Connecticut Quality Council
2024 Aligned Measure Set Annual Review
Measure Specifications for Measures to be Discussed During April 18th Quality Council Meeting

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

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A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C).
  - The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts.
  - For example, a state may conduct a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening.
- When calculating the numerator, modified claims can be included depending on the intent of the modifier:
  - States can explore use of a modifier to indicate that a global developmental screening occurred. For example, Z13.42 can be used to indicate an "Encounter for screening for global developmental delays." Additional guidance on coding is available at: https://downloads.aap.org/AAP/PDF/coding_factsheet_developmentalscreeningtestingandEmotionalBehvioraassessment.pdf.
  - States should exclude a screening with a modifier if the intent of the modifier is to indicate that only a domain-specific screening occurred.
  - Modifiers that indicate that a screening was performed at a certain type of visit can be included.
- To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).

- More information about the developmental screening tools that meet the measure criteria is available at: https://aap2.silverchair-cdn.com/aap2/content_public/journal/pediatrics/145/1/10.1542_peds.2019-3449/7/peds_20193449supplementarydata.pdf.

- During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays.
- States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.
- The Bright Futures/American Academy of Pediatrics periodicity schedule includes more information about the recommendations for developmental screening and is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

This measure includes the following coding system: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

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

C. GUIDANCE ON DEVELOPMENTAL SCREENING TOOLS

Criteria for developmental screening tools used in the measure, as well as example tools that do and do not meet criteria, are included below in Section E.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

It is important to note that modified 96110 claims should not be included IF the modifier is used to indicate that the screening is for a specific domain of development (for example, social emotional screening via the ASQ-SE or autism screening). This measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

Exclusions

None.

E. MEDICAL RECORD SPECIFICATION

Denominator

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.

3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Example developmental screening tools that meet criteria for the measure

The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf), which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement:[1]

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

Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies.

Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[2]

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

The tools listed above are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria.

Tools that do NOT meet the criteria

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

[1] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." *Pediatrics*, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

[2] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." *Pediatrics,* vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

Exclusions

None.

F. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

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

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

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

G. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

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

Eye Exam for Patients With Diabetes (EED)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.
- 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 in the *Notes* that inaccessibility of one eye 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) who had a retinal eye exam.

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.*

Stratification

For Medicare only, 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

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.

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.

Diabetes Medications

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

Description	Prescription		
	• Dapagliflozin-metformin • Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Glimepiride-pioglitazone • Glipizide-metformin • Glyburide-metformin	• 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	• Empagliflozin • Ertugliflozin
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.

Numerator Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A *negative* retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Any of the following meet criteria:

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.

- Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications (Diabetes Mellitus Without Complications Value Set).
- Any code in the Eye Exam With Evidence of Retinopathy Value Set, Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Automated eye exam (CPT code 92229) billed by any provider type during the measurement year.
- Any code in the Eye Exam Without Evidence of Retinopathy Value Set billed by any provider type during the year prior to the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Diabetic retinal screening negative in prior year (CPT-CAT-II code 3072F) billed by any provider type during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (CPT Modifier code 50).
- Two unilateral eye enucleations (Unilateral Eye Enucleation Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral eye enucleation was February 1 of the measurement year, the service date for the second unilateral eye enucleation must be on or after February 15.
- Left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) and right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) on the same or different dates of service.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a left unilateral eye enucleation (ICD-10-PCS code 08T1XZZ) with service dates 14 days or more apart.
- A unilateral eye enucleation (Unilateral Eye Enucleation Value Set) and a right unilateral eye enucleation (ICD-10-PCS code 08T0XZZ) with service dates 14 days or more apart.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

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

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%) 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.

Numerator

Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
- Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Administrative

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

Medical record

At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
  - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
- Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings).
  - Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy

was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

Note

- *Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.*
- *Hypertensive retinopathy is not handled differently from diabetic retinopathy when reporting this measure; for example, an eye exam documented as positive for hypertensive retinopathy is counted as positive for diabetic retinopathy and an eye exam documented as negative for hypertensive retinopathy is counted as negative for diabetic retinopathy. The intent of this measure is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while members who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year.*
- *An eye exam result documented as "unknown" does not meet criteria.*
- *If one eye is not accessible, leading to an indeterminate result, this is not considered a result/finding.*

Data Elements for Reporting

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

Table EED-A-1/2: Data Elements for Eye Exam for Patients With Diabetes

Metric	Data Element	Reporting Instructions	A
EyeExams	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 EED-A-3: Data Elements for Eye Exam for Patients With Diabetes

Metric	SES Stratification	Data Element	Reporting Instructions	A
EyeExams	NonLisDeNondisability	CollectionMethod	Repeat per Stratification	✓
	LisDe	EligiblePopulation	For each Stratification	✓
	Disability	ExclusionAdminRequired	For each Stratification	✓
	LisDeAndDisability	NumeratorByAdminElig	For each Stratification	
	Other	CYAR	Only for Total (Percent)	
	Unknown	MinReqSampleSize	Repeat per Stratification	
	Total	OversampleRate	Repeat per Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	Repeat per Stratification	
		ExclusionEmployeeOrDep	Repeat per Stratification	
		OversampleRecsAdded	Repeat per Stratification	
		Denominator	For each Stratification	
		NumeratorByAdmin	For each Stratification	✓
		NumeratorByMedicalRecords	For each Stratification	
		NumeratorBySupplemental	For each Stratification	✓
		Rate	(Percent)	✓

Table EED-B-1/2/3: Data Elements for Eye Exam for Patients With Diabetes: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions	A
EyeExams	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 EED-C-1/2/3: Data Elements for Eye Exam for Patients With Diabetes: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions	A
EyeExams	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)	✓

*****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 Eye Exam 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**
Eye Exam for Patients With Diabetes	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.

Immunizations for Adolescents (IMA)*

*Adapted with financial support from the Centers for Disease Control & Prevention (CDC).

SUMMARY OF CHANGES TO HEDIS MY 2024

- Expanded the age criteria in the *Rules for Allowable Adjustments of HEDIS*.

Description

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

Eligible Population

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.*

Age

Adolescents who turn 13 years of age during the measurement year.

Continuous enrollment

365 days prior to the member's 13th birthday.

Allowable gap No more than one gap in enrollment of up to 45 days during the 365 days prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

Anchor date Enrolled on the member's 13th birthday.

Benefit Medical.

Event/diagnosis None.

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

Meningococcal Serogroups A, C, W, Y Either of the following meets criteria:

- At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the member's 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the member's 13th birthday.

Tdap Any of the following meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; Tdap Vaccine Procedure Value Set), with a date of service on or between the member's 10th and 13th birthdays.
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday.
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the member's 13th birthday.

HPV Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the member's 9th and 13th birthdays and with dates of service at least 146 days apart. For example,

if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25.

- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the member's 9th and 13th birthdays.
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the member's 13th birthday.

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

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

Hybrid Specification

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

Numerators For meningococcal and HPV, count either of the following*:*

- Evidence of the antigen or combination vaccine.
- Anaphylaxis due to the vaccine.

For Tdap, count any of the following:

- Evidence of the antigen or combination vaccine.
- Anaphylaxis due to the vaccine.
- Encephalitis due to the vaccine.

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

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

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

For documented history of anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's 13th birthday.

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

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

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

Note

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

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions	A
Meningococcal	CollectionMethod	Repeat per Metric	✓
Tdap	EligiblePopulation	Repeat per Metric	✓
HPV	ExclusionAdminRequired	Repeat per Metric	✓
Combo1	NumeratorByAdminElig	For each Metric	
Combo2	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 IMA-B-1/2: Data Elements for Immunizations for Adolescents: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions	A
Meningococcal	AmericanIndianOrAlaskaNative	Direct	CollectionMethod	Repeat per Metric and Stratification	✓
Tdap	Asian	Indirect	EligiblePopulation	For each Stratification, repeat per Metric	✓
HPV	BlackOrAfricanAmerican	Unknown**	Denominator	For each Stratification, repeat per Metric	
Combo1	NativeHawaiianOrOtherPacificIslander	Total	Numerator	For each Metric and Stratification	✓
Combo2	White		Rate	(Percent)	✓
	SomeOtherRace				
	TwoOrMoreRaces				
	AskedButNoAnswer*				
	Unknown**				

Table IMA-C-1/2: Data Elements for Immunizations for Adolescents: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions	A
Meningococcal	HispanicOrLatino	Direct	CollectionMethod	Repeat per Metric and Stratification	✓
Tdap	NotHispanicOrLatino	Indirect	EligiblePopulation	For each Stratification, repeat per Metric	✓
HPV	AskedButNoAnswer*	Unknown**	Denominator	For each Stratification, repeat per Metric	
Combo1	Unknown**	Total	Numerator	For each Metric and Stratification	✓
Combo2			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 Immunizations for Adolescents

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age 13 as of June 30"). Organizations may expand the age ranges for each immunization to align with the CDC's Catch-Up Immunization Schedule.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socio-economic 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 exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Meningococcal • Tdap • HPV	No	Value sets and logic may not be changed. Vaccine dose requirements may not be changed.
• Combination Rates	Yes, with limits	Organizations are not required to calculate combination rates; alternate combinations of specified immunizations are allowed.

*Kidney Health Evaluation for Patients With Diabetes (KED)**

***This measure was developed by NCQA with input from the National Kidney Foundation.**

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added instructions to report rates stratified by race and ethnicity for each product line.
- Updated the age stratifications to align with the National Kidney Foundation.
- 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 "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 with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.

Eligible Population

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. Report three age stratifications and a total rate:

- 18–64.
- 65–75.
- 76–85.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment

The measurement year.

Allowable gap

No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

December 31 of the measurement year.

Benefit

Medical.

Event/diagnosis

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 • Canagliflozin-metformin • Dapagliflozin-metformin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin

Description	Prescription		
	• Dapagliflozin-saxagliptin • Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Glipizide-metformin • Glyburide-metformin • Linagliptin-metformin	• 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 with a diagnosis of ESRD (ESRD Diagnosis 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 who had dialysis (Dialysis Procedure Value Set) any time during the member's history on or prior to December 31 of the measurement year.
- 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 66-80 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

Kidney Health Evaluation Members who received ***both*** an eGFR and a uACR during the measurement year on the same or different dates of service:

- At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).
- At least one uACR identified by either of the following:
  - ***Both*** a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) ***and*** a urine creatinine test (Urine Creatinine Lab Test Value Set) ***with*** service dates four days or less apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year.
  - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).

Data Elements for Reporting

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

Table KED-A-1/2/3: Data Elements for Kidney Health Evaluation for Patients With Diabetes

Metric	Age	Data Element	Reporting Instructions
KidneyHealthEvaluation	18-64	EligiblePopulation	For each Stratification
	65-75	ExclusionAdminRequired	For each Stratification
	76-85	NumeratorByAdmin	For each Stratification
	Total	NumeratorBySupplemental	For each Stratification
		Rate	(Percent)

Table KED-B-1/2/3: Data Elements for Kidney Health Evaluation for Patients With Diabetes: Stratifications by Race

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

Table KED-C-1/2/3: Data Elements for Kidney Health Evaluation for Patients With Diabetes: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
KidneyHealthEvaluation	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 Kidney Health Evaluation for Patients With Diabetes

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (18–85 years).
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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, 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**
Kidney Health Evaluation	No	Value sets and logic may not be changed.

Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for postpartum care before or at 12 weeks of giving birth and received the following at a postpartum visit: breastfeeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and an immunization review and update.

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per performance period** for all patients seen for postpartum care before or at 12 weeks of giving birth during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period and were seen for postpartum care at a visit before or at 12 weeks of giving birth

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Patient procedure during performance period (CPT): 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622
WITHOUT
Telehealth Modifier (including but not limited to): GQ, GT, 95, POS 02, POS 10
AND
Postpartum care visit before or at 12 weeks of giving birth

NUMERATOR:
Patients receiving the following at a postpartum visit:

- Breastfeeding evaluation and education, including patient-reported breastfeeding
- Postpartum depression screening
- Postpartum glucose screening for gestational diabetes patients
- Family and contraceptive planning counseling
- Tobacco use screening and cessation education

- Healthy lifestyle behavioral advice
- Immunization review and update

Definitions:

Breastfeeding Evaluation and Education – Patients who were evaluated for and educated about breastfeeding before or at 12 weeks postpartum.

Postpartum Depression Screening – Patients who were screened for postpartum depression before or at 12 weeks postpartum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires, and results should be documented in the medical record. Depression screening should include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).

Postpartum Glucose Screening for Gestational Diabetes – Patients who were diagnosed with gestational diabetes during pregnancy and were screened with a glucose screen before or at 12 weeks postpartum.

Family and Contraceptive Planning Counseling – Patients who were provided family and contraceptive planning counseling (*including contraception, if necessary*) before or at 12 weeks postpartum.

Tobacco Use Screening and Cessation Education – Patients who were screened for tobacco use before or at 12 weeks postpartum. Patients who used any type of tobacco who were given brief counseling (3 minutes or less) and/or pharmacotherapy.

Healthy Lifestyle Behavioral Advice – Clinicians should use discretion to determine which patients they deem appropriate for healthy lifestyle counseling. Clinicians may take into account the number of weeks that have passed since childbirth, whether the mother is breastfeeding, the degree to which the mother's body mass index (BMI) exceeds the normal range, whether postpartum depression is present, and the mother's own feelings and perceptions of her body weight. Counseling should include suggestions around healthy eating and staying active. If deemed necessary by the clinician, the conversation about healthy lifestyle choices could include a follow-up plan, including a referral to a specialist such as a registered dietitian nutritionist, primary care provider, or mental health professional for lifestyle/behavioral therapy, pharmacological interventions, dietary supplements, exercise counseling or nutrition counseling.

Immunization Review and Update – Patients whose immunization records were reviewed and who were provided with indicated immunizations, including completing series initiated antepartum or postpartum, at or before 12 weeks postpartum.

Numerator Instructions:

To satisfactorily meet the numerator ALL components (breastfeeding evaluation and education, postpartum depression screening, postpartum glucose screening for patients with gestational diabetes, family and contraceptive planning counseling, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update) must be performed according to the definitions provided above.

NUMERATOR OPTIONS:

Performance Met:	Postpartum screenings, evaluations, and education performed **(G9357)**
OR	
Performance Not Met:	Postpartum screenings, evaluations and education not performed **(G9358)**

RATIONALE:

Managing and ensuring concrete postpartum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. The American College of Obstetricians and Gynecologists (ACOG) sees the weeks following birth as a critical period for a woman and her child that sets the stage for long-term health and well-being. As such, this "fourth trimester" should include a comprehensive postpartum visit with a full assessment of physical, social, and psychological well-being.

Postpartum follow-up for depression screening, breastfeeding evaluation and education, family and contraceptive planning counseling, glucose screening for gestational diabetes, tobacco use screening and cessation education, healthy lifestyle behavioral advice, and immunization review and update are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains under recognized, underdiagnosed, and undertreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that 3 to 25 percent of women experience major depression during the year following childbirth.

Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcomes, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The ACOG Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6–12 weeks postpartum and managed appropriately.

Tobacco and nicotine use is still a major contributor to morbidity and mortality in women and men. Women who stop using tobacco and nicotine receive an immediate health and financial benefit.

ACOG acknowledges that unintended pregnancies are common and that pregnancy spacing is important for healthy families. In addition, the greatest risk of low birth weight and preterm birth occurs when the interconception interval is less than 6 months. The ACOG sees the weeks following birth as a critical period for a woman and her child that set the stage for long-term health and well-being.

The ACOG 2018 Postpartum Toolkit states that immunization in the postpartum period is a simple and effective way to protect the woman and her child from certain infections, particularly when the woman was not immunized during pregnancy. Although obstetrician–gynecologists encourage women of childbearing age to be current with their immunizations before the peripartum period, postpartum maternal immunization can prevent acute maternal infection and potential spread of illness from the woman to her newborn. Infants of breastfeeding women acquire maternal antibodies through breast milk.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have postpartum visits are excluded from this measure.

Although certain postpartum conditions, such as depression, remain an underrecognized and undertreated condition for all low-income women, this is especially the case for those from racial and ethnic minority groups. A retrospective study of New Jersey's Medicaid program found that Black and Latina women had particularly low treatment initiation rates for postpartum depression [1]. Postpartum care disparities similarly existed for general postpartum care, postpartum glucose screening, and family and contraceptive planning counseling among racial and ethnic minority groups [2,3]. Access to care barriers, health literacy variations, and care coordination challenges may also play a role in postpartum care disparities [4]. Potential solutions to improve postpartum testing rates included proactively contacting patients, establishing educational programs, and distributing mailings [5]. These studies suggest that successful implementation of this measure's intent may have positive downstream impacts on disparities in postpartum care and maternal and children's outcomes overall.

References

1. Kozhimannil, K.B., Trinacty, C.M., Busch, A.B., Huskamp, H.A., Adams, A.S. (2011). Racial and ethnic disparities in postpartum depression care among low-income women. *Psychiatric Services, 62(6),* 619-625. https://doi.org/10.1176/ps.62.6.pss6206_0619.
2. Howell, E.A., Padrón, N.A., Beane, S.J. *et al.* (2017). Delivery and payment redesign to reduce disparities in high risk postpartum care. *Maternal Child Health J, 21(3),* 432–438. https://doi.org/10.1007/s10995-016-2221-8.
3. Mathieu, I.P., Song, Y., Jagasia, S.M. (2014). Disparities in postpartum follow-up in women with gestational diabetes mellitus, *Clinical Diabetes, 32(4),* 178-182. https://doi.org/10.2337/diaclin.32.4.178.
4. Parekh, N., Jarlenski, M., Kelley, D. (2018). Prenatal and postpartum care disparities in a large Medicaid program. *Matern Child Health J, 22***,** 429–437. https://doi.org/10.1007/s10995-017-2410-0.

5. Carson, M.P., Frank, M.I., Keely, E. (2013). Original research: Postpartum testing rates among women with a history of gestational diabetes—Systematic review, *Primary Care Diabetes, 7(3),* 177-186. https://doi.org/10.1016/j.pcd.2013.04.007.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted from the referenced clinical guidelines.

Postpartum Care

The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains [1]:

- Mood and emotional well-being
- Infant care and feeding
- Sexuality, contraception, and birth spacing
- Sleep and fatigue
- Physical recovery from birth
- Chronic disease management
- Health maintenance

Breastfeeding Evaluation and Education

The USPSTF recommends interventions during pregnancy and after birth to support breastfeeding (Grade B recommendation) [2].

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated, and interventions to promote breastfeeding may not be appropriate.

Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

Postpartum Depression Screening

A screening for postpartum depression should be included in the postpartum visit [3,4]. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

Postpartum Glucose Screening for Gestational Diabetes Patients

Up to one-third of women who experienced GDM will have impaired glucose metabolism postpartum and 15% to 50% of women will develop type 2 diabetes within the decades following the affected pregnancy [5]. Postpartum follow-up with treatment has been proven to postpone or prevent this occurrence. Glucose testing should be included in the postpartum visit for patients who had pregnancies complicated by gestational diabetes [3]. ACOG recommends either a 75 g, 2-hour oral glucose tolerance test, or a fasting plasma glucose test [1]. Refer to the VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017) for more information regarding glucose screening techniques [6].

Family and Contraceptive Planning Counseling

Women should be advised to avoid interpregnancy intervals shorter than 6 months and should be counseled about the risks and benefits of repeat pregnancy sooner than 18 months. Short interpregnancy intervals also are associated with reduced vaginal birth after cesarean success for women undergoing trial of labor after cesarean [1]. Family planning and contraception should be discussed at the postpartum visit [3].

A woman's future pregnancy intentions provide a context for shared decision making regarding contraceptive options. Shared decision making brings two experts to the table: the patient and the health care provider. The health care

provider is an expert in the clinical evidence, and the patient is an expert in her experiences and values. As affirmed by the World Health Organization (WHO), when making choices regarding the timing of the next pregnancy, "Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences." Given the complex history of sterilization abuse and fertility control among marginalized women, care should be taken to ensure that every woman is provided information on the full range of contraceptive options so that she can select the method best suited to her needs [1].

Tobacco Screening and Cessation Education
One component of postpartum care be assessing mood and emotional well-being, which includes screening for tobacco use and counseling regarding relapse risk in the postpartum period [1]. An ACOG Work Group created a Tobacco and Nicotine Cessation Toolkit to support clinicians in discussing tobacco and smoking cessation with patients.

Healthy Lifestyle Behavioral Advice
Approximately 65% of reproductive-aged women are overweight or obese at the time of pregnancy and are at risk of postpartum weight retention and chronic obesity [7].

Risk factors for being overweight or obese include a sedentary lifestyle, high caloric dietary intake, family history, genetics, and individual metabolism. Regular physical activity during an uncomplicated pregnancy and the postpartum period can improve cardiorespiratory fitness and reduce the risk and downstream health consequences (e.g., heart disease, diabetes) of being overweight or obese. Postpartum women should follow the national guidelines for physical activity, which is 150 minutes of moderate exercise each week. Recommendations include a target of 20–30 minutes of exercise on most days of the week. Providing lifestyle recommendations to promote maternal health for long-term reduction in the risk of chronic obesity and its downstream sequelae of diabetes and cardiovascular disease is a key objective of the postpartum visit. Such recommendations will also result in improved health in the interpregnancy period, if further childbearing is desired [6].

The postpartum period is an opportune time for obstetrician–gynecologists and other obstetric care providers to recommend and reinforce a healthy lifestyle. Resuming exercise or incorporating new exercise routines after delivery is important in supporting lifelong healthy habits. Exercise routines may be resumed gradually after pregnancy as soon as medically safe, depending on the mode of delivery (vaginal or cesarean birth) and the presence or absence of medical or surgical complications. Some women are capable of resuming physical activities within days of delivery. Pelvic floor exercises can be initiated in the immediate postpartum period. Abdominal strengthening exercises, including abdominal crunch exercises and the drawing-in exercise, a maneuver that increases abdominal pressure by pulling in the abdominal wall muscles, have been shown to decrease the incidence of diastasis recti abdominus and decrease the inter-rectus distance in women who gave birth vaginally or by cesarean birth [7].

Immunization Review and Update
One component of postpartum care includes reviewing vaccination history and providing indicated immunizations, including completing series initiated antepartum or postpartum [1]. The postpartum visit should include a review of current vaccination status in accordance with CDC Pregnancy and Maternal Vaccination guidance, including a review of immunization status against pertussis, influenza, varicella, and rubella [3]. The influenza vaccine is an essential element of pre-pregnancy, prenatal, and postpartum care since influenza can result in serious illness, and has a higher chance of progressing to pneumonia when it occurs during the antepartum or postpartum period [8]. Likewise, women are at high risk of serious complications of seasonal and pandemic influenza infection [9].

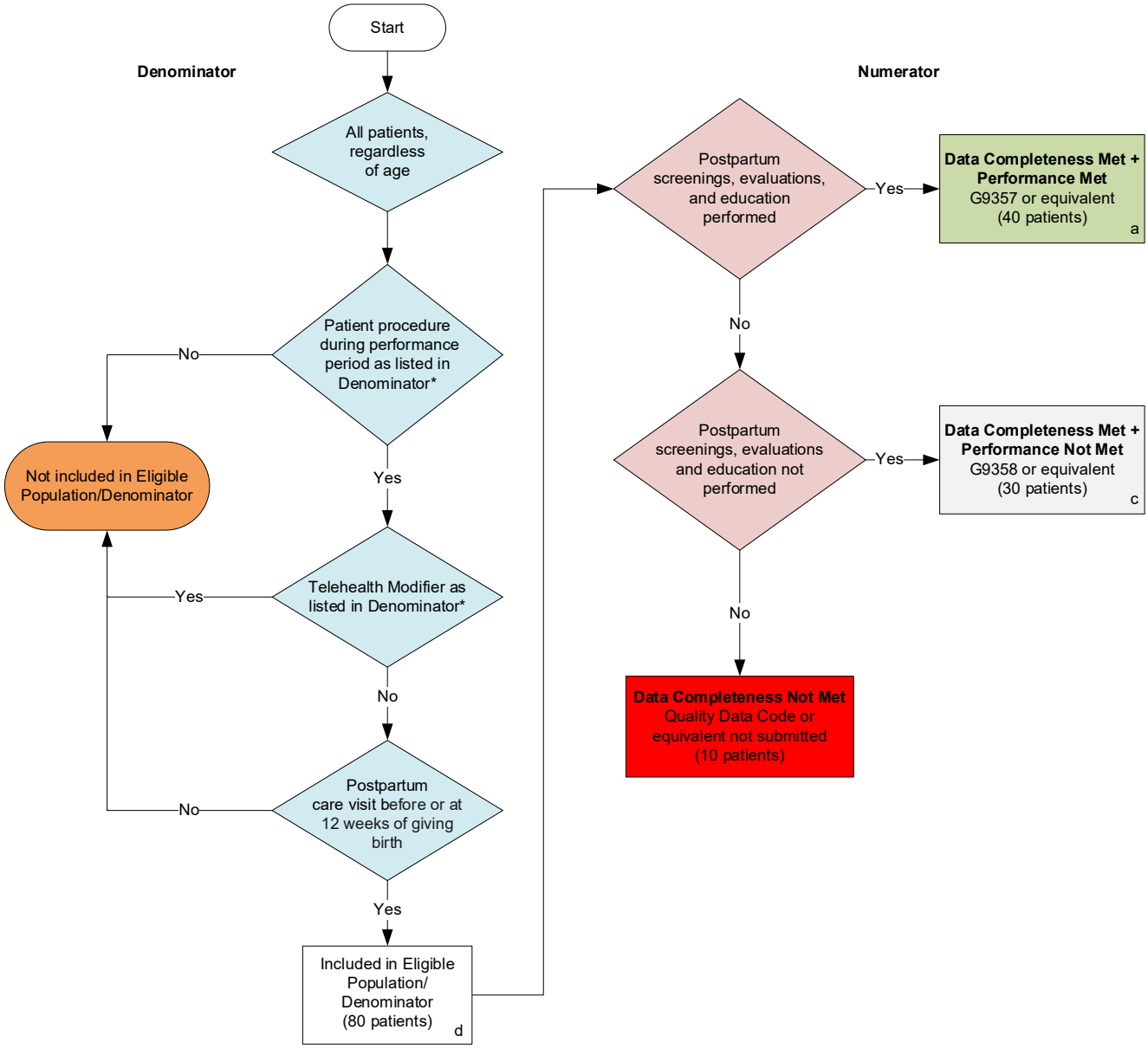
References

1. ACOG Committee Opinion No. 736: Optimizing Postpartum Care (2018, reaffirmed 2021)
2. USPSTF Final Recommendation Statement: Breastfeeding: Primary Care Interventions (2016)
3. VA/DoD Clinical Practice Guideline for the Management of Pregnancy Version 3.0 (2018)
4. ACOG Committee Opinion No. 757: Screening for Perinatal Depression (2018)
5. ACOG Tool for Postpartum Gestational Diabetes Mellitus (GDM) Follow-up
6. VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care (2017)

7. ACOG Postpartum Toolkit (2018)
8. ACOG Committee Opinion No. 732: Influenza Vaccination During Pregnancy (2018)
9. ACOG Committee Opinion No. 753: Assessment and Treatment of Pregnant Women With Suspected or Confirmed Influenza (2018)

2024 Clinical Quality Measure Flow for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

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



SAMPLE CALCULATIONS

Data Completeness=
Performance Met (a=40 patients) + Performance Not Met (c=30 patients) = 70 patients = **87.50%**
Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=
Performance Met (a=40 patients) = 40 patients = **57.14%**
Data Completeness Numerator (70 patients) = 70 patients

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Patient-Process

2024 Clinical Quality Measure Flow Narrative for Quality ID #336: Maternity Care: Postpartum Follow-up and Care Coordination

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

1. Start with Denominator.
2. Check *All patients, regardless of age*.
3. Check *Patient procedure during performance period as listed in Denominator**:
    a. If *Patient procedure during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during performance period as listed in Denominator** equals Yes, proceed to check *Telehealth Modifier as listed in Denominator**.
4. Check *Telehealth Modifier as listed in Denominator**:
    a. If *Telehealth Modifier as listed in Denominator** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Telehealth Modifier as listed in Denominator** equals No, proceed to check *Postpartum care visit before or at 12 weeks of giving birth.*
5. Check *Postpartum care visit before or at 12 weeks of giving birth*:
    a. If *Postpartum care visit before or at 12 weeks of giving birth* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Postpartum care visit before or at 12 weeks of giving birth* equals Yes, include in *Eligible Population/Denominator.*
6. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 patients in the Sample Calculation.
7. Start Numerator
8. Check *Postpartum screenings, evaluations, and education performed*:
    a. If *Postpartum screenings, evaluations, and education performed* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 patients in the Sample Calculation.
    b. If *Postpartum screenings, evaluations, and education performed* equals No, proceed to *Postpartum screenings, evaluations and education not performed*.
9. Check *Postpartum screenings, evaluations and education not performed*:

a. If *Postpartum screenings, evaluations and education not performed* equals Yes, include in *Data Completeness Met and Performance Not Met.*

    - *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 patients in the Sample Calculation.

b. If *Postpartum screenings, evaluations, and education not performed* equals No, proceed to check *Data Completeness Not Met.*

10. Check *Data Completeness Not Met*:

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

Sample Calculations:

Data Completeness equals Performance Met (a equals 40 patients) plus Performance Not Met (c equals 30 patients) divided by Eligible Population / Denominator (d equals 80 patients). All equals 70 patients divided by 80 patients. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 patients) divided by Data Completeness Numerator (70 patients). All equals 40 patients divided by 70 patients. All equals 57.14 percent.

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

NOTE: Submission Frequency: Patient-Process

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)**

***Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.**

SUMMARY OF CHANGES TO HEDIS MY 2024

- Refer to the Technical Release Notes file in the Digital Measures Package for a comprehensive list of changes.
- Revised the headers in the *Clinical Components* section of the *Rules for Allowable Adjustments of HEDIS.*
- Revised the exclusion criteria in the *Rules for Allowable Adjustments of HEDIS.*
- Added a *Denominator* section to the *Rules for Allowable Adjustments of HEDIS*.

Description	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • The percentage of children and adolescents on antipsychotics who received blood glucose testing. • The percentage of children and adolescents on antipsychotics who received cholesterol testing. • The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.
Measurement period	January 1–December 31.
Clinical recommendation statement	The American Academy of Child & Adolescent Psychiatry (AACAP) practice parameters endorse the American Psychiatric Association and American Diabetes Association recommendations for laboratory monitoring, including a fasting glucose and fasting lipid profile at baseline, 3 and 12 months (Findling, 2011). The Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children calls for more frequent monitoring in youth at baseline, 3, 6 and 12 months, and additional monitoring of fasting insulin (Pringsheim, 2011).
Citations	Findling, R.L., S.S. Drury, P.S. Jensen, J.L. Rapoport, O.G. Bukstein, H.J. Walter, S. Benson, et al. 2011. "Practice Parameter for the Use Of Atypical Antipsychotic Medications in Children and Adolescents." *J Am Acad Child Adolesc Psychiatry*. Pringsheim, T., C. Panagiotopoulos, J. Davidson, J. Ho, and Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMESA) guideline group. 2011. "Evidence-Based Recommendations for Monitoring Safety of Second-Generation Antipsychotics in Children and Youth." *Paediatrics & Child Health* 16, no. 9: 581–9.

Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Blood Glucose. – Product line: ▪ Commercial. ▪ Medicaid. – Age (for each product line): ▪ 1–11 years. ▪ 12–17 years. • Cholesterol. – Product line: ▪ Commercial. ▪ Medicaid. – Age (for each product line): ▪ 1–11 years. ▪ 12–17 years. • Blood Glucose and Cholesterol. – Product line: ▪ Commercial. ▪ Medicaid. – Age (for each product line): ▪ 1–11 years. ▪ 12–17 years.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, if there are both NDC codes and RxNorm codes on the same date of service, use only one data source for that date of service (use only NDC codes or only RxNorm codes) for reporting. This rule is not included in the measure calculation logic and must be programmed manually. **Allocation:** The member was enrolled with a medical and pharmacy benefit throughout the measurement period. No more than one gap in enrollment of up to 45 days during the measurement period. The member must be enrolled on the last day of the measurement period.

	Reporting: The total is the sum of the age stratifications. **Programming Guidance:** The requirements for identifying members in hospice using the monthly membership detail data files are not included in the measure calculation logic, and must be programmed manually. Product line stratifications are not included in the measure calculation logic, and must be programmed manually. Refer to the HEDIS Implementation Guide in the digital measure package for additional programming guidance.
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	**Initial population 1** Members 1–17 years by the end of the measurement period with at least two antipsychotic medication dispensing events (APM Antipsychotic Medications List) of the same or different medications on different dates of service during the measurement period, and who also meet criteria for participation. **Initial population 2** Same as the initial population 1. **Initial population 3** Same as the initial population 1.
Exclusions	**Exclusions 1** • 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. **Exclusions 2** Same as exclusions 1. **Exclusions 3** Same as exclusions 1.

Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** Same as denominator 1. **Denominator 3** Same as denominator 1.
Numerator	**Numerator 1—Blood Glucose** Members who received at least one test for blood glucose or HbA1c during the measurement period. Any of the following meet criteria: • Glucose Lab Test Value Set. • Glucose Test Result or Finding Value Set. • HbA1c Lab Test Value Set. • HbA1c Test Result or Finding Value Set. Do not include codes with a modifier (CPT CAT II Modifier Value Set). **Numerator 2—Cholesterol** Members who received at least one test for LDL-C or cholesterol during the measurement period. Any of the following meet criteria: • Cholesterol Lab Test Value Set. • Cholesterol Test Result or Finding Value Set. • LDL-C Lab Test Value Set. • LDL-C Test Result or Finding Value Set. Do not include codes with a modifier (CPT CAT II Modifier Value Set). **Numerator 3—Blood Glucose and Cholesterol** Members who were compliant for both the blood glucose and cholesterol indicators (numerator 1 and numerator 2).
Data criteria (element level)	
Value Sets: • **APME_HEDIS_MY2024-3.0.0** – APM Antipsychotic Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2442) – Cholesterol Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1742) – Cholesterol Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1743) – Glucose Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1751) – Glucose Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1752) – HbA1c Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1755) – HbA1c Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1756) – LDL-C Lab Test (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1769)	

  - LDL-C Test Result or Finding (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1770)
- **NCQA_Hospice-3.0.0**
  - Hospice Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1761)
  - Hospice Intervention (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1762)

Direct reference codes and codesystems:

- **NCQA_Terminology-3.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ClaimTypeCodes": 'http://terminology.hl7.org/CodeSystem/claim-type'
  - code "drug policy": 'DRUGPOL' from "ActCode"
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Pharmacy": 'pharmacy' from "ClaimTypeCodes"
  - code "retiree health program": 'RETIRE' from "ActCode"
  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"

Data Elements for Reporting

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

Table APM-E-1/2: Data Elements for Metabolic Monitoring for Children and Adolescents on Antipsychotics

Metric	Age	Data Element	Reporting Instructions
BloodGlucoseTesting	1-11	Benefit	Metadata
CholesterolTesting	12-17	InitialPopulationByEHR	For each Stratification, repeat per Metric
BloodGlucoseCholesterolTesting	Total	InitialPopulationByCaseManagement	For each Stratification, repeat per Metric
		InitialPopulationByHIERegistry	For each Stratification, repeat per Metric
		InitialPopulationByAdmin	For each Stratification, repeat per Metric
		InitialPopulation	(Sum over SSoRs)
		Exclusions	For each Stratification, repeat per Metric
		Denominator	For each Stratification, repeat per Metric
		NumeratorByEHR	For each Metric and Stratification
		NumeratorByCaseManagement	For each Metric and Stratification
		NumeratorByHIERegistry	For each Metric and Stratification
		NumeratorByAdmin	For each Metric and Stratification
		Numerator	(Sum over SSoRs)
		Rate	(Percent)

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.

Allowable Adjustments of Metabolic Monitoring of Children and Adolescents on Antipsychotics—ECDS

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed within a specified age range (ages 1–17+ years). Additionally, the upper age range may be expanded or no upper age limit may be used.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefit	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Initial Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only dispensing events that contain (or map to) codes in the medication lists and value sets may be used to identify antipsychotic medication events. Medication lists, value sets and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions: Hospice and deceased member	Yes	These exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Denominator	**Adjustments Allowed (Yes/No)**	**Notes**
Denominators	No	The logic may not be changed.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Metabolic Monitoring	No	Value sets, direct reference codes and logic may not be changed.

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.

Transitions of Care (TRC)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Revised the numerator to clarify settings where CPT Category II code modifiers should not be used (previously covered in a General Guideline).

Description

The percentage of discharges for members 18 years of age and older who had each of the following. Four rates are reported:

- *Notification of Inpatient Admission*. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- *Receipt of Discharge Information.* Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- *Patient Engagement After Inpatient Discharge*. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Medication Reconciliation Post-Discharge*. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Definitions

Medication reconciliation	A type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
Medication list	A list of medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

Eligible Population

Product lines	Medicare.
Ages	18 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The date of discharge through 30 days after discharge (31 total days).
Allowable gap	None.
Anchor date	None.
Benefit	Medical.

Event/diagnosis

An acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year. To identify acute and nonacute inpatient discharges:

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

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Observation stays that precede the inpatient stay

Do not adjust the admit date if the discharge is preceded by an observation stay; use the admit date from the acute or nonacute inpatient stay.

Readmission or direct transfer

If the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 days total), use the admit date from the first admission and the discharge date from the last discharge. To identify readmissions and direct transfers during the 31-day period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay (the admission date must occur during the 31-day period).
3. Identify the discharge date for the stay (the discharge date is the event date).

Exclude both the initial and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the admission date and the discharge date for an acute inpatient stay occur between the admission and discharge dates for a nonacute inpatient stay, include only the nonacute inpatient discharge. To identify acute inpatient discharges:

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

To identify nonacute inpatient discharges:

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).
3. Identify the admission date for the stay.
4. Identify the discharge date for the stay.

Note: *If a member remains in an acute or nonacute facility through December 1 of the measurement year, a discharge is not included in the measure for this member, but the organization must have a method for identifying the member's status for the remainder of the measurement year, and may not assume the member remained admitted based only on the absence of a discharge before December 1.*

If the organization is unable to confirm the member remained in the acute or nonacute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.

Required exclusions

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

Notification of Inpatient Admission

Administrative reporting is not available for this indicator.

Receipt of Discharge Information

Administrative reporting is not available for this indicator.

Patient Engagement After Inpatient Discharge

Patient engagement provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meet criteria for patient engagement:

- An outpatient visit, telephone visit, e-visit or virtual check-in (Outpatient and Telehealth Value Set).
- Transitional care management services (Transitional Care Management Services Value Set).

Medication Reconciliation Post-Discharge

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse on the date of discharge through 30 days after discharge (31 total days). Either of the following meet criteria:

- Medication Reconciliation Encounter Value Set.
- Medication Reconciliation Intervention Value Set. Do not include codes with a modifier (CPT CAT II Modifier Value Set).

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

The denominator is based on discharges, not on members. Members may appear more than once in the sample.

Organizations may reduce the sample size based only on the prior year's audited, product line-specific rate for the lowest rate of all TRC indicators. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Identifying the medical record

Documentation in any outpatient medical record that is accessible to the PCP or ongoing care provider is eligible for use in reporting.

Numerators

Notification of Inpatient Admission

Documentation of receipt of notification of inpatient admission on the day of admission or on the day of admission through 2 days after the admission (3 total days).

Administrative

Administrative reporting is not available for this indicator.

Medical record

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).

Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received. Any of the following examples meet criteria:

- Communication between inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission between emergency department and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and transfer (ADT) alert system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. When using a shared EMR system, documentation of a "received date" is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Indication that the member's PCP or ongoing care provider admitted the member to the hospital.
- Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.

- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the planned inpatient admission must be communicated is not limited to the day of admission through 2 days after the admission (3 total days); documentation that the PCP or ongoing care provider performed a preadmission exam or received notification of a planned admission prior to the admit date also meets criteria. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Note: *When an ED visit results in an inpatient admission, notification that a provider sent the member to the ED does not meet criteria. Evidence that the PCP or ongoing care provider communicated with the ED about the admission meets criteria.*

Receipt of Discharge Information

Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

Administrative

Administrative reporting is not available for this indicator.

Medical record

Documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Note: *If the PCP or ongoing care provider is the discharging provider, the discharge information must be documented in the medical record on the day of discharge through 2 days after the discharge (3 total days).*

When using a shared EMR system, documentation of a "received date" in the EMR is not required to meet criteria. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of discharge through 2 days after the discharge (3 total days) meets criteria.

Patient Engagement After Inpatient Discharge

Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

Administrative

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

Medical record

Documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:

- An outpatient visit, including office visits and home visits.
- A telephone visit.
- A synchronous telehealth visit where real-time interaction occurred between the member and provider using audio and video communication.
- An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not in real-time, occurred between the member and provider).

Note: *If the member is unable to communicate with the provider, interaction between the member's caregiver and the provider meets criteria.*

Medication Reconciliation Post-Discharge

Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, physician assistant or registered nurse, as documented through either administrative data or medical record review on the date of discharge through 30 days after discharge (31 total days).

Administrative

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

Medical record

Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:

- Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
- Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Documentation of the member's current medications with a notation that the discharge medications were reviewed.
- Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
- Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post-discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
- Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
- Notation that no medications were prescribed or ordered upon discharge.

Note

- *The following notations or examples of documentation do not count as numerator compliant:*
  - *Notification of Inpatient Admission and Notification of Inpatient Discharge:*
    - *Documentation that the member or the member's family notified the member's PCP or ongoing care provider of the admission or discharge.*
    - *Documentation of notification that does not include a time frame or date when the documentation was received.*
  - *Medication Reconciliation Post-Discharge:*
    - *Documentation of "post-op/surgery follow-up" without a reference to "hospitalization," "admission" or "inpatient stay" does not imply a hospitalization and is not considered evidence that the provider was aware of a hospitalization.*
- *The Medication Reconciliation Post-Discharge numerator assesses whether medication reconciliation occurred. It does not attempt to assess the quality of the medication list documented in the medical record or the process used to document the most recent medication list in the medical record.*
- *The denominator is based on the discharge date found in administrative/claims data, but organizations may use other systems (including data found during medical record review) to identify data errors and make corrections.*
  - *If a different discharge date is found in the medical record, and the organization chooses to use that date, the organization must assess all indicators using the updated discharge date, including those that were previously compliant based on administrative data.*
- *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 (i.e., within 30 days after discharge).*
- *Refer to Appendix 3 for the definition of* PCP *and* ongoing care provider*.*
- *A medication reconciliation performed without the member present meets criteria.*

Data Elements for Reporting

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

Table TRC-3: Data Elements for Transitions of Care

Metric	Age	Data Element	Reporting Instructions	A
MedicationReconciliationPostDischarge	18-64	CollectionMethod	For each Metric, repeat per Stratification	✓
PatientEngagementAfterInpatientDischarge	65+	EligiblePopulation*	For each Metric and Stratification	✓
NotificationInpatientAdmission	Total	ExclusionAdminRequired*†	For each Metric and Stratification	✓
ReceiptDischargeInformation		NumeratorByAdminElig†	For each Metric and Stratification	
		CYAR†	Only for Total (Percent)	
		MinReqSampleSize	For each Metric, repeat per Stratification	
		OversampleRate	For each Metric, repeat per Stratification	
		OversampleRecordsNumber	(Count)	
		ExclusionValidDataErrors	For each Metric, repeat per Stratification	
		ExclusionEmployeeOrDep	For each Metric, repeat per Stratification	
		OversampleRecsAdded	For each Metric, repeat per Stratification	
		Denominator	For each Stratification, repeat per Metric	
		NumeratorByAdmin†	For each Metric and Stratification	✓
		NumeratorByMedicalRecords	For each Metric and Stratification	
		NumeratorBySupplemental	For each Metric and Stratification	✓
		Rate	(Percent)	✓

*Repeat the EligiblePopulation and ExclusionAdminRequired values for metrics using the administrative method.

†These data elements are only reported or calculated for the MedicationReconciliationPostDischarge and PatientEngagementAfterInpatientDischarge Metrics.

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 Transitions of Care

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	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 the eligible population for each rate. The value sets and logic may not be changed. ***Note:*** *Organizations may choose alternate measurement-period date ranges.* *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members with documentation of medication reconciliation after each discharge).*
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
• Notification of Inpatient Admission • Receipt of Discharge Information	No	Allowable adjustments are not permitted for these components of the Transitions of Care measure.
• Patient Engagement After Inpatient Discharge • Medication Reconciliation Post-Discharge	No	Value sets and logic may not be changed.

Well-Child Visits in the First 30 Months of Life (W30)

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

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

Note

- *This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

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

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

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

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

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	Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns 30 months old.
Benefit	Medical.
Event/diagnosis	None.
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: *Rate 2*—Well-Child Visits for Age 15 Months–30 Months

Denominator The Rate 2 eligible population.

Numerator Two or more well-child visits on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. 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-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Note

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

Data Elements for Reporting

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

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

Metric	Data Element	Reporting Instructions
Age15Months	EligiblePopulation	For each Metric
Age15To30Months	ExclusionAdminRequired	For each Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

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

Metric	Race	Source	Data Element	Reporting Instructions
Age15Months	AmericanIndianOrAlaskaNative	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	Asian	Indirect	Numerator	For each Metric and Stratification
	BlackOrAfricanAmerican	Unknown**	Rate	(Percent)
	NativeHawaiianOrOtherPacificIslander	Total		
	White			
	SomeOtherRace			
	TwoOrMoreRaces			
	AskedButNoAnswer*			
	Unknown**			

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

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Age15Months	HispanicOrLatino	Direct	EligiblePopulation	For each Metric and Stratification
Age15To30Months	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 Well-Child Visits in the First 30 Months of Life

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 15 months as of June 30"). The denominator age may not be expanded.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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-Care Visits in the First 15 Months • Well-Care Visits for Age 15 Months–30 Months	No	Value sets and logic may not be changed.
Stratifications	**Adjustments Allowed (Yes/No)**	**Notes**
Well-Care Visits	Yes, with limits	Organizations may stratify the count of visits for the numerator of both rates. Value sets and logic may not be changed.

Statin Therapy for Patients With Diabetes (SPD)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Updated the event/diagnosis criteria.
- Updated the Diabetes Medications table.
- 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 "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of any intensity during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days the member is covered by at least one statin medication prescription of appropriate intensity, divided by the number of days in the treatment period.
Calculating number of days covered for multiple prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a statin medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a statin medication (for the numerator). For example, three prescriptions for the same medication are dispensed on the same day, each with a 30-days supply, sum the days supply for a total of 90 days covered by a statin. Subtract any days supply that extends beyond December 31 of the measurement year.

Use the medication lists to determine if drugs are the same or different. Drugs in different lists are considered different drugs. For example, a dispensing event from the Amlodipine Atorvastatin High Intensity Medications List and a dispensing event from the Amlodipine Atorvastatin Moderate Intensity Medications List are dispensing events for different medications.

Eligible Population: *Rate 1*—Received Statin Therapy

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

Ages 40–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical. Pharmacy during the measurement year.

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 • Canagliflozin-metformin • Dapagliflozin-metformin • Dapagliflozin-saxagliptin	• Empagliflozin-metformin • Ertugliflozin-metformin • Ertugliflozin-sitagliptin • Glimepiride-pioglitazone • Glipizide-metformin	• Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone • Metformin-saxagliptin • Metformin-sitagliptin

Description	Prescription		
	• Empagliflozin-linagliptin • Empagliflozin-linagliptin-metformin	• Glyburide-metformin • Linagliptin-metformin	
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	• Empagliflozin • Ertugliflozin	
Sulfonylureas	• Chlorpropamide • Glimepiride	• Glipizide • Glyburide	• Tolazamide • Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	• Alogliptin • Linagliptin	• Saxagliptin • Sitaglipin	

Required exclusions

Exclude members who meet any of the following criteria:

- Members with at least one of the following during the year prior to the measurement year:
  - *MI.* Discharged from an inpatient setting with an MI (MI Value Set; Old Myocardial Infarction Value Set) on the discharge claim. To identify discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
  - *CABG.* Members who had CABG (CABG Value Set) in any setting.
  - *PCI.* Members who had PCI (PCI Value Set) in any setting.
  - *Other revascularization.* Members who had any other revascularization procedure (Other Revascularization Value Set) in any setting.
- Members who had at least one encounter with a diagnosis of IVD during both the measurement year and the year prior to the measurement year. The following encounters meet criteria:

  - An outpatient visit, telephone visit, e-visit, virtual check-in or acute inpatient encounter (Outpatient, Telehealth and Acute Inpatient Value Set) with an IVD diagnosis (IVD Value Set).
  - At least one acute inpatient discharge with an IVD diagnosis (IVD Value Set) on the discharge claim. To identify an acute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
    3. Identify the discharge date for the stay.
- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- In vitro fertilization (IVF Value Set) in the measurement year or year prior to the measurement year.
- Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.
- ESRD (ESRD Diagnosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.
- Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
- Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).
- 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).

Estrogen Agonists Medications

Description	Prescription
Estrogen agonists	• Clomiphene

Dementia Medications

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

Administrative Specification: *Rate 1*—Received Statin Therapy

Denominator The Rate 1 eligible population.

Numerator The number of members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication (High, Moderate and Low Intensity Statin Medications List) during the measurement year.

High, Moderate and Low-Intensity Statin Medications

Description	Prescription	Medication Lists
High-intensity statin therapy	Atorvastatin 40-80 mg	Atorvastatin High Intensity Medications List
High-intensity statin therapy	Amlodipine-atorvastatin 40-80 mg	Amlodipine Atorvastatin High Intensity Medications List
High-intensity statin therapy	Rosuvastatin 20-40 mg	Rosuvastatin High Intensity Medications List

Description	Prescription	Medication Lists
High-intensity statin therapy	Simvastatin 80 mg	Simvastatin High Intensity Medications List
High-intensity statin therapy	Ezetimibe-simvastatin 80 mg	Ezetimibe Simvastatin High Intensity Medications List
Moderate-intensity statin therapy	Atorvastatin 10-20 mg	Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Amlodipine-atorvastatin 10-20 mg	Amlodipine Atorvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Rosuvastatin 5-10 mg	Rosuvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Simvastatin 20-40 mg	Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Ezetimibe-simvastatin 20-40 mg	Ezetimibe Simvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pravastatin 40-80 mg	Pravastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Lovastatin 40 mg	Lovastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Fluvastatin 40-80 mg	Fluvastatin Moderate Intensity Medications List
Moderate-intensity statin therapy	Pitavastatin 1–4 mg	Pitavastatin Moderate Intensity Medications List
Low-intensity statin therapy	Ezetimibe-simvastatin 10 mg	Ezetimibe Simvastatin Low Intensity Medications List
Low-intensity statin therapy	Fluvastatin 20 mg	Fluvastatin Low Intensity Medications List
Low-intensity statin therapy	Lovastatin 10-20 mg	Lovastatin Low Intensity Medications List
Low-intensity statin therapy	Pravastatin 10–20 mg	Pravastatin Low Intensity Medications List
Low-intensity statin therapy	Simvastatin 5-10 mg	Simvastatin Low Intensity Medications List

Eligible Population: *Rate 2*—Statin Adherence 80%

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

Age 40–75 years as of December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than one gap in 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. Pharmacy during the measurement year.

Event/diagnosis All members who meet the numerator criteria for Rate 1.

Administrative Specification: *Rate 2*—Statin Adherence 80%

Denominator The Rate 2 eligible population.

Numerator The number of members who achieved a PDC of at least 80% during the treatment period.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any high-intensity, moderate-intensity or low-intensity statin medication during the measurement year. Use all the medication lists above to identify statin medication dispensing events.

Step 2 To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3 Count the days covered by at least one prescription for any high-intensity, moderate-intensity or low-intensity statin medication during the treatment period. To ensure the measure does not give credit for supply that extends beyond the measurement year, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a member has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\text{Total Days Covered by a Statin Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is ≥80% for the treatment period.

Note

- *All members who are numerator compliant for Rate 1 must be used as the eligible population for Rate 2 (regardless of the data source used to capture the Rate 1 numerator). For example, if supplemental data were used to identify compliance for the Rate 1 numerator, then supplemental data will be included in identifying the Rate 2 eligible population.*

Data Elements for Reporting

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

Table SPD-1/2/3: Data Elements for Statin Therapy for Patients With Diabetes

Metric	Data Element	Reporting Instructions
ReceivedTherapy	Benefit	Metadata
Adherence	EligiblePopulation	For each Metric
	ExclusionAdminRequired	Only for ReceivedTherapy Metric
	NumeratorByAdmin	For each Metric
	NumeratorBySupplemental	For each Metric
	Rate	(Percent)

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 Statin Therapy 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 the denominator age range is allowed within the specified age range (ages 40–75 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, with limits	Apply required exclusions according to specified medication lists and 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
• Rate 1: Received Statin Therapy • Rate 2: Statin Adherence 80%	No	Medication lists, value sets and logic may not be changed.