Connecticut Quality Council
2024 Aligned Measure Set Annual Review
Measure Specifications for Measures to be Discussed During February 22nd Quality Council Meeting

Child and Adolescent Well-Care Visits (WCV)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.

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.

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

Product lines Commercial, Medicaid (report each product line separately).

Stratifications For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive, and the sum of all categories in each stratification is the Total population.*

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.
Required exclusions	Exclude members who meet either of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more well-care visits during the measurement year. Either of the following meet criteria: • A well-care visit (Well Care Visit Value Set). • An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81). 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 practitioner.
- *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.*

Data Elements for Reporting

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

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

Metric	Age	Data Element	Reporting Instructions
ChildAdolescentWellVisits	3-11	EligiblePopulation	For each Stratification
	12-17	ExclusionAdminRequired	For each Stratification
	18-21	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

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

Metric	Race	Source	Data Element	Reporting Instructions
ChildAdolescentWellVisits	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification
	Asian	Indirect	Numerator	For each Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

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

Metric	Ethnicity	Source	Data Element	Reporting Instructions
ChildAdolescentWellVisits	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification
	NotHispanicOrLatino	Indirect	Numerator	For each Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

*AskedButNoAnswer is only reported for Source= "Direct."

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of 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 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
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 hospice and deceased member exclusion are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Well-Child Visit(s)	No	Value sets and logic may not be changed.

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Revised the method for identifying advanced illness.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (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

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

Stratifications For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.

- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive and the sum of all categories in each stratification is the total population.*

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 Follow the steps below to identify the eligible population.

Step 1 Identify members who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Step 2 Remove 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.

Required exclusions Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.

- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the member's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).
- 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** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - 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 at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

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 the measurement year. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23).

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.

If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance:

- Systolic Compliant: Systolic Less Than 140 Value Set.
- Systolic Not Compliant: CPT-CAT-II code 3077F.
- Diastolic Compliant: Diastolic Less Than 90 Value Set.
- Diastolic Not Compliant: CPT-CAT-II code 3080F.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

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.

BP readings taken by the member and documented in the member's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

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).

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

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 for reference only and is not exhaustive):*
  - *A colonoscopy requires a change in diet (NPO on the day of the 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 for reference only 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-A-1/2/3: Data Elements for Controlling High Blood Pressure

Metric	Data Element	Reporting Instructions	A
ControlHighBP	CollectionMethod	Report once	✓
	EligiblePopulation	Report once	✓
	ExclusionAdminRequired	Report once	✓
	NumeratorByAdminElig	Report once	
	CYAR	(Percent)	
	MinReqSampleSize	Report once	
	OversampleRate	Report once	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Report once	
	ExclusionEmployeeOrDep	Report once	
	OversampleRecsAdded	Report once	
	Denominator	Report once	
	NumeratorByAdmin	Report once	✓
	NumeratorByMedicalRecords	Report once	
	NumeratorBySupplemental	Report once	✓
	Rate	(Percent)	✓

Table CBP-B-1/2/3: Data Elements for Controlling High Blood Pressure: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions	A
ControlHighBP	AmericanIndianOrAlaskaNative	Direct	CollectionMethod	Repeat per Stratification	✓
	Asian	Indirect	EligiblePopulation	For each Stratification	✓
	BlackOrAfricanAmerican	Unknown**	Denominator	For each Stratification	
	NativeHawaiianOrOtherPacificIslander	Total	Numerator	For each Stratification	✓
	White		Rate	(Percent)	✓
	SomeOtherRace				
	TwoOrMoreRaces				
	AskedButNoAnswer*				
	Unknown**				

Table CBP-C-1/2/3: Data Elements for Controlling High Blood Pressure: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions	A
ControlHighBP	HispanicOrLatino	Direct	CollectionMethod	Repeat per Stratification	✓
	NotHispanicOrLatino	Indirect	EligiblePopulation	For each Stratification	✓
	AskedButNoAnswer*	Unknown**	Denominator	For each Stratification	
	Unknown**	Total	Numerator	For each Stratification	✓
			Rate	(Percent)	✓

*AskedButNoAnswer is only reported for Source= "Direct."

**Race/Ethnicity = "Unknown" is only reported for Source = "Unknown" and Source = "Unknown" is only reported for Race/ Ethnicity = "Unknown."

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
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, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness 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.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)*

***Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).**

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

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

Stratifications For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.*

Ages

6 years and older as of the date of the ED visit. Report three age stratifications and a total rate:

- 6–17 years.
- 18–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

Date of the ED visit through 30 days after the ED visit (31 total days).

Allowable gap

None.

Anchor date

None.

Benefit

Medical and mental health.

Event/diagnosis

An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions

Exclude members who meet either of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the

run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** POS code 52 ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set) ***with*** POS code 53 ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 54), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set) ***with*** Telehealth POS Value Set ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits 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 required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

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

Table FUM-A-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

Metric	Age	Data Element	Reporting Instructions
FollowUp30Day	6-17	Benefit	Metadata
FollowUp7Day	18-64	EligiblePopulation	For each Stratification, repeat per Metric
	65+	ExclusionAdminRequired	For each Stratification, repeat per Metric
	Total	NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		Rate	(Percent)

Table FUM-B-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
FollowUp30Day	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	Asian	Indirect	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table FUM-C-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
FollowUp30Day	HispanicOrLatino	Direct	EligiblePopulation	For each Stratification, repeat per Metric
FollowUp7Day	NotHispanicOrLatino	Indirect	Numerator	For each Metric and Stratification
	AskedButNoAnswer*	Unknown**	Rate	(Percent)
	Unknown**	Total		

*AskedButNoAnswer is only reported for Source= "Direct."

**Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Follow-Up After Emergency Department Visit for Mental Illness

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	Age determination dates may be changed (6 years as of the date of the ED visit). 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	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
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 value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an ED visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Glycemic Status Assessment for Patients With Diabetes (GSD)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Updated the measure title.
- Added glucose management indicator as an option to meet numerator criteria.
- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- Removed the required exclusion for members who did not have a diagnosis of diabetes.
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Moved previously listed *Exclusions* to *Required exclusions*.
- Revised the method for identifying advanced illness.
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Clarified that "Unknown" is not considered a result/finding.
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

Note: *Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*

Eligible Population

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

Stratification For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.

  - Unknown.
  - Total.
- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.*

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 had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol	
Amylin analogs	• Pramlintide		
Antidiabetic combinations	• Alogliptin-metformin • Alogliptin-pioglitazone	• Empagliflozin-metformin • Ertugliflozin-metformin	• Linagliptin-metformin • Metformin-pioglitazone

Description	Prescription		
	• Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin degludec • Insulin degludec-liraglutide • Insulin detemir • Insulin glargine • Insulin glargine-lixisenatide	• 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	
Biguanides	• Metformin		
Glucagon-like peptide-1 (GLP1) agonists	• Albiglutide • Dulaglutide • Exenatide	• Liraglutide • Lixisenatide • Semaglutide	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapagliflozin	• Ertugliflozin • Empagliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitagliptin	

Required exclusions

Exclude members who meet any of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

- 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** frailty and advanced illness criteria to be excluded:
  1. **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).
  2. **Advanced Illness.** Either of the following during the measurement year or the year prior to the measurement year:
     - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
     - 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

Glycemic Status <8% Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set). The member is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: HbA1c Level Less Than 8.0 Value Set.
- Not compliant: HbA1c Level Greater Than or Equal To 8.0 Value Set.

Glycemic Status >9% Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set). The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: CPT Category II code 3046F.
- Not compliant: HbA1c Level Less Than or Equal To 9.0 Value Set.

Note: *A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9% indicate better care).*

Hybrid Specification

Denominator A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the Glycemic Status Assessment for Patients With Diabetes (GSD), Eye Exam for Patients With Diabetes (EED) and Blood Pressure Control for Patients With Diabetes (BPD) measures may use the same sample for all three measures. If the same sample is used for the three diabetes measures, the organization must first take the inverse of the Glycemic Status >9.0% rate (100 minus the Glycemic Status >9.0% rate) before reducing the sample.

Organizations may reduce the sample size based on the current year's administrative rate or the prior year's audited, product line-specific rate for the lowest rate of all GSD indicators and EED and BPD measures.

If separate samples are used for the GSD, EED and BPD measures, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for the measure.

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

Numerators

Glycemic Status<8% The result of the *most recent* glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is <8.0% as documented through 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 glycemic status assessment (HbA1c or GMI) was performed, and the result. The member is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is <8.0%.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

GMI results collected by the member and documented in the member's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

The member is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≥8.0% or is missing, or if a glycemic status assessment 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. "Unknown" is not considered a result/finding.

Glycemic Status >9% The result of the *most recent* glycemic status assessment (HbA1c or GMI) (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 Glycemic Status >9.0% 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 glycemic status assessment was performed and the result. The member is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement year.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

GMI results collected by the member and documented in the member's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

The member is not numerator compliant if the most recent glycemic status 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. "Unknown" is not considered a result/finding.

Note

- *If a combination of administrative, supplemental or hybrid data are used, the most recent glycemic status assessment must be used, regardless of data source.*

Data Elements for Reporting

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

Table GSD-A-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
LessThan8	CollectionMethod	Repeat per Metric	✓
GreaterThan9	EligiblePopulation*	For each Metric	✓
	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	NumeratorBySupplemental	For each Metric	✓
	Rate	(Percent)	✓

Table GSD-B-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Race

Metric
LessThan8
GreaterThan9

Race	Source	Data Element	Reporting Instructions	A
AmericanIndianOrAlaskaNative	Direct	CollectionMethod	Repeat per Metric and Stratification	✓
Asian	Indirect	EligiblePopulation*	For each Metric and Stratification	✓
BlackOrAfricanAmerican	Unknown***	Denominator	For each Stratification, repeat per Metric	
NativeHawaiianOrOtherPacificIslander	Total	Numerator	For each Metric and Stratification	✓
White		Rate	(Percent)	✓
SomeOtherRace				
TwoOrMoreRaces				
AskedButNoAnswer**				
Unknown***				

Table GSD-C-1/2/3: Data Elements for Glycemic Status Assessment for Patients With Diabetes: Stratifications by Ethnicity

Metric
LessThan8
GreaterThan9

Ethnicity	Source	Data Element	Reporting Instructions	A
HispanicOrLatino	Direct	CollectionMethod	Repeat per Metric and Stratification	✓
NotHispanicOrLatino	Indirect	EligiblePopulation*	For each Metric and Stratification	✓
AskedButNoAnswer**	Unknown***	Denominator	For each Stratification, repeat per Metric	
Unknown***	Total	Numerator	For each Metric and Stratification	✓
		Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the Administrative Method.

**AskedButNoAnswer is only reported for Source= "Direct."

***Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures *may not* be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of Glycemic Status Assessment 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"). Changing denominator age range is allowed within a 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
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	The hospice, deceased member, palliative care, I-SNP, LTI, frailty and advanced illness exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Glycemic Status <8.0% • Glycemic Status >9.0%	No	Value sets and logic may not be changed.

Health Equity Measure Specifications

Steward: Connecticut Office of Health Strategy
As of July 7, 2023

SUMMARY OF CHANGES FOR 2024

- No substantive changes.

Background

The Connecticut Office of Health Strategy (OHS) has adopted a health equity-focused measure for its Aligned Measure Set.[1] The *Health Equity Measure* stratifies performance for select measures in the Aligned Measure Set by race, ethnicity and language (REL). OHS developed this measure in partnership with the Quality Council, a stakeholder body of payer, provider, state agency and consumer representatives. OHS prioritized stratification of measures in the Aligned Measure Set that have evidence of disparities in performance by REL in Connecticut and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA).

Description

The performance for each of the following measures, stratified by race, ethnicity and language:

- Measure #1: Child and Adolescent Well-Care Visits
- Measure #2: Comprehensive Diabetes Care: HbA1c Control
- Measure #3: Controlling High Blood Pressure
- Measure #4: Prenatal and Postpartum Care
- Measure #5: Screening for Depression and Follow-up Plan

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	Advanced Networks (ANs) should use their own EHR-based clinical data and patient age, sex data and REL data to report stratified performance for all measures. Because Measure #1 and Measure #4 use administrative data, ANs should leverage payer-provided data for measure performance and their own REL data to report stratified performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their EHRs and report performance on the measure. Alternatively, ANs could report performance for Measure #1 and Measure

[1] Connecticut Office of Health Strategy. Quality Council 2023 Aligned Measure Set. https://portal.ct.gov/OHS/Pages/Quality-Council/Core-Measure-Set.

	#4 using data from their EHRs if it includes information on whether a patient had a well-care visit. The limit of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN.
Overall Parameters for Stratification	ANs should report stratified performance: • for each race, ethnicity and language stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.); • using patient self-reported data gathered by ANs rather than imputing a patient's REL, • for their entire patient population meeting each measure's meeting each measure's specifications, across health plans and lines of business, and • only for measures relevant to the population served by the AN (e.g., a pediatric AN will not be expected to report performance for Measures #2-4).
Data Completeness Threshold	There is no REL data completeness threshold for reporting performance stratified by REL. ANs should report on all patients for whom they have REL data.
Required REL Reporting Categories	ANs should report stratified performance for the REL categories that the AN is currently using. ANs are not expected to modify their REL categories for the purpose of reporting performance.[2] ***Note**: Each of the categories within each race, ethnicity and language stratification is mutually exclusive. Therefore, the sum of all stratifications should equal the total population.*
Measure Specifications	The *Health Equity Measure* specifications can be accessed from the CMS eCQM specifications for Eligible Professionals / Eligible Clinicians for 2022 for Measure #2, Measure #3 and Measure #5.[3] These specifications are designed for reporting by provider organizations. ANs can simply run the specifications as provided by CMS, but stratify performance by race, ethnicity and language. For Measure #1 and Measure #4, eCQM specifications are not available. Therefore, the *Health Equity Measure* specifications are adapted from NCQA's HEDIS MY 2022 specifications. The specifications are modified slightly to allow for reporting by AN. Any modifications made are within NCQA's list of Allowable Adjustments.

[2] The language category does not distinguish whether the organization is collecting data for the patient's preferred language versus language spoken.

[3] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1.

Measure Specifications Table of Contents

Measure #1: Child and Adolescent Well-Care Visits (Adapted HEDIS Specifications)[4]

Measure #1 – 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.

Measure #1 – Denominator

Initial Population	Patients 3-21 years of age during the measurement period. Report three age stratifications and total rate: • 3-11 years. • 12-17 years. • 18-21 years. • Total, or the sum of the age stratifications.
Denominator Statement	Equals Initial Population
Denominator Exclusions	• Patients in hospice or using hospice services anytime during the measurement year. • Patients who died any time during the measurement year.
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.

Measure #1 – Numerator

Numerator Statement	Patients who received one or more well-care visits 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 patient.
Numerator Exclusions	None
Guidance	This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their

[4] Source: Adapted from NCQA HEDIS MY 2021 specifications.

	EHRs and report performance on the measure. Alternatively, ANs could report performance for this measure using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN.
Codes to Identify Well-Care Visits	99381-99385; 99391-99395; 99461; G0438-G0439; S0302; S0610; S0612-S0613; Z00.00-Z00.01; Z00.110-Z00.111; Z00.121; Z00.129; Z00.2; Z00.3; Z01.411; Z01.419; Z02.5; Z76.1; Z76.2; 103740001; 170099002; 170107008; 170114005; 170123008; 170132005; 170141000; 170150003; 170159002; 170168000; 170250008; 170254004; 170263002; 170272005; 170281004; 170290006; 170300004; 170309003; 171387006; 171394009; 171395005; 171409007; 171410002; 171416008; 171417004; 243788004; 268563000; 270356004; 401140000; 410620009; 410621008; 410622001; 410623006; 410624000; 410625004; 410626003; 410627007; 410628002; 410629005; 410630000; 410631001; 410632008; 410633003; 410634009; 410635005; 410636006; 410637002; 410638007; 410639004; 410640002; 410641003; 410642005; 410643000; 410644006; 410645007; 410646008; 410647004; 410648009; 410649001; 410650001; 442162000; 783260003; 444971000124105; 446301000124108; 446381000124104; 669251000168104; 669261000168102; 669271000168108; 669281000168106
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Measure #2: Comprehensive Diabetes Care: HbA1c Control (CMS122v10)[5]

Measure #2 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c <8.0% during the measurement year.

Measure #2 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Patients who are in hospice care for any part of the measurement period.
	• Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior OR
	  ○ Advanced illness with one inpatient encounter during the measurement period or the year prior OR
	  ○ Taking dementia medications during the measurement period or the year prior.
	• Patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

[5] Source: Modified from CMS 2022 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). https://ecqi.healthit.gov/ecqm/ep/2022/cms122v10.

Measure #2 – Numerator

Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is <8.0%
Numerator Exclusions	Not applicable
Guidance	If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #3: Controlling High Blood Pressure (CMS165v10)[6]

Measure #3 – Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, , and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Measure #3 – Denominator

Initial Population	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior OR
	  ○ Advanced illness with one inpatient encounter during the measurement period or the year prior OR
	  ○ Taking dementia medications during the measurement period or the year prior.
	• Patients 81 and older with an indication of frailty for any part of the measurement period.
	• Patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has

[6] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms165v10.

	complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

Measure #3 – Numerator

Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	Not applicable
Guidance	In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. 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 patient using a non-digital device such as a manual blood pressure cuff and stethoscope. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #4: Prenatal and Postpartum Care (Adapted HEDIS Specifications)[7]

Measure #4 – 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.

Measure #4 – Denominator

Initial Population	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 initial population, which is the denominator for both rates:[8] 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. a. 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. 2. Exclude non-live births (Non-live Births Value Set).
Denominator Statement	Equals Initial Population
Denominator Exclusions	Patients in hospice or using hospice services anytime during the measurement year.
Denominator Exceptions	None
Guidance	This measure requires use of administrative data to identify well-care visits. ANs should leverage payer-provided data for measure performance. For example, payers

[7] Source: Adapted from NCQA HEDIS MY 2022 specifications.
[8] Visit https://store.ncqa.org/my-2022-quality-rating-system-qrs-hedis-value-set-directory.html to obtain the codes associated with each Value Set.

	could share a spreadsheet with information on which patients meet the numerator for the measure. ANs could use this information to update data in their EHRs and report performance on the measure. Alternatively, ANs could report performance for this measure using data from their EHRs if it includes information on whether a patient had a well-care visit. The limitation of this approach, however, is that EHR data likely would not contain information on whether a patient received a well-care visit from another AN.
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

Measure #4 – *Timeliness of Prenatal Care* Numerator

Numerator Statement	A prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP during the required time frame. Follow the steps below to identify numerator compliance: 1. Identify women attributed to the AN with a delivery during the measurement year. 2. Identify prenatal visits that occurred during the required timeframe. The practitioner type must be an OB/GYN or other prenatal care practitioner or PCP to meet criteria for a prenatal visit. 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: a. Documentation indicating the woman is pregnant or references to the pregnancy; for example: i. Documentation in a standardized prenatal flow sheet, or ii. Documentation of LMP, EDD or gestational age, or iii. A positive pregnancy test result, or iv. Documentation of gravidity and parity, or v. Documentation of complete obstetrical history, or vi. Documentation of prenatal risk assessment and counseling/education. b. 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).

	c. Evidence that a prenatal care procedure was performed, such as: i. 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 ii. TORCH antibody panel alone, or iii. A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or iv. Ultrasound of a pregnant uterus.
Numerator Exclusions	Not applicable
Guidance	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 patient, 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. Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.

Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #4 – *Postpartum Care* Numerator

Numerator Statement	A postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. 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.

Numerator Exclusions	Services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).
Guidance	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 patient, 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. Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #5: Screening for Depression and Follow-up Plan (CMS2v11)[9]

Measure #5 – Description

Percentage of patients aged 12 years and older 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 depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Measure #5 – Denominator

Initial Population	All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population
Denominator Exclusions	Patients who have been diagnosed with depression or with bipolar disorder,
Denominator Exceptions	• Patient Reason(s) • Patient refuses to participate OR • Medical Reason(s) *Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; 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).*
Rate 1	The denominator statement.
Rate 2	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.

Measure #5 – Numerator

Numerator Statement	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.
Numerator	None

[9] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms002v11.

Exclusions	
Guidance	The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure. 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, a follow-up plan must be documented on the date of the encounter, such as referral to a practitioner who is qualified to treat depression, pharmacological interventions or other interventions for the treatment of depression. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. This eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters. Screening Tools: • An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. • 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 qualifying encounter or up to 14 days prior to the date of the qualifying encounter. • The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool. Follow-Up Plan: The follow-up plan must be related to a positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening." Examples of a follow-up plan include but are not limited to:

	• 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 behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. Should a patient screen positive for depression, a clinician should: • Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan. • Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool will not qualify as a follow-up plan.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a *Note* to the *Product line* section.
- Revised the last *Note* to clarify that supplemental data can be used for required exclusions.

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

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, 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 in the eligible population prior to exclusion of outliers (denominator steps 1–5). The plan population is only used as a denominator for the Outlier Rate. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.

Outlier	Medicaid and Medicare members in the eligible population with four or more IHS between January 1 and December 1 of the measurement year. Commercial members in the eligible population with three or more IHS between January 1 and December 1 of the measurement year. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during the continuous enrollment period.
Nonoutlier	Members in the eligible population who are not considered outliers.
Classification period	365 days prior to and including Index Discharge Date.

Eligible Population

Product line	Commercial, Medicare, Medicaid (report each product line separately). ***Note:*** *Per General Guideline* Members With Dual Enrollment, *members with dual commercial and Medicaid enrollment may only be reported in the commercial product line. Members with dual Medicaid/Medicare enrollment "dual eligible" and with Medicare-Medicaid (MMP) enrollment may only be reported in the Medicare product line.*
Stratification	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:*** *Stratifications are mutually exclusive, and the sum of all six stratifications is the Total population.*
Ages	*For commercial,* 18–64 years as of the Index Discharge Date. *For Medicare,* 18 years and older as of the Index Discharge Date. *For Medicaid,* 18–64 years 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.

Required exclusion Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.

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 2 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.
- 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 Tables PCR-A-1/2 and PCR-A-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 principal discharge diagnosis, using Table CC-Mapping. For direct transfers, use the principal 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-C-3 and the standard set of risk weights for reporting in Table PCR-A-3 and Table PCR-B-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-A-3 and Table PCR-B-3 and do not assign the standard set or risk weights for the stays when reporting in Table PCR-C-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, principal 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.*

Truncate the estimated readmission risk *for each IHS* to 10 decimal places. Do not truncate or round in previous steps.

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)

Truncate the variance *for each IHS* to 10 decimal places.

For example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.

Note: *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:

- 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).
- A planned hospital stay 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 the earliest Index Discharge Date.

Step 2 Report the count of members in the plan population for each age group as the MemberCount.

Reporting: Number of Outliers

Step 1 Determine the member's age as of the earliest Index Discharge Date.

Step 2 Report the count of outlier members for each age group as the OutlierMemberCount.

Calculated: Outlier Rate

The number of outlier members (OutlierMemberCount) divided by the number of members in the plan population (MemberCount), displayed as a permillage (multiplied by 1,000), for each age group and totals. Calculated by IDSS as the OutlierRate.

Reporting: Denominator

Count the number of IHS among nonoutlier members for each age group. Report these values as the Denominator.

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-B-3.

Reporting: Skilled Nursing Care Stratification (Medicare 65+ only)

Step 1 For Medicare nonoutlier members 65 years of age and older, 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-C-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 report these values as the ObservedCount.

Calculated: Observed Readmission Rate

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Index Stays (Denominator) for each age group and totals. Calculated by IDSS as the ObservedRate.

Reporting: Count of Expected 30-Day Readmissions

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

Step 2 Round to 4 decimal places using the .5 rule and report these values as the ExpectedCount.

Calculated: Expected Readmission Rate

The Count of Expected 30-Day Readmissions (ExpectedCount) divided by the Count of Index Stays (Denominator) for each age group and totals. Calculated by IDSS as the ExpectedRate.

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 4 decimal places using the .5 rule and report these values as the CountVariance.

Calculated: O/E Ratio

The Count of Observed 30-Day Readmissions (ObservedCount) divided by the Count of Expected 30-Day Readmissions (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE. The O/E Ratio is not calculated for SES stratifications.

Note

- *Supplemental data may not be used for this measure, except for required exclusions.*

Table PCR-A-1/2: Data Element for Plan All-Cause Readmissions

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	MemberCount	For each Stratification
	45-54	OutlierMemberCount	For each Stratification
	55-64	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	18-64	Denominator	For each Stratification
		ObservedCount	For each Stratification
		ObservedRate	ObservedCount / Denominator (Percent)
		ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table PCR-A-3: Data Elements for Plan All-Cause Readmissions

Metric	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	18-44	MemberCount	For each Stratification
	45-54	OutlierMemberCount	For each Stratification
	55-64	OutlierRate	OutlierMemberCount / MemberCount (Permille)
	18-64	Denominator	For each Stratification
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	ObservedCount / Denominator (Percent)
	85+	ExpectedCount	For each Stratification
	65+	ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table PCR-B-3: Data Elements for Plan All-Cause Readmissions by SES Stratification

Metric	SES Stratification	Age	Data Element	Reporting Instructions
PlanAllCauseReadmissions	NonLisDeNondisability	18-64	Denominator	For each Stratification
	LisDe	65+	ObservedCount	For each Stratification
	Disability		ObservedRate	ObservedCount / Denominator (Percent)
	LisDeAndDisability		ExpectedCount	For each Stratification
	Other		ExpectedRate	ExpectedCount / Denominator (Percent)
	Unknown		CountVariance	For each Stratification

Table PCR-C-3:Data Elements for Plan All-Cause Readmissions for Skilled Nursing Care Stratification

Metric	Age	Data Element	Reporting Instructions
SkilledNursingCare	65-74	Denominator	For each Stratification
	75-84	ObservedCount	For each Stratification
	85+	ObservedRate	ObservedCount / Denominator (Percent)
	65+	ExpectedCount	For each Stratification
		ExpectedRate	ExpectedCount / Denominator (Percent)
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

The following table is for the Rules for Allowable Adjustments for **Risk-Adjusted Measurement** of the Plan All-Cause Readmissions measure (Count of Index Stays, Count of Observed 30-Day Readmissions, Observed Readmission Rate, Risk Adjustment Determination, Risk Adjustment Weighting, Count of Expected 30-Day Readmissions, Observed to Expected).

Eligible Population	Adjustments Allowed (Yes/No)	Notes
NONCLINICAL COMPONENTS		
Product lines	No	Organizations may not adjust product lines.
Ages	No	The age determination dates may not be changed. ***Note:*** *The denominator age may not be expanded. The ages for the risk weights may not be changed.*
Continuous enrollment, allowable gap, anchor date	No	For risk adjusted rates organizations are required to use enrollment criteria; adjustments are not allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes, with limits	Organizations may only adjust additional eligible population within the eligible population to focus on gender, sociodemographic characteristics or geographical region. ***Note:*** *NCQA recommends evaluating risk model performance and validity within adjusted populations.* *Organizations may not adjust for a clinical subpopulation (e.g., members with a diabetes diagnosis).*
Plan population	Yes	Organizations are not required to used plan population to identify outlier rates.
CLINICAL COMPONENTS		
Stratifications	**Adjustments Allowed (Yes/No)**	**Notes**
• SES Stratification • Skilled Nursing Care Stratification	No, if applied	Stratifications not required, but if they are used the value sets, logic and product lines may not be changed.
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	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.

Eligible Population	Adjustments Allowed (Yes/No)	Notes
		Note: *Organizations may include denied claims to calculate the denominator.*
Outlier	Yes, with limits	Organizations may not adjust the outlier logic. ***Note:*** *Organizations may include denied claims to calculate these events.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	No	The hospice exclusion is required. The value sets and logic may not be changed.
Risk Adjustment and Calculation of Expected Events	**Adjust Adjustments Allowed (Yes/No)**	**Notes**
• Risk Adjustment Determination • Risk Adjustment Weighting • Expected Readmissions • Variance	Yes, with limits	Risk adjustment determinations, weighting and calculations of expected events logic may not be changed. ***Note:*** *Organizations may include denied claims to calculate these events.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Unplanned Acute Readmission	Yes, with limits	Value sets and logic may not be changed. ***Note:*** *Organizations may include denied claims to calculate the numerator.*

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

The following table is for the Rules for Allowable Adjustments for **Observed Measurement** of the Plan All-Cause Readmissions Observed Events measure (Count of Index Stays, Count of Observed 30-Day Readmissions, Observed Readmission Rate).

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	When adjusting this measure to assess for observed events only, 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 50 months as of June 30"). ***Note:*** *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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
Plan population	Yes	Organizations are not required to used plan population to identify outlier rates.
CLINICAL COMPONENTS		
Stratifications	**Adjustments Allowed (Yes/No)**	**Notes**
• SES Stratification • Skilled Nursing Care Stratification	No, if applied	Stratifications are not required, but if they are used, the value sets, logic and product lines may not be changed.
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	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. ***Note:*** *Organizations may include denied claims to calculate the denominator.*

Eligible Population	Adjustments Allowed (Yes/No)	Notes
Outlier	Yes, with limits	Organizations may not adjust the outlier logic. ***Note:*** *Organizations may include denied claims to calculate these events.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice exclusion is not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Unplanned Acute Readmission	Yes, with limits	Value sets and logic may not be changed. ***Note:*** *Organizations may include denied claims to calculate the numerator.*

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Updated the event/diagnosis criteria to clarify which delivery is counted when there are multiple deliveries.
- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).
- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.

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 members, 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 estimated delivery date [EDD]).

Eligible Population

Product lines Commercial, Medicaid (report each product line separately).

Stratification For each product line, report the following stratifications by race and total, and stratifications by ethnicity and total:

- *Race:*
  - American Indian or Alaska Native.
  - Asian.
  - Black or African American.
  - Native Hawaiian or Other Pacific Islander.
  - White.
  - Some Other Race.
  - Two or More Races.
  - Asked But No Answer.
  - Unknown.
  - Total.

- *Ethnicity:*
  - Hispanic or Latino.
  - Not Hispanic or Latino.
  - Asked But No Answer.
  - Unknown.
  - Total.

Note: *Stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population.*

Age None specified.

Continuous enrollment 43 days prior to delivery through 60 days after delivery.

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

Event/diagnosis Live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting.

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

Step 1 Identify deliveries. Identify all members 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 Remove 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.

Step 4 Remove multiple deliveries in a 180-day period. If a member has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period.

Note: *The denominator for this measure is based on deliveries, not on members. All eligible deliveries that were not removed in steps 1–4 remain in the denominator.*

Required exclusions Exclude members who meet either of the following criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerator

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

Step 1 Identify members who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

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

Step 2 Identify members who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.

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

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the member'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). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- A prenatal visit (Prenatal Visits 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 Care Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- An encounter for postpartum care (Encounter for Postpartum Care Value Set). Do not include laboratory claims (claims with POS code 81).
- 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.

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 lower of the two indicators.

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 time frame. Refer to *Administrative Specification* to identify the required time frame for each member 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 member is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, ***or***
  - Documentation of last menstrual period (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 members 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 members who were not enrolled during the first trimester allow more flexibility than criteria for members who were enrolled.*
  - *For members who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For members who were not enrolled at least 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 removed 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 and for both Administrative and Hybrid data collection methods, 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-A-1/2: Data Elements for Prenatal and Postpartum Care

Metric	Data Element	Reporting Instructions	A
TimelinessPrenatalCare	CollectionMethod	For each Metric	✓
PostpartumCare	EligiblePopulation*	For each Metric	✓
	ExclusionAdminRequired*	For each Metric	✓
	NumeratorByAdminElig	For each Metric	
	CYAR	(Percent)	
	MinReqSampleSize	Repeat per Metric	
	OversampleRate	Repeat per Metric	
	OversampleRecordsNumber	(Count)	
	ExclusionValidDataErrors	Repeat per Metric	
	ExclusionEmployeeOrDep	Repeat per Metric	
	OversampleRecsAdded	Repeat per Metric	
	Denominator	Repeat per Metric	
	NumeratorByAdmin	For each Metric	✓
	NumeratorByMedicalRecords	For each Metric	
	Rate	(Percent)	✓

Table PPC-B-1/2: Data Elements for Prenatal and Postpartum Care: Stratifications by Race

Metric
TimelinessPrenatalCare
PostpartumCare

Race	Source	Data Element	Reporting Instructions	A
AmericanIndianOrAlaskaNative	Direct	CollectionMethod	For each Metric, repeat per Stratification	✓
Asian	Indirect	EligiblePopulation*	For each Stratification, repeat per Metric	✓
BlackOrAfricanAmerican	Unknown***	Denominator	For each Stratification, repeat per Metric	
NativeHawaiianOrOtherPacificIslander	Total	Numerator	For each Metric and Stratification	✓
White		Rate	(Percent)	✓
SomeOtherRace				
TwoOrMoreRaces				
AskedButNoAnswer**				
Unknown***				

Table PPC-C-1/2: Data Elements for Prenatal and Postpartum Care: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions	A
TimelinessPrenatalCare	HispanicOrLatino	Direct	CollectionMethod	For each Metric, repeat per Stratification	✓
PostpartumCare	NotHispanicOrLatino	Indirect	EligiblePopulation*	For each Stratification, repeat per Metric	✓
	AskedButNoAnswer**	Unknown***	Denominator	For each Stratification, repeat per Metric	
	Unknown***	Total	Numerator	For each Metric and Stratification	✓
			Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the Administrative Method.

**AskedButNoAnswer is only reported for Source= "Direct."

***Race/Ethnicity= "Unknown" is only reported for Source= "Unknown" and Source= "Unknown" is only reported for Race/Ethnicity= "Unknown."

Rules for Allowable Adjustments of HEDIS

The "Rules for Allowable Adjustments of HEDIS" (the "Rules") describe how NCQA's HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent.

Adjusted HEDIS measures may not be used for HEDIS health plan reporting.

Rules for Allowable Adjustments of 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 an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
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**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
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.

SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Connecticut Office of Health Strategy[1]
As of July 7, 2023

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes."[2]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	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 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.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an Advanced Network-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting payer as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: ○ The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 98970-98972; 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99417;

[1] This measure was developed based on the Rhode Island Executive Office of Health and Human Services (EOHHS) SDOH Screening measure and the Massachusetts EOHHS Health-Related Social Needs Screening measure.
[2] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 5/22/22.

	99421-99423; 99439; 99490; 99495-99496; G2212 ○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining a primary care visit: ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Denominator	A systematic sample drawn from the eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's health record. Notes: • Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator. • Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. Advanced Networks can, but are not required to, use ICD-10 Z codes to track performance for this measure electronically.
Unit of measurement	Individual
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must either be a) embedded in an EHR, or b) a PDF of the screening results must be accessible in the EHR, i.e., the

	primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results, or c) a hard copy of the screening results are in a paper health record. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009
SNOMED CT US EDITION	385765002

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Proposed New Measure for HEDIS®[1] MY 2025: Blood Pressure Control for Patients With Hypertension (BPC-E)

NCQA seeks comments on a proposed new Electronic Clinical Data System (ECDS) reported measure for inclusion in HEDIS MY 2025: *Blood Pressure Control for Patients With Hypertension* (BPC-E)*:* The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was at the following levels during the measurement period:

- <140/90 mm Hg.
- <130/80 mm Hg.

Controlling high blood pressure, or hypertension, is an important step in preventing heart attack, stroke and kidney disease, and in reducing the risk of developing other serious conditions. Health care providers and plans can help individuals manage high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

NCQA is reevaluating measures and products to better reflect existing evidence and guidelines, the evolution of claims data coding and pharmacy data practices and the use of electronic clinical data. This proposed measure is an improvement on the existing *Controlling High Blood Pressure* (CBP) HEDIS measure, which uses the hybrid reporting method (including medical record review) and focuses on blood pressure <140/90 mm Hg. The proposed measure has three key modifications:

- The measure uses the ECDS reporting method.
- The denominator includes a pharmacy data method.
- The numerator includes two rates: Blood Pressure <140/90 mm Hg, Blood Pressure <130/80 mm Hg.

NCQA's long-term goal is to include only the proposed measure in HEDIS. The existing CBP measure will remain in HEDIS while NCQA develops a transition plan.

ECDS Reporting Method

The CBP measure includes hybrid reporting which allows plans to report using either administrative-only data (Administrative Method) or administrative data supplemented with medical record review for a sample of members (Hybrid Method). Removing medical record review, where feasible, can alleviate reporting burden and facilitate the transition to digital measures. The proposed measure transitions from the Hybrid Method by using ECDS reporting. This reporting method includes data sources such as administrative claims, electronic health records, case management and health information exchanges.

Expanded Denominator

The CBP denominator specifies one way to identify individuals with hypertension: claim/encounter data requiring at least two claims-based diagnoses of hypertension within an 18-month period. NCQA analysis showed that the current denominator misses a population of people with one claims-based hypertension diagnosis. This finding and further analyses informed a new, expanded denominator that includes a second way to identify individuals with hypertension: pharmacy data requiring at least one claims-based diagnosis of hypertension and at least one dispensed anti-hypertensive medication within an 18-month period.

Our Measurement Advisory Panels supported the addition of people with one hypertension diagnosis and one dispensed anti-hypertensive medication.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Expanded Numerator

The CBP measure has one measure rate: Blood Pressure <140/90 mm Hg. Based on consideration of clinical practice guidelines from the American College of Cardiology and the American Heart Association, and on feedback from the NCQA Measurement Advisory Panel, NCQA is considering a second rate in the proposed measure: Blood Pressure <130/80 mm Hg. Evidence shows that both blood pressure targets are beneficial, and that a lower blood pressure target results in fewer cardiovascular events. Evidence and guidelines are described in the attached evidence workup.

Measurement Advisory Panel members emphasized the clinical grounds for adding the second rate to the numerator, noting that measure exclusions remove people for whom the rate is inappropriate. Measure exclusions are defined in the attached draft measure specification.

Our analyses showed that performance in the test population was better for the Blood Pressure <140/90 mm Hg rate, regardless of denominator method. Variation in performance within and across denominator methods suggests significant room for improvement in blood pressure control.

NCQA seeks general feedback on the proposed new measure.

Supporting documents include the measure specification and evidence workup.

NCQA acknowledges the contributions of the Cardiovascular, Geriatric and Technical Measurement Advisory Panels.

Blood Pressure Control for Patients With Hypertension (BPC-E)

SUMMARY OF CHANGES TO HEDIS MY 2025

- This is a first-year measure.

Description	The percentage of members18–85 years of age who had a diagnosis of hypertension (HTN) and whose most recent blood pressure (BP) was at the following levels during the measurement period: • Blood Pressure <140/90 mm Hg. • Blood Pressure <130/80 mm Hg.
Measurement period	January 1–December 31.
Clinical recommendation statement	The American Academy of Family Physicians (AAFP) strongly recommends clinicians treat adults who have hypertension to a standard blood pressure target (<140/90 mm Hg) to reduce the risk of all-cause and cardiovascular mortality. The Joint National Committee recommends that pharmacologic treatment be initiated in the general population <60 years, to lower systolic BP ≥140 mm Hg (and treat to a goal of systolic BP <140 mm Hg) and to lower diastolic BP ≥90 mm Hg (and treat to a goal of diastolic BP <90 mm Hg). The American College of Cardiology (ACC) and American Heart Association (AHA) recommend a target BP of less than 130/80 mm Hg for adults with confirmed hypertension and known cardiovascular disease (CVD) or 10-year atherosclerotic CVD event risk of 10% or higher. In addition, they have determined that a reasonable target BP for adults with confirmed hypertension, without additional markers of increased CVD risk, is less than 130/80 mm Hg.
Citations	Coles, S., L. Fisher, K. Lin, C. Lyon, A. Vosooney, and M. Bird. “Blood Pressure Targets in Adults With Hypertension: A Clinical Practice Guideline From the AAFP.” November 14, 2022. James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. “2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8).” *JAMA* 311, no. 5 (February 5, 2014): 507–20. https://doi.org/10.1001/jama.2013.284427. Whelton, P.K., R.M. Carey, W.S. Aronow, D.E. Casey, K.J. Collins, C. Dennison Himmelfarb, S.M. DePalma, et al. “2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines.” *Hypertension 71,* no. 6 (June 2018): e13–115. https://doi.org/10.1161/HYP.0000000000000065.

Characteristics	
Scoring	Proportion.
Type	Outcome.
Stratification	• <140/90 mm Hg. – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • <130/80 mm Hg – Product line: ▪ Commercial. ▪ Medicaid. ▪ Medicare. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino.

	▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment **Improvement notation** **Guidance**	None. Increased score indicates improvement. **Allocation:** The member was enrolled with a medical benefit during the measurement period. No more than one gap in enrollment of up to 45 days during the 365 days prior to the member's second 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). The member must be enrolled on the last day of the measurement period. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population. The race and ethnicity stratifications are reported by data source—direct, indirect or unknown. Race and ethnicity values of "Asked But No Answer" are only reported for Source="Direct." Race and ethnicity values of "Unknown" are only reported for Source="Unknown" and Source="Unknown" is only reported for race and ethnicity values of "Unknown." Commercial, Medicaid, Medicare (report each product line separately).
Definitions	
Participation **Participation period**	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the participation period. The measurement period.
Initial population	Members who are 18-85 years old as of the last day of the measurement period who meet either of the following criteria: **Claim/encounter data method.** At least two diagnoses of hypertension on different dates of service on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. • **Step 1:** Identify members who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set).

	• **Step 2:** Remove members who had a nonacute inpatient admission during the measurement period. 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. **Pharmacy data method.** At least one diagnosis of hypertension and at least one anti-hypertension medication dispensing event on or between January 1 of the year prior to the measurement period and June 30 of the measurement period. • **Step 1:** Identify at least one outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) ***and*** at least one dispensed antihypertensive medication (Antihypertensive Medications List). • **Step 2:** Exclude members with a nonacute inpatient admission during the measurement period. 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.
Exclusions	Exclude members who meet any of the following criteria: • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement period. • Members who die any time during the measurement period. • Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement period. Do not include laboratory claims (claims with POS code 81). • Members with a diagnosis that indicates end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the member's history on or prior to the last day of the measurement period. Do not include laboratory claims (claims with POS code 81). • Members with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set;

<table>
<tr><td></td><td>
Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the member's history on or prior to the last day of the measurement period.

Members with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement period. Do not include laboratory claims (claims with POS code 81).
Medicare members 66 years of age and older as of the last day of the measurement period who meet either of the following:

Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
Living long-term in an institution any time during the measurement period 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 period.

Members 66–80 years of age as of the last day of the measurement period (all product lines) with frailty and advanced illness. Members must meet BOTH frailty and advanced illness criteria to be excluded:

Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).
Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:

Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81).
Dispensed dementia medication (Dementia Medications List).

Members 81 years of age and older as of the last day of the measurement period (all product lines) with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS code 81).

Dementia Medications
<table>
<tr><th>Description</th><th>Prescription</th></tr>
<tr><td>Cholinesterase inhibitors</td><td>• Donepezil
• Galantamine
• Rivastigmine</td></tr>
<tr><td>Miscellaneous central nervous system agents</td><td>• Memantine</td></tr>
<tr><td>Dementia combinations</td><td>• Donepezil-memantine</td></tr>
</table>
</td></tr>
<tr><td>Denominator</td><td>The initial population, minus exclusions.</td></tr>
<tr><td>Numerator</td><td>Numerator 1: Members with a systolic and diastolic reading <140/90 mm Hg.</td></tr>
</table>

	The lowest systolic and diastolic BP values <140/90 (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) from the most recent day a BP was recorded during the measurement period, on or after the date of the second hypertension event. Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or ED visit (ED Value Set; POS code 23). 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. The member is numerator compliant if the representative 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 period or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • Systolic Compliant: Systolic Less Than 140 Value Set. • Systolic Not Compliant: CPT-CAT-II code 3077F. • Diastolic Compliant: Diastolic Less Than 90 Value Set. • Diastolic Not Compliant: CPT-CAT-II code 3080F. ***Numerator 2:*** **Members with a systolic and diastolic reading <130/80 mm Hg.** The lowest systolic and diastolic BP values <130/80 (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) from the most recent day a BP was recorded during the measurement period, on or after the date of the second hypertension event. Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or ED visit (ED Value Set; POS code 23). 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. The member is numerator compliant if the representative BP is <130/80 mm Hg. The member is not compliant if the BP is ≥130/80 mm Hg, if there is no BP reading during the measurement period or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine compliance: • Systolic Compliant: CPT-CAT-II code 3074F; CPT-CAT-II code 3077F. • Systolic Not Compliant: Systolic Greater Than or Equal To 130 Value Set. • Diastolic Compliant: CPT-CAT-II code 3078F. • Diastolic Not Compliant: Diastolic Greater Than or Equal To 80 Value Set.

Data Elements for Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table BPC-E-A-1/2/3: Data Elements for Blood Pressure Control for People With Hypertension

Metric	Data Element	Reporting Instructions
BPUnder140Over90	InitialPopulation	Repeat per Metric
BPUnder130Over80	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	Repeat per Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table BPC-E-B-1/2/3: Data Elements for Blood Pressure Control for People With Hypertension: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
BPUnder140Over90	AmericanIndianOrAlaskaNative	Direct	InitialPopulation	For each Stratification
BPUnder130Over80	Asian	Indirect	Exclusions	For each Stratification
	BlackOrAfricanAmerican	Unknown**	Denominator	For each Stratification
	NativeHawaiianOrOtherPacificIslander	Total	Numerator	For each Stratification
	White		Rate	(Percent)
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

Table BPC-E-C-1/2/3: Data Elements for Blood Pressure Control for People With Hypertension: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
BPUnder140Over90	HispanicOrLatino	Direct	InitialPopulation	For each Stratification
BPUnder130Over80	NotHispanicOrLatino	Indirect	Exclusions	For each Stratification
	AskedButNoAnswer*	Unknown**	Denominator	For each Stratification
	Unknown**	Total	Numerator	For each Stratification
			Rate	(Percent)

*AskedButNoAnswer is only reported for Source= ”Direct”

**Race/Ethnicity = “Unknown” is only reported for Source = “Unknown”; Source = “Unknown” is only reported for Race/Ethnicity = “Unknown.”

Blood Pressure Control for Patients With Hypertension
Measure Workup

Topic Overview

Importance and Prevalence

High blood pressure (HBP), also known as hypertension, occurs when the pressure in blood vessels is higher than normal (Centers for Disease Control and Prevention [CDC], 2017). The causes of hypertension can be based on genetic predisposition, environmental risk factors, overweight and obesity, sodium intake, potassium intake, physical activity and alcohol use. HBP is historically defined as BP ≥140/90 mm Hg, and many sources reference this definition. The American College of Cardiology (ACC) and the American Heart Association (AHA) released an updated guideline in 2017 that redefined HBP as BP ≥130/80 mm Hg (Whelton et al, 2017). The annual AHA *Heart Disease and Stroke Statistics* report references this definition as of the 2019 update (Benjamin et al, 2019).

In an analysis of adults with hypertension, defined as BP ≥140/90, the National Health And Nutrition Examination Survey (NHANES) found the estimated age-adjusted proportion with controlled BP increased from 31.8% in 1999-2000 to 53.8% in 2013-2014, then decreased to 43.7% in 2017-2018 (Tsao et al., 2023). Based on the new definition of HBP (≥130/80 mm Hg), NHANES estimated nearly half of United States (U.S.) adults (48.1%) had uncontrolled hypertension from 2017–2020 (CDC, 2023). Between 2017–2020, the prevalence of hypertension (systolic blood pressure ≥130 mm Hg or diastolic blood pressure ≥80 mm Hg, taking antihypertensive medication [self-report], or if the person was told on two occasions that they had hypertension) among U.S. adults 65 to 74 years of age was 72.0% in men and 75.1% in women, and 80.1% in men and 80.7% in women aged 75 years and older (Tsao et al., 2023).

The prevalence of hypertension rises with increasing age and varies by race. Data from the Framingham Heart Study found that among adults with a baseline systolic blood pressure/diastolic blood pressure (SBP/DBP) of 130–130/85–89 mm Hg, 49.5% of adults 65–94 developed hypertension, compared to 37.3% of adults 35–64 (Vasan, 2001). Among races, Black individuals have the highest prevalence of hypertension across the world (Benjamin et al., 2017). Between 2011 and 2014, the age-adjusted prevalence of hypertension among non-Hispanic Black males and females was 45% and 46.3%; 34.5% and 32.3% among non-Hispanic White males and females; 28.8% and 25.7% among non-Hispanic Asian males and females; and 28.9 and 30.7% among Hispanic males and females (Benjamin et al., 2017).

HBP increases risks of heart disease and stroke, leading causes of death in the U.S. (CDC, 2022). A person with HBP is four times more likely to die from a stroke and three times more likely to die from heart disease (CDC, 2021). The National Center for Health Statistics reported that in 2020 there were over 670,000 deaths with HBP as a primary or contributing cause (CDC, 2022). Between 2010 and 2020, the number of deaths due to HBP rose by 54.8% (Tsao et al., 2023). Age-adjusted death rates attributable to HBP in 2020 were almost twice as high in non-Hispanic Black males (325.3 deaths per 100,000) than in non-Hispanic White males (175.7 deaths per 100,000) (Tsao et al., 2023).

For risk of cardiovascular disease, a 1999–2019 analysis found that mortality for men was 76% greater for those with systolic blood pressure (≥160 mm Hg) than for men with systolic blood pressure between 100 and <110 mm Hg, and 31% and 147% greater for those with diastolic blood pressure between 80 and <90 mm Hg and ≥100 mm Hg, respectively, than for men with diastolic blood pressure between 70 and <80 mm Hg.

Mortality for women was 61%, 75% and 113% greater for those with systolic blood pressure from 130 to <140 mm Hg, 140 to <160 mm Hg and ≥160 mm Hg, respectively, than for women with systolic blood

pressure between 100 and <110 mm Hg, and 45% greater for those with diastolic blood pressure from 80 to <90 mm Hg and 145% greater for women with diastolic blood pressure ≥100 mm Hg than for women with diastolic blood pressure between 70 and <80 mm Hg (Elfassy et al., 2023).

Financial importance and cost-effectiveness	Hypertension was the primary cause of approximately 3.7 million hospital outpatient visits in 2011 and about 900,000 emergency department visits in 2012 (Benjamin et al, 2017). It cost the U.S. approximately $131B each year, averaged over 12 years, from 2002–2014 (Kirkland et al., 2018). Total direct costs of HBP are projected to increase to $200B by 2030 (Benjamin et al, 2017). A study on cost-effectiveness of treating hypertension found that controlling HBP in patients with cardiovascular disease based on intensive (110-130 mm Hg) or standard (130-150 mm Hg) SBP control could be effective and cost-saving (Liao et al., 2023).

Supporting Evidence for Treating Blood Pressure to Lower Targets

Despite varying definitions and treatment recommendations of HBP by different organizations, all guidelines agree that controlling HBP will significantly reduce the risks of cardiovascular disease mortality and lead to better health outcomes, such as reduction of heart attacks, stroke and kidney disease (James et al., 2014). Current guidelines issued by organizations, including the ACC and the AHA, define hypertension as blood pressure consistently at or above 130/80 mm Hg. Likewise, these guidelines suggest providers treat most patients to a blood pressure target of <130/80 (Whelton et al. 2018). More recently, in 2022, the American Academy of Family Physicians (AAFP) released updated guidelines that suggested providers consider treating patients to a blood pressure of <135/85. This update comes in response to low-moderate quality evidence that suggests treating patients to a lower threshold result in fewer cardiac events. This guideline also recommends treating patients to a threshold of <140/90 but recognizes that treating patients to a lower threshold is shown to decrease risk of myocardial infarction (Coles et al., 2022).

Many studies have shown that controlling HBP reduces cardiovascular events and mortality. The Systolic Blood Pressure Intervention Trial (SPRINT) investigated the impact of obtaining an SBP goal of <120 mm Hg compared to <140 mm Hg among patients 50 and older with established cardiovascular disease, and found that the patients with the former goal had reduced cardiovascular events and mortality. The study also found that patients with a BP of ≥130 mm Hg had increased cardiovascular risk (SPRINT, 2015). Evidence and guidelines suggest that treating patients to a lower threshold results in fewer cardiac events. The measure currently focuses on a relatively healthy population and excludes older, frail adults and those with advanced illnesses. With this information in mind, NCQA received support from the Geriatric Measurement Advisory Panel, Technical Measurement Advisory Panel and Cardiovascular Measurement Advisory Panel to incorporate the lower evidence-based target of <130/80 mm Hg into a new BP control concept.

Therapeutic options	There are nonpharmacological and pharmacological options to prevent and control HBP. Nonpharmacological options include lifestyle changes that individuals with elevated blood pressure or HBP can make such as weight loss, dietary changes (reducing sodium intake and increasing potassium intake), increasing physical activity, reducing the consumption of alcohol, quitting smoking and getting better sleep (CDC, 2016; Eckel et al., 2013; Whelton et al., 2017; Barone Gibbs et al., 2021; Mayo Clinic, 2022; National Heart, Lung, and Blood Institute, 2022). When nonpharmacological options alone do not control an individual's HBP, clinicians may prescribe medications, alongside continued nonpharmacological approaches (James et al., 2014; Whelton et al., 2017). Pharmacological treatment is based on the individual's BP, age, cardiovascular risk factors and other existing comorbidities such as chronic kidney disease (James et al., 2014; Whelton et al.,

2017). Recommendations for first-line drug therapy include calcium channel blockers (CCB), angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) and thiazide diuretics. These can be prescribed as a monotherapy or in combination (James et al., 2014; Whelton et al., 2017). After evaluation, if a patient is still not reaching BP goals, the physician can add additional medication classes (e.g., beta blocker, aldosterone antagonist) (James et al., 2014).

As with most medications, there are risks of side effects. CCBs can cause palpitations, swollen ankles, constipation, headaches and/or dizziness. ACE inhibitors may cause skin rash, loss of taste and, in rare cases, kidney damage. ARBs may cause occasional dizziness. Diuretics can cause a decrease in potassium, leading to weakness, leg cramps or fatigue (American Heart Association, 2017).

Health care disparities

There are disparities in awareness, treatment and control of hypertension. NHANES data from 2015–2018 showed that among people 20–39 with hypertension, 37% were aware of their condition, 17% were under current treatment and 7% had their hypertension under control (Virtani et al., 2021). Older adults are more likely to be aware of and receive treatment for their hypertension. Of adults ≥60 years of age with hypertension, 75% were aware of their condition, 69% were under current treatment and 29% had their hypertension under control (Virani et al., 2021). When compared to non-Hispanic White and non-Hispanic Black adults, Hispanic and non-Hispanic Asian adults are less likely to be aware of their hypertension, and less likely to require treatment for managing it (Virani et al., 2021). In terms of socioeconomic status (SES), a meta-analysis of 51 studies demonstrated that lower SES is linked to increased risk of hypertension. Lower-educated individuals are twice as likely to have hypertension than higher-educated individuals (Leng et al., 2015; Nakagomi et al., 2022).

Gaps in care

Over three years of HEDIS data, commercial, Medicare and Medicaid product lines have shown a slight decrease in performance of controlling HBP, which indicates widespread gaps in care and continued room for improvement. The average performance from 2019–2021 was 54% for commercial plans, 67% for Medicare plans and 58% for Medicaid plans.

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Specific Guideline Recommendations

Clinical Practice Guideline: Treatment Target Recommendations

Organization, Year	Population	Systolic Blood Pressure Target Recommendation (mmHg)	Diastolic BP Target Recommendation (mmHg)	Grade of Recommendation
American Academy of Family Physicians, 2022	Adults with hypertension	<140	<90	Strong recommendation, high quality evidence
	Adults with hypertension	<135	<85	Weak recommendation, moderate quality of evidence
American College of Cardiology/American Heart Association, 2017	For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher a BP	<130	<80	COR I, Level of evidence SBP: B-R SR Level of evidence DBP: C-EO
	For adults with confirmed hypertension, without additional markers of increased CVD risk	<130 Note: The narrative of the guideline also includes the following regarding this population: “The clinical trial evidence is strongest for a target BP of 140/90 mm Hg in this population. However, observational studies suggest that these individuals often have a high lifetime risk and would benefit from BP control earlier in life.”	<80	COR IIb SBP Level of evidence B-NR DBP Level of evidence C-EO
	Adults with hypertension and Chronic Kidney Disease	<130	<80	COR I SBP Level of evidence BR-SR DBP Level of evidence C-EO

Organization, Year	Population	Systolic Blood Pressure Target Recommendation (mmHg)	Diastolic BP Target Recommendation (mmHg)	Grade of Recommendation
	Hypertensive adults after kidney transplant	<130	<80	COR IIa SBP Level of evidence B-NR DBP Level of evidence C-EO
	Noninstitutionalized ambulatory community dwelling adults ≥65 years of age	<130	<80	COR I Level of evidence A
	Adults ≥65 years of age with hypertension and a high burden of comorbidity and limited life expectancy	Use clinical judgement, patient preferences, and a team-based approach to assess risk/benefit is reasonable for decisions regarding intensity of BP lowering and choice of antihypertensive drugs		COR IIa Level of evidence C-EO
American College of Physicians and the American Academy of Family Physicians, 2017	Hypertensive adults ≥60 years	<150	N/A	Strong, high-quality evidence
	Hypertensive adults ≥60 years with a history of stroke or transient ischemic attack	<140	N/A	Weak, moderate-quality evidence
	Hypertensive adults ≥60 years with high cardiovascular risk	<140	N/A	Weak, low-quality evidence
Eight Report of the Joint National Committee, 2014	General hypertensive population of adults <60 years of age	<140	<90	Grade E for SBP < 140 mmHg Grade A for DBP for ages 30 -59 Grade E for DBP for ages 18-29
	General hypertensive population of adults ≥60 years or older	<150	<90	A

Grading System Key

American College of Cardiology/American Heart Association: Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatment, or Diagnostic Testing in *Patient Care*

Class (Strength) of Recommendation

Class	Suggestion for Practice
I (Strong) Benefit >>> Risk	Suggested phrases for writing recommendations: • Is recommended • Is indicated/useful/effective/beneficial • Should be performance/administered/other • Comparative-Effectiveness Phrases: – Treatment/strategy A is recommended/indicated in preference to treatment B – Treatment A should be chosen over treatment B
Class IIa (Moderate) Benefit >> Risk	Suggested phrases for writing recommendations: • Is reasonable • Can be useful/effective/beneficial • Comparative-Effective Phrases: – Treatment/strategy A is probably recommended/indicated in preference to treatment B – It is reasonable to choose treatment A over treatment B
Class IIb (weak) Benefit ≥ Risk	Suggested phrases for writing recommendations: • May/might be reasonable • May/might be considered • Usefulness/effectiveness is unknown/unclear/uncertain or not well established
Class III: No Benefit (moderate) Benefit = Risk	Suggested phrases for writing recommendations: • Is not recommended • Is not indicated/useful/effective/beneficial • Should not be performed/administered/other
Class III: Harm (strong) Risk > Benefit	Suggested phrases for writing recommendations: • Potentially harmful • Causes harm

Class	Suggestion for Practice
	• Associated with excess morbidity/mortality • Should not be performed/administered other

Level (Quality) of Evidence

Level	Definition
A	• High-quality evidence from more than 1 randomized control trial (RCT) • Meta-analyses of high-quality RCTs • One or more RCTs corroborated by high-quality registry studies
B-R (randomized)	• Moderate-quality evidence from 1 or more RCTs • Meta-analyses of moderate-quality RCTs
B-NR (nonrandomized)	• Moderate-quality evidence from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies • Meta-analyses of such studies
C-LD (limited data)	• Randomized or nonrandomized observational or registry studies with limitations of design or execution • Meta-analyses of such studies • Physiological or mechanistic studies in human subjects
C-EO (Expert Opinion)	Consensus of expert opinion based on clinical experience

America College of Physicians' Guideline Grading System

Quality of Evidence	Strength of Recommendation	
	Benefits clearly outweigh risks and burden or risks and burden clearly outweigh benefits	Benefits finely balanced with risks and burden
High	Strong	Weak
Moderate	Strong	Weak
Low	Strong	Weak
Insufficient evidence to determine net benefits or risks		

Type of Evidence	Quality Rating
• Well-designed, well-executed RCTs that adequately represent populations to which the results are applied and directly assess effects on health outcomes • Well-conducted meta-analyses of such studies • Highly certain about the estimate of effect; further research is unlikely to change our confidence in the estimate of effect	High
• RCTs with minor limitations affecting confidence in, or applicability of, the results • Well-designed, well-executed non–randomized controlled studies and well-designed, well-executed observational studies • Well-conducted meta-analyses of such studies • Moderately certain about the estimate of effect; further research may have an impact on our confidence in the estimate of effect and may change the estimate	Moderate
• RCTs with major limitations • Non–randomized controlled studies and observational studies with major limitations affecting confidence in, or applicability of, the results • Uncontrolled clinical observations without an appropriate comparison group (e.g., case series, case reports) • Physiological studies in humans • Meta-analyses of such studies • Low certainty about the estimate of effect; further research is likely to have an impact on our confidence in the estimate of effect and is likely to change the estimate.	Low

Eight Report of the Joint National Committee—Evidence Quality Rating

Grade	Strength of Recommendation
A	Strong Recommendation There is high certainty based on evidence that the net benefit is substantial.
B	Moderate Recommendation There is moderate certainty based on evidence that the net benefit is moderate to substantial or there is high certainty that the net benefit is moderate.
C	Weak Recommendation There is at least moderate certainty based on evidence that there is a small net benefit.
D	Recommendation Against There is at least moderate certainty based on evidence that it has no net benefit or that risks/harms outweigh benefits.

Grade	Strength of Recommendation
E	Expert Opinion (“There is insufficient evidence or evidence is unclear or conflicting, but this is what the committee recommends.”) Net benefit is unclear. Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, but the committee thought it was important to provide clinical guidance and make a recommendation. Further research is recommended in this area.
N	No Recommendation for or against (“There is insufficient evidence or evidence is unclear or conflicting.”) Net benefit is unclear. Balance of benefits and harms cannot be determined because of no evidence, insufficient evidence, unclear evidence, or conflicting evidence, and the committee thought no recommendation should be made. Further research is recommended in this area.