominator Exception } (b^1=10 \text{ patients}) + \text{Performance Not Met } (c^1=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^1=100 \text{ patients})} = \frac{90 \text{ patients}}{100 \text{ patients}} = \mathbf{90.00\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=70 \text{ patients})}{\text{Data Completeness Numerator (90 patients)} - \text{Denominator Exception } (b^1=10 \text{ patients})} = \frac{70 \text{ patients}}{80 \text{ patients}} = \mathbf{87.50\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.
**In the event that the tobacco status is unknown submit G9905.
NOTE: Submission Frequency: Patient-Process

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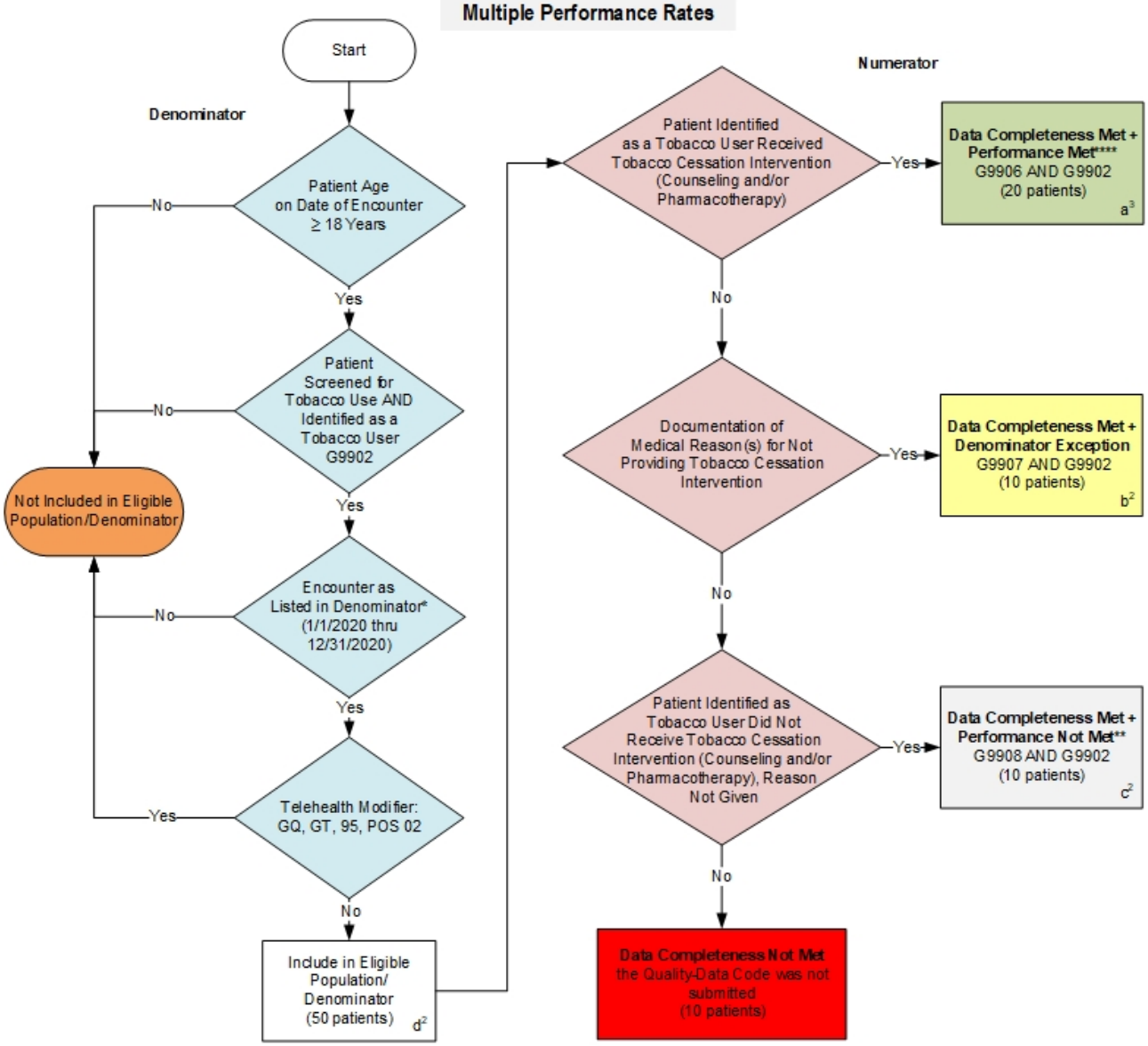
Submission Criteria Two

Multiple Performance Rates



SAMPLE CALCULATIONS SUBMISSION CRITERIA TWO:

Data Completeness=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients}) + \text{Denominator Exception } (b^2=10 \text{ patients}) + \text{Performance Not Met } (c^2=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^2=50 \text{ patients})} = \frac{40 \text{ patients}}{50 \text{ patients}} = \mathbf{80.00\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients})}{\text{Data Completeness Numerator (40 patients)} - \text{Denominator Exception } (b^2=10 \text{ patients})} = \frac{20 \text{ patients}}{30 \text{ patients}} = \mathbf{66.67\%}$$

*See the posted measure specification for specific coding and instructions to submit this measure.
**In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit G9908.
****This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906.
NOTE: Submission Frequency: Patient-Process

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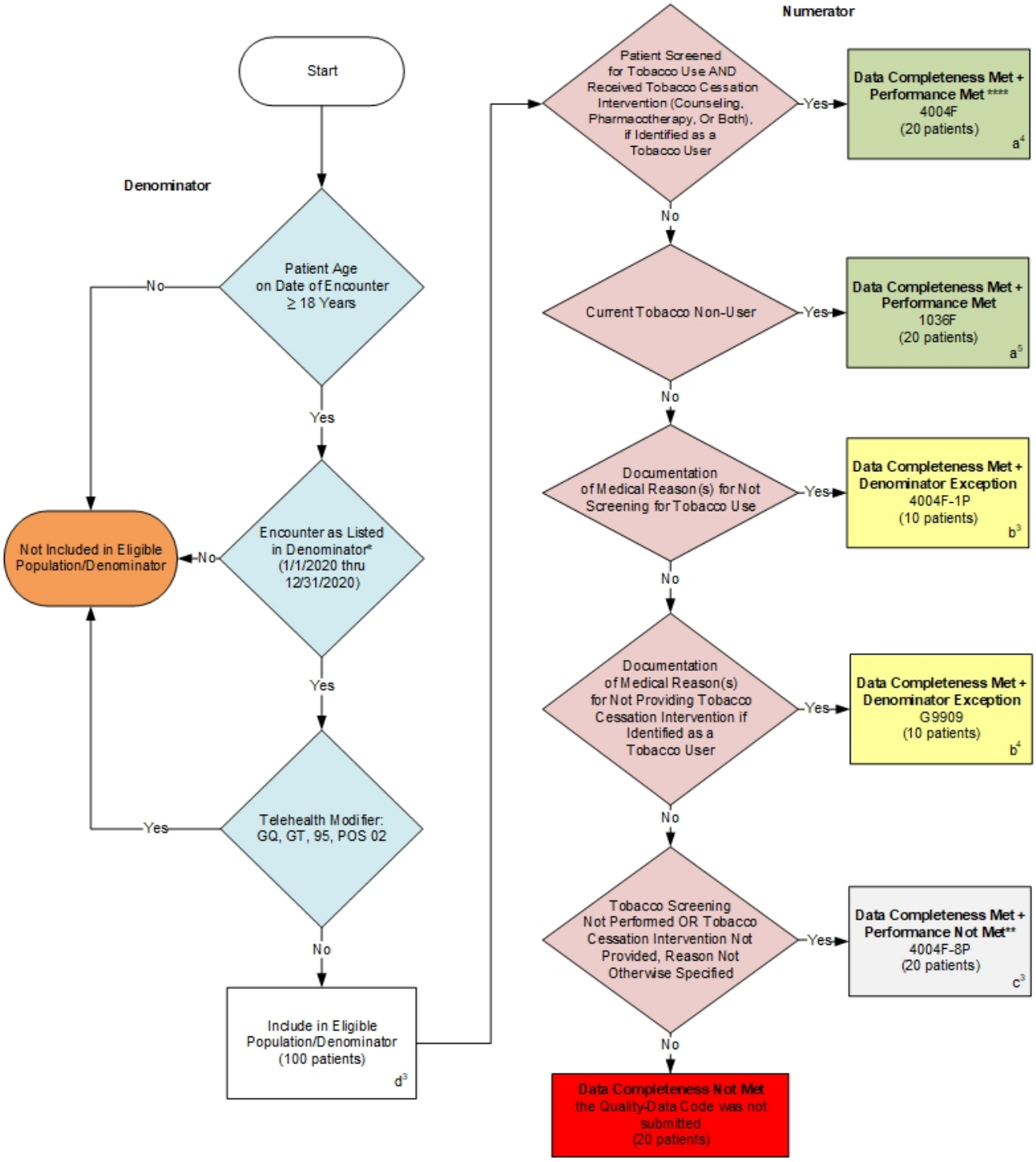
Submission Criteria Three

Multiple Performance Rates



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SAMPLE CALCULATIONS SUBMISSION CRITERIA THREE:

Data Completeness=

Performance Met (a^4+a^5=40 patients) + Denominator Exception (b^3+b^4=20 patients) + Performance Not Met (c^3=20 patients) = 80 patients = **80.00%**

Eligible Population / Denominator (d^3=100 patients) = 100 patients

Performance Rate=

Performance Met (a^4+a^5=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b^3+b^4=20 patients) = 60 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
**In the event that a patient is identified as a user but did not receive tobacco cessation intervention submit 4004F-8P.
****This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit 4004F.
NOTE: Submission Frequency: Patient-Process

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2020 Medicare Part B Claims Flow Narrative for Quality ID #226 NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

Submission Criteria One:

1. Start with Denominator
2. Check Patient Age:
    a. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals No during the measurement period, do not include in Eligible Population. Stop Processing.
    b. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals Yes during the measurement period, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in Denominator equals Yes, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, include in Eligible Population.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^1 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check Patient Screened for Tobacco Use AND Identified as a Tobacco User:
    a. If Patient Screened for Tobacco Use AND Identified as a Tobacco User equals Yes, include in Data Completeness Met and Performance Met.
    b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 50 patients in the Sample Calculation.
    c. If Patient Screened for Tobacco Use AND Identified as a Tobacco User equals No, proceed to check Patient Screened for Tobacco Use AND Identified as a Tobacco Non-User.
8. Check Patient Screened for Tobacco Use AND Identified as a Tobacco Non-User:
    a. If Patient Screened for Tobacco Use AND Identified as a Tobacco Non-User equals Yes, include in Data Completeness Met and Performance Met.

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b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 20 patients in the Sample Calculation.

c. If Patient Screened for Tobacco Use AND Identified as a Tobacco Non-User equals No, proceed to check Documentation of Medical Reason(s) for Not Screening for Tobacco Use.

9. Check Documentation of Medical Reason(s) for Not Screening for Tobacco Use:

   a. If Documentation of Medical Reason(s) for Not Screening for Tobacco Use equals Yes, include in Data Completeness Met and Denominator Exception.

   b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

   c. If Documentation of Medical Reason(s) for Not Screening for Tobacco Use equals No, proceed to check Patient Not Screened for Tobacco Use, Reason Not Given.

10. Check Patient Not Screened for Tobacco Use, Reason Not Given:

    a. If Patient Not Screened for Tobacco Use, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    c. If Patient Not Screened for Tobacco Use, Reason Not Given equals No, proceed to check Data Completeness Not Met.

11. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS SUBMISSION CRITERIA ONE:

Data Completeness=

$$\frac{\text{Performance Met } (a^1+a^2=70 \text{ patients}) + \text{Denominator Exception } (b^1=10 \text{ patients}) + \text{Performance Not Met } (c^1=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^1=100 \text{ patients})} = \frac{90 \text{ patients}}{100 \text{ patients}} = 90.00\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=70 \text{ patients})}{\text{Data Completeness Numerator (90 patients)} - \text{Denominator Exception } (b^1=10 \text{ patients})} = \frac{70 \text{ patients}}{80 \text{ patients}} = 87.50\%$$

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Submission Criteria Two:

1. Start with Denominator
2. Check Patient Age:
    a. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals No, do not include in Eligible Population. Stop Processing.
    b. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals Yes, proceed to check Patient Screened for Tobacco Use AND Identified as a Tobacco User.
3. Check Patient Screened for Tobacco Use AND Identified as a Tobacco User:
    a. If Patient Screened for Tobacco Use AND Identified as a Tobacco User equals Yes, proceed to check Encounter Performed.
    b. If Patient Screened for Tobacco Use AND Identified as a Tobacco User equals No, do not include in Eligible Population. Stop Processing.
4. Check Encounter Performed:
    a. If Encounter as Listed in Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in Denominator equals Yes, proceed to check Telehealth Modifier.
5. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, include in Eligible Population.
6. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^2 equals 50 patients in the Sample Calculation.
7. Start Numerator
8. Check Patient Identified as a Tobacco User Received Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy):
    a. If Patient Identified as a Tobacco User Received Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy) equals Yes, include in Data Completeness Met and Performance Met.

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b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^3 equals 20 patients in the Sample Calculation.

c. If Patient Identified as a Tobacco User Received Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy) equals No, proceed to check Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention.

9. Check Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention:

   a. If Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention equals Yes, include in Data Completeness Met and Denominator Exception.

   b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 10 patients in the Sample Calculation.

   c. If Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention equals No, proceed to check Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy), Reason Not Given.

10. Check Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy), Reason Not Given:

    a. If Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy), Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    c. If Patient Identified as Tobacco User Did Not Receive Tobacco Cessation Intervention (Counseling and/or Pharmacotherapy), Reason Not Given equals No, proceed to check Data Completeness Not Met.

11. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality-Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

SAMPLE CALCULATIONS SUBMISSION CRITERIA TWO:

Data Completeness=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients}) + \text{Denominator Exception } (b^2=10 \text{ patients}) + \text{Performance Not Met } (c^2=10 \text{ patients})}{\text{Eligible Population / Denominator } (d^2=50 \text{ patients})} = \frac{40 \text{ patients}}{50 \text{ patients}} = 80.00\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^3=20 \text{ patients})}{\text{Data Completeness Numerator (40 patients)} - \text{Denominator Exception } (b^2=10 \text{ patients})} = \frac{20 \text{ patients}}{30 \text{ patients}} = 66.67\%$$

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Submission Criteria Three:

1. Start with Denominator
2. Check Patient Age:
    a. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals No, do not include in Eligible Population. Stop Processing.
    b. If Patient Age on Date of Encounter is greater than or equal to 18 Years equals Yes, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in Denominator equals Yes, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier:
    a. If Telehealth Modifier equals Yes, do not include in Eligible Population. Stop Processing.
    b. If Telehealth Modifier equals No, include in Eligible Population.
5. Denominator Population:
    a. Denominator Population is all Eligible Patients in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d^3 equals 100 patients in the Sample Calculation.
6. Start Numerator
7. Check Patient Screened for Tobacco Use AND Received Tobacco Cessation Intervention (Counseling, Pharmacotherapy, or Both), if Identified as a Tobacco User:
    a. If Patient Screened for Tobacco Use AND Received Tobacco Cessation Intervention (Counseling, Pharmacotherapy, or Both), if Identified as a Tobacco User equals Yes, include in Data Completeness Met and Performance Met.
    b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^4 equals 20 patients in the Sample Calculation.
    c. If Patient Screened for Tobacco Use AND Received Tobacco Cessation Intervention (Counseling, Pharmacotherapy, or Both), if Identified as a Tobacco User equals No, proceed to check Current Tobacco Non-User.
8. Check Current Tobacco Non-User:

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a. If Current Tobacco Non-User equals Yes, include in Data Completeness Met and Performance Met.

b. Data Completeness Met and Performance Met letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a[5] equals 20 patients in the Sample Calculation.

c. If Current Tobacco Non-User equals No, proceed to check Documentation of Medical Reason(s) for Not Screening for Tobacco Use.

9. Check Documentation of Medical Reason(s) for Not Screening for Tobacco Use:

   a. If Documentation of Medical Reason(s) for Not Screening for Tobacco Use equals Yes, include in Data Completeness Met and Denominator Exception.

   b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b[3] equals 10 patients in the Sample Calculation.

   c. If Documentation of Medical Reason(s) for Not Screening for Tobacco Use equals No, proceed to check Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention if Identified as a Tobacco User.

10. Check Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention if Identified as a Tobacco User:

    a. If Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention if Identified as a Tobacco User equals Yes, include in Data Completeness Met and Denominator Exception.

    b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b[4] equals 10 patients in the Sample Calculation.

    c. If Documentation of Medical Reason(s) for Not Providing Tobacco Cessation Intervention if Identified as a Tobacco User equals No, proceed to check Tobacco Screening Not Performed OR Tobacco Cessation Intervention Not Provided, Reason Not Otherwise Specified.

11. Check Tobacco Screening Not Performed OR Tobacco Cessation Intervention Not Provided, Reason Not Otherwise Specified:

    a. If Tobacco Screening Not Performed OR Tobacco Cessation Intervention Not Provided, Reason Not Otherwise Specified equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c[3] equals 20 patients in the Sample Calculation.

    c. If Tobacco Screening Not Performed OR Tobacco Cessation Intervention Not Provided, Reason Not Otherwise Specified equals No, proceed to check Data Completeness Not Met.

12. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality-Data Code was not submitted. 20 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

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SAMPLE CALCULATIONS SUBMISSION CRITERIA THREE:

Data Completeness=

Performance Met (a^4+a^5=40 patients) + Denominator Exception (b^3+b^4=20 patients) + Performance Not Met (c^3=20 patients) = 80 patients = **80.00%**

Eligible Population / Denominator (d^3=100 patients) = 100 patients

Performance Rate=

Performance Met (a^4+a^5=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (80 patients) – Denominator Exception (b^3+b^4=20 patients) = 60 patients

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Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the definition of last enrollment segment.
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) to the Timeliness of Prenatal Care rate (administrative specification) and clarified in the *Notes* that services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates.
- Updated the Hybrid specification to indicate that sample size reduction is allowed using only the current year's administrative rate for MY 2020; for MY 2021, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.
- Added examples of "pregnancy diagnosis" in the Hybrid specification of the Timeliness of Prenatal Care indicator.

Description

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Definitions

First trimester	280–176 days prior to delivery (or EDD).
Last enrollment segment	The period of continuous enrollment (with no gaps in enrollment) during the pregnancy with the start date that is closest to the delivery date. Use guideline "Members Who Switch Products/Product Lines" in the *General Guidelines for Data Collection and Reporting* to determine continuous enrollment.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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	None specified.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.

Allowable gap No allowable gap during the continuous enrollment period.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis *Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.* Include women who delivered in any setting.

Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1 Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: *The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.*

Step 2 Exclude non-live births (Non-live Births Value Set).

Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit during the required timeframe. Follow the steps below to identify numerator compliance.

Step 1 Identify women whose last enrollment segment started before, on or between 280 and 219 days before delivery (or EDD).

These women must have a prenatal visit during the first trimester.

Step 2 Identify women whose last enrollment segment started less than 219 days before delivery (or EDD).

These women must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the woman's enrollment start date during the pregnancy meet criteria.

Step 3 Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Postpartum Care A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Note: *The practitioner requirement only applies to the Hybrid Specification. The organization is not required to identify practitioner type in administrative data.*

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line.

For MY 2020 reporting, the organization may reduce the sample size using the current year's administrative rate. The prior year's reported rate may not be used when reducing the sample size for MY 2020 reporting.

For MY 2021 reporting, organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.

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

Numerator

Timeliness of Prenatal Care A prenatal visit during the required timeframe. Refer to the Administrative Specification to identify the required timeframe for each woman based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

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

Medical record

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of *one* of the following.

- Documentation indicating the woman is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of LMP, EDD or gestational age, ***or***
  - A positive pregnancy test result, ***or***
  - Documentation of gravidity and parity, ***or***
  - Documentation of complete obstetrical history, ***or***
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, ***or*** pelvic exam with obstetric observations, ***or*** measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), ***or***
  - TORCH antibody panel alone, ***or***
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, ***or***
  - Ultrasound of a pregnant uterus.

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative

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

Medical record

Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.

- Glucose screening for women with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Note

- *Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.*
  - *For women whose last enrollment segment started before, on or between 280 and 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.*
- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.
- *For both rates, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

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

Table PPC-1/2: Data Elements for Prenatal and Postpartum Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*For each of the 2 rates*	*For each of the 2 rates*
Eligible population	*For each of the 2 rates*	*For each of the 2 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*For each of the 2 rates*
Current year's administrative rate (before exclusions)		*For each of the 2 rates*
Minimum required sample size (MRSS)		*For each of the 2 rates*
Oversampling rate		*For each of the 2 rates*
Number of oversample records		*For each of the 2 rates*
Number of medical records excluded because of valid data errors		*For each of the 2 rates*
Number of employee/dependent medical records excluded		*For each of the 2 rates*
Records added from the oversample list		*For each of the 2 rates*
Denominator		*For each of the 2 rates*
Numerator events by administrative data	*For each of the 2 rates*	*For each of the 2 rates*
Numerator events by medical records		*For each of the 2 rates*
Reported rate	*For each of the 2 rates*	*For each of the 2 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Prenatal and Postpartum Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	NA	There are no ages specified in this measure.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the value sets may be used to identify visits. The value sets and logic may not be changed. Organizations may not change the logic but may change the delivery date and account for the impact on other date-dependent events. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with deliveries).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Timeliness of Prenatal Care • Postpartum Care	No	Value sets and logic may not be changed. If the delivery-date range is changed, all numerator events must be measured in relation to the new range.

Quality ID #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2020COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent quality-data code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 12 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99201, 99202, 99203, 99204, 99205, 99212,99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324,99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401*, 99402*, 99403*, 99483, 99484, 99492, 99493,99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444

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NUMERATOR:
Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter

Definitions:
Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation or assessment for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Examples of a follow-up plan include but are not limited to:
* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

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Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patient has an active diagnosis of depression prior to any encounter during the measurement period- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period- F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter . Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.

Numerator Quality-Data Coding Options:

Depression Screening or Follow-Up Plan not Documented, Patient not Eligible

Denominator Exclusion: **G9717:** Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

OR

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented

Performance Met: **G8431:** Screening for depression is documented as being positive AND a follow-up plan is documented

OR

Screening for Depression Documented as Negative, Follow-Up Plan not Required

Performance Met: **G8510:** Screening for depression is documented as negative, a follow-up plan is not required

OR

Screening for Depression not Completed, Documented Reason

Denominator Exception: **G8433:** Screening for depression not completed, documented reason

OR

Screening for Depression not Documented, Reason not Given

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***Performance Not Met:* G8432:** Depression screening not documented, reason not given

OR

Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

***Performance Not Met:* G8511:** Screening for depression documented as positive, follow-up plan not documented, reason not given

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt & Brody, 2014). 2016 U.S. survey data indicate that 12.8 percent of adolescents (2.2 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment; 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE in the past year, with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) has been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy with an increased risk of suicide (Siu & the U.S. Preventive Services Task Force [USPSTF], 2016). Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 15% of women. Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (Molenaar et al., 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients: "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner et al., 2010, p. 948). “In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated” (Sui on behalf of USPSTF, 2016, p. 360 & p. 364) Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. “In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011” (Sui & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

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CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui on behalf of, USPSTF, 2016, p. 360).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (Wilkinson et al., 2013, p. 16).

Adult Recommendation (18 years and older):

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."

2. "Clinicians should establish and maintain follow-up with patients."

3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle et al., 2016 p.p. 8–10)

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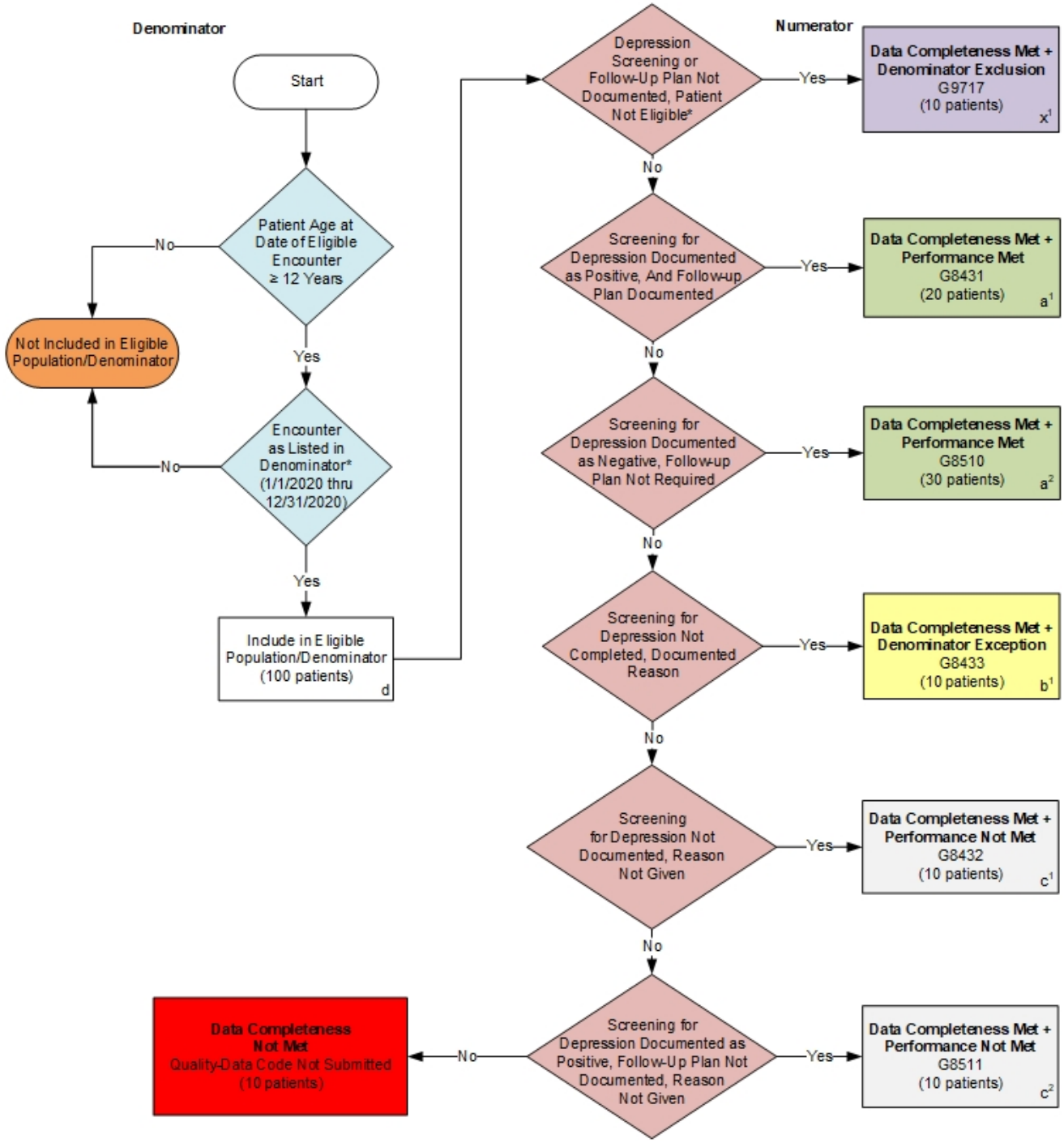
2020 Medicare Part B Claims Flow for Quality ID #134 NQF #0418: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



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SAMPLE CALCULATIONS:

Data Completeness Rate=

Denominator Exclusion (x^1=10 pts) + Performance Met (a^1+a^2=50 pts) + Denominator Exception (b^1=10 pts) + Performance Not Met (c^1+c^2=20 pts) = 90 patients = **90.00%**

Eligible Population / Denominator (d=100 patients) = 100 patients

Performance Rate=

Performance Met (a^1+a^2=50 patients) = 50 patients = **71.43%**

Data Completeness Numerator (90 patients) - Denominator Exclusion (x^1=10 patients) - Denominator Exception (b^1=10 patients) = 70 patients

*See the posted measure specification for specific coding and instruction to submit this measure.

NOTE: Submission Frequency: Patient-Process

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2020 Medicare Part B Claims Flow Narrative for Quality ID #134 NQF #0418: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

***Disclaimer**: Refer to the measure specification for specific coding and instructions to submit this measure*.

1. Start with Denominator
2. Check Patient Age:
    a. If the Patient Age is greater than or equal to 12 Years on Date of Eligible Encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing.
    b. If the Patient Age is greater than or equal to 12 Years on Date of Eligible Encounter equals Yes during the measurement period, proceed to check Encounter Performed.
3. Check Encounter Performed:
    a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.
    b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible Population.
4. Denominator Population:
    a. Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 100 patients in the Sample Calculation.
5. Start Numerator
6. Check Depression Screening or Follow-Up Plan Not Documented, Patient Not Eligible:
    a. If Screening for Depression or Follow-Up Plan Not Documented, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exclusion.
    b. Data Completeness Met and Denominator Exclusion letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter x^1 equals 10 patients in the Sample Calculation.
    c. If Screening for Depression or Follow-Up Plan Not Documented, Patient Not Eligible equals No, proceed to check Screening for Depression Documented as Positive, And Follow-up Plan Documented.
7. Check Screening for Depression Documented as Positive, And Follow-up Plan Documented:
    a. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals Yes, include in Data Completeness Met and Performance Met.
    b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^1 equals 20 patients in the Sample Calculation.
    c. If Screening for Depression Documented as Positive, And Follow-up Plan Documented equals No, proceed to check Screening for Depression Documented as Negative, Follow-up Plan Not Required.
8. Check Screening for Depression Documented as Negative, Follow-up Plan Not Required:

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a. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals Yes, include in Data Completeness Met and Performance Met.

b. Data Completeness Met and Performance Met letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a^2 equals 30 patients in the Sample Calculation.

c. If Screening for Depression Documented as Negative, Follow-up Plan Not Required equals No, proceed to check Screening for Depression Not Completed, Documented Reason.

9. Check Screening for Depression Not Completed, Documented Reason:

   a. If Screening for Depression Not Completed, Documented Reason equals Yes, include in the Data Completeness Met and Denominator Exception.

   b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 patients in the Sample Calculation.

   c. If Screening for Depression Not Completed, Documented Reason equals No, proceed to check Screening for Depression Not Documented, Reason Not Given.

10. Check Screening for Depression Not Documented, Reason Not Given:

    a. If Screening for Depression Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^1 equals 10 patients in the Sample Calculation.

    c. If Screening for Depression Not Documented, Reason Not Given equals No, proceed to check Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given.

11. Check Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given:

    a. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

    b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c^2 equals 10 patients in the Sample Calculation.

    c. If Screening for Depression Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals No, proceed to check Data Completeness Not Met

12. Check Data Completeness Not Met:

    a. If Data Completeness Not Met, the Quality Data Code was not submitted. 10 patients have been subtracted from the Data Completeness Numerator in the Sample Calculation.

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SAMPLE CALCULATIONS:

Data Completeness Rate=

$$\frac{\text{Denominator Exclusion } (x^1=10 \text{ pts}) + \text{Performance Met } (a^1+a^2=50 \text{ pts}) + \text{Denominator Exception } (b^1=10 \text{ pts}) + \text{Performance Not Met } (c^1+c^2=20 \text{ pts})}{\text{Eligible Population / Denominator (d=100 patients)}} = \frac{90 \text{ patients}}{100 \text{ patients}} = \mathbf{90.00\%}$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2=50 \text{ patients})}{\text{Data Completeness Numerator (90 patients) - Denominator Exclusion } (x^1=10 \text{ patients}) \text{ - Denominator Exception } (b^1=10 \text{ patients})} = \frac{50 \text{ patients}}{70 \text{ patients}} = \mathbf{71.43\%}$$

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PCMH+ Measure List
January 10, 2017

Measure Name	Description	Steward	NQF #	PCMH+ Measure Type
Adolescent well-care visits	This measure is used to assess the percentage of enrolled members 12 through 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.	NCQA		Scoring
Annual fluoride treatment ages 0<4	Annual fluoride treatment ages 0<4 (in a pediatric or dental setting)	DSS		Reporting Only
Annual monitoring for persistent medications (roll-up)	The percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. - Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) - Digoxin - Diuretics - Total Rate will be measured	NCQA	2371	Reporting Only
Appropriate treatment for children with upper respiratory infection	Percentage of children 3 months to 18 years of age with a diagnosis of URI who were not dispensed an antibiotic medication. A higher rate indicates appropriate care (i.e. the proportion for whom antibiotics were not prescribed)	NCQA	0069	Reporting Only
Asthma Medication Ratio	The percentage of members 5-64 years of age with persistent asthma and had a ratio of controller medications to total medications of 0.50 or greater during the measurement year.	NCQA	1800	Reporting Only
Avoidance of antibiotic treatment in adults with acute bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate indicates appropriate care (i.e. the proportion for whom antibiotics were not prescribed)	NCQA	0058	Scoring
Behavioral Health Screening 1-17	The percentage of children ages 1-17, who were screened for developmental or behavioral problems using a validated survey intstrument, approved by the AAP.	DSS		Challenge
Breast cancer screening	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in a two year period.	NCQA	2372	Reporting Only

PCMH+ Measure List
January 10, 2017

Measure Name	Description	Steward	NQF #	PCMH+ Measure Type
Cervical cancer screening	Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21–64 who had cervical cytology performed every 3 years. - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	NCQA	0032	Reporting Only
Chlamydia screening in women	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA	0033	Reporting Only
Developmental screening in the first three years of life. Three age breakouts (ages 1, 2, and 3)	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age. (The total of the three ages will be scored)	OHSU	1448	Scoring
Diabetes eye exam	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had at least one eye exam (retinal) performed in a two year period.	NCQA	0055	Reporting Only
Diabetes HbA1c Screening	Adults age 18-75 with a diagnosis of Type I or Type II diabetes who received at least one HbA1c screening during the measurement year.	NCQA	0057	Scoring
Diabetes: medical attention for nephropathy	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year.	NCQA	0062	Reporting Only
ED Usage	Emergency department usage (Excludes mental health and chemical dependency services).	NCQA		Scoring
Follow-up care for children prescribed ADHD medication	The percentage of children ages 6-12 as of the Index Prescription Start Date(IPSD) newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: • Initiation Phase and Continuation Phase	NCQA	0108	Reporting Only

PCMH+ Measure List
January 10, 2017

Measure Name	Description	Steward	NQF #	PCMH+ Measure Type
Human Papillomavirus Vaccine for Adolescents (HPV)*	The percentage of adolescents 13 years of age who had three doses of the HPV vaccine by their 13th birthday.*	NCQA	1959	Reporting Only
Medication management for people with asthma	Medication Management for people with asthma age 5-64 (age 5-18 breakout can be used for pediatric practices). Percent of patients with *persistent* asthma who were prescribed and remained on asthma "controller medication" for at least 75% of their treatment period.	NCQA	1799	Scoring
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing	NCQA		Challenge
Oral evaluation, dental services	Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year	American Dental Association	2517	Reporting Only
PCMH CAHPS	Consumer Assessment of Healthcare Providers and Systems ® CAHPS - PCMH version.		N/A	Scoring
Post-Hospital Admission Follow-up	Percentage of adults age 21-75 with an inpatient “medical" or psych admission with a claim for post-admission follow-up with a physician, PA, or APRN within seven days of the inpatient discharge. Medical admissions are defined as all admissions that are not maternity or surgery related.	DSS		Challenge

PCMH+ Measure List
January 10, 2017

Measure Name	Description	Steward	NQF #	PCMH+ Measure Type
Prenatal care & Postpartum care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA	1517	Scoring
Readmission	Readmissions Within 30 Days (PH and BH)	MMDN		Challenge
Use of imaging studies for low back pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.	NCQA	0052	Reporting Only
Well-child visits in the first 15 months of life	Percentage of patients 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. •Six or more well-child visits	NCQA	1392	Scoring
Well-child visits in the third, fourth, fifth and sixth years of life	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	NCQA	1516	Reporting Only

* Males have been added to the 2017 HEDIS Measure

Medication Management for People With Asthma (MMA)

SUMMARY OF CHANGES TO HEDIS 2020

- Updated value sets to identify acute inpatient events for the event/diagnosis.
- Modified medication lists to make them compatible with digital measure formatting.
- Clarified the telehealth requirements for identifying the event/diagnosis.
- Added Benralizumab to the "Anti-interleukin-5" description in the Asthma Controller Medications List.
- Clarified in step 4 that the equation must be multiplied by 100 before rounding to the nearest whole number.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days that a member is covered by at least one asthma controller medication, divided by the number of days in the treatment period.
Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is filled. Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

- *Two prescriptions* for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each).
- *Two prescriptions* for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).
- *Two prescriptions* for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).

Inhaler dispensing event

When *identifying the eligible population*, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection or intravenous dispensing event

Each injection or intravenous infusion counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Calculating number of days covered for the numerator

If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication. For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller.

Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

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).

Ages Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

The total is the sum of the age stratifications for each product line.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date December 31 of the measurement year.

Benefits Medical. Pharmacy during the measurement year.

Event/diagnosis Follow the steps below to identify the eligible population for the measure.

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set). To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

- At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or online assessments (Online Assessments Value Set) on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

  Only three of the four visits may be an outpatient telehealth visit, a telephone visit or an online assessment. Identify outpatient telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	• Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Subcutaneous
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Subcutaneous
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Subcutaneous
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Intravenous
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation

Description	Prescriptions	Medication Lists	Route
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	• Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	• Levalbuterol	Levalbuterol Medications List	Inhalation

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Step 3: Required exclusions Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
  - Emphysema Value Set.
  - Other Emphysema Value Set.
  - COPD Value Set.
  - Obstructive Chronic Bronchitis Value Set.
  - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
  - Cystic Fibrosis Value Set.
  - Acute Respiratory Failure Value Set.
- Members who had no asthma controller medications dispensed during the measurement year. Use all the medication lists in the Asthma Controller Medications table above to identify asthma controller medications.

Administrative Specification

Denominator The eligible population.

Numerators

Medication Compliance 50% The number of members who achieved a PDC of at least 50% for their asthma controller medications during the measurement year.

Medication Compliance 75% The number of members who achieved a PDC of at least 75% for their asthma controller medications during the measurement year. Follow the steps below to identify numerator compliance.
Use all the medication lists in the Asthma Controller Medications table above to identify asthma controller medications.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication during the measurement year.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for an asthma controller medication during the treatment period. To ensure that a days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Medication Compliance 50% Sum the number of members whose PDC is ≥50% for their treatment period.

Medication Compliance 75% Sum the number of members whose PDC is ≥75% for their treatment period.

Data Elements for Reporting

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

Table MMA-1/2/3: Data Elements for Medication Management for People With Asthma

Data Elements	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*
Number of required exclusions	*For each age stratification and total*
Numerator events by administrative data	*Each rate, for each age stratification and total*
Numerator events by supplemental data	*Each rate, for each age stratification and total*
Reported rate	*Each rate, for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Medication Management for People With Asthma

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 5–64 years). The denominator age may be expanded to 65 years of age and older.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. ***Note:*** *This measure uses dispensed medications; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	No	Apply required exclusions according to specified value sets.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Medication compliance 50% • Medication compliance 75%	No	Medication Lists and logic may not be changed.

Asthma Medication Ratio (AMR)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Removed the restriction that only three of the four visits with an asthma diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Clarified in step 1 when the diagnosis must be on the discharge claim.
- Added Dupilumab to the "Anti-interleukin-4" description in the Dupilumab Medications List.
- Clarified NDC code mapping requirements in the *Notes.*

Description

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Definitions

Oral medication dispensing event

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Inhaler dispensing event

When *identifying the eligible population*, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection dispensing event

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Use the medication lists to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Units of medication

When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event.

Use the package size and units columns in the medication lists to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.

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).

Ages

Ages 5–64 as of December 31 of the measurement year. Report the following age stratifications and total rate:

- 5–11 years.
- 12–18 years.
- 19–50 years.
- 51–64 years.
- Total.

Continuous enrollment

The total is the sum of the age stratifications for each product line.

The measurement year and the year prior to the measurement year.

Allowable gap

No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment.

Anchor date

December 31 of the measurement year.

Benefits

Medical. Pharmacy during the measurement year.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set).
- At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) ***and*** at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all the medication lists in the tables below to identify asthma controller and reliever medications.
- At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (the measurement year or the year prior to the measurement year).

Step 3: Required exclusions Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year:
  - Emphysema Value Set.
  - Other Emphysema Value Set.
  - COPD Value Set.
  - Obstructive Chronic Bronchitis Value Set.
  - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
  - Cystic Fibrosis Value Set.
  - Acute Respiratory Failure Value Set.

- Members who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists in the tables below to identify asthma controller and reliever medications.

Administrative Specification

Denominator The eligible population.

Numerator The number of members who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in the Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in the Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1 For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5 Sum the total number of members who have a ratio of 0.50 or greater in step 4.

Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	• Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	• Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	• Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	• Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	• Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	• Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	• Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	• Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation

Description	Prescriptions	Medication Lists	Route
Inhaled steroid combinations	• Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	• Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	• Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	• Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	• Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	• Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	• Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	• Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	• Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	• Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	• Zileuton	Zileuton Medications List	Oral
Methylxanthines	• Theophylline	Theophylline Medications List	Oral

Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- *Do not use RxNorm codes when assessing the numerator.*
- *When mapping NDC codes, medications described as "injection," "prefilled syringe," "subcutaneous," "intramuscular" or "auto-injector" are considered "injections" (route).*
- *When mapping NDC codes, medications described as "metered dose inhaler," "dry powder inhaler" or "inhalation powder" are considered "inhalation" (route) medications.*
- *Do not map medications described as "nasal spray" to "inhalation" medications.*

Data Elements for Reporting

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

Table AMR-1/2: Data Elements for Asthma Medication Ratio

Data Elements	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Number of required exclusions	*For each age stratification and total*
Numerator events by administrative data	*For each age stratification and total*
Numerator events by supplemental data	*For each age stratification and total*
Reported rate	*For each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Asthma Medication Ratio

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select "age as of June 30"). The denominator age may be changed within the specified age range (ages 5–64 years). The denominator age may also be expanded to 65 years of age and older.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. *Note: This measure uses dispensed medications; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	No	Apply required exclusions according to specified value sets.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Medication ratio of 0.50 or greater	No	Medication Lists and logic may not be changed.

Comprehensive Diabetes Care (CDC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Retired the "HbA1c control (<7.0%) for a selected population" indicator.
- Retired the "Medical Attention for Nephropathy" indicator for the commercial and Medicaid product lines.
- Clarified in the measure description that organizations must use the same data collection method for the HbA1c testing and control indicators (this information was previously included in the General Guidelines).
- Removed the restriction that only one of the two visits with a diabetes diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added palliative care as a required exclusion.
- Deleted the HbA1c Level 7.0–9.0 Value Set.
- Updated the Administrative Specification logic and value sets for the Eye Exam indicator.
- Added telephone visits, e-visits and virtual check-ins to the Administrative Specification as appropriate settings for BP readings.
- Added Nebivolol-valsartan to the "Antihypertensive combinations" description in the ACE inhibitor and ARB Medications List.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- Added polycystic ovarian syndrome to the optional exclusions.
- Added a *Note* to the *Denominator-Sample Size Reduction* section in the Hybrid Specification.
- Clarified that documentation of "HB1c" meets criteria for the Hybrid Specification of the HbA1c testing indicator.
- Clarified that eye exam results read by a system that provides an artificial intelligence (AI) interpretation meet criteria.
- Removed the requirements for remote monitoring devices to allow BPs taken by any digital device.
- Removed the exclusion of BP readings reported or taken by the member.
- Revised the Data Elements for Reporting tables.
- In the *Rules for Allowable Adjustments* section, clarified that the required exclusions criteria may be adjusted with limits.

Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.*
- HbA1c poor control (>9.0%).*
- HbA1c control (<8.0%).*
- Eye exam (retinal) performed.
- Medical attention for nephropathy.**
- BP control (<140/90 mm Hg).

*Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.

**This indicator is only reported for the Medicare product line.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure 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, Medicare (report each product line separately).

Stratification For only Medicare, for only the Eye Exam (retinal) indicator, report the following SES stratifications and total:

- Non-LIS/DE, Nondisability.
- LIS/DE.
- Disability.
- LIS/DE and Disability.
- Other.
- Unknown.
- Total Medicare.

Note: *The stratifications are mutually exclusive and the sum of all six stratifications is the total population. The stratifications are reported in a separate table.*

Ages 18–75 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 measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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 There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:

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

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set),e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

  Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Albiglutide • Liraglutide (excluding *Saxenda*®)	

Description	Prescription		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Required exclusion

Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusions

Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- 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:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
       1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
– A dispensed dementia medication (Dementia Medications List).

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Testing An HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

HbA1c Poor Control >9% Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the *most recent* HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

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Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

HbA1c Control <8%

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

Eye Exam

Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.

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- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy).
- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set or Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year.
- Any code in the Diabetic Retinal Screening Negative In Prior Year Value Set billed by any provider type during the measurement year.
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) ***with*** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) ***and*** right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) with service dates 14 days or more apart.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test ***or*** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening or monitoring test (Urine Protein Tests Value Set).
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set).
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set).
- Evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set).
- Evidence of nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set).
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted).

- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor and ARB Medications List).

ACE Inhibitor and ARB Medications

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan	• Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan	• Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Nebivolol-valsartan • Sacubitril-valsartan • Trandolapril-verapamil		

BP Control <140/90 mm Hg

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Value Set) telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), or a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

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Exclusions *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Hybrid Specification

Denominator

Organizations should use a sample size of 411.

For Medicare reporting, the denominator for the Total Medicare SES stratification is the entire systematic sample. Do not pull samples for each stratification. The individual stratifications for the denominators and all numerators must sum to the total.

Denominator—sample size reduction

The organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate among all the reported CDC indicators. The lowest rate for all reported indicators must be used when reducing the sample size.

Note: *The rate for the HbA1c control (<7.0%) for a selected population indicator may not be used to reduce the MY 2020 or MY 2021 sample size because it was retired. The rate for the Medical attention for nephropathy indicator may not be used to reduce the MY 2020 or MY 2021 sample size for the commercial and Medicaid product lines because it was retired.*

Numerators

HbA1c Testing

An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative

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

Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. Count notation of the following in the medical record:

- A1c
- HbA1c
- HgbA1c
- HB1c
- Hemoglobin A1c
- Glycohemoglobin A1c
- Glycohemoglobin
- Glycated hemoglobin
- Glycosylated hemoglobin

HbA1c Poor Control >9%

The *most recent* HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).*

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

HbA1c Control <8% The *most recent* HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.

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

Medical record At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The member is numerator compliant if the most recent HbA1c level during the measurement year is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c level during the measurement year is ≥8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Eye Exam Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

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

Medical record At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.

- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
  - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Medical Attention for Nephropathy

A nephropathy screening or monitoring test during the measurement year ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Note: *A process flow diagram is included at the end of this specification to help implement this measure.*

Administrative

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

Medical record

Any of the following during the measurement year meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  - 24-hour urine for albumin or protein.
  - Timed urine for albumin or protein.
  - Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
  - Urine for albumin/creatinine ratio.
  - 24-hour urine for total protein.
  - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of a nephrectomy.

- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor/ ARB therapy during the measurement year. Any of the following meet criteria:
  - Documentation that a prescription for an ACE inhibitor/ARB was written during the measurement year.
  - Documentation that a prescription for an ACE inhibitor/ARB was filled during the measurement year.
  - Documentation that the member took an ACE inhibitor/ARB during the measurement year.

BP Control <140/90 mm Hg

The *most recent* BP level (taken during the measurement year) is <140/90 mm Hg, as documented through administrative data or medical record review.

Administrative

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

Medical record

The organization should use the medical record from which it abstracts data for the other CDC indicators. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the member's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the member receives care.

Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The member is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

Exclusions *(optional)*

Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Note

- *Organizations may select a data collection method (Administrative vs. Hybrid) at the indicator level, but the method used for HbA1c testing and control rates must be consistent.*
- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *To facilitate HEDIS reporting the denominator for all rates must be the same. While an eye exam is not possible, services measured in the other indicators are important for members with bilateral eye enucleation. For these reasons bilateral eye enucleation is considered a numerator hit (rather than an optional exclusion).*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting the Eye Exam indicator; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of the Eye Exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.*
- *If an organization chooses to apply the optional exclusions, members must be numerator negative for at least one indicator, with the exception of HbA1c Poor Control (>9%). Remove members from the eligible population who are numerator negative for any indicator (other than for HbA1c Poor Control [>9%]) and substitute members from the oversample. Do not exclude members who are numerator compliant for all indicators except HbA1c Poor Control (>9%), because a lower rate indicates better performance for this indicator.*
- *When excluding BP readings from the BP Control <140/90 mm Hg indicator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.*

  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.*
- *BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive procedures (this list is just for reference, and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*
  - *Wart or mole removal.*

Data Elements for Reporting

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

Table CDC-1/2: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*Each of the 5 rates*	*Each of the 5 rates*
Eligible population	*Each of the 5 rates*	*Each of the 5 rates*
Number of required exclusions	*Each of the 5 rates*	*Each of the 5 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 5 rates*
Current year's administrative rate (before exclusions)		*Each of the 5 rates*
Minimum required sample size (MRSS)		*Each of the 5 rates*
Oversampling rate		*Each of the 5 rates*
Number of oversample records		*Each of the 5 rates*
Number of medical records excluded because of valid data errors		*Each of the 5 rates*
Number of administrative data records excluded		*Each of the 5 rates*
Number of medical records excluded		*Each of the 5 rates*
Number of employee/dependent medical records excluded		*Each of the 5 rates*
Records added from the oversample list		*Each of the 5 rates*
Denominator		*Each of the 5 rates*
Numerator events by administrative data	*Each of the 5 rates*	*Each of the 5 rates*
Numerator events by supplemental data	*Each of the 5 rates*	*Each of the 5 rates*
Numerator events by medical records		*Each of the 5 rates*
Reported rate	*Each of the 5 rates*	*Each of the 5 rates*

Table CDC-A-3: Data Elements for Comprehensive Diabetes Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	*Each of the 6 rates*	*Each of the 6 rates*
Eligible population	*Each of the 6 rates*	*Each of the 6 rates*
Number of required exclusions	*Each of the 6 rates*	*Each of the 6 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 6 rates*
Current year's administrative rate (before exclusions)		*Each of the 6 rates*
Minimum required sample size (MRSS)		*Each of the 6 rates*
Oversampling rate		*Each of the 6 rates*
Number of oversample records		*Each of the 6 rates*
Number of medical records excluded because of valid data errors		*Each of the 6 rates*

	Administrative	Hybrid
Number of administrative data records excluded		*Each of the 6 rates*
Number of medical records excluded		*Each of the 6 rates*
Number of employee/dependent medical records excluded		*Each of the 6 rates*
Records added from the oversample list		*Each of the 6 rates*
Denominator		*Each of the 6 rates*
Numerator events by administrative data	*Each of the 6 rates*	*Each of the 6 rates*
Numerator events by supplemental data	*Each of the 6 rates*	*Each of the 6 rates*
Numerator events by medical records		*Each of the 6 rates*
Reported rate	*Each of the 6 rates*	*Each of the 6 rates*

Table CDC-B-3: Data Elements for Comprehensive Diabetes Care: Eye Exam (Medicare SES Stratifications only. Report the Total Medicare population in Table CDC-A-3)

	Administrative	Hybrid
Eligible population	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Number of required exclusions	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Denominator		*Each of the 6 stratifications*
Numerator events by administrative data	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Numerator events by medical records		*Each of the 6 stratifications*
Numerator events by supplemental data	*Each of the 6 stratifications*	*Each of the 6 stratifications*
Reported rate	*Each of the 6 stratifications*	*Each of the 6 stratifications*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Comprehensive Diabetes Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing denominator age range is allowed within specified age range (ages 18–75 years). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied; value sets and logic may not be changed.
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.

Numerator Criteria	Adjustments Allowed (Yes/No)	Notes
• Hemoglobin A1c (HbA1c) testing • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm HG)	No	Medication lists, value sets and logic may not be changed.

*Kidney Health Evaluation for Patients With Diabetes (KED)**

***This measure was developed by NCQA with input from the National Kidney Foundation.**

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- First-year measure (MY 2020).

Description

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), 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, Medicare (report each product line separately).

Ages 18–85 years as of December 31 of the measurement year. Report three age stratifications and a total rate:

- 18–64.
- 65–74.
- 75–85.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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 Follow the steps below to identify the eligible population.

Step 1 There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

  Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone • Canagliflozin-metformin • Dapagliflozin-metformin • Empagliflozin-linagliptin	• Empagliflozin-metformin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human • Insulin human inhaled	
Meglitinides	• Nateglinide	• Repaglinide	

Description	Prescription		
Glucagon-like peptide-1 (GLP1) agonists	• Dulaglutide • Exenatide	• Albiglutide • Liraglutide (excluding *Saxenda®)*	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin	• Dapagliflozin	• Empagliflozin
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Step 2: Required exclusions Exclude members who meet any of the following criteria:

- Members with evidence of ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Step 3: Exclude members who meet any of the following criteria:

Note: *Supplemental and medical record data may not be used for these exclusions.*

- Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following:
  - Enrolled in an Institutional SNP (I-SNP) any time during the measurement year.
  - Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year.
- 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:
  1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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):
     - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis

(Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).

– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:

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

– A dispensed dementia medication (Dementia Medications List).

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Administrative Specification

Denominator The eligible population.

Numerator

Kidney Health Evaluation Members who received ***both*** of the following during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
- At least one uACR identified by ***both*** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.

Exclusions *(optional)*

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the member was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Data Elements for Reporting

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

Table KED-1/2/3: Data Elements for Kidney Health Evaluation for Patients With Diabetes

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Number of required exclusions	*For each age stratification and total*
Number of optional exclusions	*For each age stratification and total*
Number of numerator events by administrative data	*For each age stratification and total*
Number of numerator events by supplemental data	*For each age stratification and total*
Reported rate	*For each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

***Note**: These allowable adjustments are for use for the MY 2021.*

Rules for Allowable Adjustments for Kidney Health Evaluation for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (18–85 years).
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Kidney Health Evaluation	No	Value sets and logic may not be changed.

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Revised the time frame in the event/diagnosis criteria to look for two outpatient visits with a diagnosis of hypertension in the first six months of the measurement year and the year prior to the measurement year.
- Removed the restriction that only one of the two visits with a hypertension diagnosis be an outpatient telehealth, telephone visit, e-visit or virtual check-in when identifying the event/diagnosis.
- Added palliative care as a required exclusion.
- Added telephone visits, e-visits and virtual check-ins to the advanced illness exclusion.
- Added Donepezil-memantine to the "Dementia combinations" description in the Dementia Medications List.
- In the Administrative Specification, added telephone visits, e-visits and virtual check-ins as appropriate settings for BP readings.
- Updated the Hybrid Specification to indicate that sample size reduction is not allowed for MY 2020; sample size reduction is allowed for MY 2021.
- Removed the requirements for remote monitoring devices to allow BPs taken by any digital device.
- Removed the exclusion of BP readings reported or taken by the member.
- Added the "Number of required exclusions" data element to the Data Elements for Reporting table.
- Added guidance for adjusting required exclusions in the *Rules for Allowable Adjustments* section.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If 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, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., 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	Members who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set). • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set).
Required exclusion	Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Exclusions	Exclude members who meet any of the following criteria: ***Note:*** *Supplemental and medical record data may not be used for these exclusions.* • Medicare members 66 years of age and older as of December 31 of the measurement year who meet either of the following: – Enrolled in an Institutional SNP (I-SNP) any time during the measurement year. – Living long-term in an institution any time during the measurement year as identified by the LTI flag in the Monthly Membership Detail Data File. Use the run date of the file to determine if a member had an LTI flag during the measurement year. • 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:

1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) 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):
   - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
     3. Identify the discharge date for the stay.
   - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
   - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
     1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
     2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
     3. Identify the discharge date for the stay.
   - A dispensed dementia medication (Dementia Medications List).

- Members 81 years of age and older as of December 31 of the measurement year (all product lines) with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Dementia Medications

Description	Prescription		
Cholinesterase inhibitors	• Donepezil	• Galantamine	• Rivastigmine
Miscellaneous central nervous system agents	• Memantine		
Dementia combinations	• Donepezil-memantine		

Administrative Specification

Denominator The eligible population.

Numerator Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

The BP reading must occur *on or after* the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80–89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Exclusions *(optional)*

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the admission date for the stay.

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Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

For MY 2020 reporting, because Controlling High Blood Pressure has been significantly revised, sample size reduction is not allowed.

For MY 2021 reporting, the organization may reduce the sample size using the current year's administrative rate or the prior year's audited, product line specific rate.

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

Identifying the medical record

All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the member's PCP.
- If the member had more than one PCP for the time-period, identify the PCP who most recently provided care to the member.
- If the member did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the member.
- If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Numerator

The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member's BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a member's BP is adequately controlled, the representative BP must be identified.

Administrative

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

Medical record

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
- Taken by the member using a non-digital device such as with a manual blood pressure cuff and a stethoscope.

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The member is not compliant if the BP reading is ≥140/90 mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Exclusions *(optional)*

Refer to the *Administrative Specification* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, ***or*** evidence of ESRD, dialysis, nephrectomy or kidney transplant any time during the member's history through December 31 of the measurement year.

Note

- *When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).*
- *An EMR can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.*
- *When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet or a change in medication. For example (this list is just for reference, and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of procedure) and a medication change (a medication is taken to prep the colon).*
  - *Dialysis, infusions and chemotherapy (including oral chemotherapy) are all therapeutic procedures that require a medication regimen.*
  - *A nebulizer treatment with albuterol is considered a therapeutic procedure that requires a medication regimen (the albuterol).*
  - *A patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.*
- *BP readings taken on the same day that the member receives a common low-intensity or preventive procedure are eligible for use. For example, the following procedures are considered common low-intensity or preventive (this list is just for reference, and is not exhaustive):*
  - *Vaccinations.*
  - *Injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine).*
  - *TB test.*
  - *IUD insertion.*
  - *Eye exam with dilating agents.*
  - *Wart or mole removal.*

Data Elements for Reporting

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

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

	Admin	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of required exclusions	✓	✓
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 medical records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Controlling High Blood Pressure

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 18–85 years). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events that contain (or map to) codes in the value sets may be used to identify visits. Value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	Yes	The palliative care exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Optional Exclusions	No, if applied	Optional exclusions are not required, but if they are used, only specified exclusions may be applied. Value sets may not be changed.
Exclusions: I-SNP, LTI, Frailty or Advanced Illness	Yes	These exclusions are not required. Refer to Exclusions in the Guidelines for the Rules for Allowable Adjustments.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Adequate control of blood pressure	No	Value sets and logic may not be changed.

Use of Imaging Studies for Low Back Pain (LBP)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- In the *Rules for Allowable Adjustments* section, clarified that the numerator criteria may be adjusted with limits.

Description

The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.

Calculation

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).

Definitions

Intake Period	January 1–December 3 of the measurement year. The Intake Period is used to identify the first eligible encounter with a primary diagnosis of low back pain.
IESD	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a principal diagnosis of low back pain.
Negative Diagnosis History	A period of 180 days (6 months) prior to the IESD when the member had no claims/encounters with any diagnosis of low back pain.

Eligible Population

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

Product line	Commercial, Medicaid (report each product line separately).
Ages	18 years as of January 1 of the measurement year to 50 years as of December 31 of the measurement year.
Continuous enrollment	180 days (6 months) prior to the IESD through 28 days after the IESD.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	IESD.
Benefit	Medical.

Event/diagnosis Follow the steps below to identify the eligible population.

Step 1 Identify all members in the specified age range who had any of the following during the Intake Period:

- An outpatient visit (Outpatient Value Set), observation visit (Observation Value Set) or an ED visit (ED Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
  - Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).
- Osteopathic or chiropractic manipulative treatment (Osteopathic and Chiropractic Manipulative Treatment Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Physical therapy visit (Physical Therapy Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- Telephone visit (Telephone Visits Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).
- E-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set).

Step 2 Determine the IESD. For each member identified in step 1, determine the earliest episode of low back pain. If the member had more than one encounter, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) during the 180 days (6 months) prior to the IESD.

Step 4: Required exclusions Exclude any member who had a diagnosis for which imaging is clinically appropriate. Any of the following meet criteria:

- *Cancer.* Cancer any time during the member's history through 28 days after the IESD. Any of the following meet criteria:
  - Malignant Neoplasms Value Set.
  - Other Neoplasms Value Set.
  - History of Malignant Neoplasm Value Set.
  - Other Malignant Neoplasm of Skin Value Set.
- *Recent trauma.* Trauma (Trauma Value Set) any time during the 3 months (90 days) prior to the IESD through 28 days after the IESD.
- *Intravenous drug abuse.* IV drug abuse (IV Drug Abuse Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Neurologic impairment*. Neurologic impairment (Neurologic Impairment Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *HIV.* HIV (HIV Value Set) any time during the member's history through 28 days after the IESD.

- *Spinal infection.* Spinal infection (Spinal Infection Value Set) any time during the 12 months (1 year) prior to the IESD through 28 days after the IESD.
- *Major organ transplant.* Major organ transplant (Organ Transplant Other Than Kidney Value Set; Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time in the member's history through 28 days after the IESD.
- *Prolonged use of corticosteroids.* 90 consecutive days of corticosteroid treatment any time during the 366-day period that begins 365 days prior to the IESD and ends on the IESD.

  To identify consecutive treatment days, identify calendar days covered by at least one dispensed corticosteroid (Corticosteroid Medications List). For overlapping prescriptions and multiple prescriptions on the same day assume the member started taking the second prescription after exhausting the first prescription. For example, if a member had a 30-day prescription dispensed on June 1 and a 30-day prescription dispensed on June 26, there are 60 covered calendar days (June 1–July 30).

  Count only medications dispensed during the 12 months (1 year) prior to and including the IESD. When identifying consecutive treatment days, do not count days supply that extend beyond the IESD. For example, if a member had a 90-day prescription dispensed on the IESD, there is one covered calendar day (the IESD).

  No gaps are allowed.

Corticosteroid Medications

Description	Prescription	
Corticosteroid	• Hydrocortisone	• Methylprednisolone
	• Cortisone	• Triamcinolone
	• Prednisone	• Dexamethasone
	• Prednisolone	• Betamethasone

Step 5 Calculate continuous enrollment. Members must be continuously enrolled for 180 days (6 months) prior to the IESD through 28 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD.

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*

Data Elements for Reporting

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

Table LBP-1/2: Data Elements for Use of Imaging Studies for Low Back Pain

	Administrative
Measurement year	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Reported rate	✓

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

SUMMARY OF CHANGES TO HEDIS 2020

- Revised the measure name.
- Expanded the age range to members 3 months of age and older.
- Changed the measure from a member-based denominator to an episode-based denominator.
- Revised the Intake Period.
- Removed the IESD definition.
- Revised the Negative Competing Diagnosis time frame.
- Added the Medicare product line.
- Added age ranges, age stratifications and a total rate to the eligible population.
- Updated the continuous enrollment and allowable gap requirements.
- Removed "with or without a telehealth modifier" language; refer to *General Guideline 43*.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Deleted the Cystic Fibrosis Value Set from step 3 in the event/diagnosis criteria (codes for cystic fibrosis were moved to the Comorbid Conditions Value Set).
- Added instructions for deduplicating eligible episodes to the event/diagnosis criteria.
- Revised the Data Elements for Reporting table.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did *not* result in an antibiotic dispensing event).

Definitions

Intake Period A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

Episode Date The date of service for any outpatient, telephone, online assessment, observation or ED visit during the Intake Period with a diagnosis of acute bronchitis/bronchiolitis.

Negative Medication History

To qualify for Negative Medication History, the following criteria must be met:

- A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.

A prescription is considered active if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Comorbid Condition History

A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.

Negative Competing Diagnosis

The Episode Date and 3 days following the Episode Date when the member had no claims/encounters with any competing diagnosis.

Eligible Population

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

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Ages

Members who were 3 months or older as of the Episode Date.

Report three age stratifications and a total rate:

- 3 months–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

30 days prior to the Episode Date through three days after the Episode Date (34 total days).

Allowable gap

No gaps in enrollment during the continuous enrollment period.

Anchor date

None.

Benefits

Medical and pharmacy.

Event/diagnosis

Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set).

Do not include outpatient, ED or observation visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 2 Determine all acute bronchitis/bronchiolitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessment, observation or ED visits with a diagnosis of acute bronchitis/bronchiolitis.

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was filled 30 days prior to the Episode Date or was active on the Episode Date.

Step 5 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).

Step 7 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.*

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date.

AAB Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Streptomycin • Tobramycin	
Aminopenicillins	• Amoxicillin	• Ampicillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Linezolid • Metronidazole	• Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gemifloxacin	• Levofloxacin • Moxifloxacin	• Ofloxacin
Rifamycin derivatives	• Rifampin		
Second-generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfadiazine	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Supplemental data may not be used for this measure.*

Data Elements for Reporting

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

Table AAB-1/2/3: Data Elements for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total*.
Numerator events by administrative data	*For each age stratification and total*.
Reported rate	*For each age stratification and total*.

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed. ***Note:*** *Changes to these criteria can affect how the event/diagnosis will be calculated using the Intake Period, Episode Date, IESD, Negative Medication History, Negative Competing Diagnosis, Negative Comorbid Condition History.*
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits, diagnoses and medication history. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Dispensed Prescription for Antibiotic Medication	No	Medication lists, value sets and logic may not be changed. Organizations may include denied claims to calculate the numerator.

Appropriate Treatment for Upper Respiratory Infection (URI)

SUMMARY OF CHANGES TO HEDIS 2020

- Revised the measure name.
- Expanded the age range to members 3 months of age and older.
- Changed the measure from a member-based denominator to an episode-based denominator.
- Revised the Episode Date definition, removed the IESD definition and added the Negative Comorbid Condition History definition.
- Added the Medicare product line.
- Added age ranges, age stratifications and a total rate to the eligible population.
- Removed the anchor date requirements.
- Added instructions for excluding outpatient visits that result in an inpatient stay.
- Removed the requirement to exclude episode dates where there was any diagnosis other than upper respiratory infection on the same date.
- Added telehealth visits to the event/diagnosis criteria.
- Added *Penicillin G Benzathine* to the "Natural penicillins" description in the CWP Antibiotic Medications List.
- Added a comorbid condition exclusion to the event/diagnosis criteria.
- Added instructions for deduplicating eligible episodes to the event/diagnosis criteria.
- Revised the Data Elements for Reporting table.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.

Calculation

The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate URI treatment (i.e., the proportion of episodes that did not result in an antibiotic dispensing event.

Definitions

Intake Period A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.

Episode Date The date of service for any outpatient, telephone, online assessments, observation or ED visit during the Intake Period with a diagnosis of URI.

Negative Medication History

To qualify for Negative Medication History, the following criteria must be met:

- A period of 30 days prior to the Episode Date when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
- No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date.

A prescription is considered active if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

Negative Comorbid Condition History

A period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.

Negative Competing Diagnosis

The Episode Date and three days following the Episode Date when the member had no claims/encounters with a competing diagnosis.

Eligible Population

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

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Ages

Members who were 3 months of age or older as of the Episode Date.

Report three age stratifications and total rate:

- 3 months–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).

Allowable gap

No gaps in enrollment during the continuous enrollment period.

Anchor date

None.

Benefits

Medical and pharmacy.

Event/diagnosis

Follow the steps below to identify the eligible population:

Step 1 Identify all members who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an online assessment (Online Assessments Value Set) an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of URI (URI Value Set).

Exclude outpatient, ED or observation visits that result in an inpatient stay (Inpatient Stay Value Set).

Step 2 Determine all URI Episode Dates. For each member identified in step 1, determine all outpatient, telephone, online assessments, observation or ED visits with a URI diagnosis.

Step 3 Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

- HIV Value Set.
- HIV Type 2 Value Set.
- Malignant Neoplasms Value Set.
- Other Malignant Neoplasm of Skin Value Set.
- Emphysema Value Set.
- COPD Value Set.
- Comorbid Conditions Value Set.
- Disorders of the Immune System Value Set.

Step 4 Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (CWP Antibiotic Medications List) was filled 30 days prior to the Episode Date or was active on the Episode Date.

Step 5 Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis Value Set.
- Competing Diagnosis Value Set.

Step 6 Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).

Step 7 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator.*

Administrative Specification

Denominator The eligible population.

Numerator Dispensed prescription for an antibiotic medication from the CWP Antibiotic Medications List on or 3 days after the Episode Date.

CWP Antibiotic Medications

Description	Prescription	
Aminopenicillins	• Amoxicillin	• Ampicillin
Beta-lactamase inhibitors	• Amoxicillin-clavulanate	
First generation cephalosporins	• Cefadroxil • Cefazolin	• Cephalexin
Folate antagonist	• Trimethoprim	
Lincomycin derivatives	• Clindamycin	
Macrolides	• Azithromycin • Clarithromycin • Erythromycin	• Erythromycin ethylsuccinate • Erythromycin lactobionate • Erythromycin stearate
Natural penicillins	• Penicillin G potassium • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase-resistant penicillins	• Dicloxacillin	
Quinolones	• Ciprofloxacin • Levofloxacin	• Moxifloxacin • Ofloxacin
Second generation cephalosporins	• Cefaclor • Cefprozil	• Cefuroxime
Sulfonamides	• Sulfamethoxazole-trimethoprim	
Tetracyclines	• Doxycycline • Minocycline	• Tetracycline
Third-generation cephalosporins	• Cefdinir • Cefixime • Cefpodoxime	• Ceftibuten • Cefditoren • Ceftriaxone

Note

- *Although denied claims are not included when assessing the numerator, all claims (paid, suspended, pending and denied) must be included when identifying the eligible population.*
- *Supplemental data may not be used for this measure.*

Data Elements for Reporting

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

Table URI-1/23: Data Elements for Appropriate Treatment for Upper Respiratory Infection

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*For each age stratification and total.*
Numerator events by administrative data	*For each age stratification and total.*
Reported rate	*For each age stratification and total.*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Appropriate Treatment for Upper Respiratory Infection

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range. The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed. ***Note:*** *Changes to* the*se criteria can affect how* the *event/diagnosis will be calculated using* the *Intake Period, Episode Date, IESD, Negative Medication History, Negative Competing Diagnosis.*
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits, diagnoses and medication history. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Dispensed Prescription for Antibiotic Medication	No	Medication lists, value sets and logic may not be changed. Organizations may include denied claims to calculate the numerator.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

SUMMARY OF CHANGES TO HEDIS 2020

- Updated the exclusions (step 4) for both rates.
- Clarified in the continuous enrollment criteria of Rate 2 how to handle members who switch between products.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
2. *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 300 days following the IPSD (10 months).
New Episode	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Eligible Population: Rate 1—Initiation Phase

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).

Ages Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Continuous enrollment 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Allowable gap None.

Anchor date None.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population for the Initiation Phase.

Step 1 Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List) during the 12-month Intake Period.

ADHD Medications

Description	Prescription		
CNS stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate	• Dextroamphetamine • Lisdexamfetamine	• Methylphenidate • Methamphetamine
Alpha-2 receptor agonists	• Clonidine	• Guanfacine	
Miscellaneous ADHD medications	• Atomoxetine		

Step 2 Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4 Exclude members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 30 days after the IPSD. Either of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set).
- An acute inpatient discharge with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). To identify an acute inpatient discharge:

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

Administrative Specification: *Rate 1—Initiation Phase*

Denominator The Rate 1 eligible population.

Numerator An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).

Note:

- *Do not count a visit on the IPSD as the Initiation Phase visit.*
- *Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).*

Eligible Population: *Rate 2—C&M Phase*

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).

Ages Six years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Continuous enrollment Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1. However, if an organization reports products combined, then a member who switches between those products (e.g., the products included in the HEDIS reporting entity) is included in both rates. For example, if an organization reports HMO and POS products combined and a member switches from HMO to POS between the

Rate 1 and Rate 2 continuous enrollment period, the member is included in both Rate 1 and Rate 2.

Allowable gap One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid beneficiary 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 None.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population for the C&M Phase.

Step 1 Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2 Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3 Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4 Exclude members who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the 300 days (10 months) after the IPSD. Either of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set).
- An acute inpatient discharge with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.

Administrative Specification: *Rate 2—C&M Phase*

Denominator The Rate 2 eligible population.

Numerator Identify all members who meet the following criteria:

- Numerator compliant for *Rate 1—Initiation Phase,* ***and***
- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD.

Only one of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) or a telehealth visit.

Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Visit Value Set).
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set).
- A telephone visit (Telephone Visits Value Set).

Exclusions *(optional)*

Exclude from the denominator for both rates, members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

Note

- *For members who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 3 for the definition of prescribing practitioner.*
- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).*

Data Elements for Reporting

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

Table ADD-1/2: Data Elements for Follow-Up Care for Children Prescribed ADHD Medication

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	*Each of the 2 rates*
Number of optional exclusions	*Each of the 2 rates*
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Follow-Up Care for Children Prescribed ADHD Medication

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. ***Note:*** *This measure uses newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	No, if applied	The optional exclusions are not required, but if they are used, only the specified exclusions may be applied and the value sets may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Initiation Phase	No	Value sets and logic may not be changed.
Continuation and Management Phase	Yes, with limits	Value sets and logic may not be changed. Timing of visit determination may be changed.

*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)**

***Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.**

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Clarified in the *Rules for Allowable Adjustments of HEDIS* that when adjusting ages, the upper age range may be expanded or there may be no upper age limit.

Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

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).
Ages	1–17 years as of December 31 of the measurement year. Report two age stratifications and a total rate for each of the three indicators: • 1–11 years. • 12–17 years. • Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (Antipsychotic Medications List; Antipsychotic Combination Medications List; Prochlorperazine

Medications List) of the same or different medications, on different dates of service during the measurement year.

Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol	• Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone	• Pimozide • Quetiapine • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine	• Thioridazine • Trifluoperazine	
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate • Risperidone	

Antipsychotic Combination Medications

Description	Prescription	
Psychotherapeutic combinations	• Fluoxetine-olanzapine	• Perphenazine-amitriptyline

Prochlorperazine Medications

Description	Prescription
Phenothiazine antipsychotics	• Prochlorperazine

Administrative Specification

Denominator The eligible population.

Numerator

Blood Glucose Members who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Members who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol Members who received both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

Data Elements for Reporting

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

Table APM-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*Each indicator, for each age stratification and total*
Numerator events by supplemental data	*Each indicator, for each age stratification and total*
Reported rate	*Each indicator, for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Guidance for Allowable Adjustments for Metabolic Monitoring for Children and Adolescents on Antipsychotics

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within a specified age range (ages 1–17+ years). Additionally, the upper age range may be expanded, or no upper age limit may be used.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only dispensing events that contain (or map to) codes in the medication lists and value sets may be used to identify antipsychotic medication events. Medication lists, value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Metabolic monitoring	No	Value sets and logic may not be changed.

2020 CMS Web Interface

MH-1 (NQF 0710): Depression Remission at Twelve Months

Measure Steward: MNCM

NARRATIVE MEASURE SPECIFICATION

DESCRIPTION:
The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

IMPROVEMENT NOTATION:
Higher score indicates better quality

INITIAL POPULATION:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial Patient Health Questionnaire-9 item version (PHQ-9) or Patient Health Questionnaire-9 Modified for Teens and Adolescents (PHQ-9M) score greater than nine during the index event.

DENOMINATOR:
Equals Initial Population

DENOMINATOR EXCLUSIONS:
Patients with a diagnosis of bipolar disorder
Patients with a diagnosis of select personality disorders
Patients with a diagnosis of schizophrenia or psychotic disorder
Patients with a diagnosis of pervasive developmental disorder
Patients who were permanent nursing home residents

DENOMINATOR EXCEPTIONS:
None

NUMERATOR:
Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five.

NUMERATOR EXCLUSIONS:
Not Applicable

DEFINITION:
Denominator Identification Period - The period in which eligible patients can have an index event. The denominator identification period occurs prior to the measurement period and is defined as 14 months to two months prior to the start of the measurement period. The denominator identification period is from 11/1/2018 to 10/31/2019. For patients with an index event, there needs to be enough time following index for the patients to have the opportunity to reach remission twelve months +/- 60 days after the index event date.

Index Event Date - The date in which the first instance of elevated PHQ-9 or PHQ-9M greater than nine AND diagnosis of depression or dysthymia occurs during the denominator identification period (11/1/2018 to 10/31/2019). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).

Measure Assessment Period - The index event date marks the start of the measurement assessment period for each patient which is 14 months (12 months +/- 60 days). This 14 month measure assessment period allows for measurement of the patient's remission status at both six and 12 months (Quality ID #411: Depression Remission at Six Months). This assessment period is fixed and does not "start over" with a higher PHQ-9 or PHQ-9M that may occur after the index event date.

Remission - Is defined as a PHQ-9 or PHQ-9M score of less than five.

Twelve Months - Is defined as the point in time from the index event date extending out twelve months and then allowing a grace period of sixty days prior to and sixty days after this date. The most recent PHQ-9 or PHQ-9M score less than five obtained during this four month period is deemed as remission at twelve months, values obtained prior to or after this period are not counted as numerator compliant (remission).

GUIDANCE:

None

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission requires the following:

- Determine if the patient's medical record can be found
  - If you can locate the medical record select "Yes"

  OR

  - If you cannot locate the medical record select "No - Medical Record Not Found"

  OR

  - Determine if the patient is qualified for the sample
    - If the patient is deceased, in hospice, moved out of the country or did not have Fee-for-Service (FFS) Medicare as their primary payer select "Not Qualified for Sample", select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance Patient Confirmation

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, *the patient is completed but not confirmed. The patient will be "skipped" and another patient must be submitted in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.*

If "Not Qualified for Sample" is selected and the date is unknown, *you may enter the last date of the measurement period (i.e., 12/31/2020).*

The Measurement Period is defined *as January 1 – December 31, 2020.*

NOTE:

- ***In Hospice:*** *Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)*
- ***Moved out of Country:*** *Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period*
- ***Deceased:*** *Select this option if the patient died during the measurement period*
- ***Non-FFS Medicare:*** *Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient has an active diagnosis of major depression or dysthymia during the denominator identification period (11/1/2018 to 10/31/2019)
  - If the patient has a documented diagnosis of major depression or dysthymia in the medical record select "Yes"

  OR

  - If you are unable to confirm the diagnosis of major depression or dysthymia for the patient select "Not Confirmed - Diagnosis"

  OR

  - If there is a denominator exclusion for patient disqualification from the measure select "Denominator Exclusion"

  OR

  - If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Denominator and Denominator Exclusion codes can be found in the 2020 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

Note: *This outcome measure is indicated for patients with a diagnosis of major depression or dysthymia. These diagnosis codes are identified during the CMS sampling process and can be found in the Denominator Codes tab in the MH_Coding Document. Confirmation of the diagnosis of major depression or dysthymia can occur using any of the following methods:*

- *Diagnosis code on the encounter or problem list (regardless of vendor assigned description of the code)*
- *Words "major depression", "major depressive disorder", "dysthymia", "dysthymic disorder", "pervasive depressive disorder" (DSM 5 term for dysthymia) on progress notes or problems lists can be used to confirm the diagnosis. Additionally, in paper records, the description "depression" may be used with the option to confirm by billing code.*

If "Not Confirmed – Diagnosis" or "Denominator Exclusion" or "No – Other CMS Approved Reason" is selected, *the patient will be "skipped" and another patient must be submitted in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.*

Other CMS Approved Reason *is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.*

To submit a skip request, follow these steps:

1. *After confirming the beneficiary for the sample, scroll to the measure you would like to skip.*
2. *When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.*
3. *In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary's condition and*

why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

NOTE:

- ***Active Diagnosis of Major Depression or Dysthymia*** *is defined as a diagnosis that is either on the patient's problem list, a diagnosis code description listed on the encounter, or is documented in a progress note indicating that the patient is being treated or managed for the disease or condition during the denominator identification period*
- ***Patient must be age 12 years or older*** *at the time of the index event (confirming diagnosis and PHQ-9 or PHQ-9M greater than 9)*

- ***Index Event Date*** *is defined as the date on which the first instance of elevated PHQ-9 or PHQ-9M greater than 9 AND diagnosis of major depression or dysthymia occurs during the denominator identification period (11/1/2018 to 10/31/2019). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).*
- ***Denominator Exclusions -*** *active diagnosis of bipolar disorder, personality disorder (select types; cyclothymic, borderline, histrionic and factitious), schizophrenia, psychotic disorder or pervasive developmental disorder any time prior to the end of the measure assessment period. Patients who were a permanent nursing home resident any time during the denominator identification period or the measure assessment period.*
- ***Permanent Nursing Home Resident*** *is defined as a patient who is residing in a long-term residential facility any time during the denominator identification period or before the end of the measurement assessment period. It does not include patients who are receiving short-term rehabilitative services following a hospital stay, nor does it include patients residing in assisted living or group home settings*
- ***Two rates will be reported*** *– Adolescent patients aged 12 to 17 and Adult patients aged 18 years and older.*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the denominator identification period between 11/1/2018 and 10/31/2019
    - If the patient did have a PHQ-9 or PHQ-9M administered during the denominator identification period select "Yes"

    OR

    - If the patient did not have a PHQ-9 or PHQ-9M administered during the denominator identification period select "No"

Denominator codes can be found in the 2020 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

If "No" is selected, *the patient is not considered denominator eligible. The patient will be "skipped" and another patient must be submitted in their place, if available.*

NOTE:

- ***PHQ-9 or PHQ-9M administration*** *does not require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk)*
- ***Index event date*** *is the date in which the first instance of elevated PHQ-9 or PHQ-9M greater than 9 AND diagnosis of depression or dysthymia occurs during the denominator identification period (11/1/2018 to 10/31/2019). Patients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).*
- ***Measure Assessment Period-*** *the index event date marks the start of the measurement assessment period for each patient which is 14 months (12 months +/- 60 days)*. This 14 month measure assessment period allows for measurement of the patient's remission status at both six and 12 months (Quality ID #411: Depression Remission at Six Months). *This assessment period is fixed and does not start over with a higher PHQ- 9 or PHQ-9M that may occur after the index date*

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient had a PHQ-9 or PHQ-9M score greater than 9 between 11/1/2018 and 10/31/2019
  - If the patient did have a PHQ-9 or PHQ-9M greater than 9 during the denominator identification period select "Yes"

    IF YES

    - Record the date of the index PHQ-9 or PHQ-9M score greater than 9 in **MM/DD/YYYY** format. This is the patient's index date.

    AND

    - Enter the score of the PHQ-9 or PHQ-9M associated with the Index Date

  OR

  - If the patient did not have a PHQ-9 or PHQ-9M greater than 9 during the denominator identification period select "No"

Denominator codes can be found in the 2020 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Denominator

If "No" is selected, *the patient is not considered denominator eligible. The patient will be "skipped" and another patient must be submitted in their place, if available.*

NOTE:

- ***Enter the first instance of PHQ-9 or PHQ-9M greater than 9*** *that is also associated with a diagnosis of major depression or dysthymia during the time period of 11/1/2018 and /10/31/2019. This is the Index Event Date for this patient and marks the start of the 14 month assessment period (12 months +/- 60 days)*
- ***All nine questions*** *must be answered to have a valid summary score. If a patient chooses more than one response for a single question, select the "worse" response (higher number) to calculate the summary score*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient had one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period (12 months +/- 60 days from the Index Event Date). Within the +/- 60 day window (120 days total), the most recent PHQ-9 or PHQ-9M is used to determine remission.
    - If the patient did have one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period, select "Yes"

    OR

    - If the patient did not have one or more PHQ-9s or PHQ-9Ms administered during the Measurement Assessment Period, select "No"

Numerator codes can be found in the 2020 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***The only tools appropriate*** *for indicating remission is a completed PHQ-9 or PHQ-9M*

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if the patient achieved remission with a follow-up PHQ-9 or PHQ-9M performed and a score less than 5 at 12 months (+/- 60 days) of the initial (index event date) PHQ-9 or PHQ-9M score greater than 9
  - If the patient did have a PHQ-9 or PHQ-9M less than 5 select "Yes"

    IF YES

    - Record the date of the PHQ-9 or PHQ-9M score less than 5 in **MM/DD/YYYY** format. This is the patient's Remission Date.
    - If the patient had more than one PHQ-9 or PHQ-9M administered during the +/- 60 day window (120 days total), enter the date of the most recent PHQ-9 or PHQ-9M

    AND

    - Enter the score of the PHQ-9 or PHQ-9M associated with the Remission Date

  OR

  - If the patient did not have a PHQ-9 or PHQ-9M less than 5 select "No"

Numerator codes can be found in the 2020 CMS Web Interface MH Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance Numerator

NOTE:

- ***If more than one PHQ-9 or PHQ-9M score was obtained*** *between the 10 and 14 month window, select the most recent PHQ-9 or PHQ-9M date and score within that window*
- ***Scores obtained prior to or after*** *this period are not counted as numerator compliant (remission)*
- ***Patient remission****, a follow-up PHQ-9 or PHQ-9M result less than 5, may be determined during a telehealth encounter*
- ***PHQ-9 or PHQ-9M administration*** *does not require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk)*

FOLLOW-UP, RESPONSE, AND REMISSION MEASURE SPECIFICATIONS AND CALCULATION

Measure Specifications

NOTE: The Index Periods and Assessment Periods detailed in the Measure Specifications below are NOT the dates of service that should be submitted. See the *Data Collection Technical Guide* for instructions to identify the correct service dates for submission.

Summary of Changes	• Preliminary 2021 MY dates added to Measurement Period for reference. • Clarifying language added to Eligible Specialties and Eligible Providers sections. • Clarification regarding permissible administration of the PHQ-9 and PHQ-9M tools added as a footnote. See appendices of Data Collection Technical Guide for specific guidance regarding assessment tool administration.

Depression: Follow-Up, Response & Remission Measurement Period, Denominator & Exclusions		
Description	See measure specific description(s) below.	
Measurement Period	Denominator Identification Period: • FINAL 2020 MY: November 1, 2018 through October 31, 2019 • PRELIMINARY 2021 MY: November 1, 2019 through October 31, 2020 Measure Assessment Period: For each patient, the measure assessment period begins with an index event and is 14 months (12 months + 60 days) in length.	
Eligible Population	**Eligible Specialties for diagnosing Depression/ Dysthymia^**	Family Medicine, Internal Medicine, Geriatric Medicine, Psychiatry, Behavioral Health, Pediatric/Adolescent Medicine
	Eligible Providers for diagnosing Depression/ Dysthymia^	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN) These providers are also eligible, if supervised by a physician: Licensed Psychologist (LP), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT)
	Ages	12 years of age or older at the index event

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	Event (Index)	An index event occurs when ALL the following criteria are met during an encounter*: • a PHQ-9 or PHQ-9M result greater than nine • an active diagnosis of Major Depression or Dysthymia (*Major Depression or Dysthymia* Value Set) • the patient is NOT in a prior measure assessment period * For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry or psychotherapy visit, telephone, or online encounter. PHQ-9 or PHQ-9M score greater than 9 can be documented on the same date or up to seven days prior to the encounter (index event) and this date occurs during the denominator identification measurement period. This allows for pre-visit planning and administering the PHQ-9 or PHQ-9M just prior to an encounter.
Denominator	The eligible population who had index events during the denominator identification period.	
Numerator	See measure specific numerator definition(s) below.	
Required Exclusions	The following exclusions must be applied to the eligible population: • Patient had an active diagnosis of Bipolar Disorder (*Bipolar Disorder* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Schizophrenia or Psychotic Disorder (*Schizophrenia Psychotic Disorder* Value Set) any time prior to the end of their measure assessment period	
Allowable Exclusions	The following exclusions can be applied to the eligible population: • Patient had an active diagnosis of Personality Disorder – Emotionally Labile (*Personality Disorder - Emotionally Labile* Value Set) any time prior to the end of their measure assessment period • Patient had an active diagnosis of Pervasive Developmental Disorder (*Pervasive Disorder* Value Set) any time prior to the end of their measure assessment period • Patient was a permanent nursing home resident at any time during the denominator identification period or measure assessment period • Patient was in hospice or receiving palliative care at any time during the denominator identification period or measure assessment period • Patient died prior to the end of their measure assessment period	
Measure Scoring	Rate/Proportion Results are always stratified by age: • Adolescents (12-17 years of age) • Adults (18 years of age or older)	
Interpretation of Score	Higher score indicates better quality	
Measure Type	Outcome	
^Any member of the health care team can administer a PHQ-9 or PHQ-9M assessment tool to a patient. Additionally, patients can self-administer via patient portal, email, or mail		

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Depression: Remission at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission six months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, six months (+/- 60 days) after an index event

Depression: Remission at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who reached remission 12 months (+/- 60 days) after an index event
Numerator	The number of patients in the denominator who reached remission, with a PHQ-9 or PHQ-9M result less than five, 12 months (+/- 60 days) after an index event

Depression: Response at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, six months (+/- 60 days) after an index event.

Depression: Response at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia who demonstrated a response to treatment 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who demonstrated a response to treatment, with a PHQ-9 or PHQ-9M result that is reduced by at least 50 percent since the index PHQ-9/PHQ-9M result, 12 months (+/- 60 days) after an index event.

Depression: Follow-up at Six Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool six months (+/- 60 days) after an index event.

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Depression: Follow-up at Twelve Months	
Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with Major Depression or Dysthymia with an index PHQ-9/PHQ-9M score greater than nine who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.
Numerator	The number of patients in the denominator who have a completed PHQ-9 or PHQ-9M tool 12 months (+/- 60 days) after an index event.

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eCQM Title	**Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment**		
eCQM Identifier (Measure Authoring Tool)	177	**eCQM Version number**	8.1.000
NQF Number	1365e	**GUID**	848d09de-7e6b-43c4-bedd-5a2957ccffe3
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	PCPI(R) Foundation (PCPI[R])		
Measure Developer	American Medical Association (AMA)		
Measure Developer	PCPI(R) Foundation (PCPI[R])		
Endorsed By	National Quality Forum		
Description	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk		
Copyright	Copyright 2019 PCPI(R) Foundation and American Medical Association. All Rights Reserved.		
Disclaimer	The Measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications. The Measure, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measure for commercial gain, or incorporation of the Measure into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measure require a license agreement between the user and the PCPI(R) Foundation (PCPI[R]) or the American Medical Association (AMA). Neither the AMA, nor the former AMA-convened Physician Consortium for Performance Improvement(R) (AMA-PCPI), nor PCPI, nor their members shall be responsible for any use of the Measure. AMA and PCPI encourage use of the Measure by other health care professionals, where appropriate. THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND. 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. The AMA, the PCPI and its members and former members of the AMA-PCPI disclaim 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 2004-2018 American Medical Association. LOINC(R) is copyright 2004-2018 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms(R) (SNOMED CT[R]) copyright 2004-2018 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2018 World Health Organization. All Rights Reserved. Due to technical limitations, registered trademarks are indicated by (R) or [R].		
Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Research has shown that patients with major depressive disorder are at a high risk for suicide attempts and completion - among the most significant and devastating sequelae of the disease. Suicide risk is a critical consideration in children and adolescents with MDD and an important aspect of care that should be assessed at each visit and subsequently managed to minimize that risk. Additionally, the importance of the assessments is underscored by research that indicates that many individuals who die by suicide do make contact with primary care providers and mental health services beforehand. More specifically, approximately 15% of suicide victims aged 35 years or younger had seen a mental health professional within 1 month of suicide while approximately 23% had seen a primary care provider within 1 month of suicide.		
Clinical Recommendation Statement	The evaluation must include assessment for the presence of harm to self or others (MS) (American Academy of Child and Adolescent Psychiatry, 2007). Suicidal behavior exists along a continuum from passive thoughts of death to a clearly developed plan and intent to carry out that plan. Because depression is closely associated with suicidal thoughts and behavior, it is imperative to evaluate these symptoms at the initial and subsequent assessments. For this purpose, low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can be used. Also, it is crucial to evaluate the risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that might influence the desire to attempt suicide. The risk for suicidal behavior increases if there is a history of suicide attempts, comorbid psychiatric disorders (e.g., disruptive disorders, substance abuse), impulsivity and aggression, availability of lethal agents (e.g., firearms), exposure to negative events (e.g., physical or sexual abuse, violence), and a family history of suicidal behavior (American Academy of Child and Adolescent Psychiatry, 2007). A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder (Category I). Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness (Category I) (American Psychiatric Association, 2010, reaffirmed 2015).		
Improvement Notation	Higher score indicates better quality		
Reference	American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with depressive disorders. Journal of the American Academy of Child and Adolescent Psychiatry, 46(11), 1503-1526. Retrieved from https://www.jaacap.org/article/S0890-8567(09)62053-0/fulltext		
Reference	American Psychiatric Association Work Group on Major Depressive Disorder. (2010, October). Practice guideline for the treatment of patients with major depressive disorder. 3rd edition. Retrieved from http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf (This guideline was reaffirmed in October 2015.)		
Reference	Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. American Journal of Psychiatry, 159(6), 909-916.		
Definition	Numerator Definition: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g.,		

	religious belief, concern not to hurt family) that may influence the desire to attempt suicide. 2. Current severity of suicidality. 3. Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding.
Guidance	A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. Suicide risk assessments completed via telehealth services can also meet numerator performance. This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment. Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic below, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone.
Transmission Format	TBD
Initial Population	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator	Equals Initial Population
Denominator Exclusions	None
Numerator	Patient visits with an assessment for suicide risk
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex

Table of Contents

Population Criteria

Initial Population

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

None

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
        such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

Numerator Exclusions

None

Denominator Exceptions

None

Stratification

None

Definitions

Denominator

```
"Initial Population"
```

Initial Population

```
"Major Depressive Disorder Encounter" MDDEncounter
    with ["Patient Characteristic Birthdate": "Birth date"] BirthDate
        such that Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")>= 6
            and Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")< 17
```

Major Depressive Disorder Encounter

```
( ["Encounter, Performed": "Office Visit"]
    union ["Encounter, Performed": "Outpatient Consultation"]
    union ["Encounter, Performed": "Psych Visit - Diagnostic Evaluation"]
    union ["Encounter, Performed": "Psych Visit - Family Psychotherapy"]
    union ["Encounter, Performed": "Psych Visit - Psychotherapy"]
```

```
union ["Encounter, Performed": "Psychoanalysis"]
union ["Encounter, Performed": "Group Psychotherapy"]
union ["Encounter, Performed": "Telehealth Services"] ) ValidEncounter
where exists ( ValidEncounter.diagnoses EncounterDiagnosis
            where EncounterDiagnosis in "Major Depressive Disorder-Active"
)
      and ValidEncounter.relevantPeriod during "Measurement Period"
```

Numerator

```
"Major Depressive Disorder Encounter" MDDEncounter
      with ["Intervention, Performed": "Suicide risk assessment (procedure)"] SuicideRiskAssessment
            such that SuicideRiskAssessment.relevantPeriod during MDDEncounter.relevantPeriod
```

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Functions

Global.CalendarAgeInYearsAt(BirthDateTime DateTime, AsOf DateTime)

```
years between ToDate(BirthDateTime)and ToDate(AsOf)
```

Global.ToDate(Value DateTime)

```
DateTime(year from Value, month from Value, day from Value, 0, 0, 0, 0, timezone from Value)
```

Terminology

- code "Birth date" ("LOINC Code (21112-8)")
- code "Suicide risk assessment (procedure)" ("SNOMEDCT Code (225337009)")
- valueset "Ethnicity" (2.16.840.1.114222.4.11.837)
- valueset "Group Psychotherapy" (2.16.840.1.113883.3.526.3.1187)
- valueset "Major Depressive Disorder-Active" (2.16.840.1.113883.3.526.3.1491)
- valueset "Office Visit" (2.16.840.1.113883.3.464.1003.101.12.1001)
- valueset "ONC Administrative Sex" (2.16.840.1.113762.1.4.1)
- valueset "Outpatient Consultation" (2.16.840.1.113883.3.464.1003.101.12.1008)
- valueset "Payer" (2.16.840.1.114222.4.11.3591)
- valueset "Psych Visit - Diagnostic Evaluation" (2.16.840.1.113883.3.526.3.1492)
- valueset "Psych Visit - Family Psychotherapy" (2.16.840.1.113883.3.526.3.1018)
- valueset "Psych Visit - Psychotherapy" (2.16.840.1.113883.3.526.3.1496)
- valueset "Psychoanalysis" (2.16.840.1.113883.3.526.3.1141)
- valueset "Race" (2.16.840.1.114222.4.11.836)
- valueset "Telehealth Services" (2.16.840.1.113883.3.464.1003.101.12.1031)

Data Criteria (QDM Data Elements)

- "Encounter, Performed: Group Psychotherapy" using "Group Psychotherapy (2.16.840.1.113883.3.526.3.1187)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Family Psychotherapy" using "Psych Visit - Family Psychotherapy (2.16.840.1.113883.3.526.3.1018)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis (2.16.840.1.113883.3.526.3.1141)"
- "Encounter, Performed: Telehealth Services" using "Telehealth Services (2.16.840.1.113883.3.464.1003.101.12.1031)"
- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Payer: Payer" using "Payer (2.16.840.1.114222.4.11.3591)"
- "Patient Characteristic Race: Race" using "Race (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex (2.16.840.1.113762.1.4.1)"
- "Intervention, Performed: Suicide risk assessment (procedure)" using "Suicide risk assessment (procedure) (SNOMEDCT Code 225337009)"
- "Patient Characteristic Birthdate: Birth date" using "Birth date (LOINC Code 21112-8)"

Supplemental Data Elements

SDE Ethnicity

```
["Patient Characteristic Ethnicity": "Ethnicity"]
```

SDE Payer

```
["Patient Characteristic Payer": "Payer"]
```

SDE Race

```
["Patient Characteristic Race": "Race"]
```

SDE Sex

```
["Patient Characteristic Sex": "ONC Administrative Sex"]
```

Risk Adjustment Variables

None

Measure Set	None