Connecticut Quality Council
2024 Aligned Measure Set Annual Review
Measure Specifications for Measures to be Discussed During May 16th Quality Council Meeting

Health Measure TIPS (To Improve Performance Sheet): Behavioral Health Screening in the First 18 Years of Life (BEH)

Importance of the Quality Measure

Approximately one in five children have a mental, emotional, or behavioral disorder such as anxiety, depression, ADHD, and disruptive behavior disorder. It is recommended that a behavioral health screening be performed annually at regular well-child visits beginning at birth and through age 18.[2] Early identification of behavioral disorders is critical to the well-being of children and their families. Unfortunately, only an estimated 20% of children with mental, emotional, or behavioral disorders received care from a specialized mental healthcare provider.[1] Without early diagnosis and treatment, mental disorders can interfere with a child's healthy development, with problems extending into adulthood. Early identification of behavioral issues, along with timely referrals to specialists and services, can improve behavioral outcomes across the lifespan of a child. It is the Department of Social Services' (DSS) goal that all HUSKY Health members ages 1 to 18 receive a developmental and/or behavioral health screen, at least annually.

Please note that the Department of Social Services will reimburse for developmental and behavioral health screenings, including those that are performed at intervals outside of the annual Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit.

This quality metric is recognized by a number of national quality improvement measure stewards, and supports an objective of the *Healthy People 2030* initiative developed by the U.S. Department of Health and Human Services and the Office of Disease Prevention and Health Promotion.

Quality Measure Description

The percentage of children ages 1-18 years who received a behavioral health screening during the measurement year

HUSKY Health wants to help you improve your behavioral health screening rates in the first 18 years of life, and improve health outcomes for your HUSKY Health patients. **Adherence to this measure is determined by claims data.**

Required Medical Record Documentation

- Date of service for the behavioral health screening
- Documentation of the validated screening tool used (Refer to Provider Bulletin 2015-70 for validated tools for this measure)
- Evidence of a screening result (positive or negative) or a screening score (a numeric value associated with the validated screening tool)

*Code for Behavioral Health Screening

CODE	MODIFIERS
96127	Use modifier **U3** for a positive screen and **U4** for a negative screen.

Quality Improvement Opportunities

- Assess for risk factors for developmental problems such as, preterm birth, low birthweight, environmental risk like lead exposure
- Incorporate workflows for staff to provide parents/guardians with screening forms prior to the visit so they can be reviewed together with the provider
- Optimize EHR system to prompt validated behavioral health screening tool and documentation
- Be sure to discuss mental and behavioral health in a destigmatizing manner

Tools & Resources for Healthcare Professionals

- Screening and Diagnosis of Autism Spectrum Disorder for Healthcare Providers: https://www.cdc.gov/ncbddd/autism/hcp-screening.html
- Parent Training in Behavior Management for ADHD: https://www.cdc.gov/ncbddd/adhd/behavior-therapy.html

Resources for Patients and Families

- Anxiety and Depression in Children: Get the Facts: https://www.cdc.gov/childrensmentalhealth/features/anxiety-depression-children.html
- Positive Parenting Tips: https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html

Additional Information on HUSKY Health

For information on quality improvement, quality measures, or the programs and services made available through the HUSKY Health program:

- Visit: https://portal.ct.gov/husky, click "**Information for Providers**," then "**Health Measures**" under the "**Reports & Resources**" menu item
- Email: Quality@chnct.org
- Call: 1.866.317.3301

References:

[1]CDC. (2021). Improving Access to Children's Mental Health Care. https://www.cdc.gov/childrensmentalhealth/access.html

[2]American Academy of Pediatrics. (2021). Recommendations for Preventative Pediatric Health Care. Bright Futures/American Academy of Pediatrics. https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

**Code sets are routinely updated. Please reference the current year's manuals when billing for services. Not all codes listed above are reimbursable. For a list of codes reimbursed by DSS, please refer to the Physician Office and Outpatient Services Fee Schedule on the Connecticut Medical Assistance Program website: www.ctdssmap.com.*

MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of January 1 of the measurement year.
- The opioid medications used to calculate this measure are in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10-CM codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice or palliative care may be identified using the codes in the Hospice Encounter Value Set, Hospice Intervention Value Set, and Palliative Care Value Set available in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply when there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
  - If prescriptions are filled on the **same day**, states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled, one with a 7-day supply and the other with a 30-day supply, on October 15 during the measurement year, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply.

- If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on January 15, 2023 for a 30-day supply, and the second, on January 20, 2023 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table COB-A.
Benzodiazepine	See medications listed in Table COB-B.
Concurrent use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days during the measurement year. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 30 days before the end of the measurement year. (i.e., January 1–December 2).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip.

Sickle cell disease diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip.
Palliative care	Any beneficiary with an ICD-10-CM diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/ diagnosis	Use the steps below to determine the eligible population. Step 1 • Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. • Exclude days' supply that occur after the end of the measurement year. Note: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Event/ diagnosis (continued)	Step 2 Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year. Step 3 Exclude beneficiaries with at least one of the following during the measurement year: • Hospice. • Cancer diagnosis. • Sickle cell disease diagnosis. • Palliative care.

Table COB-A. Opioid Medications[a,b]

Benzohydrocodone	Hydrocodone	Morphine	Oxymorphone
Buprenorphine	Hydromorphone	Opium	Pentazocine
Butorphanol	Levorphanol	Oxycodone	Tapentadol
Codeine	Meperidine		Tramadol
Dihydrocodeine	Methadone		
Fentanyl			

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sublingual sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (e.g., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

- Two or more prescription claims for any benzodiazepine (Table COB-B) with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days

Follow the steps below to identify beneficiaries for the numerator.

Step 1

From the denominator population, identify beneficiaries with two or more prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2

Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioids and benzodiazepine prescriptions during the measurement year. Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of supply and overlap that occur after the end of the measurement year.

Note:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3

Count the number of beneficiaries with concurrent use for 30 or more cumulative days. This is the numerator.

Table COB-B. Benzodiazepine Medications[a,b]

Alprazolam	Clorazepate	Lorazepam	Temazepam
Chlordiazepoxide	Diazepam	Midazolam	Triazolam
Clobazam	Estazolam	Oxazepam	
Clonazepam	Flurazepam	Quazepam	

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Centers for Disease Control and Prevention (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain available at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

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

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

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

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

Eligible Population

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

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

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

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

Ages

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

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

The total is the sum of the age stratifications.

Continuous enrollment

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

Allowable gap

None.

Anchor date

None.

Benefit

Medical and mental health.

Event/diagnosis

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

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

Multiple visits in a 31-day period

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

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

ED visits followed by inpatient admission

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

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

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

Required exclusions

Exclude members who meet either of the following criteria:

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

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

- Members who die any time during the measurement year.

Administrative Specification

Denominator The eligible population.

Numerators

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

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

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

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

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

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (6 years as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an ED visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

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

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

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

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

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

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

The total is the sum of the age stratifications.

Continuous enrollment

Date of discharge through 30 days after discharge.

Allowable gap

None.

Anchor date

None.

Benefits

Medical and mental health (inpatient and outpatient).

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. 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 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.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

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 (the admission date must occur during the 30-day follow-up period).
4. Identify the discharge date for the stay.

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

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Required exclusions

Exclude members who meet either of the following criteria:

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

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** POS code 52).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Transitional Care Management Services Value Set) ***with*** POS code 53.
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set) ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.

- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of* mental health provider. *Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

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

Table FUH-A-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

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

Table FUH-B-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Race

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

Table FUH-C-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness: Stratifications by Ethnicity

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

Rules for Allowable Adjustments of Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes	The hospice and deceased member exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments*.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

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].

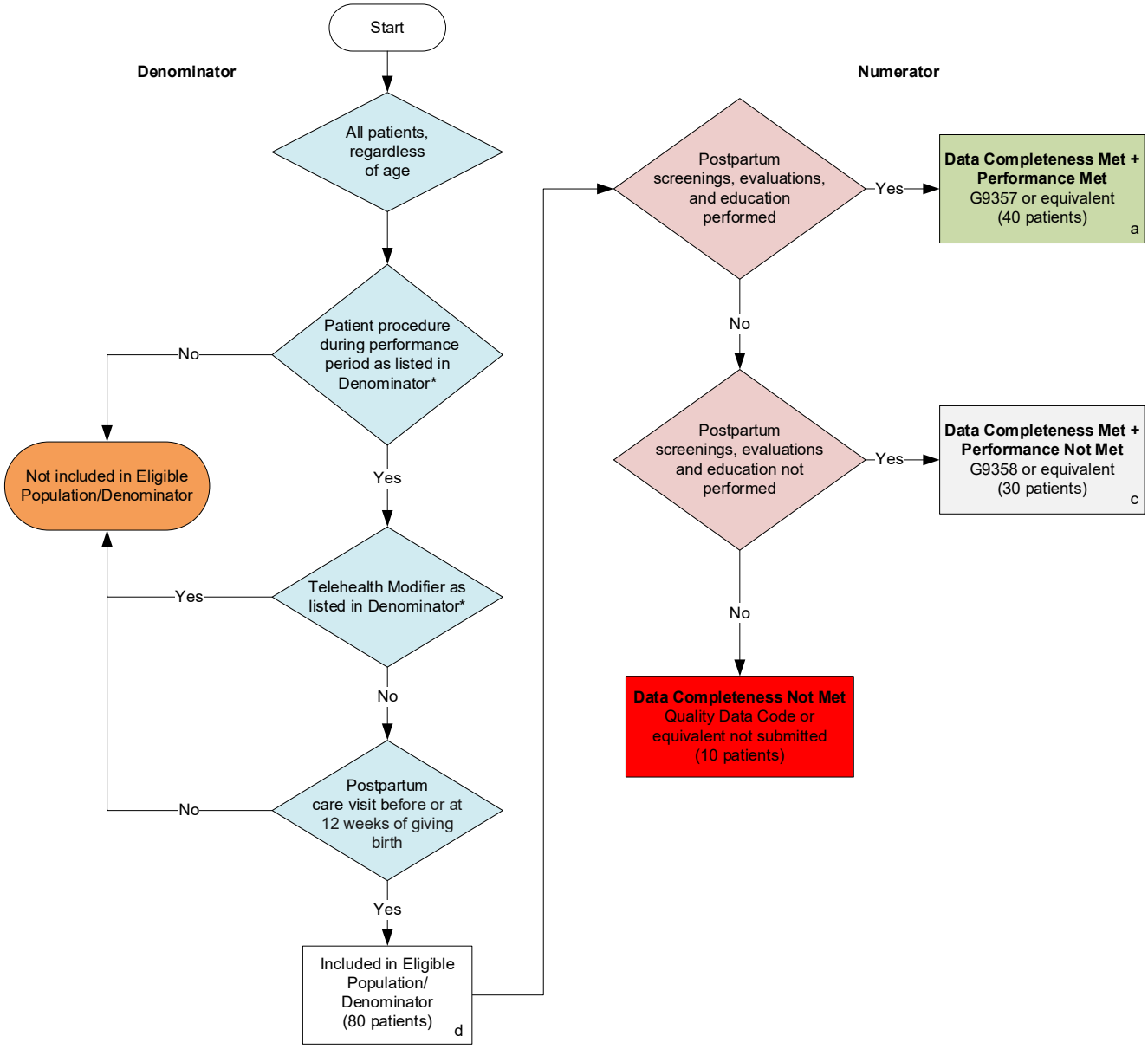
References

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.

Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinician & Group Survey 3.0

Population Version: Adult
Language: English

Read about the Patient-Centered Medical Home Item Set.

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Questions		Placement and Other Instructions
PCMH1.	Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays? 1☐ Yes 2☐ No	After core question 8
PCMH2.	Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you see a specialist for a particular health problem? 1☐ Yes 2☐ No → **If No, go to PCMH4**	After core question 18
PCMH3.	In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After PCMH2 Note: Use with PCMH2
PCMH4.	Please answer these questions about the provider named in Question 1 of this survey. In the last 6 months, did someone from this provider's office talk with you about specific goals for your health? 1☐ Yes 2☐ No	After PCMH3
PCMH5.	In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health? 1☐ Yes 2☐ No	After PCMH4
PCMH6.	In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress? 1☐ Yes 2☐ No	After PCMH5

Supplemental Patient-Centered Medical Home Items for the CAHPS® Clinician & Group Survey 3.0

Population Version: Child
Language: English

Read about the Patient-Centered Medical Home Item Set.

Users of the CAHPS® Clinician & Group Survey are free to incorporate supplemental items in order to meet the needs of their organizations, local markets, and/or audiences. Some items cover events that occur with low frequency in the general population. You should include them only if your sample design is likely to yield a sufficient number of responses to those questions for statistical analysis and reporting.

Questions	Placement and Other Instructions
PCMH1. Did this provider's office give you information about what to do if your child needed care during evenings, weekends, or holidays? 1☐ Yes 2☐ No	After core question 15
PCMH2. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did your child see a specialist for a particular health problem? 1☐ Yes 2☐ No → **If No, go to PCMH4**	After core question 25
PCMH3. In the last 6 months, how often did the provider named in Question 1 seem informed and up-to-date about the care your child got from specialists? 1☐ Never 2☐ Sometimes 3☐ Usually 4☐ Always	After PCMH2 Note: Use with PCMH2
PCMH4. Please answer these questions about the provider named in Question 1 of this survey. In the last 6 months, did you and someone from this provider's office talk about the kinds of behaviors that are normal for your child at this age? 1☐ Yes 2☐ No	After PCMH3
PCMH5. In the last 6 months, did you and someone from this provider's office talk about how your child's body is growing? 1☐ Yes 2☐ No	After PCMH4
PCMH6. In the last 6 months, did you and someone from this provider's office talk about your child's moods and emotions? 1☐ Yes 2☐ No	After PCMH5

Questions	Placement and Other Instructions
PCMH7. In the last 6 months, did you and someone from this provider's office talk about things you can do to keep your child from getting injured? 1☐ Yes 2☐ No	After PCMH6
PCMH8. In the last 6 months, did you and someone from this provider's office talk about how much or what kind of food your child eats? 1☐ Yes 2☐ No	After PCMH7
PCMH9. In the last 6 months, did you and someone from this provider's office talk about how much or what kind of exercise your child gets? 1☐ Yes 2☐ No	After PCMH8
PCMH10. In the last 6 months, did you and someone from this provider's office talk about how your child gets along with others? 1☐ Yes 2☐ No	After PCMH9

Plan All-Cause Readmissions (PCR)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

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

Definitions

IHS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the numerator.
Plan population	Members in the eligible population prior to exclusion of outliers (denominator steps 1–5). The plan population is only used as a denominator for the Outlier Rate. Members must be 18 and older as of the earliest Index Discharge Date. The plan population is based on members, not discharges. Count members only once in the plan population. Assign members to the product/product line in which they are enrolled at the start of the continuous enrollment period of their earliest IHS. If the member has a gap at the beginning of this continuous enrollment period, assign the member to the product/product line in which they were enrolled as of their first enrollment segment during this continuous enrollment period.

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

Eligible Population

Product line	Commercial, Medicare, Medicaid (report each product line separately). ***Note:*** *Per General Guideline* Members With Dual Enrollment, *members with dual commercial and Medicaid enrollment may only be reported in the commercial product line. Members with dual Medicaid/Medicare enrollment "dual eligible" and with Medicare-Medicaid (MMP) enrollment may only be reported in the Medicare product line.*
Stratification	For only Medicare IHS, report the following SES stratifications and total: • Non-LIS/DE, Nondisability. • LIS/DE. • Disability. • LIS/DE and Disability. • Other. • Unknown. • Total Medicare. ***Note:*** *Stratifications are mutually exclusive, and the sum of all six stratifications is the Total population.*
Ages	*For commercial,* 18–64 years as of the Index Discharge Date. *For Medicare,* 18 years and older as of the Index Discharge Date. *For Medicaid,* 18–64 years as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.

Event/diagnosis An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year.

The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year.

Follow the steps below to identify acute inpatient and observation stays.

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

Administrative Specification

Denominator The eligible population.

Step 1 Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges:

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

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be considered distinct stays.

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

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3 Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 Exclude hospital stays for the following reasons:

- The member died during the stay.
- Members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.

- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Tables PCR-A-1/2 and PCR-A-3.

Note: *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.*

Step 7 Assign each remaining acute inpatient or observation stay to an age and stratification category using the reporting instructions below.

Risk Adjustment Determination

For each IHS among nonoutlier members, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation Stay Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.

Surgeries Determine if the member underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.

Discharge Condition Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC-Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge.

Exclude diagnoses that cannot be mapped to Table CC-Mapping.

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

Risk Adjustment Weighting

For each IHS among nonoutliers, use the following steps to identify risk adjustment weights based on observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65+, commercial, Medicaid). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

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

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

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

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

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

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

Step 6 Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, principal discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS:

$$\text{Estimated Readmission Risk} = \frac{e^{(\sum \text{WeightsForIHS})}}{1+e^{(\sum \text{WeightsForIHS})}}$$

OR

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

Note: *"Exp" refers to the exponential or antilog function.*

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

Step 7 Calculate the Count of Expected Readmissions for each age and stratification category. The Count of Expected Readmissions is the sum of the Estimated Readmission Risk calculated in step 6 for each IHS in each age and stratification category.

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

Step 8 Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS.

Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk)

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

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

Note: *Organizations must sum the variances for each stratification and age when populating the Variance cells in the reporting tables. When reporting, round the variance to 4 decimal places using the .5 rule.*

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

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

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the *Guidelines for Risk Adjusted Utilization Measures.*

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

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

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

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

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

Reporting: Number of Members in Plan Population

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

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

Reporting: Number of Outliers

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

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

Calculated: Outlier Rate

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

Reporting: Denominator

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

Reporting: SES Stratification (Medicare only)

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

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

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

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

Step 1 For Medicare nonoutlier members 65 years of age and older, determine if the IHS was discharged or transferred to skilled nursing care (Skilled Nursing Stay Value Set).

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

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

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

Reporting: Numerator

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and report these values as the ObservedCount.

Calculated: Observed Readmission Rate

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

Reporting: Count of Expected 30-Day Readmissions

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

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

Calculated: Expected Readmission Rate

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

Reporting: Variance

Step 1 Calculate the total (sum) variance for each SES stratification (Medicare only), skilled nursing stratification (Medicare only) and age group.

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

Calculated: O/E Ratio

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

Note

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

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

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

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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

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

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

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 50 months as of June 30"). ***Note:*** *The denominator age may not be expanded.*
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
Plan population	Yes	Organizations are not required to used plan population to identify outlier rates.
CLINICAL COMPONENTS		
Stratifications	**Adjustments Allowed (Yes/No)**	**Notes**
• SES Stratification • Skilled Nursing Care Stratification	No, if applied	Stratifications are not required, but if they are used, the value sets, logic and product lines may not be changed.
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed. ***Note:*** *Organizations may include denied claims to calculate the denominator.*

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

Prenatal and Postpartum Care (PPC)

SUMMARY OF CHANGES TO HEDIS MY 2024

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

Description

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

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

Definitions

First trimester 280–176 days prior to delivery (or estimated delivery date [EDD]).

Eligible Population

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

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

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

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

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

Age None specified.

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

Allowable gap None.

Anchor date Date of delivery.

Benefit Medical.

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

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

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

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

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

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

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

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

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

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

Administrative Specification

Denominator The eligible population.

Numerator

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

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

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

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

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

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

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

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- A prenatal visit (Prenatal Visits Value Set) ***with*** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

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

- A postpartum visit (Postpartum Care Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- An encounter for postpartum care (Encounter for Postpartum Care Value Set). Do not include laboratory claims (claims with POS code 81).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

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

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

Hybrid Specification

Denominator

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

Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate for the lower of the two indicators.

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

Numerator

Timeliness of Prenatal Care

A prenatal visit during the required time frame. Refer to *Administrative Specification* to identify the required time frame for each member based on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.

Administrative

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

Medical record

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

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

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

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

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

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

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
  - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.
- Notation of postpartum care, including, but not limited to:
  - Notation of "postpartum care," "PP care," "PP check," "6-week check."
  - A preprinted "Postpartum Care" form in which information was documented during the visit.
- Perineal or cesarean incision/wound check.
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders.
- Glucose screening for members with gestational diabetes.
- Documentation of any of the following topics:
  - Infant care or breastfeeding.
  - Resumption of intercourse, birth spacing or family planning.
  - Sleep/fatigue.
  - Resumption of physical activity.
  - Attainment of healthy weight.

Note

- *Criteria for identifying prenatal care for members who were not enrolled during the first trimester allow more flexibility than criteria for members who were enrolled.*
  - *For members who were enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.*
  - *For members who were not enrolled at least 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.*
- *Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for this measure.*
- *For each member, the organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently. If the organization elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7*

of the measurement year, the member is removed as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.

- *The organization may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.*
- *A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.*
- *The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*
- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioner.
- *For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.*

Data Elements for Reporting

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

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

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

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

Metric
TimelinessPrenatalCare
PostpartumCare

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

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

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

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

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

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

Rules for Allowable Adjustments of HEDIS

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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.

Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

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

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

NOTE: *Patient encounters for this measure conducted via telehealth (including but not limited to encounters coded with GQ, GT, 95, POS 02, POS 10) are allowable.*

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 aged 12 years and older at the beginning of the performance period with at least one qualifying encounter during the performance period

Definition:
Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusions) – Patients who have been diagnosed with bipolar disorder

- The following codes would be sufficient to define the Denominator Exclusion of bipolar disorder: F30.2, F30.3, F30.4, F30.8, F30.9, F30.10, F30.11, F30.12, F30.13, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9
- For historical reference purposes these ICD-9 codes if documented would be sufficient to define the Denominator Exclusion of bipolar disorder: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82, 296.89

DENOMINATOR NOTE: *The intent of the measure is to screen for depression in patients who have never had a diagnosis of bipolar disorder prior to the eligible encounter used to evaluate the numerator. Patients who have been diagnosed with bipolar disorder will be excluded from the measure.*

**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 12 years at the beginning of the performance period
AND
Patient encounter during the performance period (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92622, 92625, 96105, 96110*, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97802, 97803, 98966, 98967, 98968, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99401*, 99402*, 99403*, 99424, 99441, 99442, 99443, 99483, 99484, 99491, 99492, 99493, 99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0270, G0271, G0402, G0438, G0439, G0444
AND NOT
DENOMINATOR EXCLUSION:
Documentation stating the patient has had a diagnosis of bipolar disorder: G9717

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

Definitions:
Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized.

Examples of standardized depression screening tools include but are not limited to:

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

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

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Examples of a follow-up plan include but are not limited to:

- Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
- Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options

Patients with a Documented Reason for not Screening for Depression (Denominator Exceptions) –

Patient Reason(s):

Patient refuses to participate in or complete the depression screening

OR

Medical Reason(s):

Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 calendar days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan must be documented on the date of or up to two calendar days after the date of the encounter, such as referral to a provider for additional evaluation, pharmacological interventions, or other interventions for the treatment of depression. An example to illustrate the follow-up plan documentation timing: if the encounter is on a Monday from 3-4 pm (day 0) and the patient screens positive, the clinician has through anytime on Wednesday (day 2) to complete follow-up plan documentation.

This is a patient-based measure. Depression screening is required once per measurement period, not at all encounters. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter.

The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count towards a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a patient screening positively, the eligible clinician would need to provide one of the aforementioned follow-up actions, which does not include use of a standardized depression screening tool.

The follow-up plan MUST still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator. However, documentation of the follow-up plan can occur up to two calendar days after the qualifying encounter, in accordance with the policies of an eligible clinician or provider's practice or health system. All services should be documented during, or as soon as practicable, after the qualifying encounter in order to maintain an accurate medical record.

Should a patient screen positive for depression, a clinician should:

- Only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
- Opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. However, for the purposes of this measure, a suicide risk assessment or additional screening using a standardized tool, will not qualify as a follow-up plan.

Numerator Options:

Performance Met:	Screening for depression is documented as being positive AND a follow-up plan is documented **(G8431)**
OR	
Performance Met:	Screening for depression is documented as negative, a follow-up plan is not required **(G8510)**
OR	
Denominator Exception:	Screening for depression not completed, documented patient or medical reason **(G8433)**
OR	
Performance Not Met:	Depression screening not documented, reason not given **(G8432)**
OR	
Performance Not Met:	Screening for depression documented as positive, follow-up plan not documented, reason not given **(G8511)**

RATIONALE:

Depression affects more than two hundred sixty million people across the world and is a leading cause of disability, with a variety of depressive disorders that are independent risk factors for chronic diseases, such as cardiovascular disease and diabetes, lending screening for depression as paramount to identify depressive disorders that can affect the most vulnerable populations [1]. Results from a 2018 U.S. survey data indicated that 14.4 percent of adolescents (3.5 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.4 million adolescents) having one MDE with severe impairment [2]. The odds of a diagnosis of depression are believed to be 2.6 times greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed [3]. Children and teens with major depressive disorder (MDD) have been found to have difficulty carrying out their daily activities, relating to others, growing up healthy, and are at an increased risk of suicide [4].

The same 2018 study indicated that 7.2 percent of adults aged 18 or older (17.7 million adults) had at least one MDE with 4.7 percent of adults (11.5 million adults) having one MDE with severe impairment in the past year [2]. Moreover, it is estimated 22.9 percent of adult patients with chronic pain (2.2 million adults) were diagnosed with comorbid depression from 2011 to 2015, with an upward trend of prevalence among Black Americans, patients aged 65 to 84 years old, Medicare and Medicaid insured patients, and patients from zip code areas with low annual household incomes [5].

Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families [6]. It's estimated that the global prevalence of antenatal (or perinatal) depression ranges from 15 to 65 percent, with current or previous exposure to abuse and violence, lack of social support, and family history of mental disorders being risk factors. Depressive symptoms measured during pregnancy have been shown to influence the quality of the postpartum mother-infant relationship [7]. Additionally, the risk of low birth weight and preterm birth is higher among infants born from depressed mothers [8].

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. Multiple social costs of depression have been identified, such as reduced educational achievements, poor financial success and role performance, higher amount of days out of role, and increased risk of job loss [1]. Depression also imposes significant economic burden through direct and indirect costs, supporting the need for regular depression screening. "In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011" [9].

Numerous studies have found significant disparities in depression prevalence and treatment among racial/ethnic minorities. One study revealed that Indigenous adults are at a high risk for posttraumatic stress disorder, depression, suicide, substance use disorder, and concurrent behavioral health disorders secondary to these initial health problems [10]. Additionally, though rates of depression are lower among Blacks and Hispanics than among whites, depression among Blacks and Hispanics is likely to be more recurrent. Furthermore, 48 percent of whites receive mental health services, compared to just 31 percent of Blacks and Hispanics, and 22 percent of Asians [11]. Asian Americans and Black Americans are also significantly more likely to utilize emergency rooms for depression treatment, which contributes to inconsistent follow-up care [12].

While primary care providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 46 percent of depressed patients [13]. "In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36 percent to 44 percent of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated" [4]. Furthermore, evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

This measure seeks to align with USPSTF clinical guideline recommendations as well as the Healthy People 2030 recommendation to increase the proportion of adolescents and adults who are screened and receive treatment for depression and makes an important contribution to the quality domain of community and population health [14,15].

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CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" [1].

Adult Recommendation (18 years and older):

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" [2].

"The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions (B recommendation)" [3].

The American College of Obstetricians and Gynecologists (ACOG) provides the following recommendation: "All obstetrician–gynecologists and other obstetric care providers should complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient" [4].

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

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."
2. "Clinicians should establish and maintain follow-up with patients."
3. "Clinicians should screen and monitor depression in pregnant and post-partum women" [5].

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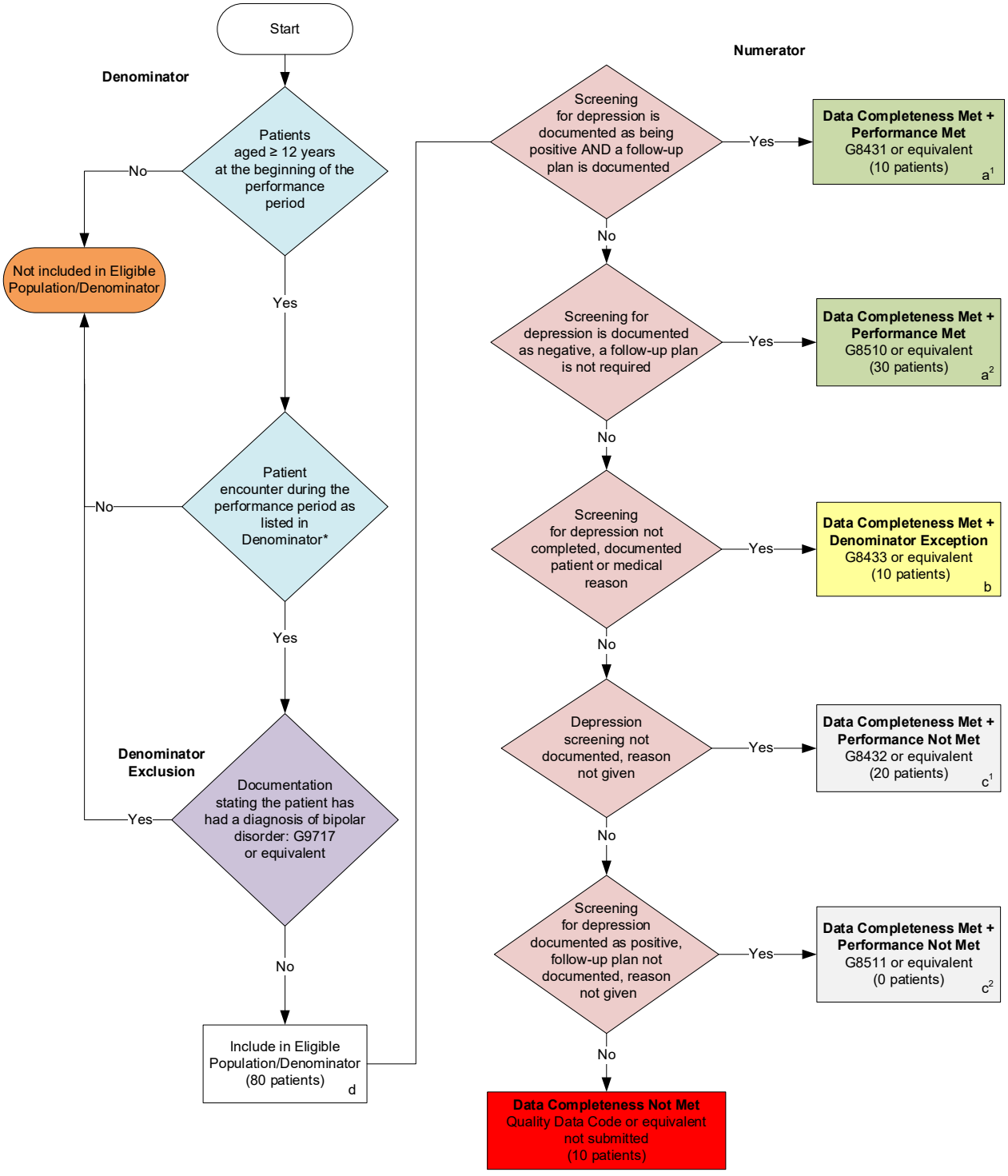
2024 Clinical Quality Measure Flow for Quality ID #134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

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



SAMPLE CALCULATIONS

Data Completeness Rate=

Performance Met (a^1+a^2=40 patients) + Denominator Exception (b=10 patients) + Performance Not Met (c^1+c^2=20 patients) = 70 patients = **87.50%**

Eligible Population / Denominator (d=80 patients) = 80 patients

Performance Rate=

Performance Met (a^1+a^2=40 patients) = 40 patients = **66.67%**

Data Completeness Numerator (70 patients) - Denominator Exception (b=10 patients) = 60 patients

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

NOTE: Submission Frequency: Patient-Intermediate

2024 Clinical Quality Measure Flow Narrative for Quality ID #134: Preventative Care and Screening: Screening for Depression and Follow-Up Plan

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

1. Start with Denominator
2. Check *Patients aged greater than or equal to 12 years at the beginning of the performance period*:
    a. If *Patients aged greater than or equal to 12 years at the beginning of the performance period* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 12 years at the beginning of the performance period* equals Yes, proceed to check *Patient encounter during the performance period as listed in Denominator**.
3. Check *Patient encounter during the performance period as listed in Denominator**:
    a. If *Patient encounter during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during the performance period as listed in Denominator** equals Yes, proceed to check *Documentation stating the patient has had a diagnosis of bipolar disorder*.
4. Check *Documentation stating the patient has had a diagnosis of bipolar disorder:*
    a. If *Documentation stating the patient has had a diagnosis of bipolar disorder* equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Documentation stating the patient has had a diagnosis of bipolar disorder* equals No, include in *Eligible Population/Denominator*.
5. 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.
6. Start Numerator
7. Check *Screening for depression is documented as being positive AND a follow-up plan is documented*:
    a. If *Screening for depression is documented as being positive AND a follow-up plan is documented* 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^1 equals 10 patients in the Sample Calculation.
    b. If *Screening for depression is documented as being positive AND a follow-up plan is documented* equals No, proceed to check *Screening for depression is documented as negative, a follow-up plan is not required.*
8. Check *Screening for depression is documented as negative, a follow-up plan is not required*:
    a. If *Screening for depression is documented as negative, a follow-up plan is not required* 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^2 equals 30 patients in the Sample Calculation.

b. If *Screening for depression is documented as negative, a follow-up plan is not required* equals No, proceed to check *Screening for depression not completed, documented patient or medical reason*.

9. Check *Screening for depression not completed, documented patient or medical reason*:

   a. If *Screening for depression not completed, documented patient or medical reason* equals Yes, include in *Data Completeness Met and Denominator Exception*.

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

   b. If *Screening for depression not completed, documented patient or medical reason* equals No, proceed to check *Depression screening not documented, reason not given*.

10. Check *Depression screening not documented, reason not given*:

    a. If *Depression screening not documented, reason not given* 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^1 equals 20 patients in the Sample Calculation.

    b. If *Depression screening not documented, reason not given* equals No, proceed to check *Screening for depression documented as positive, follow-up plan not documented, reason not given.*

11. Check *Screening for depression documented as positive, follow-up plan not documented, reason not given*:

    a. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals Yes, include in *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^2 equals 0 patients in the Sample Calculation.

    b. If *Screening for depression documented as positive, follow-up plan not documented, reason not given* equals No, proceed to check *Data Completeness Not Met*.

12. Check *Data Completeness Not Met*:

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

Sample Calculations:

Data Completeness Rate equals Performance Met (a^1 plus a^2 equals 40 patients) plus Denominator Exception (b equals 10 patients) plus Performance Not Met (c^1 plus c^2 equals 20 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^1 plus a^2 equals 40 patients) divided by Data Completeness Numerator (70 patients) minus Denominator Exception (b equals 10 patients). All equals 40 patients divided by 60 patients. All equals 66.67 percent.

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

NOTE: Submission Frequency: Patient-Intermediate

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.

Substance Use Assessment in Primary Care

Steward: Inland Empire Health Plan

NQF #: N/A

SUMMARY OF CHANGES FOR 2023

- Added ages 11-17 years to the measure.
- Removed HCPCS codes G0396 and G0397 from the list of qualifying numerator codes and added code H0001.
- Added an example list of qualifying screening tools.

Description

The percentage of members 11 years and older who were screened for substance use during the measurement year.

Definitions

Screening Tools	Examples of Substance Use Assessment in Primary Care screening tools include but are not limited to: • Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID) • Tobacco, Alcohol, Prescription medication, and other Substances (TAPS) • National Institute on Drug Abuse (NIDA) Quick Screen for adults ○ The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening • Drug Abuse Screening Test (DAST-10) • Alcohol Use Disorders Identification Test (AUDIT-C) • Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents • Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents • Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Stratification	None.

Ages	11 years and older during the measurement year. Report two age stratifications and total rate: • 11-17 years. • 18 years and older. • Total.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31st of the measurement year.
Lookback period	12 months prior.
Benefit	Medical.
Event/diagnosis	None.
Exclusions	None.

Specifications

Data Source	Claims.
Denominator	All Members aged 18 years and older during the measurement year. Member counted only once in the denominator.
Numerator	Members who were screened for substance use at least once during the measurement year.

Numerator Codes

Codes To Identify Substance Use Assessment in Primary Care			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g., Audit DAST) and Brief Intervention (SBI) Services 15 to 30 minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g., Audit DAST) and Brief Intervention (SBI) Services 15 to 30 minutes

Substance Use Assessment in Primary Care	HCPS	G0442	Annual Alcohol Misuse Screening 15 minutes
Substance Use Assessment in Primary Care	HCPS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPS	H0001	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPS	H0049	Alcohol and/or Drug Screening
Substance Use Assessment in Primary Care	HCPS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

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.

*Use of Opioids at High Dosage (HDO)**

***Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).**

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 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Note: *A lower rate indicates better performance.*

Definitions

Calculating number of days covered for the denominator

Use the following steps to identify and calculate covered days for the denominator.

Step 1 Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day *or* dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events.

Identify the start and end dates: The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days. For example:

- If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21.
- If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14.
- If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20, and a 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.

Step 2 For all other dispensing events (i.e., multiple prescriptions for the same medication on different days without overlap, and multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days.

Step 3 Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.

Identifying same or different drugs

To identify "same" or "different" drugs, use Table HDO-A, which identifies the medications lists for the measure. Dispensing events from any of the Fentanyl medication lists, even if they are on different rows, are all considered the "same" drug.

For all other types of opioids, the table includes a "Medication Lists" column that identifies the "same" high-risk medications by grouping them on the same row. For example, a dispensing event from the Codeine Sulfate 15 mg Medications List is considered the same drug as a dispensing event from the Codeine Sulfate 30 mg Medications List. Conversely, a dispensing event from the Codeine Sulfate 15 mg Medications List is considered a different drug than a dispensing event from the Acetaminophen Codeine 15 mg Medications List because they are in different table rows.

Treatment period

To identify the treatment period: For all dispensing events, identify the start and end dates for each dispensing event individually. The treatment period start date is the start date of the earliest dispensing event during the measurement year. The treatment period end date is the last end date during the measurement year.

MME

Morphine milligram equivalent. The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic (Table HDO-A).

Opioid dosage unit

For each dispensing event, use the following calculation to determine the opioid dosage unit.

# of Opioid Dosage Units per day = (opioid quantity dispensed) / (opioid days supply)

MME daily dose

For each dispensing event, use the following calculation to determine the MME daily dose. Convert each medication into the MME using the appropriate MME conversion factor and strength associated with the opioid product of the dispensing event (refer to Table HDO-A for MME conversion factor and strength).

MME Daily Dose = (# of opioid dosage units per day) X (strength (e.g., mg, mcg)) X (MME conversion factor [Table HDO-A]).

Example 1: 10 mg oxycodone tablets X (120 tablets / 30 days) X 1.5 = 60 MME/ day

Example 2: 25 mcg/hr fentanyl patch X (10 patches / 30 days) X 7.2 = 60 MME/ day

Total daily MME

The total sum of the MME daily doses for all opioid dispensing events on 1 day.

Average MME

The average MME for all opioids dispensed during the treatment period.

Eligible Population

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

Age 18 years and older as of January 1 of the measurement year.

Continuous enrollment The measurement year.

Allowable gap None.

Anchor date None.

Benefit Medical and pharmacy.

Event/diagnosis Use the steps below to determine the eligible population.

Step 1 Identify members who met both of the following criteria during the measurement year:

- Two or more opioid dispensing events on different dates of service. Use all the medication lists in Table HDO-A to identify opioid medication dispensing events.
- ≥15 total days covered by opioids.

Required exclusions Exclude members who met any of the following any time during the measurement year:

- Cancer (Malignant Neoplasms Value Set). Do not include laboratory claims (claims with POS code 81).
- Sickle cell disease (Sickle Cell Anemia and HB S Disease Value Set). Do not include laboratory claims (claims with POS code 81).
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set).
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5). 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.

Administrative Specification

Denominator The eligible population.

Numerator The number of members whose average MME was ≥90 during the treatment period. Follow the steps below to identify numerator compliance.

Step 1 Use all the medication lists in Table HDO-A to identify all opioid medication dispensing events during the measurement year.

Step 2 For each member, calculate the MME daily dose for each medication dispensing event.

Step 3 For a single dispensing event, multiply the MME daily dose by the dispensing event's days supply. For example, a dispensing event with a MME daily dose of 90 and a days supply of 5 would have a total MME of 450 for that dispensing event. As multiple dispensing events can overlap on one calendar day, for each day, sum the MME daily doses for all dispensing events to determine the total daily MME for that day.

Step 4 Determine the treatment period.

Step 5 Determine the average MME. Sum the total daily MME for the treatment period and divide by the number of days in the treatment period. Members whose average MME was ≥90 meet the numerator criteria.

Table HDO-A: Opioid Medications[1]

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Benzhydrocodone	Acetaminophen Benzhydrocodone 4.08 mg Medications List Acetaminophen Benzhydrocodone 6.12 mg Medications List Acetaminophen Benzhydrocodone 8.16 mg Medications List	4.08 mg 6.12 mg 8.16 mg	1.2
Butorphanol	Butorphanol 10 MGPML Medications List	10 mg	7
Codeine	Codeine Sulfate 15 mg Medications List Codeine Sulfate 30 mg Medications List Codeine Sulfate 60 mg Medications List	15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Codeine 2.4 MGPML Medications List Acetaminophen Codeine 15 mg Medications List Acetaminophen Codeine 30 mg Medications List Acetaminophen Codeine 60 mg Medications List	2.4 mg 15 mg 30 mg 60 mg	0.15
Codeine	Acetaminophen Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Butalbital Caffeine Codeine 30 mg Medications List	30 mg	0.15
Codeine	Aspirin Carisoprodol Codeine 16 mg Medications List	16 mg	0.15
Dihydrocodeine	Acetaminophen Caffeine Dihydrocodeine 16 mg Medications List	16 mg	0.25
Fentanyl buccal or sublingual tablet, transmucosal lozenge (mcg)[2]	Fentanyl 100 mcg Medications List Fentanyl 200 mcg Medications List Fentanyl 300 mcg Medications List Fentanyl 400 mcg Medications List Fentanyl 600 mcg Medications List Fentanyl 800 mcg Medications List Fentanyl 1200 mcg Medications List Fentanyl 1600 mcg Medications List	100 mcg 200 mcg 300 mcg 400 mcg 600 mcg 800 mcg 1200 mcg 1600 mcg	0.13

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Fentanyl oral spray (mcg)[3]	Fentanyl 100 MCGPS Oral Medications List Fentanyl 200 MCGPS Oral Medications List Fentanyl 400 MCGPS Oral Medications List Fentanyl 600 MCGPS Oral Medications List Fentanyl 800 MCGPS Oral Medications List	100 mcg 200 mcg 400 mcg 600 mcg 800 mcg	0.18
Fentanyl nasal spray (mcg)[4]	Fentanyl 100 MCGPS Nasal Medications List Fentanyl 300 MCGPS Nasal Medications List Fentanyl 400 MCGPS Nasal Medications List	100 mcg 300 mcg 400 mcg	0.16
Fentanyl transdermal film/ patch (mcg/hr)[5]	Fentanyl 12 MCGPH Medications List Fentanyl 25 MCGPH Medications List Fentanyl 37.5 MCGPH Medications List Fentanyl 50 MCGPH Medications List Fentanyl 62.5 MCGPH Medications List Fentanyl 75 MCGPH Medications List Fentanyl 87.5 MCGPH Medications List Fentanyl 100 MCGPH Medications List	12 mcg 25 mcg 37.5 mcg 50 mcg 62.5 mcg 75 mcg 87.5 mcg 100 mcg	7.2
Hydrocodone	Hydrocodone 10 mg Medications List Hydrocodone 15 mg Medications List Hydrocodone 20 mg Medications List Hydrocodone 30 mg Medications List Hydrocodone 40 mg Medications List Hydrocodone 50 mg Medications List Hydrocodone 60 mg Medications List Hydrocodone 80 mg Medications List Hydrocodone 100 mg Medications List Hydrocodone 120 mg Medications List	10 mg 15 mg 20 mg 30 mg 40 mg 50 mg 60 mg 80 mg 100 mg 120 mg	1
Hydrocodone	Acetaminophen Hydrocodone .5 MGPML Medications List Acetaminophen Hydrocodone .67 MGPML Medications List Acetaminophen Hydrocodone 2.5 mg Medications List Acetaminophen Hydrocodone 5 mg Medications List Acetaminophen Hydrocodone 7.5 mg Medications List Acetaminophen Hydrocodone 10 mg Medications List	.5 mg .67 mg 2.5 mg 5 mg 7.5 mg 10 mg	1
Hydrocodone	Hydrocodone Ibuprofen 2.5 mg Medications List Hydrocodone Ibuprofen 5 mg Medications List Hydrocodone Ibuprofen 7.5 mg Medications List Hydrocodone Ibuprofen 10 mg Medications List	2.5 mg 5 mg 7.5 mg 10 mg	1
Hydromorphone	Hydromorphone 1 MGPML Medications List Hydromorphone 2 mg Medications List	1 mg 2 mg	4

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Hydromorphone 3 mg Medications List	3 mg	
	Hydromorphone 4 mg Medications List	4 mg	
	Hydromorphone 8 mg Medications List	8 mg	
	Hydromorphone 12 mg Medications List	12 mg	
	Hydromorphone 16 mg Medications List	16 mg	
	Hydromorphone 32 mg Medications List	32 mg	
Levorphanol	Levorphanol 2 mg Medications List	2 mg	11
	Levorphanol 3 mg Medications List	3 mg	
Meperidine	Meperidine 10 MGPML Medications List	10 mg	0.1
	Meperidine 50 mg Medications List	50 mg	
	Meperidine 100 mg Medications List	100 mg	
Methadone[6]	Methadone 1 MGPML Medications List	1 mg	3
	Methadone 2 MGPML Medications List	2 mg	
	Methadone 5 mg Medications List	5 mg	
	Methadone 10 mg Medications List	10 mg	
	Methadone 10 MGPML Medications List	10 mg	
	Methadone 40 mg Medications List	40 mg	
Morphine	Morphine 2 MGPML Medications List	2 mg	1
	Morphine 4 MGPML Medications List	4 mg	
	Morphine 5 mg Medications List	5 mg	
	Morphine 10 mg Medications List	10 mg	
	Morphine 15 mg Medications List	15 mg	
	Morphine 20 MGPML Medications List	20 mg	
	Morphine 20 mg Medications List	20 mg	
	Morphine 30 mg Medications List	30 mg	
	Morphine 40 mg Medications List	40 mg	
	Morphine 45 mg Medications List	45 mg	
	Morphine 50 mg Medications List	50 mg	
	Morphine 60 mg Medications List	60 mg	
	Morphine 75 mg Medications List	75 mg	
	Morphine 80 mg Medications List	80 mg	
	Morphine 90 mg Medications List	90 mg	
	Morphine 100 mg Medications List	100 mg	
	Morphine 120 mg Medications List	120 mg	
	Morphine 200 mg Medications List	200 mg	
Morphine	Morphine Naltrexone 20 mg Medications List	20 mg	1
	Morphine Naltrexone 30 mg Medications List	30 mg	
	Morphine Naltrexone 50 mg Medications List	50 mg	
	Morphine Naltrexone 60 mg Medications List	60 mg	
	Morphine Naltrexone 80 mg Medications List	80 mg	
	Morphine Naltrexone 100 mg Medications List	100 mg	
Opium	Belladonna Opium 30 mg Medications List	30 mg	1
	Belladonna Opium 60 mg Medications List	60 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
Oxycodone	Oxycodone 1 MGPML Medications List	1 mg	1.5
	Oxycodone 5 mg Medications List	5 mg	
	Oxycodone 7.5 mg Medications List	7.5 mg	
	Oxycodone 9 mg Medications List	9 mg	
	Oxycodone 10 mg Medications List	10 mg	
	Oxycodone 13.5 mg Medications List	13.5 mg	
	Oxycodone 15 mg Medications List	15 mg	
	Oxycodone 18 mg Medications List	18 mg	
	Oxycodone 20 mg Medications List	20 mg	
	Oxycodone 20 MGPML Medications List	20 mg	
	Oxycodone 27 mg Medications List	27 mg	
	Oxycodone 30 mg Medications List	30 mg	
	Oxycodone 36 mg Medications List	36 mg	
	Oxycodone 40 mg Medications List	40 mg	
	Oxycodone 60 mg Medications List	60 mg	
	Oxycodone 80 mg Medications List	80 mg	
Oxycodone	Acetaminophen Oxycodone 1 MGPML Medications List	1 mg	1.5
	Acetaminophen Oxycodone 2 MGPML Medications List	2 mg	
	Acetaminophen Oxycodone 2.5 mg Medications List	2.5 mg	
	Acetaminophen Oxycodone 5 mg Medications List	5 mg	
	Acetaminophen Oxycodone 7.5 mg Medications List	7.5 mg	
	Acetaminophen Oxycodone 10 mg Medications List	10 mg	
Oxycodone	Aspirin Oxycodone 4.84 mg Medications List	4.84 mg	1.5
Oxycodone	Ibuprofen Oxycodone 5 mg Medications List	5 mg	1.5
Oxymorphone	Oxymorphone 5 mg Medications List	5 mg	3
	Oxymorphone 7.5 mg Medications List	7.5 mg	
	Oxymorphone 10 mg Medications List	10 mg	
	Oxymorphone 15 mg Medications List	15 mg	
	Oxymorphone 20 mg Medications List	20 mg	
	Oxymorphone 30 mg Medications List	30 mg	
	Oxymorphone 40 mg Medications List	40 mg	
Pentazocine	Naloxone Pentazocine 50 mg Medications List	50 mg	0.37
Tapentadol	Tapentadol 50 mg Medications List	50 mg	0.4
	Tapentadol 75 mg Medications List	75 mg	
	Tapentadol 100 mg Medications List	100 mg	
	Tapentadol 150 mg Medications List	150 mg	
	Tapentadol 200 mg Medications List	200 mg	
	Tapentadol 250 mg Medications List	250 mg	
Tramadol	Tramadol 5 MGPML Medications List	5 mg	0.1
	Tramadol 50 mg Medications List	50 mg	
	Tramadol 100 mg Medications List	100 mg	
	Tramadol 150 mg Medications List	150 mg	
	Tramadol 200 mg Medications List	200 mg	

Type of Opioid	Medication Lists	Strength	MME Conversion Factor
	Tramadol 300 mg Medications List	300 mg	
Tramadol	Acetaminophen Tramadol 37.5 mg Medications List	37.5 mg	0.1

[1] National Center for Injury Prevention and Control. CDC compilation of benzodiazepines, muscle relaxants, stimulants, zolpidem, and opioid analgesics with oral morphine milligram equivalent conversion factors, 2017 version. Atlanta, GA: Centers for Disease Control and Prevention; 2017. Available at https://www.cdc.gov/drugoverdose/resources/data.html.

[2] MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given tablet or lozenge/troche.

[3] MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and 38% greater bioavailability for oral sprays compared to lozenges/tablets.

[4] MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

[5] MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parenteral fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24-hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

[6] Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Washington State Interagency Guideline on Prescribing Opioids for Pain (http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf).

Note

- *Do not include denied claims when identifying the eligible population (except for required exclusions) or assessing the numerator for this measure.*
- *Do not include supplemental data when identifying the eligible population or assessing the numerator. Supplemental data can be used for only required exclusions for this measure.*
- *This measure does not include* the *following opioid medications:*
  - *Injectables.*
  - *Opioid cough and cold products.*
  - *Ionsys® (fentanyl transdermal patch).*
    - *This is for inpatient use only and is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).*
  - *Methadone for the treatment of opioid use disorder.*

Data Elements for Reporting

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

Table HDO-1/2/3: Data Elements for Use of Opioids at High Dosage

Metric	Data Element	Reporting Instructions
OpioidUseHighDosage	Benefit	Metadata
	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	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 Use of Opioids at High Dosage

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, allowable gap, anchor date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	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 medications that contain (or map to) codes in the medication lists may be used to identify opioid use. The medication lists and logic may not be changed. Organizations may include denied claims to calculate the denominator.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required exclusions	Yes, with limits	Apply required exclusions according to specified value sets. The hospice, deceased member and palliative care exclusions are not required. Refer to *Exclusions* in the *Guidelines for the Rules for Allowable Adjustments.*
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
Members Receiving High-Dosage Opioids	Yes, with limits	Medication lists and logic may not be changed. Organizations may include denied claims to calculate the numerator.

MEASURE OUD-AD: USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1).
- Four separate rates representing the following types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
  - Buprenorphine (Rate 2).
  - Oral naltrexone (Rate 3).
  - Long-acting, injectable naltrexone (Rate 4).
  - Methadone (Rate 5).
- Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip. Table OUD-B designates which medications are assigned to the separate rates. Filter on the "Numerator" column to identify which NDC codes are assigned to each rate.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

This measure includes the following coding systems: HCPCS, NDC, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ diagnosis	Beneficiaries who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip.
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For each beneficiary in the denominator population, follow the steps below to identify beneficiaries for the total numerator and the numerator for each rate.

Total

Identify beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.

Buprenorphine

Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 2 in the Numerator column in Table OUD-B.

Oral Naltrexone

Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 3 in the Numerator column in Table OUD-B.

Long-Acting, Injectable Naltrexone

Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 4 in the Numerator column in Table OUD-B.

Methadone

Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-adult-non-hedis-value-set-directory.zip. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of beneficiaries with evidence of at least one prescription (Numerator 1) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

E. ADDITIONAL NOTES

None.

Back Pain After Lumbar Discectomy/Laminectomy

CMIT Measure ID: 85 **| CMIT ID:** 00085-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 **| Revision:** 3 **| Program:** Merit-Based Incentive Payment System Program

View Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, back pain is rated by the patients as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) postoperatively for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Numerator

Numerator 1: All eligible patients whose back pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS or Numeric Pain scale at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose back pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) or Numeric pain scale at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/ laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 1): Patient had a lumbar fusion on the same date as the discectomy/ laminectomy procedure Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 2): Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis.

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures increased 15-fold, from 1.3 to 19.9 per 100,000 Medicare beneficiaries. Complications increased with increasing surgical invasiveness, from 2.3% among patients having decompression alone to 5.6% among those having complex fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50- 3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures.

Evidence

The measure result is the average change in back pain as rated on a 0 - 10 visual analog scale before and after lumbar discectomy/laminotomy by all eligible patients. Field testing was conducted with 11 practice groups, resulting in an overall average change in back pain of 3.0, with group level results ranging from 1.4 to 4.9. The distribution of results demonstrates significant variation in the magnitude of improvement in symptoms with surgery.

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

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CMS Meaningful Measures

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Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

CMIT Measure ID: 116 | **CMIT ID:** 00116-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 07/27/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery,[based on completing a preoperative and post-operative visual function survey]

Properties

Date of Information

07/27/2022

Abbreviated Measure Title

Not Available

Description

Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery,[based on completing a preoperative and post-operative visual function survey]

Numerator

Return to Top

Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function survey.

Denominator

All patients aged 18 years and older who had cataract surgery

Denominator Exclusions

Not available

Rationale

1) Scientific Basis for Measuring Visual Function Outcomes after Cataract Surgery. Visual function has been described as having multiple components, including central near, intermediate, and distance visual acuity; peripheral vision; visual search; binocular vision; depth perception; contrast sensitivity; perception of color; adaptation; and visual processing speed. Visual function also can be measured in terms of functional disability caused by visual impairment. Many activities are affected by more than one of these visual components. Health services researchers have increasingly emphasized function and quality of life as the outcomes of treatment that are most critical and applicable to the patient. As previously stated, the primary purpose in managing a patient with cataract is to improve functional vision and the quality of life. In well-designed observational studies, cataract surgery consistently has been shown to have a significant impact on vision- dependent function. The Cataract Patient Outcomes R

Evidence

Several studies have reported an association between improved visual function after cataract surgery and improved health-related quality of life. The purpose of this measure is to evaluate if visual function has improved following cataract surgery. The Cataract Patient Outcomes Research Team (PORT) reported that almost 90% of patients under-going first-eye cataract surgery noted improvement in functional status and satisfaction with vision. (Steinberg, E. P., Tielsch, J. M., Schein, O. D., Javitt, J. C., Sharkey, P., Cassard, S. D., Legro, M. W., Diener-West, M., Bass, E. B., & Damiano, A. M. (1994). National study of cataract surgery outcomes. Variation in 4-month postoperative outcomes as reflected in multiple outcome measures. Ophthalmology, 101(6), 1131–1141. https://doi.org/10.1016/s0161-6420(94)31210-3).

Denominator Exceptions

Patient care survey was not completed by patient

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

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Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

CMIT Measure ID: 117 **| CMIT ID:** 00117-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 05/10/2019 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Properties

Date of Information

05/10/2019

Abbreviated Measure Title

Not Available

Description

Percentage of patients aged 18 years and older who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Numerator

Return to Top

Patients 18 years and older who were satisfied with their care within 90 days following cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey.

Denominator

All patients aged 18 years and older who had cataract surgery

Denominator Exclusions

Not available

Rationale

1) Scientific Basis for Measuring Patient Satisfaction after Cataract Surgery Patient satisfaction is a valuable performance indicator for measuring the quality of care delivered by ophthalmologists providing cataract surgery. In the broadest sense, patient satisfaction is an assessment of the patient s experience with the care process delivered by health plans, clinicians, health systems, hospitals, etc. This experience can cover domains as diverse as information/education, interpersonal manner, emotional support, accessibility, convenience, outcomes or results, environment, personalization, involvement in care, finances, etc. In 1996, The American Academy of Ophthalmology launched the National Eyecare Outcomes Network (NEON) database. From January 1, 1996 through March 30, 2001, 249 ophthalmologists at 114 different practice sites submitted data to the NEON cataract surgery database. Post-operative patient satisfaction responses were collected for 6,154 patients, or about 34.5% of all patients who had pre-operative forms submitted. This assessment was performed at a median of 4.1 weeks postoperatively for all patients enrolled in the database. A 12-item questionnaire was used to assess patient satisfaction. Patient satisfaction was associated with younger age and absence of ocular comorbidity. Other studies of patient satisfaction after cataract surgery were conducted in Austria and in Spain. The Austrian study found that patients with pre-existing eye disease, including those patients with improved visual acuity after surgery, were the least satisfied with the results of surgery. In these cases, improved patient education prior to surgery could be helpful in improving patient satisfaction. The Spanish study found that patient satisfaction was associated with expectations prior to surgery. Most patients are satisfied with their care and results after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this satisfaction after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement. Use of this indicator in Medicare Part B Claims reporting method would require some modification to the current reporting of post-operative care for patients undergoing cataract surgery, since this indicator would be operative during the 90-day global period. However, there is a strong and practical precedent for such modifications in that reporting arrangements have previously been made to accommodate co-management of care by different providers during the post-operative period. A similar adjustment to allow for filing of a claim of meeting this goal at one point in the 90-day global period would be sufficient, potentially drawing upon the methods to demarcate the onset of co-management transfer of post-operative care. Various patient satisfaction instruments exist, but an instrument developed by the program, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility off services. AHRQ first launched the CAHPS program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. At that time, numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and

Evidence

Not Available

Denominator Exceptions

Patient care survey was not completed by patient

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

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Dermatitis - Improvement in Patient-Reported Itch Severity

CMIT Measure ID: 1663 **| CMIT ID:** 01663-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/27/2023 **| Revision:** 6 **| Program:** Merit-Based Incentive Payment System Program

View Description

The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Properties

Date of Information

03/27/2023

Abbreviated Measure Title

Not Available

Description

The percentage of patients, aged 18 years and older, with a diagnosis of dermatitis where at an initial (index) visit have a patient reported itch severity assessments performed, score greater than or equal to 4, and who achieve a score reduction of 2 or more points at a follow up visit.

Numerator

Patients who achieve an assessment score that is reduced by 2 or more points (minimal clinically important difference) from the initial (index) assessment score.

Denominator

All patients aged 18 years and older, with a diagnosis of dermatitis with an initial (index visit) Numeric Rating Scale (NRS), Visual Rating Scale (VRS), or ItchyQuant assessment score of greater than or equal to 4 who are returning for a follow-up visit.

Denominator Exclusions

None

Rationale

Various types of dermatitis are chronically pruritic and are tremendously burdensome. Atopic dermatitis (AD) is a chronic skin disease in which pruritus is responsible for much of the disease burden and morbidity borne by patients. It is estimated that in the U.S. alone, 31.6 million people have symptoms of AD, with 17.8 million meeting the criteria for AD. The effects of this disease are substantial; with direct costs estimated to be between $1 and $4 billion. Other types of dermatitis, such as contact dermatitis and seborrheic dermatitis (SD) are also chronic, pruritic conditions which greatly affect patients. Approximately 6 million people in the U.S. have SD with direct and indirect costs estimated to be $230 million. These various forms of dermatitis also greatly impact the quality-of-life patients have. In one study looking at the patient burden in adults with moderate to severe AD, 85% reported problems with the frequency of their itch and 41.5% reported itching for 18 hours or more a day. With this persistence of itching, 55% of patients showed AD-related sleep disturbance 5 days a week or more and 21.8% showed clinically relevant anxiety or depression. In another study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality-of-life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from CP patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus. Additionally, studies of CP have shown patients to have a 17% higher mortality risk as well as being strongly associated with poorer general health. Moreover, data from the National Ambulatory Medical Care Survey (1999-2009) found that a total of 77 million patient visits for itch were made during the 11-year time period. This was an average of 7 million visits per year, which represented approximately 1% of all outpatient visits. Also, further analysis showed that although the majority visits (58.6%) were for new instances of itch, almost a third (32%) were for chronic pruritus. This measure aims to improve pruritus in patients who carry a large burden with this disease; by assessing itch and aiming to make the symptom more manageable.

Evidence

Various types of dermatitis are chronically pruritic and are tremendously burdensome. Atopic dermatitis (AD) is a chronic skin disease in which pruritus is responsible for much of the disease burden and morbidity borne by patients. It is estimated that in the U.S. alone, 31.6 million people have symptoms of AD, with 17.8 million meeting the criteria for AD. The effects of this disease are substantial; with direct costs estimated to be between $1 and $4 billion. Other types of dermatitis, such as contact dermatitis and seborrheic dermatitis (SD) are also chronic, pruritic conditions which greatly affect patients. Approximately 6 million people in the U.S. have SD with direct and indirect costs estimated to be $230 million.

Denominator Exceptions

None

Numerator Exceptions

Not Available

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

Functional Status After Lumbar Surgery

CMIT Measure ID: 276 | **CMIT ID:** 00276-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2. la) at three months (6 to 20 weeks) postoperatively

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients age 18 and older who had lumbar discectomy/laminectomy procedure, functional status is rated by the patient as less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2. la) at three months (6 to 20 weeks) postoperatively

Numerator

Return to Top

Numerator 1: All eligible patients whose functional status is less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI version 2.1a) at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose functional status is less than or equal to 22 OR an improvement of 30 points or greater on the Oswestry Disability Index (ODI Version 2.1a) patient reported outcome tool at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients with lumbar fusion procedure Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR 1 EXCLUSIONS: Patient had a lumbar fusion on the same date as the discectomy/laminectomy procedure AND NOT Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis: - Patients with a diagnosis of lumbar spine region cancer at the time of the procedure - Patients with a diagnosis of acute lumbar spine region fracture at the time of the procedure - Patients with a diagnosis of lumbar spine region infection at the time of the procedure - Patients with a diagnosis of lumbar neuromuscular, idiopathic, or congenital scoliosis Denominator 2 Exclusions: Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis: - Patients with a diagnosis of lumbar spine region cancer at the time of the procedure - Patients with a diagnosis of acute lumbar spine region fracture at the time of the procedure - Patients with a diagnosis of lumbar spine region infection at the time of the procedure - Patients with a diagnosis of lumbar neuromuscular, idiopathic, or congenital scoliosis

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures increased 15-fold, from 1.3 to 19.9 per 100,000 Medicare beneficiaries. Complications increased with increasing surgical invasiveness, from 2.3% among patients having decompression alone to 5.6% among those having complex fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life-threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50- 3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

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Functional Status After Primary Total Knee Replacement

CMIT Measure ID: 279 | **CMIT ID:** 00279-07-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 09/20/2021 | **Revision:** 2 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) or a 71 or greater on the KOOS, JR tool at one year (9 to 15 months) postoperatively.

Properties

Date of Information

09/20/2021

Abbreviated Measure Title

Not Available

Description

For patients age 18 and older who had a primary total knee replacement procedure, functional status is rated by the patient as greater than or equal to 37 on the Oxford Knee Score (OKS) or a 71 or greater on the KOOS, JR tool at one year (9 to 15 months) postoperatively.

Numerator

All eligible patients whose functional status is greater than or equal to 37 on the Oxford Knee Score (OKS) or greater than or equal to 71 on

Return to Top

the KOOS, JR patient reported outcome tool at one year (9 to 15 months) postoperatively.

Denominator

Patients 18 years of age or older as of October 1 of the denominator identification period who had a total knee replacement procedure performed during the denominator identification period.

Denominator Exclusions

None

Rationale

Annually there are over 500,000 total knee replacement (TKR) procedures performed in the United States. It is projected that by 2030 the volume of this procedure will increase to over 3.48 million per year due to the aging baby-boomers, increased obesity and indications for TKR that extend to both younger as well as older patients (AAOS 2006 Kurtz). From 2000 to 2006, the Medicare TKR rate overall in the United States increased 58%, from 5.5 to 8.7 per 1000 and TKR revisions currently represent 8.2% of all Medicare dollars spent (Ong 2006). It is estimated that annual hospital charges for TKR will approach 40.8 billion dollars annually by 2015 (Kaiser-Permanente 2007). For the Minnesota Medicare population in 2006, 9,856 patients underwent a primary hip or knee replacement procedure (DRG 544) and 1,174 patients had a hip or knee revision (DRG 545). Nationally, for DRG 544 the average charge per hospitalization was $38,447 with an average payment of $11,916 (Value driven health care 2008 CMS). Target was derived from a study Patient acceptable symptom states after total hip or knee replacement at mid-term follow-up [Kuerentjes JC, Van Tol FR Bone Joint Res 2014; 3:7 13]. Receiver operating characteristic (ROC) curves identified a PASS threshold of 42 for the Oxford Hip Score (OHS) after Total Hip Replacement (THR) and 37 for the OKS after TKR. THR patients with an OHS greater than or equal to 42 and TKR patients with an OKS greater than or equal to 37 had a higher NRS for satisfaction and a greater likelihood of being willing to undergo surgery again. The Patient Acceptable Symptom State (PASS), the highest level of symptom beyond which patients consider themselves well. PASS was compared to post-op OKS to determine an equivalent OKS threshold. OKS score greater than or equal to 37 indicates the achievement of an acceptable symptom state and correlates with a higher numeric rating scale for satisfaction [ROC curves PASS threshold of 37 with sensitivity of 76.3% and specificity of 76.5%]

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

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User Guide

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Functional Status Change for Patients with Elbow, Wrist or Hand Impairments

CMIT Measure ID: 283 | **CMIT ID:** 00283-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 06/16/2023 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

06/16/2023

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with elbow, wrist, or hand impairments. The change in FS is assessed using the FOTO Elbow/Wrist/Hand FS PROM. The measure is adjusted to patient

Return to Top

characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Elbow/Wrist/Hand FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with elbow, wrist or hand impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Elbow/Wrist/Hand FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1874)

Evidence

Not Available

Denominator Exceptions

Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason) Documentation of medical reason(s) for not providing tobacco cessation intervention on the date of the encounter or within the previous 12 months if identified as a tobacco user (e.g., limited life expectancy, other medical reason)

Numerator Exceptions

Not applicable

Risk Adjusted

Yes

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

Functional Status Change for Patients with Hip Impairments

CMIT Measure ID: 285 | **CMIT ID:** 00285-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with hip impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Return to Top

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with hip impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1872)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

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How It Works

Privacy Policy

User Guide

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Functional Status Change for Patients with Knee Impairments

CMIT Measure ID: 286 | **CMIT ID:** 00286-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with knee impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Return to Top

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with knee impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care. Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available.

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1873)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record. Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery. Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown). Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

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Privacy Policy

User Guide

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Functional Status Change for Patients with Low Back Impairments

CMIT Measure ID: 287 | **CMIT ID:** 00287-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with low back impairments. The change in FS is assessed using the FOTO Low Back FS PROM. The measure is adjusted to patient characteristics known

Return to Top

to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Low Back FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with a low back impairment who have initiated a Treatment Episode

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Low Back FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-2632)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments

CMIT Measure ID: 288 | **CMIT ID:** 00288-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is

Return to Top

adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the LEPF PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with foot, ankle or lower leg impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the LEPF PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-1874)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

Functional Status Change for Patients with Neck Impairments

CMIT Measure ID: 289 | **CMIT ID:** 00289-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 5 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with neck impairments. The change in FS is assessed using the FOTO Neck FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk-adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Return to Top

Patients who were presented with the Neck FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients aged 14 years and older with neck impairments who initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care OR Patient unable to complete the Neck FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available.

Rationale

Neck impairments provide a common reason for patients seeking care in healthcare settings. During 2017, the FOTO database recorded 414,436 episodes of care across multiple healthcare systems and clinics throughout the United States. Prevalence estimates from epidemiologic studies on neck pain (defined as pain in the neck, with or without pain referred into one or both upper limbs, that lasts for at least 1 day) have a mean 1-year prevalence range of 23%1 to 37%2 and a mean lifetime prevalence of 49%.2 Consequently, neck pain is recognized as a global health care burden.3,4 Assessment of functional status using PROMs in patients with neck pain is an essential step in addressing this burden, provided the scores can be interpreted in clinically useful ways to inform patient-centered clinical decision making. The Neck FS PROM offers the advantages of modern scientific measurement methods like item response theory (IRT). IRT and related methods provide a number of measurement advantages including valid assumptions of interval scaling, superior scale coverage, uni-dimensionality for valid score change interpretations, and precise methods for evaluating components of the measures such as the functional questions and scales. IRT additionally forms the basis for computer adaptive testing (CAT) administration which reduces patient burden by minimizing the number of functional questions the patient must respond to in order to obtain a precise estimate of the patient s functional ability level. When combined with robust risk adjustment to provide for fair comparisons between providers, the Neck FS PROM forms the basis for a valuable patient reported outcome performance measure (PRO-PM). 1. Hoy DG, Protani M, De R, Buchbinder R. The epidemiology of neck pain. Best Pract Res Clin Rheumatol. 2010;24:783-792. https://doi. org/10.1016/j.berh.2011.01.019. 2. Fejer R, Kyvik KO, Hartvigsen J. The prevalence of neck pain in the world population: a systematic critical review of the literature. Eur Spine J. 2006;15:834-848. https://doi.org/10.1007/ s00586-004-0864-4 3. Hoy D, March L, Woolf A, et al. The global burden of neck pain: estimates from the Global Burden of Disease 2010 study. Ann Rheum Dis. 2014;73:1309-1315. https://doi.org/10.1136/ 4. Hurwitz EL, Randhawa K, Yu H, Cot P, Haldeman S. The Global Spine Care Initiative: a summary of the global burden of low back and neck pain studies. Eur Spine J. 2018;27:796-801. https:// doi.org/10.1007/s00586-017-5432-9

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record OR Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery OR Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) OR Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

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Functional Status Change for Patients with Shoulder Impairments

CMIT Measure ID: 290 | **CMIT ID:** 00290-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 4 | **Program:** Merit-Based Incentive Payment System Program

View Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with shoulder impairments. The change in FS is assessed using the FOTO Shoulder FS PROM. The measure is adjusted to patient characteristics known

Return to Top

to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.

Numerator

Patients who were presented with the Shoulder FS PROM at Initial Evaluation (Intake) and at or near Discharge (Status) for the purpose of calculating the patient's Residual Score.

Denominator

All patients 14 years and older with shoulder impairments who have initiated a Treatment Episode.

Denominator Exclusions

Documentation stating patient has a diagnosis of a degenerative neurological condition such as ALS, MS, or Parkinson s diagnosed at any time before or during the episode of care Patient unable to complete the Shoulder FS PROM at Initial Evaluation and/or Discharge due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available

Rationale

Functional deficits are common in the general population and are costly to the individual, their family, and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being, and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association (APTA). Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment. Change in functional status represents the Activities and Participation domain of the International Classification of Functioning, Disability and Health. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode. The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this measure. (NQMC-2633)

Evidence

Not Available

Denominator Exceptions

Ongoing care not clinically indicated because the patient needed a home program only, referral to another provider or facility, or consultation only, as documented in the medical record Ongoing care not medically possible because the patient was discharged early due to specific medical events, documented in the medical record, such as the patient became hospitalized or scheduled for surgery Ongoing care not possible because the patient self-discharged early (e.g., financial or insurance reasons, transportation problems, or reason unknown) Patient refused to participate

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

Hip and Knee Osteoarthritis
Informed, Patient-Centered Decision Measure
User Guide

I. Purpose:
To measure the extent to which patients are informed and receive treatments that match their goals and preferences.

II. Survey Versions:

- Decision Quality IPC Version: Treatments for Hip Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Decision Quality IPC Version: Treatments for Knee Osteoarthritis v2.0, ©2010 [updated 2012, 2016].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Cadera v.2.0 ©2012 [updated 2016] [Spanish version of Hip].
- Hoja de Trabajo Sobre La Calidad de Decision en Tratamientos de Osteoartritis de Rodilla v.2.0 ©2012 [updated 2016] [Spanish version of Knee].

III. Timing
The decision quality instrument (DQI) is designed to be administered after a decision has been made. For the IPC measure, the DQI survey is administered up to 6 months after surgery.

IV. Scoring:
The surveys contain 5 knowledge items and one preference item and are scored as follows.

1. Knowledge Score: For each fact, a correct response receives one point (see Table 1). Missing responses receive 0 points. A total score is calculated for all patients who complete at least half of the items. Total scores are scaled from 0-100%.

Table 1: Knowledge items and correct responses

Question	Correct response
#1. Which treatment is most likely to provide relief from hip/knee pain caused by osteoarthritis?	Surgery
# 2. After hip/knee replacement surgery, about how many months does it take most people to get back to doing their usual activities?	2 to 6 months
# 3. If 100 people have hip/knee replacement surgery, about how many will need to have the same hip/knee replaced again in less than 15[knee]/20 [hip] years?	Less than half
# 4. If 100 people have hip/knee replacement surgery, about how many will have less hip/knee pain after the surgery?	90 (hip); 80 (knee)
# 5. Serious complications can happen after hip/knee replacement surgery including life threatening blood clots, infections, heart attacks, and even	4

death. If 100 people have hip/knee replacement surgery, about how many will have a serious complication within 3 months after surgery?	

Note: "I don't know" ("no estoy seguro" in Spanish version) can be added as a response to knowledge items. An "I don't know response" receives 0 points (see feasibility section for considerations with including this response option).

2. Concordance: We use patients' preferred treatment, assessed with a single item, "Which treatment did you want to do to treat your knee [hip] osteoarthritis?" with possible responses (Non surgical treatments, surgery, I am not sure). For the IPC measure, only patients who mark a preference for surgery are considered to be "matched."

V. Informed, Patient Centered Hip and Knee Replacement Surgery (NQF Measure #2958): In 2016, NQF endorse a measure that is derived from patient responses to the Hip or Knee Decision Quality Instruments. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis within the past 6 months.

- **Numerator Statement:** The numerator is the number of respondents who have an adequate knowledge score (60% or greater) and a clear preference for surgery.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone primary knee or hip replacement surgery for treatment of knee or hip osteoarthritis.
- **Denominator Exclusions:** Respondents who are missing 3 or more knowledge items do not get a total knowledge score and are excluded. Similarly, respondents who do not indicate a preferred treatment are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.

Sampling: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a primary knee or hip replacement surgery are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents. A list of ICD and CPT codes to identify patients with hip and knee osteoarthritis who are undergoing a primary joint replacement are available from the measure developer (decisions@partners.org).

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

A sample size of about 150 would be needed to detect differences in proportions of 15% for the measure (e.g. from 25% to 40%) with 80% power. This size difference is what we have observed between sites that do and do not make an effort to do shared decision making.

Proxy respondents are not permitted. The patients who receive the procedure should answer the survey questions.

VI. Development Process:
This has been described in detail in Sepucha et al (2008), briefly to generate the survey we:

- Conducted a review of the clinical evidence & of focus groups and interviews with patients to generate a candidate set of facts and goals salient to the decision
- Surveyed a convenience sample of patients (n=88) and a multidisciplinary group of clinical experts (n=51) to rate the facts and goals for importance, completeness, and accuracy.
- Drafted the instrument and then conducted cognitive interviews with patients who had knee or hip osteoarthritis (n=10) to evaluate items for acceptability and comprehension
- Conducted field test to evaluate the instruments

Three field tests were used to evaluate psychometric properties:

- A cross-sectional study with 382 adults with knee or hip osteoarthritis in the U.S.
- A survey of 45 primary care providers and specialists in the U.S.
- A randomized controlled trial comparing use of knee and hip osteoarthritis decision aids to control with 127 patients in Canada

Additional studies have used the measure and examined relationship to other constructs.

VII. Psychometric Properties:
These data are taken from Sepucha et al (2011).
Feasibility: The survey was feasible and had very low missing data. Note: "I am not sure" was a response category for the knowledge items in the field test. We took it out of the worksheet versions as we felt that it was better to force respondents to guess; however, removing this response may increase missing items.
Acceptability: The survey was acceptable with high response rates when administered by mail and by phone, and took less than 5 minutes to complete.
Reliability:

- Knowledge score: Short term (~4 week) retest reliability ICC=0.80 (95% CI 0.69 to 0.87), n=91
- The short term (~4 week) retest reliability for the treatment preference is ICC > 0.72.

Note: We did not calculate the internal consistency of the knowledge score because the items do not draw from a single underlying construct.

Validity

- Discriminant validity (Sepucha et al 2011):
    - The total knowledge score discriminated between patients and providers, mean differences of 19%, 95% CI (13%, 25%), p<0.001 for knee and 15%, 95% CI (9%, 21%), p<0.001 for hip
    - The total knowledge scores also discriminated between patients who had seen a decision aid and those who had not, (67% (SD 21.2%) vs. 51% (SD 24.9%), p<0.0001.)
    - The treatment preference item was able to discriminate among patients with different goals. For example, patients who stated a preference for surgery, those who were unsure and those who stated a preference for non-surgical options (model predicted probability of surgery 0.74 vs. 0.59 vs. 0.40, respectively, p<0.001 for all comparisons).
- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field test. (Sepucha et al 2008)
- Predictive validity: Patients who made IPC decisions had higher better health outcomes (EQ-5D, KOOS and Harris Hip Scores) and less decision regret compared to those who did not have concordant care. (See Sepucha et al 2018).
- Construct validity: Patients who reported more shared decision making were more likely to have IPC decisions. (See Brodney et al 2019).

Reproducibility: The short knowledge score had high reproducibility when compared with the longer version, R=0.92 p <0.001

VIII. Appropriate Use

The DQIs are protected by copyright. They are available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from them
- Do not alter them except for customization for a specific condition and reformatting

Suggested Citations for the DQIs:

Sepucha KR. Knee [or Hip] Osteoarthritis Decision Quality Instrument v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016].

Sepucha KR. Decision Quality Worksheet: Treatments for Knee [or Hip] Osteoarthritis. v.2.0. ©Massachusetts General Hospital, 2010 [updated 2012, 2016]. Downloaded from: http://www.massgeneral.org/decisionsciences/research/DQ_Instrument_List.aspx.

Suggested Citation of the User Guide:

Sepucha KR. Hip and Knee Osteoarthritis Decision Quality Instrument User Guide. © 2019. Available from: https://www.mghdecisionsciences.org.

IX. Selected References

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X. Questions or comments? Please contact us at decisions@partners.org or visit our website at https://www.mghdecisionsciences.org

DECISION QUALITY WORKSHEET
TREATMENTS FOR HIP OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your hip osteoarthritis.

Please check the box ☑ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your hip osteoarthritis?

- ☐ Hip replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Hip Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about hip osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from hip pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have hip replacement surgery, about how many will need to have the same hip replaced again in less than 20 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have hip replacement surgery, about how many will have less hip pain after the surgery?

- ☐ 30
- ☐ 50
- ☐ 70
- ☐ 90

2.4. Serious complications happen after hip replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have hip replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After hip replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

The End.
Thank you.

DECISION QUALITY WORKSHEET
TREATMENTS FOR KNEE OSTEOARTHRITIS

Instructions

This survey has questions about what it was like for you to make decisions about treating your knee osteoarthritis.

Please check the box ☑ to answer each item.

Your answers will tell us two important things:

1. What matters most to you?
2. How well did we do our job of giving you information?

Thank you!

Section 1: What Matters Most to You

1.1. Which treatment did you want to have to treat your knee osteoarthritis?

- ☐ Knee replacement surgery
- ☐ Non-surgical treatment options
- ☐ I am not sure

Section 2: Facts About Knee Osteoarthritis

This set of questions asks about some facts doctors think are important for patients to know about knee osteoarthritis. The correct answer to each question is based on medical research. Please do your best to answer each question.

2.1. Which treatment is most likely to provide relief from knee pain caused by osteoarthritis?

- ☐ Surgery
- ☐ Non-surgical treatments
- ☐ Both are about the same

2.2. If 100 people have knee replacement surgery, about how many will need to have the same knee replaced again in less than 15 years?

- ☐ More than half
- ☐ About half
- ☐ Less than half

2.3. If 100 people have knee replacement surgery, about how many will have less knee pain after the surgery?

- ☐ 20
- ☐ 40
- ☐ 60
- ☐ 80

2.4. Serious complications happen after knee replacement surgery including life-threatening blood clots, infections, heart attacks, and even death.

If 100 people have knee replacement surgery, about how many will have a serious complication within 3 months after surgery?

- ☐ 4
- ☐ 10
- ☐ 14
- ☐ 20

2.5. After knee replacement surgery, about how many months does it take most people to get back to doing their usual activities?

- ☐ Less than 2 months
- ☐ 2 to 6 months
- ☐ 7 to 12 months
- ☐ More than 12 months

The End.
Thank you.

Leg Pain After Lumbar Discectomy/Laminectomy

CMIT Measure ID: 411 | **CMIT ID:** 00411-01-C-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 | **Revision:** 3 | **Program:** Merit-Based Incentive Payment System Program

View Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

For patients 18 years of age or older who had a lumbar discectomy/laminectomy or fusion procedure, leg pain is rated by the patient as less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) Pain scale or a numeric pain scale at three months (6 to 20 weeks) for discectomy/laminectomy or at one year (9 to 15 months) postoperatively for lumbar fusion patients. Rates are stratified by procedure type; lumbar discectomy/laminectomy or fusion procedure.

Return to Top

Numerator

Numerator 1: All eligible patients whose leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the VAS or Numeric Pain scale at three months (6 to 20 weeks) postoperatively Numerator 2: All eligible patients whose leg pain is less than or equal to 3.0 OR an improvement of 5.0 points or greater on the Visual Analog Scale (VAS) or Numeric Pain scale at one year (9 to 15 months) postoperatively.

Denominator

Denominator 1: Patients with lumbar discectomy/laminectomy procedure Patients 18 years of age or older as of January 1 of the denominator identification period who had a lumbar discectomy/laminectomy procedure performed during the denominator identification period Denominator 2: Patients with lumbar fusion procedure Patients 18 years of age or older as of October 1 of the denominator identification period who had a lumbar fusion procedure performed during the denominator identification period.

Denominator Exclusions

DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 1): Patient had a lumbar fusion on the same date as the discectomy/ laminectomy procedure Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis DENOMINATOR EXCLUSIONS (SUBMISSION CRITERIA 2): Patient had cancer, acute fracture or infection related to the lumbar spine OR patient had neuromuscular, idiopathic, or congenital lumbar scoliosis.

Rationale

Mechanical low back pain (LBP) remains the second most common symptom-related reason for seeing a physician in the United States. Of the US population, 85% will experience an episode of mechanical LBP at some point during their lifetime. Fortunately, the LBP resolves for the vast majority within 2-4 weeks. For individuals younger than 45 years, mechanical LBP represents the most common cause of disability and is generally associated with a work-related injury. For individuals older than 45 years, mechanical LBP is the third most common cause of disability, and a careful history and physical examination are vital to evaluation, treatment, and management (Hills et al 2022). Overall, spine surgery rates have declined slightly from 2002-2007, but the rate of complex fusion procedures increased 15-fold, from 1.3 to 19.9 per 100,000 Medicare beneficiaries. Complications increased with increasing surgical invasiveness, from 2.3% among patients having decompression alone to 5.6% among those having complex fusions. After adjustment for age, comorbidity, previous spine surgery, and other features, the odds ratio (OR) of life- threatening complications for complex fusion compared with decompression alone was 2.95 (95% confidence interval [CI], 2.50-3.49). A similar pattern was observed for rehospitalization within 30 days, which occurred for 7.8% of patients undergoing decompression and 13.0% having a complex fusion (adjusted OR, 1.94; 95% CI, 1.74-2.17). Adjusted mean hospital charges for complex fusion procedures were US $80,888 compared with US $23,724 for decompression alone (Deyo, R. JAMA 2010). The MNCM Spine Surgery Measure development workgroup developed patient reported outcome measures for two populations of patients undergoing different lumbar spine procedures, a more complex procedure (lumbar fusion) and a second procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. In 2018, the development workgroup reconvened and redesigned the measure construct to a target-based measure and additionally expanded the denominator for this measure to include all lumbar discectomy laminectomy procedures. Rationale for measure construct and calculation change: Target score based on 2016 study in the Spine Journal Fetke, TF et al "What level of pain are patients happy to live with after surgery for lumbar degenerative disorders?" This study compared the Core Outcomes Measures Index (COMI) and symptom well-being questions to two 0 to 10 graphic ratings scales for back and leg pain. Most spine interventions decrease pain but rarely do they totally eliminate it. Reporting of the percent of patients achieving a pain score equivalent to the ""acceptable symptom state"" may represent a more stringent target for denoting surgical success in the treatment of painful spinal disorders. For disc herniation, this is less than or equal to 2, and for other degenerative pathologies it is less than or equal to 3. The OR benchmark of change (5.0) derived from MNCM data (3 years); the average change in points of patients that did achieve the target of less than or equal to 3.0. Rationale for the expansion of the denominator and addition of exclusions: During the original development of this measure, the intent was to have a homogeneous population procedure that represented the most common procedure CPT code 63030 for the most common diagnosis of disc herniation. This strategy did not translate well from ICD-9 to ICD-10 diagnosis codes and the volume of eligible denominator patients dropped significantly. In 2018, the MNCM development workgroup reconvened for measure construct redesign and adopted a broader denominator population; all applicable discectomy laminectomy procedure codes and not limited by a type of diagnosis (includes all). With this decision, the workgroup decided to adopt the same exclusions for the spine fusion population and added exclusions for spine related cancer, acute fracture or infection, neuromuscular, idiopathic or congenital scoliosis.

Evidence

The measure result is the average change in leg pain as rated on a 0 - 10 visual analog scale before and after lumbar discectomy/laminotomy by all eligible patients. Field testing was conducted with 11 practice groups, resulting in an overall average change in leg pain of 4.3, with group level results ranging from 2.2 to 5.8. The distribution of results demonstrates significant variation in the magnitude of improvement in symptoms with surgery.

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

2024 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Patient-Reported Outcome-Based Performance Measure – High Priority

DESCRIPTION:
The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM Patient Reported Outcome Measure (PROM) a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice.

INSTRUCTIONS:
This measure is to be submitted **once per performance period**. For each MIPS eligible clinician, group, subgroup*, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. All valid survey results (as defined in the specification) should be included in the aggregate score. For MIPS eligible groups, subgroups*, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians' part of the group, subgroups*, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup*, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.

NOTE: *Data for the measure are collected using the PCPCM PRO instrument. The target population is all active patients attributed to the clinician or practice. Every active patient receives an invitation to complete the PCPCM PROM during their birth month. A patient is defined as active if the patient has had a documented interaction with the practice within 12 months of their birth month during the measurement period.*

**Subgroups are only available through MVP reporting. All measure-specific criteria must be met by the subgroup.*

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:
Total number of completed PCPCM PRO instruments received in the reporting period

Definitions*:*
A completed PCPCM PRO instrument – A PCPCM PRO instrument for which the patient has responded to at least 8 of 11 items.
Active patient – The patient has had a documented interaction with the practice within 12 months of their birth month during the measurement period.

DENOMINATOR NOTE: *The target population is all active patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month. The target population is defined the same, regardless of unit of analysis (clinician, practice, or system).*

The PCPCM PRO is the same for all patients, regardless of age. Because the PCPCM PRO applies to all patients and is not particular to a clinical encounter, it is administered once a year to each patient during their birth month. All surveys received during the measurement period should be counted.

For each MIPS eligible clinician, group, subgroup, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. For MIPS eligible groups, subgroups*, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians' part of the group, subgroups*, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup*, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.*

**Subgroups are only available through MVP reporting. All measure-specific criteria must be met by the subgroup.*

Table 1- PCPCM PRO instrument questions

How would you assess your primary care experience?	Definitely = 4	Mostly = 3	Somewhat = 2	Not at all = 1
My practice makes it easy for me to get care.	Definitely	Mostly	Somewhat	Not at all
My practice is able to provide most of my care.	Definitely	Mostly	Somewhat	Not at all
In caring for me, my doctor considers all factors that affect my health.	Definitely	Mostly	Somewhat	Not at all
My practice coordinates the care I get from multiple places.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice knows me as a person.	Definitely	Mostly	Somewhat	Not at all
My doctor and I have been through a lot together.	Definitely	Mostly	Somewhat	Not at all
My doctor or practice stands up for me.	Definitely	Mostly	Somewhat	Not at all
The care I get takes into account knowledge of my family.	Definitely	Mostly	Somewhat	Not at all
The care I get in this practice is informed by knowledge of my community.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to stay healthy.	Definitely	Mostly	Somewhat	Not at all
Over time, my practice helps me to meet my goals.	Definitely	Mostly	Somewhat	Not at all

Denominator Criteria (Eligible Cases):
All patients with a completed PCPCM PRO instrument during the reporting period

NUMERATOR:
The calculated PCPCM PRO-PM performance score

NUMERATOR NOTE: *Scoring for the PCPCM PRO-PM is completed through a simple 4 step process using the PCPCM PRO to assess the broad scope of primary care from a patient's perspective.*

- ***Step One: Exclude incomplete patient responses.*** *Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.*
- ***Step Two: Calculate PCPCM PRO item specific mean scores.*** *Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.*

  Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis

  An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.
- ***Step Three: Calculate the PCPCM PRO total score.*** *The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.*
- ***Step Four: Converting PCPCM PRO total scores and to PCPCM PRO-PM performance score.*** *In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.*

RATIONALE:

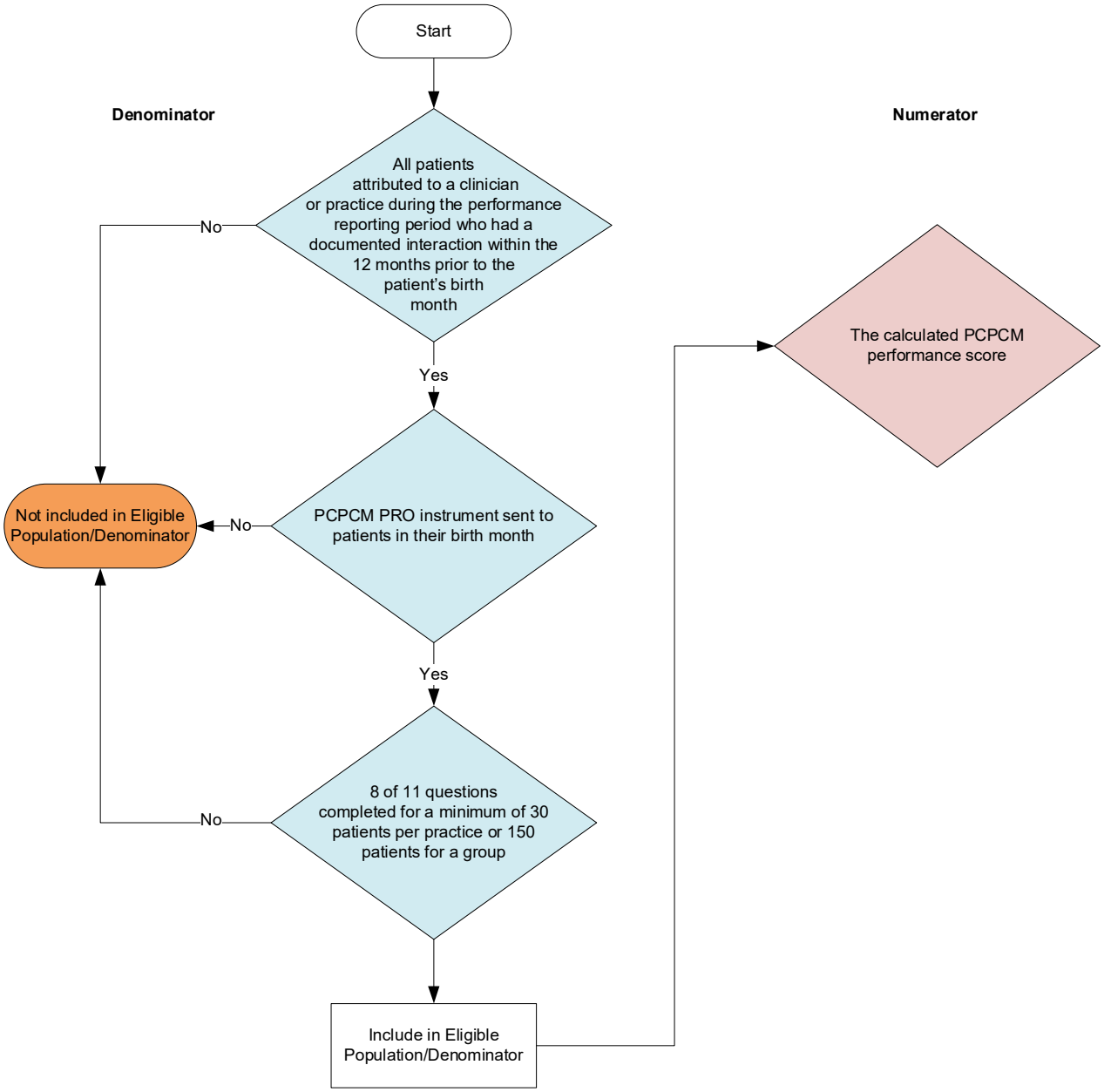
The Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) uses the PCPCM PROM - a comprehensive and parsimonious set of 11 patient-reported items - to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature. It is not a consumer satisfaction survey – it is a patient assessment of whether the functions of primary care are being met by their clinician, or practice, and to what extent.

CLINICAL RECOMMENDATION STATEMENTS:

The IOM Report on Primary Care calls for care to be personalized at the patient level, with care integrated for whole people to overcome the many problems of fragmented and depersonalized care. The PCPCM-PM complements more narrow disease-specific quality measures, and can be used to integrate care for whole people. (Institute of Medicine. Donaldson MS, Yordy KD, Lohr KN, and Vanselow NA, editors. Committee on the Future of Primary Care, Division of Health Care Services. National Academy Press. Washington, D.C. 1996.)

2024 Clinical Quality Measure Flow for Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

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



PCPCM PRO-PM Sample Calculation

Step 1: Exclude incomplete patient responses

Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations

Step 2: Calculate PCPCM PRO item specific mean scores*

How would you assess your primary care experience?	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	PCPCM PRO Instruments Mean Score
Item 1: My practice makes it easy for me to get care.	3	2	1	2	3	2	**2.17**
Item 2: My practice is able to provide most of my care.	4	2	1	N/A	4	2	**2.60**
Item 3: In caring for me, my doctor considers all factors that affect my health.	3	4	2	4	3	4	**3.33**
Item 4: My practice coordinates the care I get from multiple places.	4	4	4	4	4	4	**4.00**
Item 5: My doctor or practice knows me as a person.	1	1	1	3	1	1	**1.33**
Item 6: My doctor and I have been through a lot together.	3	1	1	1	3	1	**1.67**
Item 7: My doctor or practice stands up for me.	2	2	1	1	2	2	**1.67**
Item 8: The care I get takes into account knowledge of my family.	4	3	2	2	N/A	3	**2.80**
Item 9: The care I get in this practice is informed by knowledge of my community.	3	3	3	2	3	3	**2.83**
Item 10: Over time, my practice helps me to stay healthy.	2	1	3	2	2	1	**1.83**
Item 11: Over time, my practice helps me to meet my goals.	3	3	3	4	3	3	**3.17**

*For each MIPS eligible clinician, group, subgroup, virtual group, and APM Entity, a minimum of 30 PCPCM PRO instruments per clinician are needed for submission of this measure. All valid survey results (as defined in the specification) should be included in the aggregate score. For MIPS eligible groups, subgroups, virtual groups, and APM entities with 5 or more clinicians, a minimum of 150 PCPCM PRO instruments per TIN for each site/location associated with the clinicians part of the group, subgroups, virtual groups, and APM entities are needed for submission of this measure. If the MIPS eligible group, subgroup, virtual group, and APM entity with 5 or more clinicians encompasses multiple sites/locations, each site/location would need to meet the PCPCM PRO instruments requirements as stated.

Step 3: Calculate the PCPCM PRO total score

	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10	Item 11	Total Mean Score
PCPCM PRO Instruments Mean Score	2.17	2.60	3.33	4.00	1.33	1.67	1.67	2.80	2.83	1.83	3.17	27.40

PCPCM PRO Total Score (27.40)/11= 2.49

Step 4: Converting PCPCM PRO total scores to PCPCM PRO-PM performance score

PCPCM PRO-PM Performance Score = (2.49/4)x100 = 62.27%

See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Procedure

2024 Clinical Quality Measure Flow Narrative for Quality ID #483 (CBE 3568): Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

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

1. Start with Denominator
2. Check *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month*:
    a. If *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *All patients attributed to a clinician or practice during the performance reporting period who had a documented interaction within the 12 months prior to the patient's birth month* equals Yes, proceed to *PCPCM PRO instrument sent to patients in their birth month.*
3. Check *PCPCM PRO instrument sent to patients in their birth month.*
    a. If *PCPCM PRO instrument sent to patients in their birth month* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *PCPCM PRO instrument sent to patients in their birth month* equals Yes, proceed to *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group*.
4. Check *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group*.
    a. If *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *8 of 11 questions completed for a minimum of 30 patients per practice or 150 patients for a group* equals Yes, include in *Eligible Population/Denominator*.
5. Denominator Population:
    - Denominator Population is all Eligible Patients in the Denominator.
6. Start Numerator
7. Check *The calculated PCPCM performance score.*

PCPCM PRO-PM Sample Calculation:

Step One: Exclude incomplete patient responses. Any PCPCM PRO instrument for which a patient failed to answer at least 8 of the 11 items is excluded from calculations.

Step Two: Calculate PCPCM PRO item specific mean scores. Patients choose one of four response options for each item in the PCPCM PRO instrument. In scoring the PCPCM PRO, the first step requires determining an item mean score for each of the 11 items. Since the instrument scale is word based – Definitely, Mostly, Somewhat, Not At All – each response option must be assigned a value. Values are assigned as follows: Definitely = 4, Mostly = 3, Somewhat = 2, Not At All = 1.

Calculating the mean score for each item then requires looking across all PCPCM PRO instruments received for the entity being assessed during the analysis period. For example, if the entity is a clinician, then all completed (see Step One) PCPCM PRO instruments collected for that clinician are included in the calculation. If the entity is a practice, then all PCPCM PRO instruments collected for that practice are included in the analysis

An entity's score for each PCPCM PRO item is calculated as a mean, i.e., the summary of all responses across PCPCM PRO instruments received for the entity, divided by the number of instruments received. This process leads to 11 item specific PCPCM PRO scores. Means should be reported to two decimal points.

Step Three: Calculate the PCPCM PRO total score. The PCPCM PRO total score for the entity is calculated by determining the mean of the 11 scored PRO items. This is done by adding the mean scores of all 11 PRO items and then dividing by 11. PRO means should be reported to two decimal points.

Step Four: Converting PCPCM PRO total scores to PCPCM PRO-PM performance score. In order to use the PCPCM PRO as a performance measure for reporting, the 4 point PCPCM PRO scale must be converted to a 0-100 performance scale. To do this, the PCPCM PRO total score for an entity, as calculated in Step Three, is divided by 4 and then multiplied by 100.

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

NOTE: Submission Frequency: Procedure

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.

Postpartum Depression Screening and Follow-Up (PDS-E)*

***Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit https://www.chcf.org/ to learn more. Also supported by the Zoma Foundation.**

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*.
- Added data elements tables for race and ethnicity stratification reporting.

Description	The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period. • *Follow-Up on Positive Screen.* The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation) The American College of Obstetricians and Gynecologists (ACOG) recommends multiple postpartum visits no later than 12 weeks after birth that include a full assessment of psychological well-being, including screening for postpartum depression and anxiety with a validated instrument. The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's 1-, 2-, 4- and 6-month visits. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	American Academy of Pediatrics. Earls, M.F. 2010. "Committee on Psychosocial Aspects of Child and Family Health. Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice." *Pediatrics* 126(5):1032–9.

	American College of Obstetricians and Gynecologists. 2018. "Screening for Perinatal Depression. ACOG Committee Opinion No. 757." *Obstetrics & Gynecology* 132(5):e208-12. U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Depression Screening. – Product line: ▪ Commercial. ▪ Medicaid. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Follow-Up on Positive Screen. – Product line: ▪ Commercial. ▪ Medicaid. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White.

	▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** • The denominator for this measure is based on deliveries, not on members. • Initial population: – Include deliveries that occur in any setting. – Determine the delivery date using the date as of the end of the delivery procedure. – 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:*** *Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and participation before removing multiple deliveries in a 180-day period.* • This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. • Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated. **Allocation:** The member was enrolled with a medical benefit on the delivery date through 60 days following the delivery date, with no gaps in enrollment. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population. The race and ethnicity stratifications are reported by data source—direct, indirect or unknown. Race and ethnicity values of "Asked But No Answer" are only reported for Source="Direct." Race and ethnicity values of "Unknown" are

only reported for Source="Unknown" and Source="Unknown" is only reported for race and ethnicity values of "Unknown."

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.

The race and ethnicity stratifications data source logic is 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

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.

Participation period

The delivery date through 60 days following the date of delivery.

Depression Screening Instrument

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®1	55758-7	Total score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

<table>
<tr><td></td><td>
<table>
<tr><th>Instruments for Adults (18+ years)</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td><td>Total score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td><td>Total score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]</td><td>89208-3</td><td>Total score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>89209-1</td><td>Total score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td><td>Total score ≥17</td></tr>
<tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>90853-3</td><td>Total score ≥30</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>71354-5</td><td>Total score ≥10</td></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>71777-7</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>71965-8</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>90221-3</td><td>Total score ≥31</td></tr>
</table>
[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.
</td></tr>
<tr><td>Initial population</td><td>Initial population 1
Deliveries (Deliveries Value Set) during September 8 of the year prior to the measurement period through September 7 of the measurement period when the member also meets the criteria for participation.

Initial population 2
Same as the initial population 1.</td></tr>
<tr><td>Exclusions</td><td>• Exclude all episodes for 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.</td></tr>
<tr><td>Denominator</td><td>Denominator 1
The initial population, minus exclusions.

Denominator 2
All deliveries from numerator 1 with a positive finding for depression during the 7–84 days following the date of delivery.</td></tr>
</table>

Numerator	**Numerator 1—Depression Screening** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7–84 days following the delivery date. **Numerator 2—Follow-Up on Positive Screen** Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set; ICD-10-CM code Z71.82). • A dispensed antidepressant medication (Antidepressant Medications List). ***OR*** Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*
Data criteria (element level)	
Value Sets: • **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) • **NCQA_Perinatal-2.0.0** – Deliveries (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1072) • **NCQA_Screening-2.0.0** – Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503) – Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)	

  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)
  - Symptoms of Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2392)
- **NCQA_Stratification-2.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **NCQA_Screening-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'
- **NCQA_Terminology-3.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
  - code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
  - code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
  - code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
  - code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
  - code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'
  - code "Other": 'OTH' from "NullFlavor" display 'Other'
  - code "retiree health program": 'RETIRE' from "ActCode"

  - code "subsidized health program": 'SUBSIDIZ' from "ActCode"
  - code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
  - code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'
- **PDSE_HEDIS_MY2024-3.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
  - code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
  - code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
  - code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
  - code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
  - code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

Data Elements for Reporting

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

Table PDS-E-A-1/2: Data Elements for Postpartum Depression Screening and Follow-Up

Metric	Data Element	Reporting Instructions
Screening	InitialPopulationByEHR	Repeat per Metric
FollowUp	InitialPopulationByCaseManagement	Repeat per Metric
	InitialPopulationByHIERegistry	Repeat per Metric
	InitialPopulationByAdmin	Repeat per Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table PDS-E-B-1/2: Data Elements for Postpartum Depression Screening and Follow-Up: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
Screening	AmericanIndianOrAlaskaNative	Direct	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	Asian	Indirect	Exclusions	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 PDS-E-C-1/2: Data Elements for Postpartum Depression Screening and Follow-Up: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Screening	HispanicOrLatino	Direct	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	NotHispanicOrLatino	Indirect	Exclusions	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)

*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 Postpartum Depression Screening and Follow-Up

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 age criteria for this measure.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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 events or diagnoses that contain (or map to) codes in the VSDs may be used to identify visits with a diagnosis. The VSDs and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusion: 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**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, direct reference codes and logic may not be changed.

*Prenatal Depression Screening and Follow-Up (PND-E)**

***Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit https://www.chcf.org/ to learn more. Also supported by the Zoma Foundation.**

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- Revised the exclusion criteria in the *Rules for Allowable Adjustments of HEDIS.*
- Added a *Denominator* section to the *Rules for Allowable Adjustments of HEDIS*.
- Added data elements tables for race and ethnicity stratification reporting.

Description	The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. • *Depression Screening.* The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.
Measurement period	January 1–December 31.
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation) The American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during pregnancy or the postpartum period for depression and anxiety symptoms using a standardized, validated tool. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)
Citations	American College of Obstetricians and Gynecologists. 2018. “Screening for Perinatal Depression. ACOG Committee Opinion No. 757.” *Obstetrics & Gynecology* 132(5):e208–12. U.S. Preventive Services Task Force. 2016. “Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement.” *Annals of Internal Medicine* 164:360–6.

	U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.
Characteristics	
Scoring	Proportion.
Type	Process.
Stratification	• Depression Screening. – Product line: ▪ Commercial. ▪ Medicaid. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown. – Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown. • Follow-Up on Positive Screen. – Product line: ▪ Commercial. ▪ Medicaid. – Race (for each product line): ▪ Race—American Indian or Alaska Native. ▪ Race—Asian. ▪ Race—Black or African American. ▪ Race—Native Hawaiian or Other Pacific Islander. ▪ Race—White. ▪ Race—Some Other Race. ▪ Race—Two or More Races. ▪ Race—Asked But No Answer. ▪ Race—Unknown.

	– Ethnicity (for each product line): ▪ Ethnicity—Hispanic or Latino. ▪ Ethnicity—Not Hispanic or Latino. ▪ Ethnicity—Asked But No Answer. ▪ Ethnicity—Unknown.
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**General Rules:** • The denominator for this measure is based on deliveries, not on members. • Initial population: – Include deliveries that occur in any setting. – Determine the delivery date using the date as of the end of the delivery procedure. – 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:*** *Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and participation before removing multiple deliveries in a 180-day period.* • This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument. • Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated. **Allocation:** The member was enrolled with a medical benefit 28 days prior to the delivery date through the delivery date, with no gaps in enrollment. **Reporting:** For all plans, the race and ethnicity stratifications are mutually exclusive, and the sum of all categories in each stratification is the total population. The race and ethnicity stratifications are reported by data source—direct, indirect or unknown. Race and ethnicity values of "Asked But No Answer" are only reported for Source="Direct." Race and ethnicity values of "Unknown" are only reported for Source="Unknown" and Source="Unknown" is only reported for race and ethnicity values of "Unknown."

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.

The race and ethnicity stratifications data source logic is 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

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.

Participation period

28 days prior to the delivery date through the delivery date.

Pregnancy start date

Pregnancy start date is calculated by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the delivery date.

Depression screening instrument

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (≤17 years)	Total Score LOINC Codes	Positive Finding
Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
Patient Health Questionnaire Modified for Teens (PHQ- 9M)®	89204-2	Total score ≥10
Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
Beck Depression Inventory—Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	71354-5	Total score ≥10
PROMIS Depression	71965-8	Total score (T Score) ≥60

[1]Brief screening instrument. All other instruments are full-length.
[2]Proprietary; may be cost or licensing requirement associated with use.

	<table><tr><th>Instruments for Adults (18+ years)</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr><tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td><td>Total score ≥10</td></tr><tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td><td>Total score ≥3</td></tr><tr><td>Beck Depression Inventory—Fast Screen (BDI-FS)®[1,2]</td><td>89208-3</td><td>Total score ≥8</td></tr><tr><td>Beck Depression Inventory (BDI-II)</td><td>89209-1</td><td>Total score ≥20</td></tr><tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td><td>Total score ≥17</td></tr><tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>90853-3</td><td>Total score ≥30</td></tr><tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>71354-5</td><td>Total score ≥10</td></tr><tr><td>My Mood Monitor (M-3)®</td><td>71777-7</td><td>Total score ≥5</td></tr><tr><td>PROMIS Depression</td><td>71965-8</td><td>Total score (T Score) ≥60</td></tr><tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>90221-3</td><td>Total score ≥31</td></tr></table> [1]Brief screening instrument. All other instruments are full-length. [2]Proprietary; may be cost or licensing requirement associated with use.
Initial population	**Initial population 1** Deliveries (Deliveries Value Set) during the measurement period that meet the following criteria: • Meet requirements for participation. • Have a gestational age assessment (SNOMED CT code 412726003; value is not null) or gestational age diagnosis within 1 day of the delivery date. A code from any of the following value sets meets criteria for gestational age diagnosis: – Weeks of Gestation Less Than 37 Value Set. – 37 Weeks Gestation Value Set. – 38 Weeks Gestation Value Set. – 39 Weeks Gestation Value Set. – 40 Weeks Gestation Value Set. – 41 Weeks Gestation Value Set. – 42 Weeks Gestation Value Set. – 43 weeks gestation (ICD-10-CM code Z3A.49).

	Initial population 2 Same as the initial population 1.
Exclusions	**Exclusions 1** • Deliveries that occurred at less than 37 weeks gestation. Length of gestation in weeks is identified by one of two methods: – Gestational age assessment (SNOMED CT code 412726003; value <37 weeks), ***or*** – Gestational age diagnosis (Weeks of Gestation Less Than 37 Value Set). • Exclude all episodes for 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.
Denominator	**Denominator 1** The initial population, minus exclusions. **Denominator 2** All deliveries from numerator 1 with a positive finding for depression during pregnancy.
Numerator	**Numerator 1—Depression Screening** Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy (on or between pregnancy start date and the delivery date). • *Deliveries between January 1 and December 1 of the measurement period:* Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date). • *Deliveries between December 2 and December 31 of the measurement period:* Screening should be performed between the pregnancy start date and December 1 of the measurement period. **Numerator 2—Follow-Up on Positive Screen** Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: • An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set).

	• A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set; ICD-10-CM code Z71.82). • A dispensed antidepressant medication (Antidepressant Medications List). ***OR*** Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*

Data criteria (element level)

Value Sets:

- **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)
- **NCQA_Perinatal-2.0.0**
  - 37 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1509)
  - 38 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1510)
  - 39 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1511)
  - 40 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1512)
  - 41 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1513)
  - 42 Weeks Gestation (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1514)
  - Deliveries (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1072)
  - Weeks of Gestation Less Than 37 (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1479)
- **NCQA_Screening-2.0.0**
  - Antidepressant Medications (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1503)
  - Behavioral Health Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1383)
  - Depression Case Management Encounter (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1389)
  - Depression or Other Behavioral Health Condition (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1501)
  - Follow Up Visit (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.1385)

  - Symptoms of Depression (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2392)
- **NCQA_Stratification-2.0.0**
  - American Indian or Alaska Native Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2365)
  - Asian Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2366)
  - Black or African American Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2367)
  - Hispanic or Latino Detailed Ethnicity (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2368)
  - Native Hawaiian or Other Pacific Islander Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2369)
  - White Detailed Race (https://www.ncqa.org/fhir/valueset/2.16.840.1.113883.3.464.1004.2370)

Direct reference codes and codesystems:

- **NCQA_Perinatal-2.0.0**
  - codesystem "ICD10CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - codesystem "SNOMEDCT": 'http://snomed.info/sct/731000124108'
  - code "[Z3A.49] Greater than 42 weeks gestation of pregnancy": 'Z3A.49' from "ICD10CM" display '[Z3A.49] Greater than 42 weeks gestation of pregnancy'
  - code "Length of gestation at birth (observable entity)": '412726003' from "SNOMEDCT" display 'Length of gestation at birth (observable entity)'
- **NCQA_Screening-2.0.0**
  - codesystem "ICD-10-CM": 'http://hl7.org/fhir/sid/icd-10-cm'
  - code "Exercise counseling": 'Z71.82' from "ICD-10-CM" display 'Exercise counseling'
- **NCQA_Terminology-3.0.0**
  - codesystem "ActCode": 'http://terminology.hl7.org/CodeSystem/v3-ActCode'
  - codesystem "ConditionClinicalStatusCodes": 'http://terminology.hl7.org/CodeSystem/condition-clinical'
  - codesystem "NullFlavor": 'http://terminology.hl7.org/CodeSystem/v3-NullFlavor'
  - codesystem "RaceAndEthnicityCDC": 'https://www.hl7.org/fhir/us/core/CodeSystem-cdcrec'
  - code "active": 'active' from "ConditionClinicalStatusCodes"
  - code "American Indian or Alaska Native": '1002-5' from "RaceAndEthnicityCDC" display 'American Indian or Alaska Native'
  - code "Asian": '2028-9' from "RaceAndEthnicityCDC" display 'Asian'
  - code "Asked but no answer": 'ASKU' from "NullFlavor" display 'Asked but no answer'
  - code "Black or African American": '2054-5' from "RaceAndEthnicityCDC" display 'Black or African American'
  - code "Hispanic or Latino": '2135-2' from "RaceAndEthnicityCDC" display 'Hispanic or Latino'
  - code "managed care policy": 'MCPOL' from "ActCode"
  - code "Native Hawaiian or Other Pacific Islander": '2076-8' from "RaceAndEthnicityCDC" display 'Native Hawaiian or Other Pacific Islander'
  - code "Non Hispanic or Latino": '2186-5' from "RaceAndEthnicityCDC" display 'Non Hispanic or Latino'

- code "Other": 'OTH' from "NullFlavor" display 'Other'
- code "retiree health program": 'RETIRE' from "ActCode"
- code "subsidized health program": 'SUBSIDIZ' from "ActCode"
- code "Unknown": 'UNK' from "NullFlavor" display 'Unknown'
- code "White": '2106-3' from "RaceAndEthnicityCDC" display 'White'

- **PNDE_HEDIS_MY2024-3.0.0**
  - codesystem "LOINC": 'http://loinc.org'
  - code "Beck Depression Inventory Fast Screen total score [BDI]": '89208-3' from "LOINC" display 'Beck Depression Inventory Fast Screen total score [BDI]'
  - code "Beck Depression Inventory II total score [BDI]": '89209-1' from "LOINC" display 'Beck Depression Inventory II total score [BDI]'
  - code "Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]": '89205-9' from "LOINC" display 'Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]'
  - code "Edinburgh Postnatal Depression Scale [EPDS]": '71354-5' from "LOINC" display 'Edinburgh Postnatal Depression Scale [EPDS]'
  - code "Final score [DUKE-AD]": '90853-3' from "LOINC" display 'Final score [DUKE-AD]'
  - code "Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]": '55758-7' from "LOINC" display 'Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]'
  - code "Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]": '44261-6' from "LOINC" display 'Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]'
  - code "Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]": '89204-2' from "LOINC" display 'Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]'
  - code "PROMIS-29 Depression score T-score": '71965-8' from "LOINC" display 'PROMIS-29 Depression score T-score'
  - code "Total score [CUDOS]": '90221-3' from "LOINC" display 'Total score [CUDOS]'
  - code "Total score [M3]": '71777-7' from "LOINC" display 'Total score [M3]'

Data Elements for Reporting

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

Table PND-E-A-1/2: Data Elements for Prenatal Depression Screening and Follow-Up

Metric	Data Element	Reporting Instructions
Screening	InitialPopulationByEHR	Repeat per Metric
FollowUp	InitialPopulationByCaseManagement	Repeat per Metric
	InitialPopulationByHIERegistry	Repeat per Metric
	InitialPopulationByAdmin	Repeat per Metric
	InitialPopulation	(Sum over SSoRs)
	ExclusionsByEHR	Repeat per Metric
	ExclusionsByCaseManagement	Repeat per Metric
	ExclusionsByHIERegistry	Repeat per Metric
	ExclusionsByAdmin	Repeat per Metric
	Exclusions	(Sum over SSoRs)
	Denominator	For each Metric
	NumeratorByEHR	For each Metric
	NumeratorByCaseManagement	For each Metric
	NumeratorByHIERegistry	For each Metric
	NumeratorByAdmin	For each Metric
	Numerator	(Sum over SSoRs)
	Rate	(Percent)

Table PND-E-B-1/2: Data Elements for Prenatal Depression Screening and Follow-Up: Stratifications by Race

Metric	Race	Source	Data Element	Reporting Instructions
Screening	AmericanIndianOrAlaskaNative	Direct	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	Asian	Indirect	Exclusions	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 PND-E-C-1/2: Data Elements for Prenatal Depression Screening and Follow-Up: Stratifications by Ethnicity

Metric	Ethnicity	Source	Data Element	Reporting Instructions
Screening	HispanicOrLatino	Direct	InitialPopulation	For each Stratification, repeat per Metric
FollowUp	NotHispanicOrLatino	Indirect	Exclusions	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)

*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 Depression Screening and Follow-Up

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 age criteria for this measure.
Allocation	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Using a benefit is not required; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on 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	Value sets, direct reference codes and logic may not be changed.
Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	Yes, with limits	Apply exclusions according to specified value sets. Organizations may choose to not exclude deliveries that occurred at less than 37 weeks gestation.
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**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, direct reference codes and logic may not be changed.

Psoriasis - Improvement in Patient-Reported Itch Severity

CMIT Measure ID: 1661 **| CMIT ID:** 01661-02-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 03/26/2024 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

The percentage of patients aged 8 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 3 or more points at a follow up visit.

Properties

Date of Information

03/26/2024

Abbreviated Measure Title

Not Available

Description

The percentage of patients aged 8 years and older, with a diagnosis of psoriasis where at an initial (index) visit have a patient reported itch severity assessment performed, score greater than or equal to 4, and who achieve a score reduction of 3 or more points at a follow up visit.

Numerator

Patients who achieve an assessment score that is reduced by 3 or more points (minimal clinically important difference) from the initial

Return to Top

(index) assessment score.

Denominator

All patients aged 8 years and older, with a diagnosis of psoriasis with an initial (index visit) Numeric Rating Scale (NRS), Visual Rating Scale (VRS), or ItchyQuant assessment score of greater than or equal to 4 who are returning for a follow-up visit.

Denominator Exclusions

None

Rationale

Psoriasis is a chronic inflammatory disease in which pruritus is a frequent symptom. Approximately 7.4 million people in the United States have psoriasis. Direct costs of the disease are estimated between $51.7 and $63.2 billion, with the total economic burden estimated to be between $112 and $135 billion. Chronic inflammatory skin diseases, such as psoriasis, are pruritic and tremendously burdensome; with more than 70% of psoriasis patients suffering from itch. Itch has profound effects on patients, especially in geriatric populations, where there is increased incidence of pruritus. For those over 65 years old, itch is the most common skin complaint. The number of patients with pruritus is expected to increase as the elderly population grows - becoming 25% of the US population by 2025. Pruritus is a frequent and onerous symptom of psoriasis and, on its own, has significant effects on patients' quality of life. In a study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality-of-life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from chronic pruritus (CP) patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus.

Evidence

Psoriasis is a chronic inflammatory disease in which pruritus is a frequent symptom. Approximately 7.4 million people in the United States have psoriasis. Direct costs of the disease are estimated between $51.7 and $63.2 billion, with the total economic burden estimated to be between $112 and $135 billion. Chronic inflammatory skin diseases, such as psoriasis, are pruritic and tremendously burdensome; with more than 70% of psoriasis patients suffering from itch. Itch has profound effects on patients, especially in geriatric populations, where there is increased incidence of pruritus. For those over 65 years old, itch is the most common skin complaint. The number of patients with pruritus is expected to increase as the elderly population grows - becoming 25% of the US population by 2025. Pruritus is a frequent and onerous symptom of psoriasis and, on its own, has significant effects on patients' quality of life. In a study, investigators quantified pruritic burden in a cross-sectional analysis investigating chronic pruritus and pain. They demonstrated that the quality of life impact was due to the severity of the symptom, rather than whether the symptom was pain or pruritus. Moreover, they elucidated a mean health utility score of 0.87 from chronic pruritus (CP) patients, meaning that on average, a patient would give up 13% of their life expectancy to live without pruritus. An additional study showed the effects of CP on a population-based level. Researchers found that the point prevalence of pruritus was 13.5%. When looking at 12-months the prevalence rose to 16.4% and rose again to 22% when looking at lifetime prevalence. When studied again in 2013, the lifetime prevalence rose to 25.5%. Moreover, data from the National Ambulatory Medical Care Survey (1999-2009) found that a total of 77 million patient visits for itch were made during the 11-year time period. This was an average of 7 million visits per year, which represented approximately 1% of all outpatient visits. Also, further analysis showed that although the majority of visits (58.6%) were for new instances of itch, almost a third (32%) were for chronic pruritus. Pruritus is a subjective and multifaceted symptom that manifests in patients in various ways that affect quality-of-life by contributing to the development of depression, global distress, and sleep impairment. Additionally, studies of CP have shown patients to have a 17% higher mortality risk as well as being strongly associated with poorer general health. This measure aims to improve pruritus in patients who carry a large burden with this disease; by assessing itch and aiming to make the symptom more manageable. Furthermore, the use of itch will be a measure of overall disease improvement/response.

Denominator Exceptions

None

Numerator Exceptions

Not Available

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

Centers for Medicare & Medicaid Services **Measures Inventory Tool**

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Shared Decision Making Process Survey
NQF Measure 2962
User Guide

I. Purpose:

To measure the extent to which patients are involved in the decision-making process.

II. Versions:

Shared Decision Making Process_4: 4 item version of the shared decision making process survey. The survey is able to be adapted to specific conditions and options. As shown in the Table, Item 3 varies depending on whether there are two options or more than two options.

III. Timing

The SDM Process_4 survey should be administered after a consult with a health care provider where a decision was discussed. The items were written assuming that the choice is known (e.g. that the patient is having or had surgery, taking medication, having the screening test, etc).

Modifications may be required if it is to be used before the choice is known.

IV. Scoring:

Each response is scored 0 or 1 according to the labels in the Table. Participants receive 1 point for a response of "yes" or "a lot" or "some." The total points are summed and result in total scores from 0 -4, with higher scores indicating more shared decision making. Surveys with one or more missing items do not get a total score.

Table: Shared Decision Making Process_4 survey

Instructions	**TALKING WITH YOUR HEALTH CARE PROVIDERS** Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].
Items	1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]? ☐$_1$ A lot ☐$_1$ Some ☐$_0$ A little ☐$_0$ Not at all

	2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]? ☐1 A lot ☐1 Some ☐0 A little ☐0 Not at all 3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider? [Version for situations with more than two options: Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?] ☐1 Yes ☐0 No 4. Did any of your health care providers ask if you wanted to have [test/intervention]? ☐1 Yes ☐0 No

III. NQF PRO-PM Measure #2962 specifications:

The SDMP_4 is used as the basis for a patient-reported outcome performance measure (PRO-PM). The following describes calculation for that measure.

- **Numerator Statement:** The numerator is the sum of the total scores (0-4) for all those responding.
- **Denominator Statement:** The denominator includes the number of respondents from the target population of adults who have undergone a procedure for one of the target conditions and completed the survey.
- **Denominator Exclusions:** Respondents who are missing 1 or more items do not get a total score and are excluded. No other exclusions as long as the respondent has the procedure for the designated condition.
- **Sampling**: Patients of a particular surgeon or at a particular clinical site (which could be a group of providers or a hospital or other surgical site) who had a one of the procedures are identified from medical records, claims or in some other way. Sampling should allow time for immediate recovery, while attempting to survey shortly after the procedure, for example, by sampling eligible patients 1- 6 months after the procedure. Patients can be sampled sequentially, or a pool of such patients who had the procedure in a particular time period (e.g. in the last 3 months) can be created and sampled at a rate that produces the desired number of potential respondents.

The measure can also be calculated from a population-based sample, such as a sample of a population in a geographic area. Eligible respondents could be identified from claims (such as Medicare claims files) or based on patient self- reports of having had the procedures within some time frame.

- Proxy respondents are not permitted. The patients who receive the test or intervention for the target condition should answer the survey questions.

VI. Development Process:

In 2007, a team of researchers at the University of Michigan developed several items to be used in the DECISIONS survey, the first national survey of how common medical decisions were being made in the United States [1,2]. One key goal was to develop items that would assess the extent to which shared decision making happened across 10 different medical decisions. The SDM Process Survey is based on four questions from that survey.

The survey items were derived from the shared decision making model (SDM), a conceptual framework that was first outlined by Mulley in the late 1980s [3] and extended by Mulley and Sepucha [4-5]. The model takes a systems approach to understanding and improving clinical decision making that focuses on two key participants: patients (and family) and clinicians. The model emphasizes the fundamentally social nature of the decision making task, and the fact that it cannot be completed by the clinicians or patients alone, but rather requires interactions between them. The guiding principles behind the items included: 1) patients should have adequate knowledge and experience to answer; 2) minimize need for judgment or evaluation; 3) cover the key elements necessary for a shared decision process; 4) be short and easy to adapt to a variety of settings. Although the items do not cover all possible SDM behaviors, these four elements (discussion of options, pros, cons and preferences) are foundational components in widely accepted definitions [5-7].

VII. Psychometric Properties:

Feasibility: The survey is feasible and typically has very low missing data (1-3%). [e.g. see 8]

Acceptability: The survey is acceptable with high response rates when administered by mail, online or by phone, and takes < 2 minutes to complete.

Floor and ceiling effects: The SDMP_4 has not shown floor or ceiling effects. In a national study of 10 different medical conditions, mean scores varied widely, with lowest for mammography (mean = 1.5 out of 4), and the highest for surgery for low back pain (mean = 3.2 out of 4). [8]

Reliability:

- Internal consistency: the score is technically a composite and as a result, Cronbach's alpha may not be an appropriate measure of reliability, however we have calculated it for some samples and found Cronbach alphas of 0.77 for breast cancer surgery [9], 0.78 for hip and knee osteoarthritis [10], 0.54 for spine [11], 0. 87 for hip and knee osteoarthritis [11]
- Retest reliability: short term (~4 week) retest reliability ICC=0.64 (95% CI 0.67, 0.86) [9]
- Practice level reliability: When we drew random samples of patients from the same sites who had made decisions, the correlations of the SDMP_4 scores averaged .61 [13]

Validity

- Content validity was confirmed through the extensive feedback from patients and providers in the development process as well as in the field tests.
- Construct validity: Those who had higher SDMP scores reported
    - better decision quality, [10]
    - were less likely to think they made the wrong decision, [9] and
    - reported less dissonance (conflict between what was important to them and the decision that was made). [12]
    - clinical sites that made an effort to implement SDM (with patient decision aids and/or coaching) had higher scores than usual care sites [11, 13]

VIII. Sample size considerations

The standard deviations for the measure vary by topic and sample (ranging from 0.83-1.25). We have observed a 0.3SD-0.5SD difference between sites that do and do not make an effort to do shared decision making. A sample size of about 50-60 would be needed to detect differences in proportions of .5 SD for the measure with 80% power assuming standard deviation of about 1.

IX. Appropriate Use

The SDM Process_4 is protected by copyright. It is available to use at no cost, provided that you:

- Cite the reference in any questionnaires or publications
- Do not charge for or profit from it
- Do not alter items except for customization for a specific condition/interventions and reformatting

X. Suggested Citation for the SDM Process_4 User Guide:

Sepucha KR and Fowler FJ. Shared Decision Making Process_4 User Guide v.1.0. ©Massachusetts General Hospital, 2018.

XI. References:

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4. Sepucha K and Mulley A. Extending Decision Support: Preparation and Implementation. *Patient Education and Counseling* 2003; 50 (3):269-271.
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12. Fowler FJ, Gallagher PM, Drake KM, Sepucha K. Decision Dissonance: Evaluation of an Approach to Measuring the Quality of Surgical Decision Making. Jt Comm J Qual Patient Saf 2013 Mar;39(3):136-44.

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Shared Decision Making Process Survey: SDM Process_4

For situations with two main options insert condition (e.g. knee osteoarthritis) and chosen option (e.g. surgery) and alternative option (e.g. non surgical treatment):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

3. Did any of your health care providers talk about [an alternative to intervention, e.g. non-surgical treatments/not testing] as something that you should seriously consider?

   ☐$_1$ Yes

   ☐$_0$ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

   ☐$_1$ Yes

   ☐$_0$ No

For situations with **more than** two main options insert condition (e.g. prostate cancer) and chosen option (e.g. surgery):

TALKING WITH YOUR HEALTH CARE PROVIDERS

Please answer these questions about what happened when you talked with health care providers including doctors, nurses and other health care professionals about [tests or treatments] for your [condition].

1. How much did you and your health care providers talk about the reasons you might want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

2. How much did you and your health care providers talk about the reasons you might **not** want to have [test/intervention]?

   ☐$_1$ A lot

   ☐$_1$ Some

   ☐$_0$ A little

   ☐$_0$ Not at all

3. Did any of your health care providers explain that there were choices in what you could do to treat your [condition]?

   ☐$_1$ Yes

   ☐$_0$ No

4. Did any of your health care providers ask if you wanted to have [test/intervention]?

   ☐$_1$ Yes

   ☐$_0$ No

Statin Therapy for Patients With Cardiovascular Disease (SPC)

SUMMARY OF CHANGES TO HEDIS MY 2024

- Added a laboratory claim exclusion to value sets for which laboratory claims should not be used.
- Revised the method for identifying advanced illness.
- Moved previously listed *Exclusions* to *Required exclusions.*
- Revised the "Denominator Exclusions" criteria in the Clinical Components table under *Rules for Allowable Adjustments of HEDIS*.

Description

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

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

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any statin medication of at least moderate 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 the 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 in the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same day or on different days, 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 medication 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 line

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

Age

Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

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 (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date

December 31 of the measurement year.

Benefit

Medical. Pharmacy during the measurement year.

Event/diagnosis

Members are identified for the eligible population in two ways: by event or by diagnosis. 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.

Event. Any of the following during the year prior to the measurement year meet criteria:

- *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 procedures (Other Revascularization Value Set) in any setting.

Diagnosis. Identify 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.

Required exclusions

Exclude members who meet any of the following criteria:

- Members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the 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 the 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) anytime 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 or moderate-intensity statin medication (High and Moderate Intensity Statin Medications List) during the measurement year.

High- and Moderate-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
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

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

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

Age Report two age/gender stratifications and a total rate:

- Males 21–75 years as of December 31 of the measurement year.
- Females 40–75 years as of December 31 of the measurement year.
- Total.

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 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 or moderate-intensity statin medication during the measurement year. Use all the medications 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 or moderate-intensity statin medication during the treatment period. To ensure that days supply that extends beyond the measurement year is not counted, subtract any days supply that extends beyond December 31 of the measurement year.

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

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

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 SPC-1/2/3: Data Elements for Statin Therapy for Patients With Cardiovascular Disease

Metric	Gender	Data Element	Reporting Instructions
ReceivedTherapy	F	Benefit	Metadata
Adherence	M	EligiblePopulation	For each Metric and Stratification
	Total	ExclusionAdminRequired	Only for ReceivedTherapy Metric
		NumeratorByAdmin	For each Metric and Stratification
		NumeratorBySupplemental	For each Metric and Stratification
		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 Cardiovascular Disease

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product lines	Yes	Using product line criteria is not required. Including any product line, combining product lines, or not including product line criteria is allowed.
Ages	Yes, with limits	Age determination dates may be changed (e.g., select, "age as of June 30"). The denominator age may be changed if the range is within the specified age range (ages 21–75 or 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 enrollment criteria; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on an area of interest defined by gender, race, ethnicity, socioeconomic or sociodemographic characteristics, geographic region or another characteristic.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/diagnosis	No	Only events that contain (or map to) codes in the value sets may be used to identify discharges. 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 and medication lists. 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.

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.

Urinary Symptoms Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

CMIT Measure ID: 741 | **CMIT ID:** 00741-01-E-MIPS | **Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 12/06/2022 | **Revision:** 6 | **Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.

Properties

Date of Information

12/06/2022

Abbreviated Measure Title

Not Available

Description

Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.

Return to Top

Numerator

Patients with a documented improvement of at least 3 points in their urinary symptom score during the measurement period

Denominator

Male patients with an initial diagnosis of benign prostatic hyperplasia 6 months prior to, or during the measurement period, and a urinary symptom score assessment within 1 month of initial diagnosis and a follow-up urinary symptom score assessment within 6-12 months, who had a qualifying visit during the measurement period.

Denominator Exclusions

Patients with urinary retention that starts within 1 year of initial BPH diagnosis. Patients with an initial BPH diagnosis that starts during, or within 30 days of hospitalization. Patients with a diagnosis of morbid obesity, or with a BMI Exam => 40 before the follow up urinary symptom score.

Rationale

Benign prostatic hyperplasia (BPH) is one of the most common conditions affecting older men, with a prevalence of 50% by age 60 years and 90% by the ninth decade of life (Medina, Parra, & Moore, 1999).The enlarged gland had been proposed to contribute to the overall lower urinary tract symptoms (LUTS) complex (McVary et al., 2014). Although LUTS secondary to BPH is not often a life-threatening condition, the impact of LUTS/BPH on quality of life can be significant (Wei, Calhoun, & Jacobsen, 2005). The American Urological Association Symptom Index (AUA-SI) and the International Prostate Symptom Score (IPSS) were developed to measure outcomes in studies of different treatments for BPH (Wuerstle et al., 2011). The IPSS uses the same questions as the AUA-SI, but also adds a disease-specific quality of life question (OLeary, 2005). The IPSS was adopted in 1993 by the World Health Organization. It is a reproducible, validated index designed to determine disease severity and response to therapy (D Silva, Dahm, & Wong, 2014). It includes 3 storage symptom questions (frequency, nocturia, urgency) and four voiding symptoms (feeling of incomplete emptying, intermittency, straining, and a weak stream) as well as a B question: If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that A three-point improvement in the score is considered meaningful (McVary et al., 2014).

Evidence

Not Available

Denominator Exceptions

Not applicable

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

CMS Measures Management System (MMS) Hub

CMS Meaningful Measures

CMS Pre-Rulemaking

CMS Quality Measures

NQF Quality Position System

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Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

CMIT Measure ID: 752 **| CMIT ID:** 00752-01-C-MIPS **| Measure Type:** Patient-Reported Outcome-Based Performance Measure (PRO-PM)

Date of Information: 05/10/2019 **| Revision:** 1 **| Program:** Merit-Based Incentive Payment System Program

View Description

Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.

Properties

Date of Information

05/10/2019

Abbreviated Measure Title

Not Available

Description

Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.

Numerator

Return to Top

Patients whose outcome survey score improved when assessed 3-6 months following treatment

Denominator

All patients who are treated for varicose veins with saphenous ablation and who receive an outcomes survey before and 3-6 months after treatment

Denominator Exclusions

Not available

Rationale

Surrogate measures to measure the success of varicose vein treatment with saphenous ablation have numerous flaws. The ultimate measure of success of saphenous ablation for varicose veins is an improved quality of life. This quality measure motivates physicians to assess changes in quality of life after as compared with before an ablation using one of several standardized survey instruments. This enables objective quantification of the improvement in quality of life that saphenous vein ablation provides patients with CEAP C2 disease.

Evidence

Not Available

Denominator Exceptions

Patient survey results not available

Numerator Exceptions

Not applicable

Risk Adjusted

No

Program Name Abbreviation

MIPS

Program Status

Active

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